CHAPTER 6

NURSING HOME CARE

6.1 This chapter is set against the background of the institutional, financial and administrative arrangements that apply in relation to the provision of nursing home care. Some of these arrangements are deficient in terms of the efficient delivery of nursing home services, whilst others give rise to undesirable effects on the quality and standard of patient care.

6.2 The States have primary responsibility for the provision of health care and therefore the standards of care and accommodation in nursing homes. The Commonwealth, because of its heavy involvement in the provision of nursing home benefits, is anxious to ensure that adequate minimum standards are met and so participates in a program of inspections with the States. Some upper limits may also be necessary to ensure that nursing homes do not admit patients who need a level of care more properly provided in a hospital. The Commonwealth has also attempted to reduce the differences in standards between the States.[1]

6.3 According to the Commonwealth Department of Health the major problems that exist within the present nursing home benefit arrangements are:

- Fees are not based on any analysis of nursing home cost structure but are based on the fees income that happened to apply at 30 June 1972. Accidents of the then market place have been perpetuated and any anomalies and inconsistencies existing then have been carried through to the present time;
- Profits of nursing homes have been theoretically frozen at 1972 dollar amounts as only costs necessarily incurred have been taken into account in determining fee increases since then;
- There is little incentive for proprietors to limit operating costs as costs necessarily incurred are returned in fee increases;
- Claims have been made that some proprietors have attempted to increase profits by reducing standards and quality of care by, for example, not replacing staff who are absent for short periods and skimping on repairs and maintenance;
- Nursing homes increase their fees on average three times each year. The nursing home benefit is increased once each year. As fees increase throughout the benefit year, the level of protection afforded to patients is gradually eroded, leading to many patients having to seek additional funds from savings or relatives in order to meet fees;
- The inadequate documentation of all fees control policies and guidelines which identify the need for local discretion where appropriate;
- The absence of adequate guidelines for inspection of nursing homes including standards and fees claims validation.[2]

Machinery for Setting Benefits and Fees

6.4 The level of Nursing Home Benefit is based on fees charged in non-government participating nursing homes. Benefits are reviewed annually so that the fees for 70 percent of nursing home beds in each State are covered by the benefit plus the statutory minimum patient contribution, at the time of the review. If government and deficit financed

nursing homes are included, more than 85 percent of nursing home patients would have to pay no more than the statutory patient contribution at the time of the review. Evidence was given that the Victorian government meets the gap between the standard fee and fees charged for patients in private nursing homes who are in necessitous circumstances and following careful assessment. The cost of this gap coverage is approaching $1m. annually.[3]

6.5 The Commonwealth sets the level of Nursing Home Benefit to be effective from the first pension pay period in November. In setting the level the Commonwealth takes into account estimated increases in costs in the ensuing twelve months. However, the fees can be raised by private nursing home proprietors during the year to take account of actual increased costs, with approval by the Department of Health. In setting fee levels, the Department of Health is required to maintain levels of profitability at the levels prevailing in 1972. In determining profitability, costs necessarily incurred in providing nursing care are taken into account.

6.6 Despite complaints from proprietors about the profitability of nursing homes being set at 1972 levels, new applications are received constantly to open private nursing homes and there is a flourishing market. The evidence thus points to private nursing homes being a sufficiently profitable business. The Committee therefore questions the effectiveness of freezing profits at 1972 levels. Had the policy been effective fewer proprietors would have been willing to enter the field.

6.7 Evidence has been presented that fee increases between benefit adjustments cause hardship for some patients. The Committee understands that a new mechansim for approving fees and determining benefits is being considered by the Commonwealth and is the subject of discussions between it and representatives of nursing home owners.

6.8 A feature of the nursing home benefit scheme is the wide variation between costs of providing care between States and the large increases in the rates of benefit in recent years. This is reflected in table 6.1.

Table 6.1: Commonwealth nursing home benefits ($ p. day)

	Ordinary Care			*Extensive Care*		
	Nov. 1980	*Nov. 1981*	*Nov. 1982*	*Nov. 1980*	*Nov. 1981*	*Nov. 1982*
New South Wales and Australian Capital Territory	18.10	23.00	28.05	24.10	29.00	34.05
Victoria	26.13	31.65	41.90	32.13	37.65	47.90
Queensland	16.85	20.40	24.00	22.85	26.40	30.00
South Australia and Northern Territory	24.30	27.60	32.20	30.30	33.60	38.20
Western Australia	16.00	18.55	21.65	22.00	24.55	27.65
Tasmania	18.65	20.65	25.35	24.65	26.65	31.35

Source: Commonwealth Department of Health.

6.9 Under present arrangements the Commonwealth has a virtually open-ended commitment to provide benefits to whatever standards the States set in respect of their responsibilities for the licensing and supervision of standards in nursing homes. The Committee is concerned that there are different levels of care being financed by the Commonwealth in each State.

6.10 The major element in determining costs is the number of nursing hours required to meet the needs of patients. There is no consensus on nursing hours and the figure varies from State to State. Consequently, the costs of running a nursing home varies from State to State. The Commonwealth has accommodated these variations by setting different levels of Nursing Home Benefits and different levels of subsidy for deficit funded

nursing homes. These variations in the Nursing Home Benefit and levels of subsidy represent a major inequity in the provision of Commonwealth finance.

6.11 The Department of Health argued in evidence that the major inequity is the wide differences in the levels of care that are provided between and within the various States. This is indicated by nursing hours per patient established as a requirement by the States. According to Health, the indications are that some of the States with higher standards of care are attempting to increase still further the number of nursing hours required. It was argued that the benefits and subsidies that arise from the differences in standards of care and hours are only secondarily involved in the inequities.[4] This will, in turn, be reflected in higher levels of benefit and subsidy in those States.

6.12 The Department of Health provided estimated per capita per diem Commonwealth outlays for nursing home benefits and deficit finance payments on a State basis for 1981-82. They are: New South Wales, $48.85; Victoria, $51.65; Queensland, $43.50, South Australia, $57.64; Western Australia, $43.79 and Tasmania $49. There are two factors which determine those amounts: firstly, the number of nursing home beds occupied by approved patients and, secondly, the level of benefit that is applied in the State. The $51.65 in Victoria and $57.64 in South Australia indicate that the higher requirements on nursing staffing show out the inequities in Commonwealth disbursements.[5] It might be argued that, in the absence of evidence to the contrary, much of the additional costs accrue as returns to the providers of care rather than the recipients.

6.13 In 1975 a working party, established by the Hospitals and Allied Services Advisory Council (HASAC), recommended specific standards on minimum nursing hours per patient. Attempts made to obtain agreement of the States for this common formula have been unsuccessful. Only New South Wales adheres to the HASAC standard. Other States continue to use higher staffing formulae which are set out in either State industrial awards on nursing conditions or local health regulations. In its *Review of the Auditor-General's Efficiency Audit Report: Commonwealth Administration of Nursing Home Programs* the Expenditure Committee suggested 'that, if cooperation from the States is not forthcoming, the Commonwealth should fund the number of nursing hours per patient to a uniform standard set by the Commonwealth'.[6]

6.14 The Committee recommends that:

Pending the transfer of responsibility to the States, the Commonwealth should fund the number of nursing hours per patient to a uniform standard set by the Commonwealth.

6.15 Some of the awards applying to nursing homes are a carryover from hospital awards, and in some cases go back to years well before the establishment of approved nursing homes for the purposes of the *National Health Act 1953*. The appropriateness of these provisions to the staffing of nursing homes in the 1980's appears questionable.

6.16 The Department of Health agreed, given that the Commonwealth accepts responsibility for funding nursing homes, the Commonwealth should fund to a uniform standard rather than merely have an open-ended commitment to whatever standards States decide. There would be, however, difficulties involved in adopting that approach. One of the major problems is the differences in various nursing awards among the States which require nursing homes in a particular location to be staffed to a certain level. This is something that the States cannot in all circumstances do a great deal about. It is questionable whether they have much control over it.[7]

6.17 The standard of care in private nursing homes will inevitably depend on the fees charged, the level of subsidy, the profits of the proprietors (return on funds) costs and managerial efficiency. In the long run, the return on funds must be similar to the return

on funds elsewhere in the economy and costs will reflect managerial views of efficiency and the price of inputs particularly wages.

6.18 The responsibility for the policing of adequate standards of care is primarily a matter for the States, under State health legislation and regulations. The Commonwealth has very little responsibility in the area. The Committee was informed by the Department of Health that because of the recent significant increase in nursing home benefits in October 1981 the Commonwealth is to look more carefully at the question of standards and its role.[9] However, the Committee notes that the manner in which benefits are provided as well as their level, has a bearing on efficiency and hence standards of care.

6.19 Government departments in each State have responsibilities for the oversight of establishments and there is machinery for inspection. In Victoria it was said that there has been concern for a long time that the facilities available to carry out effective inspections are inadequate. Workers who have been involved in the field of aged care for many years say that they know of establishments flouting regulations. Complaints are not brought to the attention of authorities and there is no effective mechanism for this to happen.[10] An associated problem here is responsibility for patients if a facility were closed.

6.20 The Commonwealth has expressed interest in supporting the HASAC standards of care. More recently it has been raised at the Health Ministers Conference. But, given there is a variety of standards around the country it is inevitable that it is going to be a matter of slow negotiation. If, for example, the HASAC standards were immediately applied to the Commonwealth's funding for Victoria it would have one of two results; either the patients in Victorian nursing homes simply would not be able to afford the fees of those nursing homes, or, alternatively, there would be tremendous pressure on the State Government, not to mention the Commonwealth, to do something about meeting that difference.[11]

6.21 In Victoria the State Government has faced for some time various demands to provide facilities such as separate matrons' quarters which are very costly. The Commonwealth Minister has expressed concern to the Victorian Minister in writing about the effect these demands are putting on the industry and the Commonwealth but the Commonwealth has so far been fairly ineffective in countering this requirement.

6.22 The Department of Health said that in the past the Commonwealth has been reluctant to duplicate the work of the States in relation to inspections of standards and levels of nursing. There is no separate section in the Department of Health which specifically examines levels and standards and it would appear to the Committee that little work is being done in the area at an administrative level. The reason given was that the system supports differing standards which are 'clearly visible to anybody who cares to look at them'. The result being that there is little reason for the Department to be developing model standards.[12] Health said it was up to the Government what it is prepared to do:

> 'So far we have tried negotiations. As to whether it is prepared to try the quite radical steps you (the Committee) appear to be suggesting is certainly something to which it would no doubt give consideration.'[13]

6.23 The alternate position, adopted by the Australian Nursing Homes Association is that HASAC standards are specifically stated to be minimum levels. The Association said that the Commonwealth Department of Health will not allow it to increase those levels so that they are regarded as maximum levels. It was submitted to the Committee:

> 'How can we possibly improve patient care in this country when administrative staff are allowed to make important decisions relating to the staffing of nursing homes? Our directors

of nursing are not in any position to argue with Commonwealth bureaucrats on these questions.'[14]

6.24 A further issue in relation to staffing standards is that the HASAC specifications relate only to nursing hours, with no mention of other paramedical staff, domestic staff or other support staff. Yet the quality of nursing care is considerably affected by the time spent by nurses in non-nursing tasks and the availability of other therapists. It is possible that a greater provision of nursing staff may be less effective in improving care than attention to support staff.

6.25 A high ratio of nurses to patients but with nurses performing domestic tasks is most inefficient and may result in a lower standard of care than a lower nurse patient ratio with additional support staff. Confused patients particularly may require more activity programs, conducted by therapists and paramedical aides, than nursing care.

6.26 The Committee is concerned about the apparent lack of control over Commonwealth expenditure as a result of the machinery for setting standards in nursing homes. The Committee proposes that the financial arrangements be changed so as to locate financial responsibility more closely with the functional responsibility for setting standards.

6.27 The Committee recommends that:

The Commonwealth establish a 'Nursing Home Care Program' to replace the current Nursing Home Benefit paid under the *National Health Act 1953* and the *Nursing Home Assistance Act 1974*.

6.28 Payments would be made to State authorities in order that they might either continue to pay benefits or, alternatively, 'contract out' the provision of nursing care to private, religious and charitable organizations.

6.29 The Committee recommends that:

The Nursing Home Care Program involve the following elements:

- **payments to be made through a grant to the States on a per-capita basis, with the base amount for each State in the first year to be determined in relation to the aged population currently resident in nursing homes;**
- **the Commonwealth work towards the provision of grants based on the number of aged persons in each State;**
- **a 'phasing-in' period be allowed to permit orderly re-adjustment in State hospital/nursing home systems;**
- **no payments be made in respect of nursing home beds not currently approved;**
- **relativities between the States be examined by the Grants Commission at the time of its next review of Tax Sharing Relativities; and**
- **A minimum patient contribution be retained.**

6.30 The formula on which payments would be made would necessarily involve, in the longer term, a uniform level of provision by the Commonwealth to the States. This basis would not imply that the States should actually provide uniform levels of nursing home care—either in terms of bed to population ratios or nursing hours.

6.31 The Committee does not envisage that the Commonwealth provide subsidies for the capital cost of construction or purchase of nursing homes. This would be a matter for the States to decide in the light of their priorities in relation to their hospital service systems.

Complaints against Proprietors

6.32 The Department of Health has very little control over those who apply to operate nursing homes. A proprietor who already owns a number of existing nursing homes

might apply for approval for another home. If it is known he has a particularly good reputation in the industry, that would be taken into account by the co-ordinating committee. Similarly if for some reason, the Department knew that the proprietor did not have a good reputation that would be a factor that could also influence the committee, but it is not aware of any cases where that has happened.

6.33 The reputation of the operator becomes a factor only when it is a matter of choice between one and the other. Health said that it would be very difficult to deny, without very concrete evidence, that person's right to apply and get approval to operate a nursing home. 'Otherwise we would be in the courts tomorrow and we would not be too happy about that'.[15] Whatever considerations apply at the time of initial approval, private nursing homes can be sold on the open market and there is no control, or necessary knowledge, of subsequent ownership.

6.34 The avenues available to patients or their relatives to make complaints about the way a nursing home is being conducted or operated is a very difficult area. Evidence was given that it is not at all uncommon for complaints to be made where the complainant does not want to mention the name of the patient involved. There is a lot of room then for judgment as to how valid a particular complaint is. It has to be accepted that some patients in nursing homes are less tolerant than they might be and, being in the nursing home situation, tend to see things somewhat out of proportion.[16]

6.35 In July 1982, the Nursing Homes Association launched a 'telephone complaints hotline' in N.S.W. Members of the public are able to phone the Association and leave their complaints to be attended to.[17] The Committee did not have the opportunity to assess the impact of this initiative.

6.36 Although there are organisations representing the proprietors of nursing homes, there are not any organisations actively representing the interests of patients. Although there are community organisations that would be expected to pick up this area, it has not as yet been done on an effective basis.[18] Such an organisation could provide quite a useful balance to the proprietor's organizations. The interests of the patients are not articulated in any organised fashion, which raises serious problems for policy making. It is not easy for the policy makers or developers in fact to ascertain the views of that particular group.

6.37 The fact that there is no formal consent on the part of the patient admitted to a nursing home has been raised as a concern. Evidence was given about problems arising from the lack of accountability to the patient for decisions made on his behalf and the need for protection, especially of patients who have no one to turn to. The need for some form of ombudsman was suggested.[19]

6.38 It is unlikely that nursing home patients as a group are ever going to organise themselves in an effective manner. It is possible that their relatives would not see that as something to give sufficient time to. There is evidence that not all relatives do in fact maintain an active interest. It is noted that more general welfare consumer groups such as the Pensioners' Federation have picked up the concern of nursing home patients.[20]

6.39 The number of complaints to the Health authorities on standards of care, patient care and quality of care is said to be fairly small. Every one is investigated and approached from the consumer's side, not from the proprietor's side.[21]

6.40 A representative from the Australian Council on the Ageing said that he believed that many grievances are never articulated and the Committee was given evidence that the management of institutions have very effective ways of containing complaining residents by isolation, by restraint and by just ignoring them.[22]

6.41 People who are unprotected in a nursing homes are often afraid to raise their voices in anger or protest. This fear is the first thing to be overcome in devising some giving access to an appeal mechanism. Such a mechanism would also allow staff to express their complaints.

6.42 The informal mechanism for expressions of concern is often through a family member who has been supporting the older person. These people, too, are in a bind if they have been driven to the point of physical and/or psychological exhaustion by caring and they have managed to find a place, even in an unsatisfactory establishment. They are unlikely, unless the problems are really quite dramatic, to do more than express concern and take away an even bigger load of guilt and anxiety than they had when they made the arrangements in the first place.[23]

6.43 One of the ways to overcome this problem is to ensure that each State department has an adequately staffed group of inspectors, who are able to make unscheduled visits. However while the inspectors may be able to see poor food or dirt, they are unlikely to be able to see cases of bullying or cases of unnecessary deprivation. It is not easy for old people to find another bed when present arrangements keep the supply of nursing home beds overfull. Only the ability to find a bed can provide the protection from the more subtle terms of mistreatment.

6.44 No inspector service can identify and take action against the little humiliations, yet to many people these are more serious than their physical surroundings. A solution to this problem lies in policies which compel nursing homes to compete for patients. The first step in this solution is to limit subsidy to those who need it.

6.45 The Committee recommends that:

To overcome the lack of channels of complaint against low standard nursing homes, hostels and domiciliary services an Aged Care Tribunal should be established in each State, to which aged people receiving care or their relatives can take complaints about services.

6.46 The Tribunals would have the power to investigate complaints and direct the appropriate authorities to take action. Until programs are transferred to the States they could be attached to the Commonwealth Ombudsman's Office and their annual reports could be published together with the Ombudsman's report. Upon transfer of Commonwealth programs to the States, the Tribunals would be transferred to State Ombudsman's offices, or other appropriate State agencies. The Committee considers that no more than two staff would be required in each of the larger States, and one in each of the smaller States; the total annual operating costs of the Tribunals would not be expected to exceed $250 000.

The Confused Elderly

6.47 The first requirement in care of the confused elderly is proper diagnosis to distinguish treatable conditions from chronic brain syndromes for which at present there is no cure. The Committee was given varying figures as to probable prevalence of senile dementia of the Altzheimer type in the advanced age population, over 80 years. While no firm figures can be given, it is apparent that the need for special institutional care will arise only in a relatively small proportion of cases where deterioration is pronounced and associated with gross behavioural disturbances.

6.48 Information available on nursing home patients indicate that between 30 and 50 per cent have some degree of senile brain disorder. Care of these patients is a major problem facing staff in nursing homes. A nursing home designed for physically frail and sick elderly people in a typical four-bed ward situation is not necessarily an appropriate place to care for somebody who is physically well and ambulant, but is suffering from

brain failure or senile dementia.[24] There have however been a few attempts to investigate what the appropriate forms of care might be.

6.49 The Uniting Church has set up lodges to provide care for the demented elderly in small group home situations for eight to 15 residents. The Church's opinion was that many of the mildly affected could be provided for adequately in hostels with higher subsidy, in the order of $60 per week.[25] The Committee is not convinced that a separate stream of care for the confused elderly is a desirable direction for development, and is aware of the negative consequences that such segregation can incur, albeit unintentionally. Experience in Britain with segregated facilities for the elderly mentally infirm has not been entirely successful.[26]

6.50 The potential for developing special programs within non-segregated nursing homes and hostels depends on the availability of staff for diversional activity programs and suitable architectural settings. The modification of existing facilities is a preferable, and necessary, means of providing for this group as new construction of purpose built facilities would only ever cater for a small proportion of these patients. To complement developments in institutional settings, the introduction of community based psycho-geriatric services must be seen as a high priority as many families bear an enormous responsibility in caring for these patients at home. If community services in general are lacking, those for psycho-geriatric patients are non-existent.

6.51 It was suggested to the Committee that some confused elderly people are amenable to the activities of the nursing home. Those who are quiet and gentle and not constantly wandering fit in quite comfortably with an ordinary nursing home situation and do not cause problems.[27] The problems arise with the wandering confused patient who cannot be restrained, who is constantly active, who cannot be contained in an ordinary nursing home because of fire safety regulations which prevent locking of doors.

6.52 It was argued that wandering confused patients really need a specially designed nursing home where they can wander out of doors in a safely enclosed area unrestricted by the normal routines that exist in most nursing homes. There is a particular problem with confused patients who have behavioural problems such as noisy or unpleasant habits. It is probably unfair for physically ill elderly people to have to live side by side 24 hours a day with people who are not responsible for their behaviour.[28]

6.53 It has been estimated that there are some 57 000 confused elderly people in institutions throughout Australia but that this is only the 'tip of the iceberg' of the total number in the community.[29] It was suggested that the confusion of probably 50 per cent of these people could be considerably relieved with proper assessment, diagnosis and treatment.[30]

6.54 It was put very strongly to the Committee that attention to the needs of the ambulant demented patient is urgently required. Existing nursing homes do not have the required skills. A large part of care in nursing homes involves attempting to restrict these patients to a limited area rather than providing diversional therapy and activities. One of the problems is that while staffing levels are required to be fairly intensive only *nursing* staff are included in setting staff ratios. Many nursing homes find that their existing facilities and staff levels can no longer cope with the problem. In Tasmania a number of nursing homes are saying that they cannot contain these patients any longer and are asking that some other place be found for them.[31]

6.55 Generally, nursing homes are reluctant to refer demented patients to State mental institutions. Only when a patient has become aggressive and it is not possible to control or manage him is this done. If patients are transferred to State mental hospitals, an

anomaly arises in that the same patient is no longer eligible for a Commonwealth Nursing Home benefit.

