SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE

REPORT ON
FUNDING OF AGED CARE INSTITUTIONS

JUNE 1997

© Commonwealth of Australia 1997

ISBN 0 642 25131 2

The cover photograph is reproduced by courtesy of the Australian Health and Aged Care Journal and Anglican Retirement Villages.

This document was produced from camera-ready copy prepared by the Senate Community Affairs References Committee Secretariat and printed by the Senate Printing Unit, Parliament House, Canberra

MEMBERSHIP OF THE COMMITTEE

Members

Senator Mark Bishop, Chairman	ALP, WA
Senator Sue Knowles, Deputy Chairman	LP, WA
Senator Jeannie Ferris	LP, SA
Senator Michael Forshaw	ALP, NSW
Senator Meg Lees	AD, SA
Senator Belinda Neal	ALP, NSW
Senator Kerry O'Brien	ALP, Tas
Senator Karen Synon	LP, Vic.

Former Members

Senator Sue West (former Chairperson)	ALP, NSW
Senator Helen Coonan	LP, NSW
Senator Kay Denman	ALP, Tas

Substitute Members for the Committee's inquiry into aged care institutions

Senator Alan Eggleston (for Senator Ferris)	LP, WA
Senator John Woodley (for Senator Lees)	AD, Qld

Participating Members

Senator Eric Abetz	LP, Tas
Senator Bob Brown	Greens, Tas
Senator the Hon Bob Collins	ALP, NT
Senator Mal Colston	Ind, Qld
Senator the Hon John Faulkner	ALP, NSW
Senator Dee Margetts	GWA, WA

Secretary

Mr Elton Humphery

The Senate
Parliament House
Canberra

Telephone (06) 277 3515
Fax (06) 277 5829

TABLE OF CONTENTS

LIST OF ABBREVIATIONS AND ACRONYMS

ACA	Aged Care Australia
ACHCA	Australian Catholic Health Care Association
ACOSS	Australian Council of Social Service
ACTU	Australian Council of Trade Unions
ADACAS	ACT Disability, Aged and Carer Advocacy Service
ALRC	Australian Law Reform Commission
ANF	Australian Nursing Federation
ANHECA	Australian Nursing Homes and Extended Care Association
APSF	Australian Pensioners' and Superannuants' Federation
APSL	Australian Pensioners' and Superannuants' League, Qld
CAM	Care Aggregated Module
COAG	Council of Australian Governments
COTA	Council on the Ageing
CPSA	Combined Pensioners and Superannuants Association of NSW
CSA	Community Services Australia
CSDA	Commonwealth-State Disability Agreement
DHFS	Department of Health and Family Services
FIS	Financial Information Service
HACC	Home and Community Care
HREOC	Human Rights and Equal Opportunity Commission
NANHPH	National Association of Nursing Homes and Private Hospitals
NCOSS	Council of Social Service of NSW
NSW COSCA	New South Wales Council of Senior Citizens Associations
OCRE	Other Cost Reimbursed Expenditure

OPC	Office of the Protective Commissioner
RCNA	Royal College of Nursing, Australia
RCS	Resident Classification Scale
RSL	Returned and Services League of Australia
SAM	Standard Aggregated Module
SCH	Southern Cross Homes
SCI	Single Classification Instrument
TARS	The Accommodation Rights Service

RECOMMENDATIONS

Chapter 1

Recommendation 1: The Committee recommends that the commencement date for the aged care structural reforms be delayed until 1 January 1998.

Recommendation 2: The Committee recommends that it monitor the operation of the Aged Care Bill 1997 following its enactment and review the implementation of the aged care structural reforms 12 months after the commencement of the Bill.

Chapter 2

Recommendation 3: The Committee recommends that:

- the payment of accommodation bonds for entry to nursing homes should not be introduced;
- if the Aged Care Bill 1997 is passed by the Parliament with the inclusion of accommodation bonds that the Committee's other recommendations contained in this report be implemented.

Recommendation 4: The Committee recommends that the level of accommodation bonds charged be monitored by the Aged Care Standards Agency.

Recommendation 5: The Committee recommends that in determining whether a person is a concessional resident:

- the requirement that a person has not owned a home during the preceding 2 years should be omitted; and
- the value of the person's principal place of residence should be disregarded for the purpose of the assets test.