6.56 Changes within State Psychiatric Hospitals are giving them a more positive role in psychogeriatric care rather than only being a recepticle for the most difficult cases. In conjunction with geriatric hospitals, these institutions are developing diagnostic and assessment services not only to support inpatient care but extending into the community. The development of these specialist units is seen as a basic component in achieving improved care for this group of patients who have too often 'fallen between the stools' of other services.

6.57 Care of the confused elderly was the single problem that was most repeatedly brought to the Committee's attention. The conclusion reached is that the problem will not be solved simply by the construction of special nursing homes but that action is needed to stimulate a diversity of provision in small units in existing nursing homes, and in a range of community psycho-geriatric services, such as relative support groups, relief sitting and admissions, and day-care. Fundamental to all these developments is the provision of proper diagnostic and assessment services.

Efficiency and Self-Regulation

6.58 The Executive Director of the Australian Nursing Homes Association pointed to the relative efficiency of private nursing homes. He argued that although the nursing home benefits scheme partially destroys cost effectiveness because it encourages the passing on of all costs to the consumer, the deficit financed homes were compensated for lack of inefficiency by means of the Government meeting the deficiency.[32]

6.59 It was put to the Committee that Government regulations do not impose upon proprietors and directors of nursing a proper requirement for higher levels of care. A proprietor might well ask why he should bother to improve patient care when he does not have to do so. It was claimed that too much attention is paid by government inspectors to whether or not there is a cobweb on the light bulb, and no attention at all is paid to the level of patient care.[33]

6.60 It was suggested that the proper solution is some form of self-regulatory process within the industry. It would be 'controlled' in the sense that 'unless the industry delivers the goods within a period of, say, five years of giving it control, this power would be taken away'.[34] Such an approach envisages a widening of the role of a nursing home in the community so that it takes in a whole range of other services and creates a career structure for people within the industry. It would then be able to attract people who are well qualified to give the proper levels of care and who can only retain their position within that career structure provided they upgrade their education.[35]

> 'Until it becomes an attractive career prospect to work amongst geriatric patients and the disabled and the people can see a lifetime of interesting medical, nursing, paramedical career structures within that field, we will always have this problem because the people who will be available to us to staff our nursing homes will see it as the third tier of nursing.'[36]

6.61 Self-regulation would involve building into the system such checks and balances so that a person who was not a first-class Director of Nursing would be found out over a relatively short period of time. It is said that through regular assessment over time, the level of care in a nursing home becomes fairly obvious. Patient assessment procedures would alert the Director of Nursing and proprietor of nursing homes to such things as over-medication, increased incontinence and unacceptable levels of dependency, which reflect poor nursing or management techniques. Steps can then be taken to rectify the situation. Departmental Health inspectors could use profiles from such assessments to

assess the quality of care of a particular nursing home and, where necessary, require that steps be taken to improve the situation.

6.62 The Committee notes that the very notion of control by assessments is bureaucratic. One alternative is to work towards a situation where patients can 'vote with their feet' without suffering a penalty. This is not practical at the moment because demand and supply is set by rules. However, if subsidy is paid only for those who are assessed as being in physical, social or psychological need, and domiciliary care is greatly improved, there is likely to be more appropriate choice in matching of facilities and services to the real care requirements of patients.

6.63 The Committee points out that the proposed form of self control runs the risk of a 'closed shop' developing, and a type of mercantilist scenario emerging, where the organisations collectively set up and defend a fairly rigid arrangement that is in part designed to make life comfortable for those who are controlling the controlling system. This is the outcome that the Australian Medical Association has achieved and the two airline agreement achieves for our airlines. Rather than becoming more open to the community, the system may become even more closed to outside scrutiny.

6.64 Improvements in the efficiency of operation in private nursing homes would need to be associated with changes in subsidy arrangements. This change could involve the States 'contracting out' the provisions of nursing care and payment of a subsidy to the *institution* instead of the patient. On this basis, profits would be maximized by service provision rather than simply bed occupancy. Nursing homes might then be expected to provide treatment, rehabilitation, and paramedical services as well as nursing services. It would be necessary for an effective system of inspections to be arranged. The basis of subsidy would be in the form of an undertaking to provide nursing home care and related services with the relevant State authority.

6.65 The Committee recommends that:

Health authorities explore prospects for contract nursing care in lieu of benefit arrangements to finance nursing homes.

Deficit Finance Arrangements

6.66 When deficit financing of nursing homes was introduced the policy basis was to encourage charitable organisations to provide nursing home care for the less wealthy. (See Chapter 2). The Committee became aware, from submissions, hearings and inspection of institutions, that many deficit funded nursing homes, especially those which are part of large retirement villages, are catering primarily for the middle class. This results from donation requirements and other arrangements that apply for admission to these villages.

6.67 The Committee was given evidence that patients requiring admission to nursing homes as an urgent measure to discharge them from beds in acute hospitals are almost always admitted to private nursing homes. Deficit funded nursing homes are somewhat detached from the process of movement of patients who were initially admitted to acute hospitals and subsequently need nursing home care. The most likely explanation for this situation is that deficit funded homes are much more likely to be part of a retirment village complex and thus have their beds committed. Evidence on this point has been cited previously in this Report.

6.68 The Department of Health said that it was 'unaware that the Government has expressed a clear policy that preference should be given, in deficit funded homes, to the less wealthy'.[37] According to Health, the point is that people seeking nursing home accommodation could rarely afford it without some sort of government support. In deficit funded homes, the patient is not required ever to pay more than the minimum patient

contribution, whereas that is the case in only 70 per cent of beds in private nursing homes at the time new benefits are set. However, there is no attempt by the Department to ensure that deficit funded nursing homes restrict entry, or even allocate a proportion of beds, to the less affluent in the community.

6.69 The Department of Health holds the view that the comments made by the Minister, when informing the Parliament of the purposes of the deficit financing arrangements, were addressed to the nature of care actually provided by those homes at that time. It was more the practice of charitable and benevolent homes to provide care for the less affluent in the community. The Department of Health does not know whether that was a correct or incorrect observation. The understanding is that it was an observation and certainly used as a relevant factor in indicating why the deficit financing arrangements were introduced.[38]

6.70 The Department of Health sees a difference between saying that charitable and benevolent organisations help people who are less affluent and therefore the Government will support them, as distinct from saying that the Government will give assistance on the understanding that they concentrate on care of the needy in the community.[39] The result of this piece of 'logic' is that the Department sees no difference in the class of people who go into private nursing homes and those who go into deficit funded homes and does not distinguish between the means of those people. However, the Committee considers that if the deficit financed homes are supported on the presumption that they serve the needy, some form of entry control seems necessary to ensure that this goal is realised.

6.71 The idea that deficit funded homes were to be for the needy is accepted by the Department of Veterans' Affairs. The Department does not place any of its clients in deficit funded homes because it believes that those beds are reserved for the needy. Patients are placed in private nursing homes whenever possible as the Department is able to meet fees, which seems a clear indication that deficit funded homes were to be for the less affluent.[40]

6.72 The chances of a person 'off the street' going into a deficit funded nursing home would depend on a number of factors. In particular, it would depend on whether that person has had some affiliation with a specific deficit funded home or with the religious or charitable organisation which operated it, and the location of the home in relation to an aged persons homes complex providing on-going care to people coming from the hostels and independent living units in that complex. In most cases the 'person off the street' would find it easier to get into a private home.[41]

6.73 Because of the problems identified in the deficit financing system, the Committee recommends that:

The current deficit finance arrangements be subsumed in the Nursing Home Care Program and that *all* nursing homes be subsidized on a uniform basis.

Paramedical Services and Day Care

6.74 Paramedical services, such as chiropody, occupational therapy, physiotherapy, speech therapy, etc, are regularly funded in the budgets of deficit funded homes but not in private nursing homes, thus setting up a two-tiered system where one group seems to get a better subsidised service than another. Evidence suggests that the reason is that there is special provision in the *Nursing Homes Assistance Act 1974* for Specified Services for people in the nursing home and also Approved Services for people from the local community. This measure allows a greater incentive for deficit funded homes to provide those services and to provide them in a more expensive fashion than another

nursing home itself could justify. There may be other incentives as well, but the specific provision in the Act would be a major factor in the difference.[42]

6.75 No evidence was presented of the extent to which deficit financed homes have actually developed services for community use, but a number of factors were found to inhibit this development. These factors include State government regulations and conflict over alternative development and financing of community services.

6.76 According to Health it has not been seen as necessary to extend provision for these services to private nursing homes on the grounds that one of the major considerations looked at by the co-ordinating committees is the provision of like services by the States in the local area. The State Government is seen to have responsibility for community services and the Commonwealth does not provide that sort of funding if the service is already provided.[43]

6.77 Proprietors of private homes have put it to the Committee that their in-patients are disadvantaged, in that they may have the space for a day centre and wish to provide one but they cannot gain a Commonwealth subsidy for it. If they, rather than the State, provide the service and the State does not contribute to the cost they have to charge their patients. But people who are fortunate enough to get into a deficit funded home can have day centres funded in the deficit home.

6.78 The Committee has seen deficit funded homes where there are very well equipped and highly sophisticated facilities set up for chiropodists and physiotherapists. It is inevitable that private homes do not so readily employ occupational therapists and diversional therapists because they do not attract a government grant.

6.79 The Department of Health argued that the matter of placing a day care centre in a private nursing home is within State licensing laws—if there is a reason not to provide them on a licensing basis, that is a matter for the State Government. The Commonwealth would not begin funding a private day care centre in a private nursing home. Health regards the provision of day care centres in general terms as a State responsibility. If a private entrepreneur wishes to provide a day care centre for patients in his nursing home and for patients outside his nursing home that is seen as a matter of his entrepreneurial exercise. If he wants to make a charge and make a profit that is his business.[44]

6.80 The Department of Health takes the view that the matter of provision of therapy to patients in private nursing homes could be a matter for negotiation between the private nursing home and the State community health services. If the State community health services were to provide services at day centres or in homes of people, there would be little difference between that and providing them to private nursing homes as a part of their public services. It has been mentioned to some organisations representing private nursing homes that they should approach the State governments to get community health services to provide sessional services to patients in their nursing homes.[45]

6.81 In pursuing the questions of provision of extra services to in-patients and the extension of nursing home facilities to day care for outpatients, two issues need to be resolved. The first question is whether patients receiving the same Commonwealth benefit should be entitled to the same services regardless of the type of nursing home to which they are admitted. The Committee is of the view that this should be the case. To meet this requirement, there are alternatives to attaching staff to individual nursing homes. For example, staff working from a community base may attend local nursing homes in an area on a sessional basis.

6.82 The second question involves consideration of the capacity of nursing homes, whether deficit financed or private, to provide extra services, and the desirability of

using this institutional base for community services. Evidence on the former point is contradictory, but the Committee appreciates that linking services to a nursing home may lead both patients and staff to see such services as merely forestalling inevitable admission rather than providing an alternative, and separate, system of care.

6.83 The Committee notes that the provision of community day-care facilities and services may give rise to favoured admission to nursing care in the same way as entry to nursing home care through associated independent units operates at the moment. Such a development would reduce the opportunies for people not associated with a nursing home to gain admission to nursing care.

6.84 The Committee formed the view that deficit funded homes have more support staff than there are in private homes. Private home proprietors say this is because they cannot afford to pay them and the deficit funded homes can put on as much domestic staff as they like to provide a better standard of care because they have no cost constraints upon them. According to the Department of Health there are certain fairly broad parameters, such as cost medians, to help their experienced officers in the State offices to form judgments on deficit financed budgets. These budgets are very heavily scrutinised and negotiated and in many cases cut back. There are appeals from time to time to the Minister on budget decisions. It is not seen as an open-cheque arrangement.[46] The view of the Committee is however that controls are not always as effective as they could, or should be.

6.85 It was suggested to the Committee that there should be more provision for married couples in the environment of institutional care. The approach of Government is fairly strict in that there are so many beds for so many patients. Government subsidies have been helpful in relieving the acute needs of old people but there has been little development in maintaining the unity of the aged couple when one partner requires permanent nursing home care. The question that arises here is whether special provision has to be made or whether more could be made of opportunities available in deficit financed homes which have associated hostels and independent living units. It again appears that a couple who have remained at home have difficulty gaining access directly to nursing home and other accommodation in these complexes when they have not previously been in the 'lower levels' of accommodation.

Classification for Extensive Care Benefit

6.86 Commonwealth medical officers (CMO's) are not allowed to examine patients to check on the need for the extensive care classification or to ensure that standards of care are adequate. Present inspections by the Commonwealth are limited to physical facilities. The Committee was advised that the Australian Nursing Homes Association has absolutely no confidence in the authority of Commonwealth medical officers, linked as they are to the cost questions involved, to make proper assessment of extensive care patients.

6.87 It was claimed that CMO's walk into a nursing home and the only fact that they appear to take into account is whether a patient is ambulant or not. They do not take into account any other medical reason behind the request for extensive care.[47] The system is said to create great distrust and ill will among the professional nurses because they see the CMO as only an instrument of economic control and not as somebody taking proper account of a patient's needs.[48] It was argued that 'The Commonwealth medical officers have shown an incredible inability to appreciate what is involved in nursing extensive care patients.'[49]

6.88 Against these objections however, is a fact that a high proportion of patients in private nursing homes do receive the Extensive Care Benefit, and when allowance is made

for extra funding under deficit financing and additional State resources in State nursing homes, a higher level of care is provided than is apparent simply from the proportion of patients classified as Extensive Care.

Conflict of Interest

6.89 A feature alleged to affect admissions to nursing home accommodation is the interest which some doctors have in their operation through direct or otherwise beneficial ownership. According to the Department of Health, the general belief expressed at a recent Health Ministers conference was that it is certainly not desirable for a doctor to admit a patient to a nursing home or private hospital without disclosing to the patient if he has a beneficial interest, in accordance with the Australian Medical Association code of ethics. The Ministers noted that a Senate Select Committee had been established to inquire into private hospitals and nursing homes and that a part of the terms of reference related to ownership and conflict of interest in ownerships. The States decided that they would wait until the Senate Select Committee met. The Commonwealth Ministers suggested to the State Ministers that they make submissions to the Senate Select Committee.[50]

6.90 A matter of concern to the Committee is the conflict of interest which may arise from the ownership of private nursing homes by medical practitioners. The introduction of assessment teams as recommended in Chapter 8 will reduce the opportunity for conflict to the patient or the taxpayer. Where a medical practitioner proposes admission on an NH5 form, the medical practitioner plays a vital role in admission. Once in nursing homes, patients require regular medical attention from practitioners. A conflict of interest arises if the practitioner in either case has a beneficial interest in the nursing home. The patient or the patient's relatives are not always informed. As put to the Committee by the Australian Nursing Homes Association:

> 'Obviously there is a conflict of interest on the part of the medical man who is putting his patients into either his own private hospital or his own nursing home without the patient being advised of the doctor's beneficial interest . . . the ethics should be that the doctor tell the patient or whoever is responsible for the patient that he owns that place and the patient can go somewhere else.'[51]

6.91 The Committee is not suggesting that medical practitioners, or anyone else, should not have a financial interest in nursing homes. It does believe, however, that a conflict of interest arises from the ownership of nursing homes by medical practitioners responsible for the health care of patients in these homes, and the patients or their relatives should be made aware of this situation. Even without a beneficial interest, there is a view that the nursing home patient is at risk of over-servicing, but evidence from Health indicates this area is subject to the same scrutiny as other medical services.[52]

6.92 The Committee recommends that:

> **Each non-government nursing home be required to make publicly available and provide to potential patients the names, addresses and occupations of all substantial beneficial owners of the home and the proportion owned.**

CHAPTER 7

HOME CARE SERVICES

7.1 This chapter identifies and examines the many issues involved in achieving an appropriate balance between institutional and home care services. Attention is given to the limitations and gaps in the provision of home care services, at both a general level and with particular reference to existing Commonwealth programs. The extent to which limitations in home care services are due to resource problems and to management problems is particularly considered in making recommendations for change.

Institutional Care and Home Care as Alternatives

7.2 On 26 February, 1969, when the Minister for Health announced details of the Commonwealth's offer to the States for assistance in the provision of Home Care Services, he referred to the development of a 'comprehensive programme for the care of the aged, particularly the frail aged, in their own homes'. He pronounced that: 'This home care programme will comprise a most important part of a comprehensive health and social welfare scheme that the Commonwealth is developing to assist the needy in our community'.[1]

7.3 Dr Forbes said that in bringing such a program into effect 'we have been seeking to identify those who are most in need so that we can provide them with the extra help they may require whether by way of direct financial assistance or by way of services'. He referred to the offer by the Prime Minister to the States based on proposals put forward by the States themselves: 'proposals which include the essential ingredients for a comprehensive and effective programme for the care of the aged including the sick aged in their own homes or, where necessary, in nursing homes'.[2]

7.4 It was put to the Committee that despite 'the lip service paid by legislators and others for the need for decreased hospital costs, actual coverage for home health services remains severely limited. Insurance companies continue to pay for repeated hospitalization and long term placement in chronic care facilities, while denying payment for simpler, less expensive, palliative and maintenance services, which are frequently of greater benefit to the patient and family. Many patients can not afford to go home even though family members are willing and professional services could be made available, as Government and health insurance benefits only apply for more expensive institutional care'.[3] At the same time many individuals and families carry a considerable burden of care, and the costs involved, without any relief from government.

7.5 The Department of Health pointed out that while evaluation studies show that community care services are cheaper than institutional services, an important aspect of this kind of care is the contribution of voluntary labour and relatives. If these were to be replaced by paid workers, the cost effectiveness of home care would be less.[4] Health also pointed out:

> 'In talking about cost effectiveness, it is important to identify which costs we are considering —the total cost of the service to the community, to the government, or the net cost to the patient. Arguments which advocate the extension of domiciliary care services and the restriction of institutional services often fail to take account of the practical problems involved in such a substitution in emphasis of service provision. Institutions by their very nature are

much less flexible than domiciliary care in adapting to meet particular needs in particular situations.[5]

7.6 The N.S.W. Department of Youth and Community Services endorsed this view, stating that supporting the aged in their own homes with the assistance of domiciliary services is in many cases more desirable and less expensive than the provision of institutional care. It may not, however, be as cheap as it appears in the first instance when a less than adequate service is being provided. The Department also argued, along with many others giving evidence to the Inquiry that home care is not a substitute for institutional care. A mix of both services is seen as essential. The Department suggested that much of the pressure on such accommodation has resulted from a dearth of alternatives.[6]

7.7 The view that institutional care and formal home care are the only alternatives is a somewhat narrow view—other possibilities are neglect and inadequate care at home without any formal services, or recourse to boarding houses and other 'services' outside the formal health and welfare systems. There are also numerous aged people whose disabilities do not make them likely to enter a nursing home, but whose well being and functioning could be improved with additional support. For this group, services are needed not as an alternative to institutional care, but in their own right as a means of maintaining independence.

7.8 Home Care can be defined 'as all those supportive or developmental services which assist families or individuals to function within their own homes'. The present relatively narrow range of services available should not be seen to restrict what would be required as a part of a comprehensive home care package.[7] Such a package could include:

- home help for housework, laundry, shopping and cooking
- home repairs, maintenance and alterations
- home nursing services
- integrated home health service
- meals on wheels (7 days a week)
- special transport services
- telephone and other communication provisions
- aids for daily living
- monitoring, visiting and contact service
- day care and activity programmes
- psychogeriatric services.

It is not anticipated or even suggested that any one person could be provided, economically, with all these services on a 24 hour, seven day a week basis. However, it might well be that, for a limited period, one person could need many of these services such as during an acute illness or the temporary absence of a caring relative.

7.9 Difficulties arise in comparing the effectiveness of home care services to institutional care because of the unequal development of the systems—the former being far less well developed than the latter. Many domiciliary services now operating are less than fully effective because, among other factors, their small scale incurs high administrative costs. Services are general rather than specialised, staff skills are limited in some areas and hours of operation are restricted. With further development, the realisation of economies of scale could make many services more effective, and hence yield very different results in comparison with other forms of care.

7.10 In order for home care to achieve the functions of enabling people to remain in their own houses as an effective alternative to institutional care, services need to be provided in such a way as to be comprehensive, guaranteed, co-ordinated, flexible and well-known.[8]

7.11 With the increase in the aged population it is likely that more demands are going to be made on governments to provide care for the aged. It then becomes a question of where resources will be best allocated. Additional funds for home care can assist in achieving the most appropriate use of the available accommodation facilities. It is unlikely there will be any lessening in real terms in the demand for accommodation—even with a growth in support for home care. However, given that demand is a function of cost to the consumer, demand will be directly related to the level of subsidy available. If home care does not receive more support, then it is almost certain that there will be growing pressure for institutional care, which is both more costly and is in some cases less desirable.

7.12 The relationship between provision of more of one type of care and less of another is however far from a simple or automatic inverse relationship. Figures at aggregate level can be misleading, disguising differences between local areas. Some local areas may be well provided with both institutional and community services, while others have neither.

7.13 One of the factors reducing the use of home care is that not all professionals working in the area—including general practitioners—are aware of the range of services that is already available. The Domiciliary Care Committee of the N.S.W. Council on the Ageing is looking at providing a way of informing key people in communities about the range of services that are available and is particularly aiming at general practitioners who come into contact with large numbers of elderly people.[9] This is an educative process. As well as changing the outlook of those currently working in health and related areas, there is a need to expand training of personnel. A recommendation for training programs is made as part of the Extended Care Program (see Chapter 8).

The Organization and Delivery of Home Care Services

7.14 A feature of the domiciliary sector is its disorganization. There is no one body in any State to argue on behalf of the many agencies providing domiciliary services. Neither is there a unified voice to advise Government on priorities say between home nursing and delivered meals. The situation reflects competing priorities with individual organizations all attempting to maximize their share of the resources available.

7.15 With a few exceptions, where services are formalized, such as the Home Help Service of New South Wales and home nursing organizations, the provision of services to any area is determined by the need as identified by a welfare agency. On this basis services may not be provided where they are needed most, even though each agency allocated its resources well. Areas in which no organisations choose to operate will be neglected while those which can exert a command over resources may gain services out of proportion to need.

7.16 From evidence received and from the Committee's observations while inspecting facilities in all States, it is apparent that there are marked regional variations in the services available and in many areas there are few service options available. While the distribution of nursing home and hostel development is controlled, to an imperfect degree, by Commonwealth State Co-ordinating Committees, there are no mechanisms at the Commonwealth level which attempt to ensure an equitable geographic distribution of domiciliary care services. It appears to the Committee that availability of aged care services is a product of the determination of local interests—voluntary agencies health care professionals and politicians—rather than a reflection of the needs of old people in the area.

7.17 The Committee has gained the impression that existing 'umbrella' welfare organizations were unable, or unwilling to be involved in the co-ordination process and

would rather concentrate their efforts on advisory roles, and in turn, tell others, usually government, what is to be done. Unfortunately, the reliance by government on informal and voluntary networks for advice means that the results of these 'information exercises' do not always find their way into policy.

7.18 The objectives of the Australian Assistance Plan (AAP), which was 'designed to provide, on a regional basis, social planning organizations to facilitate the co-ordinated development of welfare services in the community' is no longer part of the Commonwealth welfare policy package. The functions of the AAP were transferred to the States under the Federalism policy.

7.19 The experience of the AAP demonstrated the difficulty in obtaining co-ordination and co-operation at the regional and local level. In the field of care of the aged, the Committee has become aware of the contrast between the frequent mention of planning and delivery at a regional level and the absence of actual organisations which could carry out these functions. Apart from the regional Geriatric Services operating in some States, which are largely concerned with public sector activity, regional co-ordinating bodies could at best be described as incipient.

7.20 The Committee was impressed by the initiative being shown in the organization and delivery of welfare services for the aged by some local government authorities, but is also aware of the uneven nature of this development. The work being done in the Fitzroy City Council and Marrickville Council, for example, demonstrates that local government is capable of providing the leadership, not only in the provision of services under Commonwealth and State subsidies, but co-ordinating the efforts of other welfare agencies. It was stated that co-ordination 'obviously involves consultation with other local agencies which have a broader perspective of what is needed . . . Other agencies have accepted that this needs to be done and they will work co-operatively in the process. The structure is not simply a local government committee, it is a community committee of various people with local government taking on the co-ordinating and servicing role'.[10]

7.21 Little is known of the organizational characteristics of voluntary welfare bureaucracies, but it is probable that much of the difficulty in the organization and delivery of services at the local level could be resolved by local initiative involving greater co-ordination and co-operation. While management solutions were commonly put forward to improve the organisation and co-ordination of local and regional service delivery, the Committee is aware that there are often underlying resource problems.

7.22 It also appears that co-ordination between agencies has proceeded further in areas with better service provision, while in some areas, resources are so limited that there are virtually no services to co-ordinate. Put another way, it is easier to work out how to make a cake given the right ingredients, but a recipe without the ingredients will not produce results. Different patterns of service development and integration observed by the Committee and documented in submissions also demonstrate clearly that there is no one model for development, but that variety is needed to accommodate differing needs and levels of services in local areas and regions.

7.23 The appropriate institution to promote co-ordination of services at the local and regional level, in the first instance, is the State Government. While the Commonwealth might have the authority to provide finance, it is State and local authorities which have the power, and the responsibility, to approve, licence and regulate. Commonwealth policies and objectives can be quite meaningless in the face of legal and institutional barriers for implementation. This is quite apart from the problems arising from boundary disputes between individual care organizations and their reluctance to surrender autonomy, despite espousals of 'co-operation'.

7.24 The Committee believes that voluntary care organizations have a vital role in the organization and delivery of community welfare services. It believes that State and local government can assist these organizations to co-ordinate their efforts and minimise overlap and concentrate on greatest need.

7.25 The evidence suggests that the States should look at their policies and priorities in respect of community based services for the aged. Such an examination should remove some of the anomalies and barriers to the development of community health and welfare systems. Bureaucratic interests are likely to oppose effective examination.

7.26 Whereas the inequities and anomalies in nursing home benefits and staffing standards have been extensively raised in the course of this Inquiry, the question of standards of provision of community care has not been canvassed. The Committee is concerned at the marked variations that do exist, and would seek to reach agreement with the States about some mechanism for distributing resources to ensure a basic minimum provision in all areas to overcome present inequities. Without some overseeing of the distribution of public sector funding for community care services, variations between regions could well be exacerbated rather than reduced as and when additional resources become available.

7.27 The Committee recommends that:

> **A mechanism for planning the distribution of community care services be developed in consultation with the States, and that allocation of financial assistance be made on a consideration of need rather than relying on local initiatives and submissions for funding.**

Nursing Homes, Day Care and Community Care

7.28 It was put to the Committee repeatedly by some organizations that existing nursing homes would provide suitable vehicles for the organization and delivery of community based home care services. The Uniting Church, for example, said in evidence that we 'should be thinking of new ways to use existing facilities rather than thinking of what new facilities can be provided.'[11] It was suggested that most church sponsored homes had kitchens designed to prepare extra meals should they be required in the community.[12]

7.29 It was put strongly to the Committee that a nursing home should not be an isolated institution within the community, but part of the community, with the community supporting it and with its services reaching out into the surrounding community. This would give people the confidence that if they are prepared to defer nursing home admission there will be support services for them: short term admissions to the nursing home, day care, which can be for 10 hours a day if that is what they need, and, eventually, a bed in the nursing home. Unless families can be given these sorts of assurances, no matter what else is done there will still be the demand for nursing home care from those who would cope at home and long waiting lists.[13]

7.30 A Matron/owner indicated that she would like to see the nursing home as a centre for community services but additional resources would be required to provide meals on wheels, laundry services, transport and paramedical services.[14] Similarly, a Tasmanian proprietor suggested that nursing homes should be seen as community centres, ideally situated to provide many necessary support services, such as day care, meals on wheels, community nurses, housekeeping help and to maintain the aged in their own homes.[15]

7.31 The expansion of nursing home activities into community based services is not only an objective of the voluntary sector. The Australian Nursing Homes Association argued that:

> 'There should be a direct encouragement, if not enforcement, to the nursing home to expand its services and facilities in such a way as to ensure that the nursing home is in fact much more than an establishment to care for the aged, away from the immediacy of life in the community and to be part of that community.'[16]

> 'We would suggest that such an end will only be achieved where there is recognition, and acceptance, of the fact that the nursing home should be the centre for a wider range of services to its local community than it is at the present time.'[17]

7.32 While these arguments are in themselves well founded the Committee has doubts about whether many nursing homes do have excess capacity in their physical facilities and staff to carry out these extended roles. A better way of integrating the nursing home into the community may also be to take the nursing home patient out to community facilities rather than bringing the community user into the nursing home. As the great majority of aged people will not need to enter a nursing home, it may be inadvisable to adopt a pattern of care that could foster a dependence on nursing homes.

7.33 One of the major barriers to these sorts of initiatives is State legislation. Thus, despite the high sounding objectives of the *Nursing Homes Assistance Act 1974* to make deficit funded nursing homes a focal point for the activities of the aged in the community, some State laws do not permit the establishment and operation of day centres in nursing homes. Similar restrictions apply to the operation of temporary respite beds.

7.34 Objections have also been raised by the Commonwealth to providing community services through this Act, arguing that such services should be funded through general State health and welfare budgets. Several community services commenced with Commonwealth funding under the Community Health Program have subsequently come to be part of the general budgets in this way. These issues of differential funding under different acts and programs are taken up further in Chapter 9.

Services under the *States Grants (Home Care) 1969* and *States Grant (Paramedical Services) Act 1969*

7.35 The major problem in the present operation of the Act arises because the phrase 'in the home' is used rather than 'in order to maintain a person in the home'. Services are required to be provided strictly in the home, thereby excluding key home support services such as transport and day care services. At present both those services are provided on an *ad hoc* basis by several organisations with whatever support they can attract.

7.36 The Committee recommends that:

> **The restriction applying to services 'in the home' be removed to facilitate the provision of a wider range of services under a new Extended Care Program, which will otherwise incorporate the provisions of the *States Grants (Home Care) Act 1969*.**

7.37 Another difficulty arises because of the definition of a Senior Citizens Centre and a requirement that Welfare Officers for the Aged should be based at a Centre. Many people now believe that the salary subsidy should be available for an officer who is working towards the development and co-ordination of a broad range of welfare services in an area, but is not necessarily based at a particular Senior Citizens' Centre. Practice has certainly moved that way, and it is now primarily a matter of the legislation catching up with the directions in which the services are developing.

7.38 Senior Citizens' Centres were given formal support under the *States Grants (Home Care) Act 1969*, and there has been a proliferation of building activity with capital grants on a $2 for $1 basis. However, as a result of an absence of effective control over the distribution of grants, some municipalities have no subsidised centres while others may have several. Grants are made in response to local initiative rather than assessment of need.

7.39 The intention of the Act was that Senior Citizens' Centres should become a base for health and welfare services for the aged as well as social and recreational centres. (See para 2.28) This pattern of development has come about in some municipalities where Senior Citizens' Centres have been seen as one element in the Council's overall services for the aged. Welfare Officers have an important part to play in fostering this wider role, but again many municipalities have not established such positions while others have several. A further important factor in making Senior Citizens' Centres a base for service provision is some form of transport for the frail and disabled elderly, and municipal action in this area is also highly variable.

7.40 The more common pattern of development is that Senior Citizens' Centres have become something of a 'club', with activities and even membership controlled by a clique. Such club-like centres tend to be open only for limited hours and to refuse other groups the use of premises. It is also argued in these cases that the fit elderly and the frail do not mix together, or that migrant groups, for example, should have 'their own clubs'. The Committee is at least doubtful that Senior Citizens' Centres, as they presently operate, are a cost-effective form of assistance for the aged.

7.41 Evidence given to the Committee, and a visit made to one thriving centre in Adelaide, suggest that the barriers to wider use of Senior Citizens' Centres can be overcome. This and other practical examples demonstrate that a range of activities can be developed in a single Senior Citizens' Centre. Chiropody and meals are basic services not restricted to the frail, and day care sessions can be introduced into wider programs.

7.42 There are many advantages in bringing aged people to a Senior Citizens' Centre for therapy, over and above those gained by providing the same service at home. Programs for the frail aged also provide an opportunity for other elderly people to be volunteers, although it must be recognised that not all aged people will wish to become involved in this way.

7.43 The Committee sees that the potential in Senior Citizens' Centres as a base for community care services as yet largely unrealized. Past emphasis on buildings now needs to shift to staffing and services, including transport. Where there are a number of Senior Citizens' Centres in an area, it may be appropriate for one centre to take on more specialised service functions.

7.44 In recent years there has also been considerable growth of clubs and associations for retired people and 'the over 50's'. Even more important are clubs which make no age distinction. Such groups provide additional social and recreation opportunities for the elderly and mean that Senior Citizens' Centres are not the only facility for the older age groups in most communities. With the expansion of these other interest groups, there is even more argument for Senior Citizens' Centres to move away from the traditional 'bowls and bingo' and become more actively a base for community services.

7.45 The Committee recommends that:

Senior Citizens' Centres, or other community based centres, be a base for the development of community care services wherever possible and that the proposed Extended Care Program include provision for staffing and services to be associated with Senior Citizens' Centres.

7.46 The *States Grants (Home Care) Act 1969* does not undergo regular performance or effectiveness review. In relation to services provided the Department of Social Security advised the Committee that

> 'each relevant State department forwards to our Department each year a statement requiring us to pay 50 per cent of the home care service and in its financial statement, which is certified by the State auditor or treasurer, the State certifies that the amount it is asking us to pay has been provided, or the services have been provided, wholly or mainly for aged persons. Therefore we have a certified statement from the State department with which we cannot argue.'[18]

The Committee trusts that this 'compliance' evaluation is not all that is done in the Department of Social Security in respect of policy review.

7.47 The Committee recommends that:

> **The proposed Extended Care Program include specific provision for monitoring of expenditure distribution and service development.**

Delivered Meals Subsidy

7.48 It was put to the Committee that the 'per meal' subsidy is unable to achieve the stated purpose of the Act, 'to assist in the establishment, expansion, improvement and maintenance of delivered meals services', as only the meal is subsidised. More flexible support should be available for establishment costs, salary subsidies, volunteers expenses etc. and provision for training and consultation. The Act is unduly restrictive in limiting nutritional maintenance to a delivered hot meal, when other services, such as shopping, cooking or re-training, may be more appropriate. The Act is also unduly limiting in prescribing who is to be assisted as 'aged' or 'invalid', rather than the broad range of people who are unable to meet their own nutritional needs.[19]

7.49 The rising cost of petrol and other costs associated with private car use mean that meals-on-wheels services are finding it increasingly difficult to find volunteer drivers. Specific recognition needs to be given to transport costs as an item in the budget of meals services. Such recognition also extends the possibility of providing transport to take the aged person to have a meal at a day centre or Senior Citizens' Centre as well as delivering meals at home.

7.50 There are no funds for co-ordination and development, no assistance on a State level for training, for bringing services together in order to encourage people to look at new ways of providing services and there is no backup support. The Meals on Wheels services which are supported through hospitals are able to maintain a balance in their service but are often restricted in the number of meals they can provide without requiring the hospital to extend its facilities. The Meals-on-Wheels services which do not have a nearby hospital able to provide meals have to rely on local government in order to survive, even for day-to-day running costs. The 'per meal' subsidy rate is out of date and the method does not relate to the actual costs of the service.[20]

7.51 It has been a feature of recent hospital economy measures to cut costs by reducing or eliminating meals provided by hospital workers. The result may be that the economies of scale in providing meals as part of a large catering system are lost, and more expensive small scale means must be found. Further, the withdrawal of provision of meals by an institution as a domiciliary service may contribute to patients then seeking admission to the same or another institution. This situation is perhaps a case of something being cheaper through the back door than through the front door.

7.52 The Committee believes that the Delivered Meals Subsidy is cost effective and would like to see the program continue, but is aware of some factors limiting further development. The Committee recommends that:

The Delivered Meals Subsidy be subsumed within the proposed Extended Care Program.

Home Nursing Subsidy

7.53 The concern on the part of past governments to develop a comprehensive system of care in the community was not aimed at replacing voluntary networks with statutory caring organisations. The Home Nursing Subsidy Scheme was built around 'the charitable and public spirited' work of district and bush nursing associations 'whose efforts have brought relief to the sick and aged, particularly in the poorer area of the cities.[21] The philosophy was to encourage, rather than discourage, voluntary effort, being founded in the belief that Government community care was good only to the extent it did not undermine existing forms of care. This attitude prevails in the rationales for community care.

7.54 The Committee was impressed by the submissions made to it by various home nursing organisations. These organisations operate on a wide scale, have formalised liaison arrangements with other services, maintain records of services and monitor their activities. The cost effectiveness of home nursing demonstrates the capacity of well organised community services.

7.55 One of the limitations of the scheme is that at present the Home Nursing Subsidy Act is used only to subsidise the employment of registered nurses. The Royal District Nursing Service put it to the Committee that 'if a patient needs, for instance, only general hygiene care and is not so sick as to require care by the nurse, then somebody else if they were taught and supervised, could assist by getting the patient into the shower or into the bath and so on'.[22] It is possible to send in a health aide and the registered nurse will provide supervision and make only every third or fifth visit. A less qualified person, earning considerably less, is then able to safely provide a range of personal care. It would need to be appreciated that the aide only sees patients whom the nurse has assessed as suitable for receiving care from less qualified staff. This would lead to a more efficient allocation of scarce home nursing resources. However there is no subsidy available for Health Aides.

7.56 As an indication of the industrial difficulty likely to be put in the way of developing policy in this area the Royal Australian Nursing Federation advised the Committee that it completely rejects the idea of a Home Health Aide.[23] It was also pointed out that in some States the difference in award rates between nurses and health aides was quite small. Salary differentials are not however the only consideration, as the availability of skilled staff must also be taken into account and deployed to maximum advantage and efficiency. The Health Aide category of health worker is currently employed in some States, and it is pertinent to note that within the institutional care sector, much of the workforce is made up of State Enrolled Nurses, that is, not trained nursing sisters.

7.57 A further problem, and one that exacerbates the duplication and fragmentation of home nursing services is that the subsidy is a matched subsidy. In order for district nursing organizations to receive the Commonwealth subsidy there has to be a subsidy from the State Government. The Chesalon Organisation said that despite repeated applications over many years, no State support and hence no Commonwealth support had been received. It appeared that the N.S.W. Government has chosen to channel its funds through its own Sydney Home Nursing Service.[24]

7.58 When this organisation was pressed about the possibility of receiving matching subsidies from local government, the Committee was advised that although discussions

had not formally been held with local governments, local councils are contacted annually reminding them that a service is being provided in their area, and a small donation might emerge.[25]

7.59 In 1976, as part of a Commonwealth cost cutting measure, a ceiling was placed on the Scheme which created a great deal of pressure on the services and of course, on other forms of care. The Royal District Nursing Service in N.S.W. estimated that between 1976 and 1981, when the ceiling was lifted, it needed something like 60 additional district nurses to deal with the patients referred to it during that time. It has had to handle the lack of staff by rationing and reducing visits, sometimes cancelling them. It was decided by the RDNS that in the light of restrictions and after considerable thought that it would not restrict its boundaries or withdraw services. That would not give them any idea of the unmet need in the community.

7.60 It was put to the Committee that there is a need for home nursing which is able to provide a more suitable and flexible service for people and which can be linked with other sorts of services such as day care and short term care. Services should be able to provide real relief to families who want to care for their aged but who need more than a twice-weekly visit from a nurse. Many families who genuinely want to care for their aged relatives do not have enough supports available to them to make it possible to go on year after year. The carer eventually breaks down.[26]

7.61 In a study conducted on behalf of the Australian Council of Community Nursing, the practicability of employing Home Health Aides was tested in a demonstration project. The study showed that, under the supervision of registered nurses, Home Health Aides were able to do many of the routine tasks currently done by home nurses, thus freeing the registered nurses for duties more appropriate to their training. Furthermore, with the assistance of Home Health Aides, trained nurses were in a better position to meet demands for their specialised and skilled services from elderly people in the community and scope for maintaining very disabled patients in the community has thereby extended.

7.62 The Committee recommends that:

Categories of staff for whom salary subsidies are paid should be widened to allow for the employment of Home Health Aides.

Domiciliary Nursing Care Benefit

7.63 The Domiciliary Nursing Care Benefit, at $21 per week, is significantly less in real terms than when it was introduced. It has declined from 40 per cent of the average ordinary nursing home benefit in N.S.W., Queensland and Tasmania in 1973 to just under 12 per cent in 1982-83.

7.64 The initial requirements for eligibility of two nursing visits per week have been relaxed after the first eight weeks, with visits made monthly thereafter, mainly for supervision and advice. However, there is no allowance for reasonable 'carer's relief' and 'holiday care', without suspension of the benefit.