Recommendation 6: The Committee recommends that the quota system for concessional residents be monitored to ensure equality of access for financially disadvantaged people, particularly to aged care facilities within the prospective residents' locality.

Recommendation 7: The Committee recommends that the concessional resident supplement be substantially increased to a level that will provide for the necessary capital injection to maintain appropriately high standards of accommodation in aged care facilities.

Recommendation 8: The Committee recommends that the Government ensure equality of access to aged care facilities is provided for all aged people and that the provision of aged care services not be left to the vagaries of a market user-pays system.

Recommendation 9: The Committee recommends that funding for the $10 million capital grants program directed to rural and remote areas and for financially disadvantaged people be substantially increased.

Recommendation 10: The Committee recommends that the Government monitor the impact of the proposed funding changes to hostels, especially in relation to the financial viability of hostels; and that capital funding be provided to hostels that cater for a high proportion of financially disadvantaged residents.

Recommendation 11: The Committee recommends that the Government provide appropriate funding for the Home and Community Care program and other community services and housing programs to address the needs of financially disadvantaged Hostel Care level residents that may be affected by the withdrawal of Hostel Care level subsidies.

Chapter 3

Recommendation 12: The Committee recommends that the User Rights Principles be embodied in the principal legislation.

Recommendation 13: The Committee recommends that:

- an independent complaints mechanism be established as a matter of priority to deal with complaints made by older people or their representatives about aged care facilities;
- in formulating the model for such a mechanism, the Quality Assurance Working Group take into account the comments made by organisations and groups referred to in this chapter to enhance the functioning of the complaints mechanism; and
- the complaints mechanism be independent of all stakeholders, including the Department of Health and Family Services.

Recommendation 14: The Committee recommends that the independent complaints body be given the powers necessary to deal with disputes expeditiously and effectively.

Recommendation 15: The Committee recommends that the role of advocates and advocacy services be encouraged and expanded and that advocacy services be supported by guarantees of recurrent funding sufficient for the services to fulfil their role and responsibilities.

Recommendation 16: The Committee recommends that implied contractual terms be incorporated in all residential care agreements; and that these implied terms relate to national standards of care and that any breach be legally enforceable.

Recommendation 17: The Committee recommends the development of standard form agreements that outline the implied terms and a model agreement that incorporates fundamental rights.

Chapter 4

Recommendation 18: The Committee recommends that nursing homes continue to be required to acquit that proportion of their funding expended on nursing and personal care.

Recommendation 19: The Committee recommends that the accreditation standards and quality assurance system provide for the employment of appropriately skilled and trained nursing staff to ensure that quality of care is maintained in aged care facilities.

Recommendation 20: The Committee recommends that the Aged Care Standards Agency monitor the ratio of trained nursing staff per resident in nursing homes through a transparent reporting procedure which would signal significant change in the ratio.

Recommendation 21: The Committee recommends that the Aged Care Standards Agency be established with the necessary investigative powers to ensure that the quality of care and rights of residents are maintained and protected.

Recommendation 22: The Committee recommends that the Aged Care Standards Agency have monitoring and enforcement mechanisms in place to ensure industry compliance with care standards and be funded to meet those objectives.

Chapter 5

Recommendation 23: The Committee recommends that the requirement for prudential arrangements relating to accommodation bonds, as contained in the User Rights Principles, should be incorporated into the principal legislation.

Recommendation 24: The Committee recommends that the prudential arrangements should:

(i) provide an unconditional assurance that the balance of the accommodation bond is able to be refunded in accordance with the provisions of the Aged Care Bill 1997 when enacted;

(ii) be able to be complied with at the least cost to providers as possible, so as to ensure that as much of the amount received by way of accommodation bonds can be used for the intended purpose of capital improvement;

(iii) be mandatory for all providers of aged care who receive accommodation bonds, subject to the recommendation in respect of church run and church associated facilities;

(iv) be reasonably straightforward and easily understood by residents and their families; and

(v) be in place at the commencement date of the Aged Care Bill 1997.

Recommendation 25: The Committee recommends that while a blanket exemption for church run or church associated facilities is not appropriate, exemptions should be permitted for these facilities in certain circumstances. The relationship between each church-based facility and the relevant church will need to be considered to ensure that the facility is properly backed by the church before any exemption from the prudential arrangements is granted.