7.65 The nursing organizations do not feel that it is their responsibility to carry out the administration of a Commonwealth benefit, and this reservation extends to advising people of their entitlement. As no other agency has this responsibility, the benefit is not always paid to those who qualify. These factors have undermined what has the potential to be one of the most effective supports and incentives for maintaining people in their own home.

7.66 Home based care saves the Commonwealth a good deal more than $3 a day by keeping people out of nursing homes. There are patients who have only minor problems but happen to have a relative in the same house who receives the benefit. On the other

hand there are also patients who are severely disabled but who do not have a relative in the house and who are ineligible for the benefit. A daughter living next door does not qualify; someone in the house most of the time is required. The effect may be that a daughter or daughter-in-law is tied down not going out of the house more than a couple of hours a day for the shopping in order to qualify for the benefit.[27]

7.67 It was said that, to qualify for the benefit the way is to get yourself a job the week before grandmother comes to live with you and then resign from the job when she arrives. The benefit is then given without argument.[28] The scheme falls down badly on cost effectiveness criteria. The cost of a visit by a qualified nurse, twice a week is approximately $16, which is a costly use of community resources in relation to the benefit of $21. The RDNS said that their whole agency is geared towards moving people towards independence and teaching relatives how to cope. But if they stop visiting the benefit stops.

An Attendant Care Allowance

7.68 Many elderly people who are not in nursing homes require assistance with personal tasks, such as rising and dressing in the mornings and undressing and getting to bed at night. This assistance is provided regularly by members of the family or other close associates where available. The Domiciliary Nursing Care Benefit (DNCB) is designed as a subsidy for caring relatives. However, the caring relative must care for the patient full-time and the home must be the residence of the applicant and patient. The Personal Care Subsidy (PCS) is paid to organisations which provide hostel accommodation for persons 80 years of age or over or who are receiving approved personal care services. The Home Nursing Subsidy Scheme provides financial assistance for home nursing services but these services are not usually available for personal tasks performed once or twice a day, and the cost of a professional nurse to perform such services is out of proportion to the skill required. There are obvious gaps in the DNCB and PCS which home nursing cannot fill. An Attendant Care allowance is seen as an alternative.

7.69 The need for the Attendant Care Allowance should be determined by assessment. It would provide the assessors with another alternative to nursing home care. The amount of the allowance would be based on the amount of attendant care time required. A maximum for the allowance should be fixed at a proportion of the ordinary care nursing home benefit. As with admissions to nursing homes, approval would require a recommendation by the assessors, who would also recommend the level of the allowance to be paid. The 'attendant' could be a relative, a friend, a person hired to do the job, staff in a hostel or boarding house or staff from a community organisation or nursing organisation employing care aides.

7.70 The Committee recommends that:

> **The replacement of the Domiciliary Nursing Care Benefit and Personal Care Subsidy with an Attendant Care Allowance which would pay for unskilled assistance without which the assessment team considers an elderly person would require institutional care.**

7.71 The Committee has received submissions and evidence on alarm systems and security devices for elderly people living by themselves. The systems and devices are designed to alert a central control or relatives if the elderly people fall ill. The security provided to the elderly and to concerned relatives by these systems and devices may be a significant factor in allowing elderly people to remain at home, rather than entering nursing homes. The Committee is also aware of some limitations of alarm systems and considers their use should be limited to carefully assessed situations.

7.72 The Committee recommends that:

Alarm systems be seen as one of the elements of community care that be provided under the proposed Extended Care Program, on the advice of the assessment team.

7.73 In summary, it is apparent that many of the problems in the home care area arise from the fragmented yet restrictive programs under which various services are provided. To overcome these limitations, an Extended Care Program is proposed, with grants made to the States on the same basis as for Nursing Home Care, that is, without matching requirements. The range of services to be provided are a matter for decision at local and regional level, with these recommendations co-ordinated by the State for funding in consultation with the Commonwealth.

7.74 The Committee recommends that:

The following strategy be implemented:

- **an Extended Care Program be introduced to replace the *States Grants (Home Care) Act 1969*, the *States Grants (Paramedical Services) Act 1969*, the Home Nursing Subsidy Scheme and the Delivered Meals Subsidy;**
- **the Extended Care Program include an Attendant Care Allowance to replace the Domiciliary Nursing Care Benefit and the Personal Care Subsidy;**
- **the range of services to be funded be decided in consultation with the States to encourage a diversity of services to meet local need;**
- **resources be distributed so as to achieve a basic provision in all areas rather than solely in response to submissions for funding; and**
- **the Extended Care Program be funded through a grant without matching conditions.**

CHAPTER 8

ASSESSMENT

8.1 A major concern of the Committee has been the problem of matching available or projected services and facilities to the health and welfare needs of the aged. Unless an adequate assessment is made of the individual's total situation, including personal, social, economic, psychological and physical conditions, inappropriate services could be prescribed or provided. This mismatch could be detrimental to the client and wasteful of resources.

8.2 Assessment also provides an opportunity to aggregate information about categories of patients and clients giving a basis for consultation between agencies in order to formulate appropriate strategies for the planning and delivery of services at a local or regional level.

The Need for Assessment

8.3 The Department of Health submitted that there is general consensus that the central element in any framework of services to aged persons is assessment.[1] It was said that the primary aim of assessment is to match services to the level of care which is most appropriate to the patient's degree of dependency and to ensure in particular that patients entering facilities catering for high levels of dependency need the level of care provided.

8.4 The ability of assessment to fulfil this role will depend on the availability of a range of alternative services. Another role for assessment teams is identifying situations where needs cannot be appropriately met by existing services and drawing this to the attention of the appropriate authority so that in time a better balance of services may be developed.

8.5 The main reasons given by Health for proposing the orderly development of assessment procedures are:

- existing assessment and placement arrangements are inadequate or non-existent;
- there is evidence of inappropriate admissions to expensive institutional services;
- a system of assessment teams should increase the well-being of disabled or frail aged persons by ensuring that they receive the most appropriate available care and rehabilitation, including discharge from hospital and institutional care, where appropriate;
- regional assessment teams could be a focus for the co-ordination of the many agencies involved in the provision of aged persons' services and be well placed to identify and advise on gaps and deficiencies in the current range of services.[2]

8.6 The main function seen by the Department of Health for assessment teams is to assess the appropriate level of care for aged persons on the basis of a person's physical, medical, psychological and social needs. Where appropriate, teams may also identify the aged person's rehabilitation needs and refer him or her for remedial services. In most situations where teams are now in operation they provide both the assessment and rehabilitation functions.

8.7 Assessment teams are most often suggested in the need to control admission to long term care institutions, especially nursing homes. In practice they have been invariably the team providing rehabilitation and care and organising appropriate support services

for their patients. The majority of such teams brought to the attention of the Committee were part of the services of State general hospitals, geriatric centres or community health centres.

8.8 The Committee received several submissions from geriatric services providing assessment, and heard further evidence on their activities. Existing assessment teams provide a number of models for development, and rather than introducing a new idea, the Committee feels that a sound foundation now exists on which expanded and more formal assessment services could be based.

8.9 Assessment teams are generally seen as multi-disciplinary, comprising a geriatrician or medical practitioner with experience in geriatrics, social worker, nurse, a range of remedial therapists and consultants and an administrator. It is envisaged by the Department of Health that each team would be responsible for a specific region and would have access to the full range of services for the aged including acute hospital and rehabilitation beds in its region.

8.10 The need to have access to acute hospital and rehabilitation beds means that in the majority of cases, the assessment team will be based in hospitals, although much of their work will be in the community. In rural areas, hospitals are well known by the elderly and are already a base for some community care services. Further expansion would involve the establishment of small geriatric and rehabilitation units at selected hospitals.

8.11 Assessment teams are already operating in various parts of Australia. Their influence in selecting appropriate accommodation for patients is part of their service role to clients and general practitioners. They have no formal authority and their influence is persuasive and advisory. Assessment teams are not, however, available in many areas, particularly in the country.

8.12 The Department of Health gave evidence that there is increasing support for the proposition that patients be admitted to nursing homes only via an assessment team. It is appreciated however that this could not be contemplated until assessment teams are readily accessible.[3]

8.13 Assessment teams should assist in co-ordination of services for aged persons which are provided and funded by Commonwealth, State and local governments, and by voluntary agencies, private practising professionals and private enterprise, and through personal efforts of families and associates. In the absence of a reasonably efficient market the task of efficiently and effectively co-ordinating these services is considerable. It appears to be generally accepted that this is a task best carried out at the regional level.

8.14 The Department of Social Security pointed out that a relatively small assessment team, based in a local health system and under the control of the appropriate health authority, can determine the real needs of individuals and ensure that they go to the services they require.[4]

8.15 Evidence was sought from several large voluntary organisations conducting deficit financed nursing homes as to whether they would accept external assessment. In evidence received from the Uniting Church of Victoria on the question whether they would be prepared to accept admissions to nursing home beds only on the recommendation of an assessment team it was acknowledged that

> 'this is the direction in which we should be heading. There may be some desire to retain some autonomy in deciding on the people who are being recommended for admission to the pre-admission assessment centre but I think that this must come in time . . . . It must apply across the board eventually but the gradual introduction of such a scheme may be preferable to immediate pre-admission assessment for all types of care'.[5]

8.16 A nursing home proprietor said they would be very happy to accept that assessment provided he could still select the patients he wished to admit and providing the elderly persons themselves or their families could still decide which nursing home they wished to be admitted. He said that they would welcome an outside assessment and that it 'would get us off the hook many times'.[6]

8.17 Making the general point of the need for assessment, a private nursing home proprietor said that by spending a reasonable amount of time just talking on the telephone to families and helping them to explore available alternatives it was found quite often that an immediate nursing home bed was not the answer to the problem. A thorough assessment would not only stop inappropriate admissions but it would also help families to understand that there are alternatives.[7]

8.18 The general practitioner is frequently the first point of contact when the possible need for admission arises. The general practitioner, working in areas where multidisiplinary team services are available, frequently uses them as a treatment and information service to relieve him of the difficult and unpleasant task of taking responsibility for advising old people or their families about appropriate care and accommodation. This involvement can be seen as a modification of the role that the general practitioner currently has in admission through completion of the NH5 form.

8.19 It is acknowledged that the establishment of assessment teams operating at the State and regional level would require additional funding. It would be difficult to build in an incentive for the States to pay for them and use them if the Commonwealth were still paying all nursing home benefits. There is a limited number of nursing home beds. The assessment teams could achieve better use of these beds being an appropriate rationing device.[8]

8.20 The Department of Health envisages an assessment team for about every 250 000 head of population over all, which would result in somewhat over 50 teams across Australia. At about $200 000 per team the total cost would be about $10m.[9]

8.21 The Committee recommends that:

> **Additional finance for assessment teams be made available in the proposed Extended Care Program, with the introduction of additional teams planned in consultation with the States.**

Problems with Assessment

8.22 The Department of Social Security pointed to a number of problems involved in the introduction of mandatory assessment for admission to nursing homes. Essentially these were seen as: a shortage of adequately trained manpower; a 'lack of balance between the acute health care system and geriatrics and gerontology';[10] the 'continuing territorial disputes between health and welfare departments particularly at State level;[11] attitudes amongst the medical profession which are resistant to the notion of team assessment; and reservations amongst the aged themselves.[12] Social Security also added the important point that there is

> 'the problem of lack of hard evidence as to what numbers and types of people we are really talking about as being able to benefit from the range of home care services to which they would have to be directed if you had an assessment system in place. Then there is the chicken and egg problem. If you have not got the services, why bother assessing? If you do not assess you will never know what services you need and therefore you will never get the community pressure for those services.'[13]

8.23 The Committee recommends that:

Special attention be given to the training of staff for all levels of care of the aged as a basic input in the development of services and that appropriate training programs be part of the Extended Care Program.

Introduction of Assessment Procedures

8.24 A major improvement that is necessary to the operation and delivery of services is the introduction of effective assessment of clients to match the services provided to the needs of the clients. The Committee is conscious that assessment for nursing home admission and approval of benefits has been proposed for many years but has not been implemented at the Commonwealth level. It considers that for assessment to be introduced successfully:

- existing mechanisms should be used where possible;
- the Commonwealth should fund the assessment services; and
- approval for receiving a government funded aged care service should be contingent upon the approval of those assessing needs.

8.25 The Committee considers that it would be impractical for the Commonwealth to be involved in assessment for services for which operational control is at the State and regional level or for which people meet the cost from their own resources. Apart from Commonwealth Medical Officers there is no mechanism through which the Commonwealth could conduct its own assessment. The States could authorise voluntary agencies to act on the States' behalf in conducting assessments.

8.26 The Committee recommends that:

The Commonwealth should negotiate an arrangement with the States whereby the State Health Authorities approve admissions to participating private and deficit funded nursing homes as they currently approve admissions to their State nursing homes.

8.27 As this assessment by panels of State health commission officers probably would require an increase in staff numbers, the States would not be expected to agree to the proposal without additional funds. Once aged care programs are transferred to the States and funded by Commonwealth grants, the cost of assessment would be included in those grants. In the meantime the Commonwealth should provide a grant to the States for assessment services.

8.28 The Committee recommends that:

The Commonwealth should provide additional funds to the States for assessment teams under the proposed Extended Care Program.The expectation is that in the long run a better use of public funds would be achieved.

8.29 Assessors should not be restricted to determining whether clients should enter nursing homes: they should assess the needs of aged people referred to them and have the responsibility to arrange for provision of services so as to meet the patient's needs should the patient request it.

8.30 The Committee recommends that:

Assessment for admission to nursing home care be introduced as speedily as possible and that it be in place at the time when administration of Aged Care Programs are handed over to the States.

CHAPTER 9

PLANNING AND RESOURCE ALLOCATION

9.1 The Committee came to the conclusion that the major problems giving rise to the imbalance between institutional and home care services stemmed from the procedures for planning and allocating public sector resources. The proportion of funds contributed by the Commonwealth towards the cost of delivering facilities and services for care of the aged varies considerably from program to program.

9.2 The Commonwealth provides nearly all the funds for institutional care. This almost exclusive funding of institutional care by the Commonwealth provides an obvious financial incentive for State and local governments and voluntary organisations to maintain or increase the provision of nursing home beds. By contrast, any increase in domiciliary care services, as proposed by the great majority of witnesses making submissions to the Committee, and by recent reports on the subject, would incur significant costs to the State Governments.

9.3 Under present arrangements, the States have only limited financial control over the provision of institutional care in the private and voluntary sectors. There are no incentives for them to seek this control because the Commonwealth is funding services and facilities. Funds not expended by the Commonwealth on institutional care are not available to the States or religious and charitable organisations or the private sector for alternative uses.

Policy Formulation, Implementation and Accountability

9.4 A major problem in providing assistance and care for the aged, and one contributing significantly to the imbalance in provision of facilities and services, is that programs have been developed independently and are delivered and financed in an uncoordinated combination. Schemes have been initiated in response to particular needs of the aged with little apparent consideration of the impact on other programs and services.

9.5 The Health portfolio is accountable for more funds and appears to have a greater role in the development of policy for the aged than any other Commonwealth instrumentality. Although the Minister for Social Security has responsibility for overall coordination of welfare and health matters and responsibility for income maintenance, there is no single Minister who is seen to have prime responsibility or from whom the Government can seek comprehensive advice on overall assistance for accommodation and care for the aged or who Parliament or the public can render accountable.

9.6 The Committee recommends that:

> **All programs providing home care and accommodation for the aged be brought under the control of one Minister. On balance the Committee considers the appropriate Minister is Health. Housing assistance to remain with the Minister responsible for the *Housing Assistance Act 1981*.**

9.7 The Commonwealth has very limited operational control over the actual delivery of the facilities and services for which it provides the finance. There is a gap in the chain of accountability between those who provide the services and the Commonwealth, which provides the money. Those engaged in the delivery of services are subject to State and local government rules and regulations if not directly employed by them.

9.8 State governments operate about one quarter of nursing home beds and, except in Queensland, they licence all nursing homes. They impose standards, including nursing hours, and regulate the design and siting of homes. The States administer hospitals including geriatric units, community health services and some home nursing services. Government responsibility for the aged is thus shared between State and Commonwealth health authorities.

9.9 Involvement in assistance and care for the aged by local governments varies considerably between and within the States. It includes the provision of welfare officers, day care centres, meals-on-wheels and low-cost shared accommodation. Rebates of local government charges, such as rates, are reimbursed to some extent by State governments. Some councils operate hostels, nursing homes and independent living units. In many States, local government is responsible for administration of health regulations as well as the supervision of building standards.

9.10 Religious and charitable organisations operate a wide range of services for the aged and provide 'free' labour and funds. Private enterprises operate many nursing homes and boarding houses for old people, and provide domestic nursing, home help, companion services, security systems and other services for the aged at home.

9.11 The place of family and other informal care is recognised in policy but the relationships between the formal and informal care systems have not been taken sufficiently into account in the planning of particular schemes. It is not clear, for example, whether some existing programs are to provide services which are to be supplements to, or substitutes for, family care. Policy needs to recognise more clearly the differing situations of aged people who have families able and willing to give support, and those who are without family support.

9.12 The private sector is heavily involved in the provision of nursing home care. Its major interest is, naturally enough, profit and a return on share-holders funds. So long as subsidised beds are in short supply, there may be an inadequate incentive to provide the highest possible standard of patient care. From the Committee's observations of nursing homes in the public, private and voluntary sectors, it believes that the same standard of care can be achieved in all sectors. However, in pursuit of this endeavour there may be a conflict in terms of the cost of providing acceptable standards of patient care and maintaining adequate levels of profitability.

9.13 The Committee considers that, as a result of the divided responsibility between all levels of Government and the private sector, it has been, and is, very difficult to deliver services which provide formal care and assistance for the aged at levels which meet their functional and social needs. The divided responsibility has limited the Commonwealth Government's ability to better match public support to perceived needs.

9.14 In discussing the allocation of resources to achieve a better balance between requirements and services it has become usual to talk in terms of a 'continuum of care services'. The 'continuum of care services' concept does not mean that the aged person progresses through these levels of care, but refers to the range of services that are necessary to meet different levels of dependency. It is worth reiterating that the majority of the aged remain at home, with primary care from their own doctor and acute care in hospital as necessary, and that only a minority enter or move through other levels of care.

9.15 One recent statement of the 'continuum of care' is that prepared by the Australian Council of Intergovernment Relations (ACIR).[1] The ACIR has categorised the needs of individual aged persons within the following situations:—

(a) living at home without help;
(b) living at home with community support services;

(c) living with relatives;
(d) hostel and licensed boarding home accommodation;
(e) nursing homes;
(f) geriatric accommodation in State general hospitals;
(g) acute hospital care;
(h) intensive terminal hospital care.

9.16 The December 1979 study by the Commonwealth Department of Health indicates that the overall resource cost of these situations increases from (a) to (h).[2] It is also a good approximation to state that the combined resource costs to government (or taxpayers) also follow this pattern.

9.17 The Committee was advised of some of the costs associated with delivery of services in various categories of care. The South Australian Health Commission stated that costs 'range from a cost of one dollar a day to deliver meals-on-wheels in South Australia; $1.90 for domiciliary care; a bit over $7 for domiciliary nursing through $33 in the private nursing home sector; $35 in the deficit funded nursing home sector; $63 in the home for incurables, which is possibly the largest nursing home in this country; $70 a day at the Hampstead Centre of Royal Adelaide Hospital; $127 a day in the general wards of a medical hospital, and $781 per occupied bed day in an intensive care unit.[3]

9.18 These are of course public sector costs. Most of the discussion is in fact in terms of the cost to taxpayers. This ignores significant private costs and lost earnings of having workers staying at home to care for aged relatives.

9.19 The Auditor-General in his *Efficiency Audit of Commonwealth Nursing Home Programs* expressed concern that there was

> 'a lack of an integrated approach to care of the aged which appears to be leading to increased financial support to high cost institutional nursing care and to a mismatch between the real care requirements of individual patients and the types of care provided.'[4]

9.20 The Expenditure Committee, in its review of the Auditor-General's Efficiency Audit, identified two causes of this mismatch from the Report. The first was that 'the planning process for nursing home care is generally isolated from the processes for related programs, that planning is fragmented between Commonwealth and State agencies and that interdepartmental program effectiveness reviews do not appear to result in an adequately integrated program directed at care of the aged and infirm'.[5] The Audit Report stated 'there is no single coherent formal strategy for rational matching of needs and services (or funding of services) for the aged and infirm'.[6]

9.21 The second apparent cause of the problem, identified by the Expenditure Committee from the Efficiency Audit is 'the lack of information for effective planning and evaluation'.[7] The Auditor concluded that the social and medical impacts of nursing home programs have not been evaluated by Health as part of a formal policy review mechanism. There is an absence of comprehensive profiles of present and future needs of the aged and infirm and an absence of comprehensive information or services currently available to them.[8]

9.22 The Committee, from its own inquiries, endorses the findings of the Efficiency Audit. However, the Committee is of the view that improvement will not be forthcoming without giving attention to resolving the fundamental problem that some programs are fully funded by the Commonwealth, some are cost shared and some are not funded at all. This problem is aggravated by the fact that the Commonwealth does not have equal control over all the areas of expenditure in which it is involved.

9.23 The divided responsibilities between Commonwealth and States is the major shortcoming which gives rise to the inadequate machinery for planning, policy

formulation and advice, as well as the lack of accountability in terms of implementation, performance and effectiveness review. In these respects the Committee echoes the sentiment of the Expenditure Committee when it examined the Auditor-General's Efficiency Audit Report:

> 'It appears to the Committee that the basic problem—the dilemma—in this area relates to questions of funding and responsibility.'[9]

9.24 The result has been the dominance and relative opulence of institutional health based facilities and the uneven and mostly inadequate supply of community based domiciliary services.

Budgeting and Allocation of Public Expenditure

9.25 Not all of the blame for the 'mismatch' between real care requirements of patients and types of care provided should be attributed to the problem of divided financial and functional responsibilities between Commonwealth and States. The procedures for determining Commonwealth budget allocations for Accommodation and Home Care for the Aged tend to reinforce the expansion of nursing home care whilst placing further pressure on the domiciliary sector.

9.26 Major Commonwealth budgetary decisions tend to be made at the appropriation level, and on a portfolio basis, rather than a 'program' basis. Because some appropriations are 'annual'—that is, terminate at the end of the financial year—and others are 'special'—that is, represent on-going authorities, the procedures for examination, review and scrutiny are not universally applied to all aspects of Commonwealth involvement in Accommodation and Home Care for the Aged. These differences give rise to imbalance in financial allocations and may lead to unintended policy outcomes. Mention was made in Chapter 2 of the impact of the virtually unrestricted growth in nursing home beds, financed from one of the Commonwealth's own capital subsidy programs, compared with the tight budgetary controls placed over funds for domiciliary care.

9.27 In a Submission to the Inquiry, the Department of Finance made the point that the annual Budget provides the main framework for expenditure review and decision making processes. Finance said that the Budget processes involve an examination of individual appropriations and programs and of expenditure in aggregate and

> 'are designed to result in each program competing for funds with every other program within a level of aggregate expenditure that the Government considers appropriate. Ministers may consider funding of programs in the light of such evaluative data as are available, but it is not, of course, possible to conduct an in depth evaluation of each program each year as part of the Budget processes; nor do the processes automatically result in the examination of particular efficiency objectives involving several programs'.[10]

9.28 The focus of the Budget processes on appropriations and individual programs (the terms are used interchangeably) and the neglect of broader efficiency objectives involving several programs, may lead to distortions in the allocation of public expenditure in the area of Accommodation and Home Care for the Aged. This outcome is particularly likely if some appropriations or programs can be subjected more readily to detailed financial control than others which provide for alternative or complementary forms of care and assistance.

9.29 Decisions on the level of funds to be allocated for Home Care Services are taken annually in the budget context. In taking those decisions, Ministers generally set limits to the number of organizations to be funded, which in turn sets a ceiling on the amount to be provided in the annual Appropriation Bills. Similar considerations apply to Home Nursing Subsidies where the number of organizations to be funded can be subject to

control, thus indirectly setting a limit on the level of public expenditure. The level of service provided under these schemes is similarly fixed.

9.30 By contrast, nursing home benefits and deficit finance subsidies are provided as *on going authorities* under the *National Health Act 1953*, the *Nursing Homes Assistance Act 1974* and the *National Welfare Fund Act 1947*. The amount provided in the Budget in any year is an estimate based on the number of beneficiaries and the level of benefits. Apart from checking the accuracy of the figuring, Ministers have little control over how much is to be provided at the time of the Budget.

9.31 More importantly, however, the number of beneficiaries in receipt of nursing home benefit is determined by the number of beds available. Decisions relating to an increase in the number of beds are taken by the Director General of Health under the *National Health Act 1953*. In making that decision, on the advice of the Commonwealth State Co-ordinating committees, the Director General is not formally required to consult with either the Department of Finance or any other Department on the budgetary implications even though the approval of new nursing home beds gives rise to significant on-going increase in Commonwealth expenditure.

9.32 Furthermore, decisions relating to the level of nursing home benefits are made by the Minister for Health on the basis of a fees survey. These decisions which might involve significant additional public expenditure are subsequently endorsed by the Government in October each year to come into effect from the first pension pay day in November. However the procedure is a contrast to setting expenditure levels for delivered meals, personal care and domiciliary care benefits, where decisions tend to be taken by Ministers in accordance with the Budget processes.

9.33 In these circumstances it is difficult to envisage how the balance between institutional and community care could ever change. Even with expansion of domiciliary services, the balance need not change, and could even regress, if outlays on institutional care continue to grow at an even faster rate.

9.34 This situation represents a serious deficiency in budgetary management and control. In effect, expenditure decisions are taken outside the budget context and without regard to priorities. It follows also that there is a serious shortcoming in the financial accountability to the Parliament.

9.35 The Committee recommends that:

Pending the introduction of the Nursing Home Care Program, decisions giving rise to the approvals of new nursing home beds or increasing nursing home benefits be subject to the formal Government approval and that the decision be made in the annual budget context reflecting overall expenditure priorities in Accommodation and Home Care for the Aged.

9.36 The South Australian Government made the obvious but important point that there is no guarantee that the existing total levels of expenditure are 'right', or that the needs of the aged would be best met by changing the pattern of existing programs. The submission added that this is not to deny that some change in the balance within programs would better meet needs. It merely sought to make the point that any justification on the ground of cost-effectiveness should take into account the possibility of reallocating existing expenditures between care for the aged and other areas of expenditures on particular programs. Such decisions require a facility for assessing relative cost effectiveness and priorities across the entire range of government programs.[11] Such considerations are outside the scope of this inquiry.

9.37 The Committee believes that there should be a co-incidence in responsibility for deciding on the allocation of expenditure and the organization and delivery of all services and facilities. It is considered that a substantial injection of funds into domiciliary care would be required to establish a system that could offer an effective alternative to nursing home care which the presently fragmented and incomplete services are unable to do. Savings on nursing home expenditure to offset increased domiciliary care expenditure may not be possible in the first year but it would be possible for either State or Commonwealth Governments to contain future nursing home expenditure so that savings are assured thereafter.

The Division of Responsibility

9.38 The Jamison Commission saw the appropriate division of responsibility between the Commonwealth and the States as follows:

> 'The Commonwealth has the responsibility of providing some funds and being satisfied that adequate health care is provided to all Australians. The States have the responsibility of administering hospital and other services and providing additional funds, and as such must encourage the efficiency of the system for the benefit of themselves as well as the users. For this reason separate objectives must be laid down by the State and Territory Governments to cover the two differing roles'.[12]

Although the Commission's conclusions apply specifically to the health and hospitals area, they also have relevance to the provision of community welfare services.

9.39 It is evident that present funding arrangements promote a heavy bias in favour of institutional care, particularly nursing home care. The Committee believes that it will not be possible to direct resources available for accommodation and home care of the aged to those areas where they can be most effectively utilized until the procedures for allocating and distributing funds are changed.

9.40 Under present arrangements, programs which provide recurrent subsidies for institutional care are fully funded by the Commonwealth, while programs which provide domiciliary care are generally cost shared. There is little financial incentive therefore for States or voluntary organisations to move towards changing the balance towards the provision of more domiciliary services. States generally contribute to the provision of home care services above and beyond the contribution required under cost sharing arrangements, but evidence suggests that the resources of voluntary groups, including labour, are becoming difficult to obtain.

9.41 The Committee considers that the actual planning and delivery of accommodation and home care services for the aged is a matter best performed by State and local government. The Committee's main reason for taking this view is that State and local governments are now responsible for regulation and supervision of facilities and services and, for constitutional and practical reasons are best fitted for that task. This arrangement will avoid confusion, damaging conflict of interest and buck-passing if these levels of government are also responsible and accountable for the support and financing of the services.

9.42 The level and extent of future Commonwealth financial involvement is taken up in Chapter 10. It is envisaged that State Government would become responsible for the distribution and allocation of subsidies and other forms of recurrent financial assistance to their own authorities, local government, religious and charitable organizations and the private sector. The Committee believes that all services should be planned and delivered on a regional basis, probably involving the active participation of local Government. A pragmatic reason for adopting this view is that a number of geriatric services currently operate in this way, and State health and welfare services are sometimes organised in this framework.

9.43 There is little doubt that most individuals and organizations would like to see greater emphasis on community based domiciliary services but as the South Australian Government pointed out:

> 'There needs *to be a greater integration of objectives in programs/facilities for the aged if the home care option is to be made more attractive.* The difficulty with this is that there are such a wide variety of organisations and agencies involved with Commonwealth, State and Local Governments in providing services and facilities to the Aged.'[13]

However, it was added that 'the State Government is concerned that there should not be an attempt to dictate to those non-government organizations that provide valuable services to the aged.'[14]

9.44 Many reviews and inquiries in the area of care for the aged have neglected the important role of local government. Local government has had a major responsibility for the care of those in need. State governments support of local government in lieu of direct provision of services is uneven and not uniformly accepted by all 800 local authorities in Australia. The organisation and delivery of community based services is well suited to local government. It was put to the Committee by the City of Fitzroy that:

> 'no decision should be made at State and Commonwealth level about putting public moneys into any institution, or day centre, or anything else without asking the local area what is needed and establishing what it already has; it has to be established whether more beds are needed or not. Some planning guidelines are needed on this but local governments must be consulted about how it all fits together and about their most urgent needs. *They very rarely are.* Most groups in other State or Commonwealth governments which make decisions on funding do not ask the local areas what is needed. Services which are not needed have been imposed on local areas. This is particularly true of nursing homes'.[15]

Other local Government Authorities expressed similar views, and the Committee endorses this sentiment.

9.45 The Committee received evidence of how local government had been able to co-ordinate the organization and delivery of services in co-operation with State authorities and voluntary organizations. It believes this trend should continue and be encouraged.

9.46 The Committee recommends that:

> **State Governments should actively assist and support local government in organizing the delivery and planning of health and welfare services for the aged.**

Planning Procedures

9.47 The Expenditure Committee, in its Review of the Auditor-General's Efficiency Audit of Nursing Home Programs commented on Audit's proposal for an integrated approach to care of the aged to correct the 'mismatch' between the real care requirements of individual patients and the types of care provided.[16] This approach was identified by the Committee to involve four parts:

- A system of patient admission and classification involving the introduction of multi-disciplinary assessment panels which would physically examine the patient and assess the need for care in accordance with established criteria.
- Community research into requirements for nursing home beds as part of a more general assessment of community requirements for the range of accommodation and support services for the aged and infirm.
- Planning for nursing home care within the structure of an integrated long-term view of the range of needs of the aged and the infirm and the development of a structured approach to providing funds and services to meet those needs.
- Evaluation of program outcomes which would include joint evaluation and planning for related programs.[17]

9.48 The Expenditure Committee stated that long-term planning, 'using the information obtained from research and assessment would entail projections of the extent to which a particular type of service is needed and where it is needed, so that such projections can be linked with formal planning of Commonwealth expenditure'.[18] The Expenditure Committee questioned whether the integrated approach to care of the aged, as suggested by the Auditor, would provide a basis for correcting the mismatch between real care requirements of individual patients and the type of care provided and, *at the same time*, reduce or contain Commonwealth expenditure.[19]

9.49 The Committee believes that an integrated approach to care of the aged consistent with containing Commonwealth expenditure is possible in terms of the changes in the financing, operation and responsibility for programs providing care for the aged as set out in this Report.

9.50 Under present arrangements the introduction of formal planning procedures by the Commonwealth, as suggested by the Auditor-General, would be difficult. The Committee takes the view that planning the allocation and distribution of facilities and services for the aged in the public sector would be best performed at the State and local government level. As mentioned previously these levels of government have responsibility for the supervision, regulation and control of services conducted either in the public or private domain.

9.51 Commonwealth influence is limited to attaching terms and conditions to financial assistance and payments. Not only do these procedures limit Commonwealth influence in setting standards for the delivery of services and provision of facilities, they also severely restrict accountability. There is no clear link between those who deliver the service and the Commonwealth which pays the money because of the intercession of State and local authorities which set standards and enforce controls.

9.52 The Committee recommends that:

Planning the organization and delivery of health and welfare services for the aged should be a matter for State and local government. Commonwealth involvement should be limited to the provision of finance for the broad, general purposes as outlined in previous recommendations, until such time as full responsibility is handed over to the States.

CHAPTER 10

CONCLUSIONS: A FRAMEWORK FOR FUTURE DEVELOPMENT

10.1 the Committee considers that the problems identified in the provision of accommodation and home care services for the aged can be best overcome by establishing an integrated framework for future development, within which recommendations for action in specific areas can be pursued. This framework should also provide a timetable for planning and implementation of the recommended changes.

10.2 The Committee recommends that:

> **A change to present arrangements to achieve: a reduction in the number of programs; responsibility to be brought under one Minister; modifications to financial arrangements to remove disincentives for the expansion of home care services; similar forms of control over all categories of program expenditure; and, a reallocation of resources between institutional and community care.**
>
> **Transfer of the restructured accommodation and home care programs to the States, over a five year period, initially through grants moving towards eventual absorption in the tax sharing arrangements.**

10.3 A three stage strategy for implementation of the proposed framework is:

- restructuring of programs and funding arrangements
- negotiations with the States
- transfer of responsibility to the States.

10.4 The Committee sees the first stage as a short term objective and the second and third stages as longer term objectives. Recommendations relating to the first stage have been included in earlier chapters. They are also summarized in the Introductory sections of the Report. The Committee is of the view that in the event that the Commonwealth is unable to proceed beyond the first stage, achievement of that objective would, of itself, result in significant improvements in the provision of acommodation and home care services.

10.5 The Committee considers that a co-ordinating body will be required to oversee the proposed changes and to enter into negotiations both between Commonwealth Departments and with the States. To this end, an Office of Care for the Aged is proposed, with detailed recommendations specified below.

Restructuring of Programs

10.6 The Committee recommends that:

> **The number of programs should be reduced to an Extended Care Program, and a Nursing Home Care Program, with subsidised housing provided under the *Housing Assistance Act 1981.***

10.7 The *Extended Care Program* should be provided as a grant to States for community and home care services. As well as replacing current programs in this area, restrictions currently applied in these separate Acts would be removed to allow flexibility

in the development of a wider range of services, including an Attendant Care Allowance and funding for Assessment Teams.

10.8 The Extended Care Program would incorporate benefits and subsidies currently provided as follows:

- the *Home Nursing Subsidy Act, 1957*
- the *States Grants (Home Care) Act, 1969*
- the *Delivered Meals Subsidy Act, 1970*
- the *States Grants (Paramedical Service) Act, 1969*
- the Domiciliary Nursing Care Benefit (*National Health Act, 1953*)
- the Personal Care Subsidy (*Aged or Disabled Persons Homes Act, 1954*)

10.9 The Domiciliary Nursing Care Benefit and Personal Care Subsidy are to be replaced by an Attendant Care Allowance. Control of the Attendant Care Allowance would come within the ambit of regional assessment teams which would assess the needs of the applicant, including in this case financial need, and recommend distribution of funds to them subject to an upper limit. The allowance is seen as another element in the range of services which the assessment team can call on.

10.10 Additional funds for existing assessment team and introduction of further teams would also be provided under the Extended Care Program.

10.11 Among additional services that may be developed under the Extended Care Program, particular attention should be given to community psychogeriatric services, and the integration of these services with other services as far as possible.

10.12 The *Nursing Home Care Program* is to replace current Nursing Home Benefits under the *National Health Act 1953* and the *Nursing Homes Assistance Act 1974*. Payments would be made to State Health Authorities in order that they can 'contract out' nursing care to private, religious and charitable organizations on the basis of subsidy. It is envisaged that the Nursing Home Care grant, while still being calculated primarily on a per capita basis, would be paid formally and directly to the organizations and institutions as a subsidy by State Health Authorities. The minimum patient contribution would be retained.

10.13 Subsidised accommodation is to be provided wholly through the *Housing Assistance Act 1981*. This change will ensure that subsidised accommodation is directed to those in need rather than the rehousing of those who have sufficient resources. The *Housing Assistance Act 1981* already provides flexibility in the form of accommodation, indirect housing assistance, and for joint ventures with local government and voluntary organizations. Decisions on the allocation of funds for different purposes under the *Housing Assistance Act 1981* should be made in consultation with State Housing authorities. Accommodation for disabled persons would be provided under a separate program.

10.14 The Committee proposes the strategy of a staged restructuring and transfer of programs as a means of ensuring that there is some change in the balance of institutional and community care. Changes to funding arrangements and controls over expenditure are designed to bring about this outcome.

10.15 The grants made under the Extended Care Program and the Nursing Home Program should be on the same basis. To overcome the disincentive arising out of cost sharing arrangements applying to some Acts providing for community care services, no matching funding should be required for any grants. The Committee considers that the advantages of a common basis for funding will more than offset any tendency of the States to reduce their contribution to home care services. Since States already make expenditure in this area above and beyond that which attracts matching

Commonwealth funds, it is anticipated that such expenditure would continue. The move to absorption in a relatively short period is also seen as a factor encouraging States to maintain their input to extended care.

10.16 It is proposed that strict control be exercised over the growth of nursing home beds during the five year transition period to bring about a further shift in resource allocation between institutional care and community care. Decisions concerning the provision of additional nursing accommodation would be made by State authorities in the light of their own priorities, and in relation to their respective State hospital systems. However, it is proposed that where decisions are made on further nursing home accommodation in areas of demonstrated scarcity generating consequent on-going expenditure under the Nursing Home Care Program, consideration should be given to alternative development of community services under the Extended Care Program. That is, the Extended Care Program should be regarded as an alternative to further expenditure under the Nursing Home Care Program.

10.17 With both programs funded through grants, the relative allocation to each will be a matter for annual decision. The opportunity for Government to consider both programs at the same time should encourage a more rational approach to planning and resource allocation. There would be an opportunity for considering alternative use of resources so that a nursing home forgone is not necessarily funds lost to the State.

Transfer of responsibility to the States

10.18 Prime responsibility for administration and control of aged care programs must rest with either the State or Commonwealth governments. The Committee notes, however, that whichever level ultimately takes prime responsibility, the other levels of government may be involved. That is, if the Federal Government were to retain control of the financing and administration of programs, the States would continue to have major responsibility for implementation and supervision. This would perpetuate the present situation. Alternatively, even if prime responsibility were shifted to State level, the Commonwealth Government would still, given the present tax sharing arrangements, have to take aged care into account when considering the level of funds to be allocated to the States.

10.19 Attempts by the Commonwealth to move more directly into the area of community services, such as through the Australian Assistance Plan, which was built around the provision of public welfare services, gave rise to resentment by local government and legal challenges by the States. Hence, the State would appear to be a logical level of government at which to place responsibility for aged care programs. If States had the responsibility, each State would be free to vary the mix of program funding according to its particular requirements, without jeopardising the funds available to other States. Among other outcomes, this move could overcome the current inequitable State by State variation in nursing home benefits.

10.20 The readiness of State Governments to carry out the planning and delivery of care for the aged is evidenced in a number of reports that have appeared in recent years setting out policy goals and strategy plans. In New South Wales, a Task Force on Medical Rehabilitation and Extended Care reported in 1975, and in South Australia, the *Report of a Working Party to the Committee on Accommodation, Domiciliary Care and Medical Rehabilitation for the Elderly* was presented in 1978. Aspects of care of the aged were covered in a report, *Needs of the Handicapped*, made to the Tasmanian Government in 1980, and an Extended Care Working Party at the Sir Charles Gardner Hospital in Perth outlined plans for Western Australia.

10.21 A document, *Care of the Aged : First Consolidated Report of the Advisory Committee*, was presented in Queensland in 1981. A Working Party on Extended Care of Aged or Disabled Persons in Victoria also reported in that year. Even though not all these reports have become official government policy, they do show that State Governments are well advanced in their deliberations in this area.

10.22 Officers of numerous State health, welfare and housing authorities stated in evidence to the Committee, that they were generally in support of the States taking more direct responsibility for expenditure decisions.

10.23 Consideration also needs to be given to the level at which the control, administration and delivery of programs should be organised. The Commonwealth-State Coordinating Committees, which provide the existing machinery for planning nursing home accommodation and some other aged care services, work on a regional basis. However, the considerable regional variations appear to indicate that the Committees are currently unable to ensure that each region is provided with the appropriate number of nursing home beds and that a range of service options is available in each region. The Commonwealth does not, at the present time have a regional policy. It does not give any attention to the planning and allocation of public sector resources below the State level.