Recommendation 26: The Committee recommends that a review of the prudential arrangements including the mechanism for granting exemptions should be undertaken every 12 months for the first 4 years. The review should incorporate an actuarial assessment of claims records.

Chapter 6

Recommendation 27: The Committee recommends that further consideration of the implications of the transfer of responsibility to the States and Territories on the provision of aged care services needs to be undertaken by all parties involved before the transfer is to occur.

Recommendation 28: The Committee recommends that before any transfer of responsibility occurs it needs to be demonstrated that improved outcomes for providers, residents and staff will result from such a transfer, and that adequate protection for all parties involved has been put in place. In addition, there needs to be certainty that transferred funds will be used for aged care services and not diverted to alternative programs.

CHAPTER 1

INTRODUCTION

Terms of Reference

1.1 The matter was referred to the Committee on 13 February 1997 for inquiry and report by 15 May 1997. The reporting date was subsequently extended to 19 June 1997.

1.2 The complete terms of reference for the inquiry are:

> Consequences for older Australians and their families arising from proposed changes announced in the 1996-97 Federal Budget to the funding of aged care institutions in Australia, with particular reference to:
>
> (a) the implications of charging an entry fee for access to a nursing home;
>
> (b) the application of an assets test to the homes of older people living alone;
>
> (c) guaranteeing equal access to nursing home care for financially disadvantaged people;
>
> (d) the role of market forces in determining the level of entry fee to be paid;
>
> (e) ensuring that a two-tiered system of nursing home care does not develop as a result of these changes;
>
> (f) ensuring that the quality of care is protected in nursing homes;
>
> (g) the need for user rights;
>
> (h) the implications of possible transfer of aged care to the States and Territories; and
>
> (i) the need for prudential arrangements that will protect residents' contributions.

Conduct of Inquiry

1.3 The inquiry was advertised in the *Weekend Australian* on 22 February 1997 and through the Internet. Submissions were invited from many parties with an interest in or associated with the provision of aged care services in Australia. Although the closing date for submissions was 21 March 1997, this deadline was subsequently extended. The Committee continued to receive submissions throughout the course of the inquiry, indicating the high level of interest in the inquiry and concern about the future of aged care services in Australia. The Committee received 118 submissions, which have been published in separate volumes and which may be obtained through

the Committee Secretariat. A list of the organisations and individuals who made a submission to the Committee's inquiry are listed in Appendix 1.

1.4 The Committee held three days of public hearings, in Sydney on 23 April and in Canberra on 24 April and 5 May 1997 respectively. Witnesses who gave evidence at the public hearings are listed in Appendix 2. Additional information was tabled at the hearings and further evidence was provided to the Committee following the hearings in answer to questions taken on notice. This information is also listed in Appendix 1.

1.5 The Committee expresses its appreciation to those who made submissions, provided additional material, or gave evidence to the inquiry.

Outline of Aged Care Structural Reform package

1.6 In the 1996-97 Budget, the Government announced a major structural reform of residential aged care, scheduled to take effect on 1 July 1997.

1.7 The reforms were proposed against a backdrop of the increasing ageing of the population and the pressures this will impose on the community's ability to care for this sector of the population. In the next three decades, the proportion of the population aged sixty-five will grow from 11.2 per cent to over 19 per cent of the population – from under two million Australians aged over sixty-five in 1991, to over five million in 2030.[1]

1.8 In 1994 Professor Bob Gregory reviewed the structure of nursing home funding arrangements and outlined options to address the deterioration in the nursing home capital stock. Professor Gregory's report documented major deficiencies in capital works and criticised the nursing home funding system as providing neither the funding nor the incentive for providers to maintain their buildings. The report estimated that ongoing funding of $125 million would be needed to allow a substantial level of immediate building and upgrading to address existing problems as well as providing a continuing provision to maintain the quality of the building stock.[2]

1.9 The report argued that there were a number of approaches to address the deterioration in the quality of nursing home building standards. The first option involved an expansion of the Government's capital funding program. Under this option, funds would be targeted at homes on a needs basis that required upgrading and replacement.

---

1 *Steps to Better Care: Implementation of the Government's Residential Aged Care Structural Reform Package*, Statement by the Minister for Family Services, 10 February 1997, p.1.