10.24 By contrast, most States use a regional approach in the planning, organization and delivery of health services. In some States this extends to other functions, such as housing and urban facilities and services. It might be expected that community based medical, para-medical and other professional staff in each region are aware of services available and the broad characteristics and requirements of the aged in the area concerned. These people are seen to be in a better position to plan, control and deliver services than more distant bureaucracy.

10.25 Community nursing, hospital-based geriatric units and many domiciliary services are already organised at the regional level. Regional organization and control of services for the aged therefore would fit comfortably with existing services provided at State level. Assessment of the needs of individual aged people should be made at the regional level. Several States already are administering assessment teams together with relevant health and other services on a regional basis.

10.26 The Committee recommends that:

The planning and delivery of programs should be conducted at the regional level

10.27 Until such time as the transfer to the States is completed the Commonwealth could appropriate the grants through either annual appropriation acts or as an on-going or 'special' appropriation. The former method has the advantage of allowing the Government greater freedom to make decisions each year about expenditure on care for the aged, as with expenditure on other budget items, within the overall budget context. Thus the amount appropriated might depend on the relative priority the Commonwealth attached to care for aged given the prevailing economic circumstances.

10.28 By contrast an ongoing, or 'special' appropriation would require further legislative action to change expenditure commitments as is the case currently with Nursing Home Benefits and Nursing Homes Assistance. Special appropriations have the advantage that the States would know that they could rely on at least a certain minimum of funds for care of the aged for planning purposes. That is, annual appropriations give greater budgetary flexibility to the Commonwealth while special appropriations give greater certainty to the States.

10.29 The Department of Health said in evidence that if the programs were to pass to the States, on a specific purposes grant basis it would be most desirable (the States seeing it as being essential) that there be Commonwealth legislation on a specific granting basis. Health gave the opinion that appropriations should be contained in the legislation, specified and indexed: otherwise States will not be attracted to support the proposals. This position was supported in evidence to the Committee from many State Authorities who were otherwise attracted to the idea of transferring responsibility.

10.30 According to the Department of Health, the States have come to look upon the Commonwealth with some sort of disfavour in the health area in the last 10 years, in that the Commonwealth has started up programs in a grandiose way with generous funding arrangments then moved out and reduced the funding so that the States have to implement the programs on their own or face the political odium of reducing them. The States have been forced to chase the Commonwealth dollar and subjugate their priorities to whatever the Commonwealth's priority may be. The States have always looked to the Commonwealth to get specific legislation with specific appropriations.[1]

10.31 The Department of Health also noted that the Federal Government has not been inclined in more recent years to include appropriations within special legislation. Appropriations are generally included in the annual Appropriation Bills which are presented to the Parliament each year. The Department of Health also stressed that if the management and administration of these programs is to be transferred to the States, now or eventually, it should be done totally. This means that the Commonwealth funding should be through the tax sharing arrangements.[2]

10.32 The Department of Health referred to the rather traumatic exercise in establishing the transfer through tax sharing of the hospitals program, the community health and school dental scheme. However, the Commonwealth, in the *States (Tax Sharing and Health Grants) Act 1981*, has established that it can put conditions on identifiable grants. These conditions were made in relation to free access of pensioner health benefit (PHB) card holders and other health care card holders to free services in the public hospital system.

10.33 If decisions are made to transfer these programs, including the very costly institutional nursing home program to the States under the Tax Sharing provision, it is possible to apply conditions to those grants. There is a penalty mechanism in the present tax sharing legislation which provides that if the Treasurer is satisfied that the States are not pulling their weight and providing for free services to PHB card holders the grant can be reduced.[3]

10.34 The Committee was advised by the Department of Health that the mechanism for setting conditions is there and it has now been proven. It has been quite effective and requires the States to carry out and provide specified services. Total flexibility with these specifications enables States to vary their programs to reflect their own priorities.

10.35 The Committee recommends that:

> **The Commonwealth negotiate an Agreement with each State to operate for a period of five years, to cover the transfer of responsibility. After five years payments should be absorbed within the Tax Sharing Arrangements.**

The Committee counsels against *immediate* absorption due to the problem that would arise in terms of fiscal relativities between the States because of the likely magnitude of the adjustments that would be required in the short term.

10.36 The Committee considers that the Agreements with the States, referred to in the previous recommendation should be the subject of legislative endorsement under a

States Grants (Extended Care) Act and a *State Grants (Nursing Home Care) Act* or other titles as the Government might determine.

Office of Care for the Aged

10.37 The Committee recommends that:

> **A special unit be established to provide the Government with policy advice on all initiatives and programs which provide facilities and services for the aged, and that this unit be given the title *Office of Care for the Aged*. The unit would advise on policy in respect of the aged among all Commonwealth agencies involved in providing assistance to the aged, namely the Departments of Health, Social Security, Veterans' Affairs, Aboriginal Affairs, and Immigration and Ethnic Affairs.**

10.38 The major purpose of the Office of Care for the Aged would be to develop a national policy on how best to provide assistance to meet the accommodation and home care needs of the aged. It would serve also as a focus for clients and organizations, as well as for people delivering accommodation and home care services to the aged.

10.39 The Office would assist in advising on and monitoring implementation of this Inquiry's recommendations, and could commission research into areas of concern, possibly through the Health Service Research and Development Grants. Once programs have been transferred to the States, the Office would have continuing responsibilities in representing the Commonwealth in negotiations with the States on the size and distribution of grants, proposed in the preceding section, and monitoring the effectiveness of the expenditure by the States.

10.40 The Office would have the responsibility for evaluation and development of government policy to ensure that the welfare of the aged is adequately taken into account in all Commonwealth programs. In these circumstances, the Committee recommends that:

> **The Office of Care for the Aged should be located within the Prime Minister's Portfolio.**

10.41 The Committee is disturbed that little action has resulted from earlier major inquiries on care for the aged. It wishes to ensure that the Parliament and the public are kept fully informed on the Government's actions to overcome existing shortcomings and its implementation of those of this Inquiry's recommendations that it accepts.

10.42 The Committee recommends that:

> **In addition to the traditional Governmental response within 6 months of the tabling of the Report of this Inquiry, the Government should present a review of the effectiveness of aged care programs to the Parliament five years after the Report is tabled. The paper should describe the Government's achievements to that time and its further plans.**

STEPHEN LUSHER
Chairman

13 October, 1982

ENDNOTES

CHAPTER 1

1. P. D. Phillips, 'Federalism and the Provision of Social Services', in J. Rae (ed.), *Social Policy in Australia: Some Perspectives 1901-75*, Cassell, Sydney, 1976.
2. It should be noted, however, that the criteria for pension eligibility do in fact determine the allocation of certain free or concessional services for pensioners. For example, a range of 'fringe benefits' is available for PHB card holders as well as free health care.
3. Australia, Parliament, Commission of Inquiry into the Efficiency and Administration of Hospitals (J. Jamison, Chairman), *Report, Volume 2, Supplement*, Parl. Paper 21, Canberra, 1981, p. 123. Emphasis by Committee.
4. Social Welfare Commission, *Care of the Aged*, AGPS, Canberra, 1975, p. 8.
5. Australia, Parliament, Commission of Inquiry into Poverty (First Main Report, Prof. R. F. Henderson, Chairman), *Poverty in Australia*, Parl. Paper 210, Canberra, 1975, p. 253.
6. Australia, Parliament, Committee on the Care of the Aged and Infirm (A. Holmes, Chairman), *Report*, Parl. Paper 46, Canberra, 1977, p. 2.
7. Commission of Inquiry into the Efficiency and Administration of Hospitals, op. cit., p. 79.
8. ibid, p. 80.
9. ibid.
10. ibid, p. 82.
11. Australia, Parliament, Office of the Auditor-General, *Report of the Auditor-General on an Efficiency Audit Report: Commonwealth Administration of Nursing Home Programs*, Parl. Paper 12, Canberra, 1981, p. 7.
12. Evidence, p. 2465.
13. Evidence, p. 964.
14. See *Budget Statements, 1982-83*, pp. 100-25.
15. ibid, pp. 87-100.
16. Commission of Inquiry into the Efficiency and Administration of Hospitals, op. cit. p. 613.
17. Evidence, p. 2239.
18. Australia. Parliament, *Parliament and Public Expenditure: Report from the House of Representatives Standing Committee on Expenditure*, Parl. Paper 66, Canberra, 1979, p. 20.
19. ibid.
20. ibid.
21. Report of the Auditor-General on an Efficiency Audit, op. cit., p. 52.
22. See for example, Australia, Parliament, *Through A Glass Darkly: Evaluation in Australian Health and Welfare Services: Report of the Senate Standing Committee on Social Welfare*, Parl. Paper 71, Canberra, 1979, p. 43.
23. Evidence, p. 2241.

CHAPTER 2

1. T. H. Kewley, *Australian Social Security Today: Major Developments from 1900 to 1978*, Sydney University Press, Sydney, 1980, pp. 144-5.
2. Australia, House of Representatives, *Hansard*, 3 November 1954, p. 2533.
3. ibid.
4. ibid.
5. ibid.
6. ibid.
7. The discussion and analysis of 'demand' and 'need' is reflected in many scholarly works. The Committee does not wish to enter this debate.
8. *Hansard*, op. cit., p. 2534.
9. ibid.
10. *Aged or Disabled Persons Homes Act 1954*, Section 3.
11. *Hansard*, op. cit.
12. The subsidy was increased to $2 for $1 in 1957.
13. *Hansard*, op. cit.
14. See below, paragraphs 2.18 to 2.25.
15. Kewley, op. cit., p. 146.
16. Australia, House of Representatives, *Hansard*, 10 October 1956, p. 1308.
17. ibid, p. 1307.
18. ibid.
19. ibid, p. 1308.
20. Australia, House of Representatives, *Hansard*, 27 November 1962, p. 2569.
21. Kewley, op. cit., p. 154.

22. ibid.
23. ibid.
24. Evidence, p. 2344.
25. Australia, Parliament, *Department of Social Services Annual Report 1966-67*, Parl. Paper 92, Canberra, 1967, p. 19.
26. Australia, Parliament, *Department of Social Services Annual Report 1968-69*, Parl. Paper 121, Canberra, 1969, p. 30.
27. Australia, Parliament, *Department of Social Services Annual Report 1969-70*, Parl. Paper 229, Canberra, 1970, p. 42.
28. ibid, p. 40.
29. Australia, House of Representatives, *Hansard*, 26 February 1969, p. 16.
30. ibid.
31. Australia, House of Representatives, *Hansard*, 27 May 1969, p. 2267.
32. Australia, House of Representatives, *Hansard*, 26 February 1969, p. 160.
33. ibid, p. 161.
34. Australia, House of Representatives, *Hansard*, 14 March 1970, p. 63.
35. ibid.
36. Australia, House of Representatives, *Hansard*, 24 October 1972, p. 3015.
37. ibid, p. 3017.
38. Australia, Parliament, *Department of Social Services Annual Report 1970-71*, Parl. Paper 171, Canberra, 1971, p. 35.
39. Australia, Parliament, *Department of Social Services Annual Report 1972-73*, Parl. Paper 156, Canberra, 1973, p. 42.
40. ibid, p. 43.
41. ibid.
42. Australia, House of Representatives, *Hansard*, 12 September 1973, p. 844.
43. ibid.
44. Evidence, p. 2834, (Department of Health).
45. Press Statement by the Minister for Social Security, 15 October 1973.
46. Australia, Parliament, *Department of Social Security Annual Report 1974-75*, Parl. Paper 165, Canberra, 1975, p 35.
47. Australia, Parliament, *Department of Social Security Annual Report 1973-74*, Parl. Paper 205, Canberra, 1975, p 55.
48. ibid. These views were also contained in the 1973-74 *Annual Report* of the Department of Social Security. It was stated that homes operated by religious and charitable organizations 'accommodate a high proportion of the less affluent pateints and are at the same time, dedicated to providing a high level of nursing care', p. 83.
49. ibid.
50. Australia, Parliament, Task Force on Co-ordination in Welfare and Health (P. Bailey, Chairman), *Proposals for a change in the Administration and Delivery of Programs*, Parl. Paper 45, Canberra, 1977.
51. ibid, p. 2.
52. ibid, p. 4.
53. Australia, Parliament, *Department of Health Annual Report 1980-81*, Parl. Paper 310, Canberra, 1981, p. 239.
54. Ministerial Statement by the Prime Minister, 'Fiscal Policy Decisions', House of Representatives, *Hansard*, 20 May 1976.
55. Press Statement by the Minister for Social Security, 8 September 1982.
56. ibid.
57. Evidence, p. 2349, (Department of Social Security).
58. Evidence, p. 2621, (Department of Housing and Construction).
59. ibid.
60. ibid, p. 2598.

CHAPTER 3

1. Committee on Care of the Aged and Infirm, op. cit., p. 17.
2. F. M. Chaney, Address to the Australian Pensioners' Federation, Canberra, May 1981, p. 8.
3. Evidence, p. 2190, (Department of Health).
4. ibid, p. 2207.
5. Evidence, p. 1617, (Australian Council on the Ageing).
6. *Budget Statement*, 1982-83, p. 108.
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APPENDIX I

PUBLIC SECTOR OUTLAYS ON HEALTH AND SOCIAL SECURITY AND WELFARE

Table 1: Estimates of public expenditure for health and welfare services

$m

	1976–77	*1977–78*	*1978–79*	*1979–80*	*1980–81*
HEALTH					
Final consumption expenditure:					
Commonwealth:					
Hospital and clinical services	287	322	331	364	432
Other	179	181	173	171	184
	466	504	504	534	616
State and local:					
Hospital and clinical services	1 986	2 225	2 460	2 725	n.a.
Other	266	307	355	401	
	2 251	2 532	2 814	3 126	3 636
Expenditure on new assets:					
Commonwealth:					
Hospital and clinical services	48	40	26	18	n.a.
Other	14	14	11	14	
	62	54	37	31	23
State and local:					
Hospital and clinical services	301	290	304	262	n.a.
Other	35	34	30	27	
	336	324	335	289	268
Total health	**3 113**	**3 414**	**3 690**	**3 981**	**4 543**
SOCIAL SECURITY AND WELFARE					
Final consumption expenditure:					
Commonwealth	212	249	283	322	380
State and local	141	174	215	250	310
Expenditure on new assets:					
Commonwealth	8	7	5	3	4
State and local	19	19	22	25	31
Total social security and welfare	**381**	**447**	**526**	**600**	**725**
Total health and welfare	**3 494**	**3 861**	**4 216**	**4 581**	**5 268**
Commonwealth (per cent)	21.4	21.0	19.7	19.4	19.4
State and local (per cent)	78.6	79.0	80.3	80.6	80.6

Source: A.B.S. *Commonwealth Government Finance* (Ref. 5502.0), *State and Local Government Finance* (Ref. 5504.0), *Australian National Accounts* (Ref. 5504.0).

Table 2: Estimates of income maintenance payments for health and welfare purposes
$m

	1976–77	*1977–78*	*1978–79*	*1979–80*
Health:				
Commonwealth:				
Hospital and clinical services	355	387	389	434
Other	785	623	809	907
	1 140	1 010	1 198	1 341
Social security and welfare:				
Commonwealth:				
Assistance to aged persons	2 508	2 961	3 258	3 541
Other	3 524	4 070	4 394	4 766
	6 032	7 031	7 652	8 307
State and local	115	134	145	207
	6 147	7 165	7 797	8 514
Total	**7 287**	**8 175**	**8 995**	**9 855**
Commonwealth (per cent)	98.4	98.4	98.4	97.9
State and local (per cent)	1.6	1.6	1.6	2.1

Source: As for Table 1.

Table 3: Total Outlay on Health and Welfare Services
$m

	1976–77	*1977–78*	*1978–79*	*1979–80*
Health:				
State and Local Authorities:				
Current Outlay	2 252	2 532	2 815	3 127
Capital Outlay	342	329	336	294
	2 594	2 861	3 151	3 421
Commonwealth:				
Current Outlay	1 608	1 525	1 715	1 887
Capital Outlay	78	61	53	36
	1 686	1 586	1 768	1 923
	4 280	4 447	4 919	5 344
Social Security and Welfare:				
State and Local Authorities:				
Current Outlay	257	323	384	448
Capital Outlay	26	26	30	30
	283	349	414	478
Commonwealth:				
Current Outlay	6 256	7 295	7 945	8 635
Capital Outlay	68	75	80	71
	6 324	7 370	8 025	8 706
	6 607	7 719	8 439	9 184
Total Outlay	**10 887**	**12 166**	**13 358**	**14 528**
Proportion of Total Public Sector Outlays	34.2	33.9	34.3	33.6

Source: As for Table 1. Also ABS *Government Finance Estimates* (5501).

APPENDIX II

Commonwealth Budget Outlays for Accommodation and Home Care Services for the Aged (*a*)

	1976–77	*1977–78*	*1978–79*	*1979–80*	*1980–81*	*1981–82*	*1982–83*
	$m	$m	$m	$m	$m	$m	$m est.
INDEPENDENT ACCOMMODATION							
1. Payments to or for the States:							
Capital Assistance:							
Rental Assistance/Pensioner Dwellings (*b*)	9	10	14	34	33	32	32
2. Payments to Organisations:							
Capital Assistance:							
Independent Living Units (*c*)	2	6	6	4	4	5	6
Total Accommodation	**11**	**16**	**20**	**38**	**38**	**37**	**38**
INSTITUTIONAL CARE							
1. Payments to Organisations:							
Capital Assistance:							
Nursing Homes (*c*)	9	12	14	16	15	28	43
Hostel Units—67% subsidy (*c*)	7	4	5	7	9	10	16
—100% subsidy	24	30	28	24	16	13	17
Recurrent Assistance:							
Personal Care Subsidy	11	13	13	14	22	24	32
Nursing Home Benefits and Payments (*e*)	234	254	269	312	382	571	740
Total Institutional Care	**285**	**313**	**329**	**373**	**444**	**646**	**848**
HOME CARE							
1. Payments to or for the States:							
Capital Assistance:							
Senior Citizens Centres	4	4	3	3	4	4	7
Recurrent Assistance							
Home Care Services	7	9	9	10	12	14	16
Welfare Officers	1	1	1	1	1	1	2
Paramedical Services	1	1	1	1	1	1	1

Commonwealth Budget Outlays for Accommodation and Home Care Services for the Aged (*a*)—*continued*

	1976–77	*1977–78*	*1978–79*	*1979–80*	*1980–81*	*1981–82*	*1982–83*
	$m	$m	$m	$m	$m	$m	$m est.
2. Payments to Organisations:							
Capital Assistance:							
Day Care Centres (*c*)	..	1	..	—	..	1	1
Recurrent Assistance							
Delivered Meals Subsidy	1	1	2	3	4	4	6
Home Nursing Subsidy	10	11	11	12	14	16	21
3. Payments to Individuals							
Domiciliary Nursing Care Benefit (*d*)	8	8	8	10	17	21	23
Total Home Care	**32**	**36**	**35**	**40**	**53**	**62**	**77**
Total Accommodation and Home Care Services	**328**	**365**	**384**	**451**	**535**	**745**	**963**

Notes: (*a*) Excludes outlays specifically for veterans, aboriginals and other special groups.
(*b*) From 1979–80, assistance relates to housing in respect of most Social Services Act and Repatriation Act pensioners.
(*c*) Provided under the *Aged or Disabled Persons Homes Act*. Allocations between independent living, nursing, hostel and day care are estimates only.
(*d*) From 1980–81, the eligibility for Domiciliary Nursing Care Benefit was extended to all handicapped persons aged 16–64.
(*e*) Relates to *all* nursing home patients.

Source: Budget Papers 1977–78 to 1982–83, Department of Social Security.

APPENDIX III

NURSING HOME BEDS

Table 1: Number of Nursing Home Beds Per 1 000 Aged Persons: Australia

	No. of beds	*Increase %*	*Beds/1 000 persons 75 and over*	*Beds/1 000 persons 70 and over*	*Beds/1 000 persons 65 and over*
30 June 1963	25 535		77.3	41.6	26.6
1964	28 685	12.3	83.7	45.7	29.4
1965	31 290	9.1	88.4	49.0	31.5
1966	33 075	5.7	90.5	50.7	32.6
1967	35 537	7.4	94.8	53.8	34.6
1968	37 883	6.6	98.9	56.5	36.3
1969	40 167	6.0	103.6	61.6	38.0
1970	42 903	6.8	109.0	62.5	41.1
1971	46 750	9.0	117.5	67.2	42.8
1972	51 286	9.7	127.0	72.3	45.9
1973	53 416	4.2	129.9	74.0	46.7
1974	54 420	1.9	129.7	73.6	46.4
1975	54 756	0.6	127.7	72.6	45.6
1976	55 578	1.5	126.4	71.6	45.0
1977	56 512	1.7	125.3	70.9	44.4
1978	58 482	3.5	125.5	70.9	44.5
1979	61 438	5.1	127.6	72.3	45.2
1980	65 289	6.3	131.2	74.1	46.6
1981	67 912	4.0	130.4	73.9	46.9

Source: Commonwealth Department of Health.