2 Professor R.Gregory, *Review of the Structure of Nursing Home Funding Arrangements:Stage 2*, May 1994, p.5.

1.10 The second option involved changes to the recurrent funding system to provide nursing home proprietors with an incentive, and the means to, maintain building quality. Under this model, market forces would be applied to the industry so that nursing homes would have a stronger financial incentive to provide high quality accommodation. This would involve more flexibility in fee setting and in the financial accountability of nursing homes.[3]

1.11 The Government's announcement in the 1996-97 Budget responded to the financial situation outlined in the Gregory report. The Government adopted the approach that given the economic climate it would not be feasible to provide the substantial additional funding needed to upgrade and maintain the building standards of nursing homes. Instead, it adopted the approach that a user pays system in the form of accommodation bonds should be introduced with the necessary protections for financially disadvantaged people.

1.12 The reforms announced in the 1996-97 Budget are now being enacted principally through the Aged Care Bill 1997 and the draft Principles, which provide much of the administrative and operational detail underlying the changes. The Aged Care Bill replaces the provisions in the *National Health Act 1953* and the *Aged or Disabled Persons Care Act 1954* under which nursing homes and hostels are currently administered.[4] The major changes proposed in the Aged Care Bill seek to replace the existing nursing home and hostel systems with a single residential care system. The Government argues that 'by removing the boundaries between hostels and nursing homes, the Bill addresses the increasing overlap in the level of dependency of residents in these two service types'.[5]

1.13 Related to the Aged Care Bill 1997 are the Aged Care (Consequential Provisions) Bill 1997 and the Aged Care (Compensation Amendments) Bill 1997. These Bills, together with the Principles, form a package to implement the aged care structural reforms announced in the 1996-97 Budget. The Consequential Provisions Bill establishes the transitional provisions and consequential amendments to move from the current legislative framework for aged care, to the new system proposed in the Aged Care Bill. The Compensation Amendments Bill inserts residential care and residential care subsidy into the *Health and Other Services (Compensation) Care Charges Act 1995* and extends the coverage of the legislation to all residential care recipients after the Aged Care Bill comes into operation.[6]

---

3 *ibid.*, pp.5, 79-80.

4 Minister's Second Reading Speech.

5 Aged Care Bill 1997, *Explanatory Memorandum*.

6 Minister's Second Reading Speeches for the respective Bills. The Aged Care Income Testing Bill 1997, which was tabled in the Senate on 26 March 1997, establishes administrative procedures to support the implementation of the income testing arrangements in the reforms. With substantive income testing provisions being contained in the Aged Care Bill, the

1.14 The reforms announced in the 1996-97 Budget will introduce several major changes, including:

- a single resident classification scale which determines the level of subsidy of each resident;
- an accreditation system based on quality assurance and a relaxation of the previous detailed acquittal requirements for nursing homes;
- income testing of residential care benefits; and
- adoption of resident entry contributions across all residential care.[7]

1.15 It is proposed that under the new single residential care system, nursing home operators will be able to charge new residents an accommodation bond which will be similar to the entry fee currently collected from hostel residents. The accommodation bond will be used to assist with the cost of improving and upgrading the physical standard of accommodation in nursing homes. There will be special provisions for financially disadvantaged people (concessional residents).[8] Before operators can become part of the new system they will need to obtain certification that their premises and services are of a standard appropriate to the needs of their aged residents.[9]

1.16 The introduction of accommodation bonds provides for a system of capital funds generation similar to that used in aged persons' hostels. Under the reforms it is therefore proposed to cease all capital funding of aged care residential facilities, with the exception of $10 million to be provided for special purposes such as to assist rural and remote facilities. In future, all capital works other than these, are to be funded from earnings from the collection and investment of accommodation bonds.[10]

1.17 In addition to the introduction of accommodation bonds, the reforms provide for a new system of assessing daily resident contributions through a system of income testing. The Government argued that 'residents should make a fair and reasonable contribution to their daily living costs' while in residential care.[11] Currently, nursing home residents pay only a standard fee per day towards their living costs. Hostel residents pay 'variable fees' which do not have an upper limit. Under the new

---

provisions in the Aged Care Income Testing Bill will therefore cease to operate once the Aged Care Bill is enacted.

7 Aged Care Bill 1997, *Explanatory Memorandum.*

8 For further details see Chapter 2.

9 Submission No.94, pp.19-22 (DHFS).

10 See Department of the Parliamentary Library, *Proposed Changes to Institutional Residential Aged Care in Australia*, March 1997, p.i.

11 'Steps to Better Care', *op.cit.*, p.4.

proposals, residents of approved facilities will be required to contribute a percentage of their private income towards the cost of their residential care.[12]

Consultative process and implementation timetable

1.18 The Government's announcement of the Aged Care Structural Reform package in the 1996-97 Budget, laid out a vision and framework for the future and made a commitment to work closely with industry and consumers in developing the layers of detail to ensure the best possible system would be implemented from 1 July 1997.

1.19 The Government clearly saw the announcement as a framework, to be refined and developed in further consultation with consumers, carers and providers.[13] Four working groups with broadly based membership were established to develop 'the layers of detail' required for the implementation of the new system. The working groups were to focus on specific aspects of the structural reform – resident classification, quality assurance, building quality, and funding and other implementation issues.[14]

1.20 The Funding and Other Implementation Issues Working Group produced an initial report in January 1997. On 10 February the Minister for Family Services, the Hon Judi Moylan, responded to issues raised by the Working Group and publicly released the report. To date, no other of the four working groups have had a report publicly released.

1.21 The Minister also released on 10 February an exposure draft of the Aged Care Bill for public comment, to 'assist the Government in finalising the legislation'. Comments on the exposure draft, which consisted of 96 Divisions in 325 pages were to be provided by 21 February 1997 – a period of 11 days. The Aged Care Bill 1997 was subsequently introduced into the House of Representatives by the Minister on 26 March 1997.

1.22 On 21 April an exposure draft of Aged Care Bill 1997 Principles was released for public comments, which were to be provided by 15 May 1997. The exposure draft contained 18 Principles, together with an indication of a further 9 Principles which had not been drafted or would not be drafted at all at this stage.

1.23 On 26 May the Minister released further details of the proposed aged care arrangements including the new resident care classification and funding structure, and the concessional resident quota and subsidy. The Minister also announced that the commencement of the Aged Care Bill would be moved to 1 October 1997 to align the

---

12 DHFS, *Fact Sheet 7: Income Testing.*

13 'Steps to Better Care', *op.cit.*, p.2.

14 Submission No.94, pp.31-2 (DHFS).

date with the implementation of income testing, a key component of the overall package.[15]

1.24 The Department of Health and Family Services (DHFS) emphasised the extensive nature of the consultation process involving consumer groups, industry groups and the unions. According to the Department the working groups have spanned all the elements of the proposed arrangements. DHFS indicated that the groups who have participated in the process 'represent the huge majority of nursing home and hostel providers. They represent a vast number of consumers and through the ACTU, who have been represented on the broad working group, represent the majority of staff'.[16]

1.25 The Australian Council of Trade Unions (ACTU), which had nominal representation on the four working groups, was critical of the working group process. The ACTU commented that:

> the limited role of the committees [working groups] was made clear at the outset. This was to merely fine tune and tinker around the edges of decisions already announced in the Budget. It was made clear to committee representatives that objections or fundamental concerns about the policy decisions were not to be addressed through this process.[17]

1.26 The Department has recognised 'the significance of the reforms and their wide ranging impact on providers and consumers', and conceded that 'in developing an implementation timetable it has been necessary to strike a balance between the desire for extensive consultation and meeting industry and consumer expectations of action to address serious and longstanding problems'.[18] DHFS advised the Committee that while there is an urgency about the reform process, measures are being taken to cushion the effect of change. These include staggering the movement of people to the new single classification instrument and not introducing accreditation until 1 January 1998.[19]

1.27 Although the Department regarded the consultative process as 'extensive', many organisations expressed in evidence concern at the inadequate time allowed for comment on the draft Bill and Principles and the lack of detailed information that has been released on the reforms. Anglicare Australia epitomised this view indicating that it broadly supported the direction the Government is taking in aged care reforms, and

---

15 Minister for Family Services, *Media Release*, 'Aged Care Structural Reform Details Announced', 26 May 1997.

16 *Transcript of Evidence*, pp.237-9 (DHFS).