Table 2: Approvals Under the Aged or Disabled Persons Homes Act

	Residential Accommodation		*Nursing*		*Percentage*
	self contained	*hostel*	*accommodation*	*Total*	*nursing*
1954–66	9 406	11 906	906	23 218	3.9
1966–67	2 827	..	400	3 227	12.4
1967–68	2 546	..	285	2 831	10.1
1968–69	1 795	1 018	529	3 342	15.8
1969–70	1 606	1 091	608	3 305	18.4
1970–71	2 206	1 152	778	4 136	18.8
1971–72	2 226	1 392	1 142	4 760	24.0
1972–73	2 008	827	1 154	3 989	28.9
1973–74	1 899	669	849	3 417	24.8
1974–75	2 243	675	992	3 910	25.4
1975–76	385	181	52	618	8.4
1976–77	233	769	1 015	2 017	50.3
1977–78	505	428	1 225	2 158	56.8
1978–79	376	310	884	1 570	56.3
1979–80	294	456	1 083	1 883	57.5
1980–81	396	990	1 676	3 062	54.7
1981–82	324	691	1 031	2 046	50.4
	31 275	22 555	15 609	69 439	22.5

Source: Department of Social Security, *Annual Reports*.

Table 3: Distribution of Nursing Home Beds

			Religious and charitable			
30 June	*Government*	*Private*	*Deficit finance*	*Other*	*Total (a)*	*Total*
1975	12 593	29 240	8 271	4 652	12 923	54 756
1976	12 908	27 914	9 739	5 017	14 756	55 578
1977	13 080	28 576	11 439	3 417	14 856	56 512
1978	13 615	28 717	12 435	3 715	16 149	58 482
1979	14 247	29 665	13 495	4 031	17 525	61 438
1980	14 890	31 374	14 649	4 376	19 025	65 289
1981	14 758	32 872	15 414	4 868	20 282	67 912
Average annual growth rate (%)	2.68	1.97	10.93	0.76	7.80	3.65

Source: Department of Health Annual Reports.
(*a*) Calculated from percentage figures quoted in Annual Reports.

APPENDIX IV

PURPOSES OF ASSISTANCE UNDER THE HOUSING AGREEMENT

(a) to meet the costs associated with the acquisition, planning and development of land primarily for residential development;
(b) to pay for the construction or acquisition of housing;
(c) to repay the principal of and pay interest on loan assistance to the State for rental housing assistance;
(d) to provide funds to such voluntary, non-profit, charitable bodies and other housing management bodies or groups as approved by the State Minister;
(e) to enable housing to be let to such charitable bodies and other organisations as are approved by the State Minister for the provision of assistance to disadvantaged persons;
(f) to engage in urban renewal activities related to public housing;
(g) to allocate funds to local government bodies for the provision of rental housing where the State Minister considers that it would be more appropriate for such rental housing assitance to be carried out by those bodies;
(h) to make proposals for, or provide bridging finance for, the provision of open space, landscaping, community facilities and for costs associated with land development, including contributions to headworks and reticulation of services;
(i) to undertake research and policy development in relation to matters not funded by the Australian Housing Research Council;
(j) to undertake and participate in joint ventures, co-operative enterprises or similar arrangements in order that public housing developments may be integrated with private housing and to achieve a desirable socio-economic mixture of housing;
(k) to lease housing from the private housing sector;
(l) to provide housing advisory services related to public housing;
(m) to provide rental subsidy for eligible persons renting private housing; and
(n) any other purposes agreed upon between the Minister and the State Minister.

APPENDIX V

CONDUCT OF INQUIRY

Hearings and Inspections

The Committee resolved on 21 May 1980 to conduct an inquiry into Accommodation and Home Care Programs for the Aged and a sub-committee consisting of the Hon. K. M. Cairns (Chairman), Mr K. Aldred, Mr J. Dawkins, Mr S. A. Lusher and Mr L. B. McLeay was appointed to conduct the inquiry. This sub-committee did not proceed before the House was dissolved on 19 September 1980.

With the election of the thirty-second Parliament the Committee resolved on 4 December 1980 to continue the inquiry and a sub-committee consisting of Mr L. B. McLeay (Chairman), Mr R. A. Braithwaite, Mr J. M. Hyde, Mr R. M. McLean and Mr J. G. Mountford was appointed. To assist the sub-committee in the inquiry two specialist advisers were appointed: Dr Bruce Ford, the Director of Rehabilitation Services, Alfred and Caulfield Hospitals, Melbourne; and Ms Anna Howe, Research Fellow at the National Research Institute of Gerontology and Geriatric Medicine, Mount Royal Hospital, Melbourne.

On 3 June 1981 the sub-committee advertised nationally inviting submissions. About 180 were received as a result of the advertisement (more were received later) and many other people and organisations contacted the sub-committee but did not make formal submissions. The sub-committee then conducted public hearings in all State capitals and Canberra. These were held on 15 July 1981 (Melbourne), 17 July 1981 (Hobart), 27 July 1981 (Perth), 29 July 1981 (Adelaide), 5 and 28 August and 14 December 1981 (Sydney), 7 August 1981 (Brisbane) and 16 and 30 October 1981 (Canberra). The hearings allowed individuals and representatives from a cross-section of organisations interested in accommodation and home care services for the aged to present their views in person and in public. In association with the hearings the sub-committee inspected the range of facilities available for caring for the aged in all States and Territories.

After the material presented in submissions and evidence was analysed, a series of preliminary conclusions was formulated and then given, on a confidential basis, to selected individuals and organisations. Comment was sought by submission or by discussion at in-camera hearings in Canberra, Sydney and Melbourne on 28, 29 and 30 June respectively.

The inquiry procedures have given interested individuals and organisations ample opportunity to present evidence and comment on matters raised. In the final phase of the inquiry, the sub-committee drafted this report.

WITNESSES

	Dates of appearance before sub-committee
COMMONWEALTH GOVERNMENT	
Department of Health	
Mr Matthew Carroll, First Assistant Director-General, Insurance, Hospitals and Nursing Homes Division	30.10.81
Dr Wilbur Cathers	29.6.82
Mr Peter John Johnstone, Assistant Director-General, Nursing Home Care and Benefits	30.10.81, 29.6.82
Mr Peter Theo Pflaum, First Assistant Director-General, Policy and Planning Division	30.10.81
Department of Housing and Construction (responsibilities now with Department of Social Security)	
Mr Robert Egan, Assistant Secretary, Housing and Policy Division	14.12.81
Mr Dugald John Monro, Senior Project Officer	14.12.81
Mr Phillip John Myssonski, Senior Executive Officer, Housing Policy Division	14.12.81

	Dates of appearance before sub-committee
Department of Social Security	
Mr John Brewer, Acting Assistant Director-General Subsidies	30.10.81, 14.12.81
Mr John David Hall, First Assistant Director-General, Social Welfare	14.12.81
Mr Kenneth Horsham, First Assistant Director-General, Welfare, Rehabilitation and Subsidies	14.12.81
Mr John Payne Lloyd, Director, Special Working Group—Aged Persons Welfare	28.6.82
Mr Colin Alexander McAlister, First Assistant Director-General, Development	30.10.81
Mr James Thomas O'Connor, Deputy Director-General	28.6.82
Mr Graham Pilger, Assistant Director-General, Subsidies	28.6.82
Mr Douglas Graham Ritchie, Assistant Director, Accommodation and Home Care	30.10.81, 28.6.82
Mr Donald Rex Scott, Acting First Assistant Director-General, Rehabilitation and Subsidies	30.10.81, 28.6.82
Mr Barry James Wight, Assistant Director-General, Housing Division	28.6.82
Department of the Treasury	
Mr Gregory Crawford, Acting Assistant Secretary, State and Local Government Finances Branch	28.6.82
Mr John Arthur Fraser, Chief Finance Officer, Fiscal and Monetary Policy Branch	28.6.82
Mr Peter McNamara, Research Officer, Fiscal and Monetary Policy Branch	28.6.82
Department of Veterans' Affairs	
Mr Paul Leonard Carty, Director, Social Work/ Welfare Services, Queensland Branch	16.10.81
Dr Myles Michael Kehoe, Acting Chief Director, Medical Services	16.10.81
Mr Barry Edward O'Shannassy, Assistant Commissioner, Treatment	16.10.81
Mr Gregory Allan Woodward, Assistant Commissioner, Finance	16.10.81
STATE GOVERNMENT	
New South Wales Department of Youth and Community Services	
Ms Rosita Chan, Aged Consultant	5.8.81
Ms Deborah Little, Liaison Officer	29.6.82
Mr Garth Nowland–Foreman, Advisor, Aged Services	5.8.81
New South Wales Health Commission	
Professor Gary Robert Andrews, Director, Department of Community Medicine, Westmead Centre	5.8.81
Mrs Joy Bertinshaw	29.6.82
Mr Warren Hickson	29.6.82
South Australian Department of Premier and Cabinet	
Mr Jeffrey Albert Walsh, Chief Project Officer	29.7.81, 30.6.82
South Australian Health Commission	
Dr Peter Murray Last, Acting Assistant Commissioner	29.7.81
Ms Judith Prescott, Principal Nurse Educator	29.7.81
Mr David James Whelan, Administrative Officer, Royal Adelaide Hospital	29.7.81
South Australian Housing Trust	
Dr Graeme Bethune, Manager	29.7.81

	Dates of appearance before sub-committee
Tasmanian Department of Health Services	
Dr James Thomas Curran, Senior Medical Officer (Community Health and Geriatrics)	17.7.81, 30.6.82
Dr Samuel Aaron Ginsberg, General Superintendent St John's Park Hospital	17.7.81
Mrs Pamela Mary Hamilton, Assistant Director Nursing, Community Health Services Southern Tasmania	17.7.81
Professor David William Kilbourne Kay, Professor of Psychiatry, Royal Hobart Hospital	17.7.81
Victorian Community Welfare Services Department	
Ms Anne Morrow	30.6.82
Victorian Health Commission	
Dr Anthony Robert Moore	30.6.82
Victorian Ministry of Housing	
Mr Anthony Vincent Cahir,	30.6.82
Ms Kathleen Hulse	30.6.82
Western Australian Government Department of Hospital and Allied Services	
Miss Jennifer Page, Social Work Supervisor, Extended Care Service	27.7.81
OTHER ORGANISATIONS	
Advisory Council for Inter-Government Relations (Tasmania)	
Mr John Jameson, Research Director	30.6.82
Aged Cottage Homes Incorporated	
Mr John Warren Pitchford, General Manager	29.7.81
Aged Services, City of Fitzroy	
Ms Derryn Wilson, Social Worker	15.7.81
Ambulance Services Melbourne	
Mr Norman Walter Branson	15.7.81
Anglican Home Mission Society	
Miss Eileen Armstrong, Director of Nursing Services	5.8.81
Mrs Barbara Squires, Social Worker	5.8.81
Australia-Greek Society for Care of the Elderly	
Dr Conn Constantinou, Vice President	15.7.81
Australian Affiliation of Voluntary Care Associations	
Mr Donald Coburn, Secretary	30.6.82
Mr David Simmonds, Treasurer	30.6.82
Australian Association on Geriatric Nursing Care	
Matron Coralie Friend, Public Relations Officer	28.8.81
Australian Council on the Ageing	
Mr Clifford John Picton, Chief Executive	14.12.81, 28.6.82
Australian Council on Community Nursing	
Mr Ronald Edward Reid, President	7.8.81
Australian Nursing Homes Association	
Mr John Gillroy, Executive Director	28.8.81, 14.12.81, 28.6.82
Australian Council of Social Service Incorporated	
Mr Murray Geddes, President	28.8.81
Ms Helen Kiel	29.6.82
Ms Joan Hartley McClintock, Secretary General	28.8.81, 29.6.82
Mr Keith Tarlo, Voluntary Researcher	28.8.81, 29.6.82
Blue Nursing Service Council	
Miss Judith Alison Hooper, Director of Nursing Services	17.8.81
Reverend Ronald Howe, Director-General	7.8.81

	Dates of appearance before sub-committee
Combined Pensioners' Association of NSW	
Mr John Robert Ken Cranston, State Representative for Health Committee	5.8.81, 29.6.82
Mr Robert George Heggen, Secretary, South Coast Regional Council	5.8.81, 29.6.82
Mrs Noreen May Hewett, Assistant State Secretary	5.8.81, 29.6.82
Mr William Ottley, Assistant State Secretary	5.8.81, 29.6.82
Flinders Medical Centre	
Dr Anthony James Radford, Professor of Primary Care and Community Medicine	29.7.81
Home Help Service of NSW	
Mr Paul Raymond Bullen, Liaison Officer (Department of Youth and Community Services)	5.8.81
Ms Maree Faulkner, Executive Officer	5.8.81
Marrickville Interagency	
Ms Lee Broadway, Secretary	29.8.81
Mr Stefan Couani, Member	29.8.81
Marrickville Municipal Council	
Mr Peter John Arnett, Chief Town Planner	28.8.81
Mr David Hugh Rollinson, Senior Community Worker	28.8.81
Mr Maurice Bernard Smith, Municipal Health Surveyor and Principal Building Inspector	28.8.81
Medox	
Ms Gerri Gregory, Area Manager	16.10.81
Milstern Holdings Pty Ltd	
Mrs Millie Phillips, Managing Director	16.10.81, 14.12.81
Monitor Protection Services Pty Ltd	
Mr Gregory Garnet Hope, General Manager	16.10.81
Mr Matthew Gorman O'Brien, Consultant	16.10.81
Mr Douglas Stuart Snowdon, Managing Director	16.10.81
Moorfields Community for Adult Care	
Mr Brian Moss, Director	15.7.81
Mount Royal Hospital	
Dr Boyne Russell, Consultant Geriatrician	15.7.81
National Council of the St Vincent de Paul Society	
Mr Cyril Joseph Nethery, President, Care for the Aged Advisory Committee	5.8.81
New South Wales Council of Social Service	
Ms Margaret Mary Barry, Member of Home Support Services Committee	5.8.81
Mrs Margaret Marjason, Co-Convenor of Home Support Services Committee	5.8.81
Nursing Homes Association of Tasmania	
Mr Bruce Anthony Collins, Secretary	17.7.81
Outstretched Hand Foundation	
Sister Teresa Plane, Mount Carmel Hospital	5.8.81
Private Geriatric Hospitals Association of Victoria	
Mr Gregory Thomas Prouse	15.7.81
Queensland Council on the Ageing	
Miss Alma Elizabeth Hartshorn, President	7.8.81
Reverend Alex William Laurie, Vice President	7.8.81
Regional Accommodation Team Services	
Ms Laurel Thelma Childs	15.7.81
Miss Helen Goodman	15.7.81
Mrs Sonia Esther Freidin	15.7.81

	Dates of appearance before sub-committee
Ms Rhonda Johns	15.7.81
Royal District Nursing Service	
Miss Valerie Douglas, Social Worker-Consultant	15.7.81
Social Welfare Action Group	
Mr Michael David Fine, Member of Working Party on Frail Aged	5.8.81
Ms Josephine Anne Harrison, Member of Working Party on Frail Aged	5.8.81
Mr Gregory Charles Twyford, Social Worker	5.8.81
Swan Cottage Homes Incorporated	
Mr Richard Cleaver, CBE, Founder and Chairman	27.7.81
Tasmanian Council on the Ageing	
Mr Graham Ashton Green	17.7.81
The Carers Association of New South Wales	
Miss Enid Rust, Member	5.8.81
Miss Clare Stevenson, Founder President	5.8.81
Uniting Church in Australia	
Reverend Chris George Budden, Research Officer, Board for Social Responsibility	5.8.81
Reverend Roy Glover, General Secretary, Board of Finance and Property	5.8.81
Mr Graham Robert Hadden, Chairman, Aged Care Division	7.8.81
Mrs Marjorie Kerry, Executive Officer, Board for Social Responsibility	5.8.81
'Victoria Lodge' Special Accommodation House	
Miss Patricia Bulmer, SRN, Director and Manager	15.7.81
Victorian Municipal Welfare Officer's Association	
Ms Derryn Wilson, Co-ordinator	15.7.81
Voluntary Care Association of Victoria	
Mr Brian Moss, Honorary Secretary	15.7.81
Voluntary Care Association (Queensland)	
Mr Arnold Fred Delbridge, President	7.8.81, 29.6.82
Volunteer Task Force	
INDIVIDUALS	
Ms Linda Hogan, Social Worker and Co-ordinator	27.7.81
Dr Adam Graycar, Social Welfare Research Centre, University of New South Wales, Kensington, New South Wales	5.8.81
Mr Wilfred Maxwell Hamlyn, Milford Road, Boonah, Queensland	7.8.81
Dr Arthur Winston Harrison, 24 Illawarra Road, North Balwyn, Victoria	15.7.81
Mr George Hastie, 46 Albert Street, Petersham, New South Wales	28.8.81
Dr Catherine Rhys Hearn, Waterman, Western Australia	27.7.81
Dr Phillip John Henschke, Repatriation General Hospital and Flinders Medical Centre, South Australia	29.7.81
Dr Neville Derrington Hicks, University of Adelaide, South Australia	29.7.81
Dr Michael Sydney Talbot Hobbs, Swanbourne, Western Australia	27.7.81
Dr Peter Murray Last, 49 Westall Street, Unley Park, South Australia	29.7.81
Mrs Eileen Veronica Louis, Petersham, New South Wales	5.8.81
Mrs Patricia Ann McAuliffe, Wembley Downs, Western Australia	27.7.81
Dr John Kenneth McKechnie, Nedlands, Western Australia	27.7.81
Dr Ludomyr John Mykyta, Haymarket, New South Wales	5.8.81
Miss Joan O'Sullivan, Mosman, New South Wales	28.8.81
Dr Elaine Frances Skinner, Eastwood, South Australia	29.7.81

INDEX OF EXHIBITS

Exhibit No.	
1.	Submission from the Secretary, Department of Housing and Construction dated 26 February 1981
2.	Submission from the Minister for Social Security dated 1 April 1981
3.	Submission from the Director-General, Department of Health dated 3 April 1981
4.	Submission from the Secretary, Department of Housing and Construction dated 14 May 1981
5.	Submission from the Manager, After Care Hospital, Collingwood, Victoria, received 30 June 1981
6.	Submission from the Medical Director, Eastern Regional Geriatric and Medical Rehabilitation Service, Northfield, South Australia, dated 24 June 1981
7.	Submission from Mrs A.E. Turner, Box Hill, Victoria dated 3 June 1981
8.	Submission from Mr and Mrs E.M. Cuthbert, Lindisfarne, Tasmania dated 4 June 1981
9.	Submission from Mr R.G. Salisbury, Terranora, New South Wales dated 4 June 1981
10.	Submission from Mr W.M. Hamlyn, Boonah, Queensland dated 7 June 1981
11.	Submission from the Manager, Fraser House, South Perth, Western Australia dated 10 June 1981
12.	Submission from Ms A. Alldis, Normanhurst, New South Wales dated 12 June 1981
13.	Submission from Mr C. Davidson, Marrickville, New South Wales dated 13 June 1981
14.	Submission from Ms J. Vearing, Epping, Victoria dated 15 June 1981
15.	Submission from Ms E.E. Crewe, Latham, Australian Capital Territory dated 20 June 1981
16.	Submission from the Manager, Mount Royal Hospital, Parkville, Victoria dated 22 June 1981
17.	Submission from Mr R.G. Salisbury, Terranora, New South Wales dated 23 June 1981
18.	Submission from the President, Tasmanian Council on the Ageing Inc. dated 29 June 1981
19.	Submission from the General Manager, Eventide Homes Appeal, Padstow Heights, New South Wales dated 29 June 1981
20.	Submission from the Council of Social Service of New South Wales dated 26 June 1981
21.	—
22.	Submission from the Special Projects Committee, Rotary Club of Pascoe Vale, Victoria dated 25 June 1981
23.	Submission from the Director, Church of England Homes for Elderly People, Hawthorn, Victoria dated 29 June 1981
24.	Submission from the Manager-Secretary, Grace McKellar House, North Geelong, Victoria dated 30 June 1981
25.	Submission from the President, Australian Greek Society for Care of the Elderly, Melbourne, Victoria dated 29 June 1981
26.	Submission from the National and Overseas Co-ordinator, Women Who Want To Be Women, Victoria dated 30 June 1981
27.	Submission from Dr P.M. Last, Unley Park, South Australia dated 29 June 1981
28.	Submission from Mrs J. Pattearson, Carina, Queensland dated 10 June 1981
29.	Submission from Mr R.G. Salisbury, Terranora, New South Wales received 3 July 1981
30.	Submission from the Senior Social Worker, Regional Accommodation Team Services, Melbourne, Victoria dated June 1981
31.	Submission from the Chief Executive, Australian Council on the Ageing dated 30 June 1981
32.	Submission from the Chairman, Wesley Court, Ivanhoe, Victoria dated 2 July 1981
33.	Submission from the Chairman, Sefton Lodge Council, East Camberwell, Victoria dated 30 June 1981

Exhibit No.