17 Submission No.79, p.2 (ACTU).

18 Submission No.94, p.32 (DHFS).

19 *Transcript of Evidence*, pp.292-3 (DHFS).

welcomed the move to an integrated system of care and to increased self-funding by older people through the payment of accommodation bonds. However, Anglicare stated that 'in our minds, the devil is in the detail – the detail that we do not have – and in the timing of the implementation of this major structural reform program'.[20]

1.28 Aged Care Australia (ACA) informed the Committee that it had 'conscientiously and consistently supported the Government's endeavours to meet its goal of July 1 implementation... We have been active in all its working parties and contributed significantly to that process. But simply we believe that we have run out of time'. ACA expressed concern at the inadequate response time for the draft Bill and Principles, but 'more importantly than that, there are some real implementation issues that have yet to be resolved'.[21]

1.29 The ACTU also indicated that there had been 'inadequate opportunities for consultation' within the organisations represented on the working groups. The community organisations involved, which rely on a minimum number of permanent staff, had real difficulty without additional resources in dealing with the amount and complexity of the material being considered.[22]

1.30 The NSW Aged Care Alliance referred to a public meeting held in Sydney on 7 April 1997 where the audience of over 650 mostly older people were extremely concerned about the reforms. Their concerns were heightened 'by the fact that many important questions could not be answered, because the actual impacts of the changes, including the amount which will have to be paid as an "accommodation bond" are not yet clear'.[23]

1.31 The Committee discusses in this report major issues which are still unresolved or about which information is not yet, or has only just become, available. These include the prudential arrangements to protect residents' accommodation bonds, the funding levels attached to the Resident Classification Scale, the subsidy rate for concessional residents, and the number of Principles yet to be drafted.

1.32 Due to the uncertainty still surrounding a large number of issues, many of the groups affected by the proposed reforms requested that the implementation of the reforms be delayed until information concerning all the issues is available, outstanding problems and concerns have been resolved and all impacts of the proposed reforms have been fully explored and debated.[24] It should be emphasised that the delay being

---

20 *Transcript of Evidence*, p.76 (Anglicare Australia).

21 *Transcript of Evidence*, p.136 (ACA). See also *Transcript of Evidence*, p.29 (NSW COSCA).

22 Submission No.79, pp.2-3 (ACTU).

23 NSW Aged Care Alliance, Additional Information, 9 May 1997, p.1.

24 Submissions No.38, p.28 (ACHCA); No.57, p.3 (Anglicare Australia); No.79, p.2 (ACTU); *Transcript of Evidence*, p.145 (ACA), p.178 (COTA); Resolution of Public Meeting called by NSW Aged Care Alliance, Additional Information (NSW ACA).

sought was not necessarily an expression of opposition to the reforms, rather it was to enable crucial details to be made available and understood, and for procedures to be implemented and necessary training undertaken to ensure a trouble-free transition to the new arrangements.

Conclusion

The Committee believes that while there are so many issues yet to be resolved and such widespread concerns still being expressed over aspects of the reforms and their implementation timetable, the commencement of the legislation should be delayed. The Committee notes that further information is becoming available on a progressive basis. Nevertheless, the Committee remains of the view that the information which has recently been made available and the manner by which it is being released provides insufficient time for its consideration by organisations prior to the scheduled commencement date. The Committee is also concerned at the Parliamentary difficulties in conducting an informed debate on the legislation without the benefit of having available all the details relating to the reforms and their operation.

Recommendation 1: The Committee recommends that the commencement date for the aged care structural reforms be delayed until 1 January 1998.

Recommendation 2: The Committee recommends that it monitor the operation of the Aged Care Bill 1997 following its enactment and review the implementation of the aged care structural reforms 12 months after the commencement of the Bill.

CHAPTER 2

ACCOMMODATION BONDS

2.1 This chapter addresses issues related to the proposed introduction of accommodation bonds for entry to nursing homes. In particular, it looks at the implications of charging accommodation bonds for access to nursing homes; the application of an assets test to the homes of older people living alone; measures to guarantee access to nursing homes for financially disadvantaged people and the role of the market in determining the level of accommodation bonds to be charged.

Accommodation bonds

2.2 Accommodation bonds will be introduced across all residential care from 1 July 1997 (now extended to 1 October 1997). The aim of the bonds is to provide a source of capital funds and incentive for nursing homes to invest in upgrading facilities. As noted in Chapter 1, Professor Gregory in a review of the structure of the funding for nursing homes, estimated that ongoing funding of $125 million a year would be needed for a substantial level of immediate building and upgrading activity to address existing problems as well as providing a continuing provision to maintain the quality of stock.[1] Aged Care Australia (ACA) indicated that the introduction of accommodation bonds will generate approximately $130 million in revenue for capital purposes in the nursing home sector after four years of operation.[2]

2.3 Accommodation bonds are a bond from which a provider can draw down a maximum of up to $2 600 (indexed) a year, for up to five years (up to a maximum of $13 000, indexed). The provider is also able to retain the interest earned. The balance of the bond is to be returned to the resident or their estate on departure. All certified aged care facilities may charge an accommodation bond to new residents.[3]

2.4 Accommodation bonds will be charged as a capital deposit on the assets of prospective residents. There is no upper limit that may be charged but residents must be left with a minimum asset level of 2.5 times the pension (currently $22 000 for singles and $45 000 for couples). There are also specific provisions for people entering care who leave a spouse, close family member or long term carer in their home. In these cases, the family home will be excluded from consideration as an asset when determining whether a person can reasonably pay a bond.

2.5 'Concessional residents' will not have to pay an accommodation bond. Concessional residents are classified as people who are full or part pensioners, who

---

1 Professor R. Gregory, *Review of the Structure of Nursing Home Funding Arrangements: Stage 2*, May 1994, p.5.

2 Submission No.60, p.9 (ACA).

3 Submission No.94, p.20 (DHFS).

have not owned their own home for the past two years and who have assets less than 2.5 times the single age pension (about $22 500).[4] Issues relating to concessional residents are discussed later in this chapter.

2.6 If the resident transfers to another facility, the bond will be 'rolled over' to the new facility and no resident will be required to pay a bond more than once. Accommodation bond refunds must be made within 2 months. An administrative fee will apply in cases where a resident stays in a facility for three months or less, or has not paid the agreed bond by the time they leave. This will be based on the amount the provider would have retained plus an externally set interest component.[5]

2.7 The quantum and timing of accommodation bond payment will be agreed between the service provider and resident at the time of entry. Providers will be required to offer each resident an agreement which sets out minimum requirements such as the amount and method of payment (Section 57-9 of the Aged Care Bill). Residents will have at least seven days after entry before they can be asked to sign an agreement in relation to payment of a bond.[6]

2.8 The money raised from accommodation bonds will be used to improve and upgrade facilities. The legislation requires that the retention amount must be used for the purpose of providing aged care services (Section 57-2(m)). If funding is not used on aged care services, providers may lose the right to charge accommodation bonds and receive supplementary funding for concessional residents. To provide an incentive to invest in upgrading building stock, only those facilities which are certified/accredited as meeting building standards will be able to charge a bond.[7]

Imposition of accommodation bonds

2.9 The Committee is opposed to the imposition of accommodation bonds for nursing home entry. It has grave concerns that the charging of accommodation bonds effectively imposes a charge for the provision of health care on those who are most vulnerable in the community – the frail elderly. The Committee believes that it will also lead to a two-tiered system of nursing home care. The Committee's specific concerns in relation to the imposition of accommodation bonds are outlined in this and succeeding Chapters of the report.

2.10 The Committee considers, however, that should the Aged Care Bill be passed by the Parliament with the inclusion of accommodation bonds, the Committee's other recommendations to improve the functioning of the legislation and the overall operation of the Aged Care Structural Reform Package should be implemented. These

---

4 Submission No.94, p.22 (DHFS).

5 Submission No.94, p.20 (DHFS).

6 Submission No.94, p.21 (DHFS).

7 Submission No.94, p.21 (DHFS).

recommendations are detailed in this Chapter and in the following Chapters of the report.