34. Submission from the Co-ordinator, Home Help Service, Townsville, Queensland dated 2 July 1981
35. Submission from the Director, Moorfields Community for Adult Care, Hawthorn, Victoria dated 3 July 1981
36. Submission from Mr J.A. Chapman, Cloverdale, Western Australia dated 25 July 1981
37. Submission from Mrs J. Harris, South Clayton, Victoria received 6 July 1981
38. Submission from the General Superintendent, St. John's Park Hospital, New Town, Tasmania dated 1 July 1981
39. Submission from the Chief Superintendent, Ambulance Service, Melbourne, Victoria dated 1 July 1981
40. Submission from the Regional Geriatrician, Ovens and Murray Hospital for the Aged, Beechworth, Victoria dated 3 July 1981
41. Submission from the Secretary, Voluntary Care Association of Victoria dated 6 July 1981
42. Submission from Ms J. Martyn, Balaclava, Victoria dated 27 June 1981
43. Submission from the City Manager/Town Clerk, City of Essendon, Victoria dated 3 July 1981
44. Submission from Mr P.J. Murphy, Diamond Creek, Victoria dated 2 July 1981
45. Submission from the Executive Secretary, Division of Community Services, Uniting Church of Australia (Victoria), Melbourne, Victoria dated 6 July 1981
46. Submission from the Administrator, Royal Hobart Hospital dated 2 July 1981
47. Submission from the President, Private Geriatric Hospitals Association of Victoria dated 7 July 1981
48. Submission from the Chairman, Working Committee on Programmes for the Confused Elderly, East Brunswick, Victoria dated 1 July 1981
49. Submission from the Council Clerk, Municipality of Penguin, Tasmania dated 1 July 1981
50. Submission from the Manager, Coleraine and District Hospital, Coleraine, Victoria dated 6 July 1981
51. Submission from the Manager, Nhill Hospital, Nhill, Victoria dated 6 July 1981
52. Submission from the Director-General of Health Services, Department of Health Services, Tasmania dated 7 July 1981
53. Submission from the Secretary, Nursing Homes Association of Tasmania dated 7 July 1981
54. Submission from the Director, Geriatrics, Rehabilitation and Extended Care Services, Health Commission of New South Wales dated 3 July 1981
55. Submission from the Chief Executive Officer, Royal District Nursing Service, Melbourne, dated 10 July 1981
56. Submission from the Director, Community Care Services, Royal Southern Memorial Hospital, Caulfield, Victoria dated 9 July 1981
57. Submission from the Convenor, Melbourne —South Yarra Group, South Yarra, Victoria dated 6 July 1981
58. Submission from the Chief Executive Officer, Blue Nursing Service Council, Toowong, Queensland received 13 July 1981
59. Submission from the Administrator, Kingston Centre Geriatric Hospital, Cheltenham, Victoria dated 7 July 1981
60. Submission from Mrs R.H. Harding, Weetangera, Australian Capital Territory dated 9 July 1981
61. Submission from Mr R.G. Salisbury, Terranora, New South Wales dated 8 July 1981
62. Submission from the Co-ordinator, Volunteer Task Force, Leederville, Western Australia dated 1 July 1981
63. Submission from the Director of Medical Services, Prince Henry's Hospital, Melbourne, Victoria dated 10 July 1981
64. Submission from Banksia Court Private Nursing Home, Croydon, Victoria dated 10 July 1981

Exhibit No.

65. Submission from the Chairman, Canberra Masonic Homes, Canberra, Australian Capital Territory dated 13 July 1981
66. Submission from the Professional Officer, Royal Australian Nursing Federation (S.A. Branch), Kent Town, South Australia dated 9 July 1981
67. Submission from the Board of Directors, Anglican Retirement Villages (Diocese of Sydney), Castle Hill, New South Wales dated 14 July 1981
68. Submission from the Executive Officer, Queensland Council on the Ageing, Brisbane, Queensland dated 13 July 1981
69. Submission from the Assistant Administrator Resthaven Homes for the Aged, Adelaide, South Australia dated 13 July 1981
70. Submission from the Administrator, Churches of Christ Christian Rest Homes Inc., Adelaide, South Australia dated 8 July 1981
71. Submission from Dr C. Rhys Hearn and Professor M. Hobbs, Queen Elizabeth II Medical Centre, University of Western Australia, Nedlands, Western Australia dated 10 July 1981
72. Submission from the General Manager, Aged Cottage Homes Incorporated, Magill, South Australia dated 13 July 1981
73. Submission from the General Secretary, Board for Social Responsibility, Uniting Church in Australia (NSW Synod), Sydney, New South Wales dated 13 July 1981
74. Submission from the President, Carers Association of New South Wales, Potts Point, New South Wales dated 13 July 1981
75. Submission from the Director, Department of Community Medicine, Parramatta Hospitals/Westmead Centre, Westmead, New South Wales dated 14 July 1981
76. Submission from the Social Welfare Action Group, Camperdown, New South Wales dated 10 July 1981
77. Submission from the Chairperson, Geriatric Interest Group, South Australian Association of Occupational Therapists, O'Halloran Hill, South Australia received 17 July 1981
78. Submission from the Financial Secretary, Australian Jewish Welfare and Relief Society, South Yarra, Victoria dated 16 July 1981
79. Submission from Swan Cottage Homes Incorporated, Bentley, Western Australia received 16 July 1981
80. Submission from the Social Planning Office, City of Fitzroy, Victoria dated 16 July 1981
81. Submission from the Department of Psychiatry, University of Tasmania, Royal Hobart Hospital, Hobart, Tasmania dated 17 July 1981
82. Submission from 'Victoria Lodge' Special Accommodation, Brunswick, Victoria received 16 July 1981
83. Submission from the Acting Chief Social Worker, Department of Social Work, Royal Perth Hospital, Perth, Western Australia dated 14 July 1981
84. Submission from the Director of Nursing Services, Chesalon Nursing Homes and Home Nursing Service, Anglican Home Mission Society, Beecroft, New South Wales dated 17 July 1981
85. Submission from the President, Australian Council of Community Nursing, Toowong, Queensland dated 15 July 1981
86. Submission from the President, Voluntary Care Association (Qld), Toowong, Queensland dated 15 July 1981
87. Submission from the Acting Secretary-General, Australian Council of Social Service Inc., Sydney, New South Wales dated 14 July 1981
88. Submission from the Community Physician, Hornsby and Ku-Ring-Gai Hospital, Hornsby, New South Wales dated 14 July 1981
89. Submission from the Aged Care Officer, Corporation of the City of Salisbury, Salisbury, South Australia dated 10 July 1981
90. Submission from the Chief Executive Officer, Gloucester Soldiers' Memorial Hospital, Gloucester, New South Wales dated 13 July 1981

Exhibit No.

91. Submission from the Convenor, Aged Care Working Party, Victorian Social Security Consultative Committee, Melbourne, Victoria dated 10 July 1981
92. Submission from the Director, Social Welfare Research Centre, University of New South Wales, Kensington, New South Wales dated 17 July 1981
93. Submission from Miss M. Algar, Camberwell, Victoria dated 20 July 1981
94. Submission from Professor E.G. Saint, Nedlands, Western Australia dated 6 July 1981
95. Submission from the Homes Administrative Officer, New South Wales Baptist Homes Trust, Marsfield, New South Wales dated 14 July 1981
96. Submission from the Executive Officer, Home Help Service of New South Wales, Sydney, New South Wales dated 17 July 1981
97. Submission from the Acting Director-General, Department of Youth and Community Services, New South Wales received 24 July 1981
98. Submission from the Assistant Secretary, Combined Pensioners' Association of New South Wales dated 23 July 1981
99. Submission from the Area Executive Officer, Central Coast Area Health Service, New South Wales dated 20 July 1981
100. Submission from the Manager and Secretary, Bendigo and Northern District Base Hospital, Victoria dated 16 July 1981
101. Submission from the Director of Research, Institute of Sports Medicine, Lewisham Hospital, New South Wales dated 10 July 1981
102. Submission from Professor R. Webster, University of Melbourne, Victoria dated 16 July 1981
103. Submission from the Acting Secretary General, Australian Council of Social Service Inc. dated 15 July 1981
104. Submission from the Chairman, Southern Cross Homes Nursing Home, South Australia dated 17 July 1981
105. Submission from Dr P.M. Last, Unley Park, South Australia received 29 July 1981
106. Submission from Dr E. Skinner, Glenside Hospital, South Australia dated 28 July 1981
107. Submission from Dr N. Hicks, University of Adelaide, South Australia received 29 July 1981
108. Submission from Professor A.J. Radford, Flinders University of South Australia dated 29 July 1981
109. Submission from the Administrative Officer, Southern Domiciliary Care and Rehabilitation Service, Daw Park, South Australia dated 21 July 1981
110. Submission from South Australian Council on the Ageing Inc. dated 20 July 1981
111. Submission from Dr B.A. Smithurst, University of Queensland, Queensland dated 20 July 1981
112. Submission from the Secretary, Eliza Purton Home for the Aged, Ulverstone, Tasmania dated 20 July 1981
113. Submission from the Deputy Town Clerk, Port Augusta, South Australia dated 16 July 1981
114. Submission from the Managing Director, Vasey Housing Limited, Hawthorn, Victoria dated 24 July 1981
115. Submission from the Premier of South Australia 28 July 1981
116. Submission from the Secretary, Aged Care Council, Department of Welfare Services, Uniting Church in Australia (Queensland Synod) dated 16 July 1981
117. Submission from the Supervisor-Services, Mt. Gambier and Districts Extended Care Service, Mt. Gambier, South Australia dated 15 July 1981
118. Submission from the Social Worker, Aged Persons Support Service, Claremont Community Health Centre, Claremont, Western Australia dated 28 July 1981
119. Submission from the President, National Council of St Vincent de Paul Society dated 26 July 1981
120. Submission from the Chairman, Victorian Foster Grandparent Committee, Victorian Council on the Ageing dated 29 July 1981

Exhibit No.	
121.	Submission from Dr C. Rhys Hearne, Queen Elizabeth II Medical Centre, Western Australia dated 27 July 1981
122.	Submission from Ms J.M. Biddle, Western Australian Council on Ageing dated 22 July 1981
123.	Submission from the Little Sisters of the Poor, Randwick, New South Wales dated 31 July 1981
124.	Submission from the Co-Convenor, Home Support Services Committee, New South Wales Council of Social Services, Sydney, New South Wales dated 5 August 1981
125.	Submission from the Executive Secretary, A.C.T. Council on the Ageing, Hughes, Australian Capital Territory dated 30 July 1981
126.	Submission from Mr N.J. Carne, Banksia Court Private Nursing Home, Croydon, Victoria dated 24 July 1981
127.	Submission from Sister Teresa Plane, Mt Carmel Hospital, Seven Hills, New South Wales dated 1 August 1981
128.	Submission from the Director of Nursing, Silver Chain Nursing Association, Perth, Western Australia dated 5 August 1981
129.	Submission from the Social Worker for the Aged, Richmond, Victoria dated 4 August 1981
130.	Submission from Monitor Protection Services Pty Ltd, Melbourne, Victoria received 7 August 1981
131.	Submission from Ms M. Lawn, Shelley, Western Australia dated 24 July 1981
132.	Submission from the Secretary, Marrickville Interagency, Petersham, New South Wales dated 29 July 1981
133.	Submission from the Chairman, Ethnic Communities' Council, Carlton South, Victoria dated 27 July 1981
134.	Submission from the Secretary, Rest Homes and Special Accommodation Houses Association, Elwood, Victoria dated 6 August 1981
135.	Submission from the Mother Superior, St Mary's Hostel, Geelong, Victoria dated 28 July 1981
136.	Submission from the General Manager, Wesley Central Mission, Brisbane, Queensland dated 27 July 1981
137.	Submission from Professor S.R. Leeder, University of Newcastle, Newcastle, New South Wales dated 29 July 1981
138.	Submission from the Regional Director, Geriatrics and Rehabilitation Services, Central Northern Health Services, Elizabeth Vale, South Australia dated 31 July 1981
139.	Submission from the Secretary, Mundubbera Senior Citizens Home Units Committee, Mundubbera, Queensland dated 3 August 1981
140.	Submission from the Geriatrician, Western General Hospital, Footscray, Victoria dated 1 August 1981
141.	Submission from the Town Clerk, Ringwood, Victoria dated 6 August 1981
142.	Submission from the State Secretary, Women's Action Alliance, Camberwell, Victoria dated 7 August 1981
143.	Submission from the Secretary, Townsville Committee on the Ageing, Townsville, Queensland dated 6 August 1981
144.	Submission from the Executive Director, New South Wales Council of the Ageing, Sydney, New South Wales received 11 August 1981
145.	Submission from the Director, National Institute of Labour Studies, Flinders University of South Australia dated 31 July 1981
146.	Submission from the Aged Care Officer, Prospect, South Australia received 11 August 1981
147.	Submission from the General Manager, Victorian Hospitals Association, Glen Waverley, Victoria dated 3 August 1981
148.	Submission from the Executive Director, Anglican Homes (Incorporated), Cottesloe, Western Australia dated 3 August 1981

Exhibit No.	
149.	Submission from the Secretary, Retired Members' Association, Amalgamated Metal Workers' and Shipwrights Union, Adelaide, South Australia dated 5 August 1981
150.	Submission from the Administrator, Winchester Rehabilitation Centre and Nursing Home, Malvern, South Australia dated 3 August 1981
151.	Submission from Mr I. White, Glen Waverley, Victoria dated 12 August 1981
152.	Submission from the Chief Executive Officer, St Joseph's Convalescent Home, Sandgate, New South Wales dated 10 August 1981
153.	Submission from Local Government Welfare Officers Association (WA), Fremantle, Western Australia received 18 August 1981
154.	Submission from the Director, Retirement Living Services Pty Ltd, North Sydney, New South Wales dated 17 August 1981
155.	Submission from the Associate Director, Social Policy and Research, Brotherhood of St Laurence, Fitzroy, Victoria dated 13 August 1981
156.	Submission from the Community District Nurse, Leeton District Hospital, Leeton, New South Wales dated 17 August 1981
157.	Submission from the Territorial Social Services Secretary, Salvation Army, Melbourne, Victoria dated 17 August 1981
158.	Submission from the Episcopal Vicar for Social Welfare, North Ringwood, Victoria dated 19 August 1981
159.	Submission from the Victorian Association of Occupational Therapists Geriatric Study Group, Richmond, Victoria dated 18 August 1981
160.	Submission from Ms J. Macpherson, Margate, Queensland dated 15 August 1981
161.	Submission from the Project Co-ordinator, Ageing and the Family Project, Australian National University, Canberra, Australian Capital Territory dated 19 August 1981
162.	Submission from Ms A. Miles and Ms. A. Allen, Unley, South Australia received 24 August 1981
163.	Submission from Mr H.G. Watson, Wembly Downs, Western Australia dated 15 July 1981
164.	Submission from Mrs C. Webb, Bassendean, Western Australia dated 30 July 1981
165.	Submission from Ms U. Bublitz, Mt Lawley, Western Australia dated 24 July 1981
166.	Submission from the Executive Director, Australian Nursing Homes Association, Sydney, New South Wales dated August 1981
167.	Submission from the Australian Association for Geriatric Nursing Care, Marrickville, New South Wales received 31 August 1981
168.	Submission from the Chief Project Officer, Premier's Department, Adelaide, South Australia dated 1 September 1981
169.	Submission from the Chairman, Swan Cottage Homes, Bentley, Western Australia dated 1 September 1981
170.	Submission from the Secretary, 'Fairview', Moree Care for the Aged Association, Moree, New South Wales dated 8 September 1981
171.	Submission from Mrs G. Gregory, Medox, Melbourne Victoria dated 15 September 1981
172.	Submission from Mr J. Stewart, Cabrini Private Hospital, Maylands, Western Australia dated 4 September 1981
173.	Submission from the Western Region Committee on the Aged, Melbourne, Victoria dated 21 August 1981
174.	Submission from the Deputy Premier, Western Australia dated 14 September 1981
175.	Submission from the Frail and Confused Elderly Committee, Royal District Nursing Service, Melbourne, Victoria dated 31 August 1981
176.	Submission from the Director, Victorian Council on the Ageing, Melbourne, Victoria dated 14 September 1981
177.	Submission from Mr J.L. Hill, Seaton, South Australia dated 9 September 1981
178.	Submission from Monitor Protection Services Pty Ltd, Melbourne, Victoria received 18 September 1981
179.	Submission from Department of Veterans' Affairs received 7 October 1981

Exhibit No.	
180.	Submission from the Premier of Tasmania dated 14 September 1981
181.	Submission from Mr N.G. Wiggett, H.A.E.T.A.S. Australia, Bayswater, Victoria 19 August 1981
182.	Submission from the President, New South Wales Council of Community Nursing, Glebe, New South Wales dated 1 September 1981
183.	Submission from the Chief Executive Officer, Goulburn Base Hospital, Goulburn, New South Wales dated 9 October 1981
184.	Submission from the Co-ordinator, Department of Extension Services, Goulburn College of Advanced Education, Goulburn, New South Wales dated 12 October 1981
185.	Submission from the Commonwealth Department of Health received 15 October 1981
186.	Submission from the Minister for Social Security dated 14 October 1981
187.	Submission from the Secretary, Department of Aboriginal Affairs dated 20 October 1981
188.	Submission from the Chairman, Capital Territory Health Commission dated 21 October 1981
189.	Submission from the Secretary, Department of Housing and Construction dated 23 October 1981
190.	Submission from the Area Manager, Medox, Melbourne, Victoria dated 22 October 1981
191.	Submission from Mr W. Hewes, Secretary, Retired Members' Association, Amalgamated Metal Workers' and Shipwrights' Union, South Australia dated 4 March 1981
192.	Submission from the Premier of Victoria dated 26 October 1981
193.	Submission from the Deputy Town Clerk, Blue Mountains City Council dated 28 October 1981
194.	—
195.	Submission from the President, Rheumatism and Arthritis Foundation of Tasmania dated 5 November 1981
196.	Submission from the Secretary, Department of Veterans' Affairs dated 6 November 1981
197.	Submission from Mrs C. Webb, Bassendean, Western Australia dated 11 November 1981
198.	Submission from the Secretary, Department of Finance dated 11 November 1981
199.	Submission from the Assistant Director-General, Nursing Home Care and Benefits Branch, Department of Health dated 20 November 1981
200.	Submission from the Acting First Assistant Director-General, Rehabilitation and Subsidies, Department of Social Security dated 23 November 1981
201.	Submission from Mrs D. McSweeney, Mount Lawley, Western Australia dated 23 November 1981
202.	Submission from the Secretary, Department of Immigration and Ethnic Affairs dated 17 December 1981
203.	Submission from the Secretary, Australian Telecommunications Commission dated 9 December 1981
204.	Submission from Mr S.T. Hoare, Yokine, Western Australia dated 6 January 1982
205.	Submission from Mr J. Tardy, Leichhardt, New South Wales dated 19 February 1982
206.	—
207.	—
208.	Submission from Dr L.J. Mykyta, Director, Division of Geriatrics, Queensland Department of Health, Brisbane, Queensland dated 18 June 1982
209.	Submission from Director-General, New South Wales Department of Youth and Community Services, Sydney, New South Wales dated 29 June 1982
210.	Submission from Mr A. F. Delbridge, Blue Nursing Service Council, Toowong, Queensland dated 29 June 1982
211.	Submission from South Australian Health Commission, Adelaide, South Australia received 30 June 1982

Exhibit No.	
212.	Submission from Ms R. Errey, Social Worker, Eversleigh Hospital, Petersham, New South Wales dated 28 June 1982
213.	Submission from Mr M. Fine, Social Welfare Action Group, Camperdown, New South Wales dated 29 June 1982
214.	Submission from the Chief Executive Officer, Royal District Nursing Service, Melbourne, Victoria dated 2 July 1982
215.	Submission from the Secretary, Department of Veterans' Affairs dated 5 July 1982
216.	Submission from the Federal Secretary, Royal Australian Nursing Federation, South Melbourne, Victoria dated 6 July 1982
217.	Submission from the President, Australian Council of Community Nursing, Toowong, Queensland dated 6 July 1982
218.	Submission from the Chairman, Capital Territory Health Commission, Canberra, A.C.T., dated 16 July 1982.
219.	Submission from the Premier of Western Australia, dated 30 July 1982.
220.	Submission from the President, Association of Self Help Organisations and Groups dated 30 July, 1982.
221.	Submission from the Director, Moorfields, Centre for Community Care, Hawthorn, Victoria, dated 4 August 1982.

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