Recommendation 3: The Committee recommends that:

- **the payment of accommodation bonds for entry to nursing homes should not be introduced;**
- **if the Aged Care Bill 1997 is passed by the Parliament with the inclusion of accommodation bonds that the Committee's other recommendations contained in this report be implemented.**

Level of bonds

2.11 In relation to hostels, where entry contributions (accommodation bonds) have been operating since 1987, a 1993 survey of hostel funding arrangements by ACA showed an average entry contribution of $26 000 (this figure was based on persons who paid a bond).[8] A more recent survey indicated, however, that the average entry contribution in hostels was $40 000 in 1994-95.[9] The Department of Health and Family Services (DHFS) stated that 75 per cent of hostels currently charge an entry contribution.[10]

2.12 DHFS stated that the entry contribution system has been operating 'successfully' in the hostel sector and that there had been no calls for hostel bonds to be capped and 'very few' complaints about the size of individual bonds.[11]

2.13 Some evidence suggested that the bonds that would be charged for nursing home entry may be considerable. The nursing home industry indicated a broad range of possible accommodation bond charges. The Australian Nursing Homes and Extended Care Association (ANHECA) indicated that the maximum bond charged could be about $100 000 for high standard facilities.[12] The National Association of Nursing Homes and Private Hospitals (NANHPH) stated that a 'ballpark' figure may be $50 000 for a single room – 'there are obviously going to be bonds set on private room accommodation, a second level on double room accommodation and probably the lowest on four-or three-bed ward accommodation'.[13] Tricare Ltd., the largest

---

8 Study cited in Submission No.94, p.44 (DHFS). See *Transcript of Evidence*, pp.277-79 (DHFS).

9 James Underwood & Associates Pty. Ltd., *1994-95 National Hostels Costs Survey*. The results were based on those hostels charging entry contributions. See also Submission No.38, p.12 (ACHCA).

10 *Transcript of Evidence*, p.278 (DHFS).

11 Submission No.94, p.44 (DHFS).

12 *Transcript of Evidence*, p.100 (ANHECA).

13 *Transcript of Evidence*, p.18 (NANHPH).

private aged care operator in Queensland, indicated that the maximum bonds charged would be $75 000 for that organisation.[14] The Australian Pensioners' and Superannuants' Federation (APSF) argued that in urban areas bonds would be around $90 000.[15]

2.14 Evidence from DHFS and others including Community Services Australia (CSA), the Australian Catholic Health Care Association (ACHCA) and NANHPH suggested that the size of accommodation bonds may be limited to an informal ceiling of $88 500 which is the cap for eligibility for rent assistance.[16] One not-for-profit provider stated at the NSW Aged Care Alliance Public Meeting held on 7 April that their organisation 'has estimated they will have to charge at least $88 500 per person to remain viable'.[17] ACHCA argued that the amount of $88 500 'will be seen as a sort of benchmark because of the impact on people's eligibility for what used to be called rent assistance and in terms of how Social Security would look at the deeming or non-deeming of accommodation bonds'.[18]

2.15 DHFS also argued that the ceiling will be reinforced by competition from existing hostels, most of which charge 'moderate entry contributions'.[19]

'Capping' of bonds

2.16 Some evidence suggested that there should be an upper limit or 'cap' on the size of accommodation bonds that could be charged.[20] APSF argued that this would help ensure that older people are less vulnerable when negotiating the financial arrangements and would ensure that they would be guaranteed some non-pension income to cover expenses while in residential care.[21]

2.17 An option suggested by Dr Marinovich was that accommodation bonds could be capped at the presumptive cost of building one nursing home or hostel unit (between $40 000 and $50 000) with the amount increased to provide for depreciation.[22]

---

14 *Transcript of Evidence*, p.69 (Tricare Ltd.).

15 Submission No.58, p.14 (APSF).

16 Submission No.94, p.44 (DHFS); *Transcript of Evidence*, p.170 (Community Services Australia); *Transcript of Evidence*, p.209 (ACHCA); *Transcript of Evidence*, p.7 (NANHPH).

17 NSW Aged Care Alliance, Additional Information, 9.5.97, pp.1-2.

18 *Transcript of Evidence*, p.209 (ACHCA).

19 Submission No.94, p.44 (DHFS).

20 Submission No.58, p.20 (APSF); *Transcript of Evidence*, p.115 (APSF); Submission No.44 p.2 (Dr Marinovitch).

21 Submission No.58, p.20 (APSF).

22 Submission No.44, p.2 (Dr Marinovich). See also *Transcript of Evidence*, pp.189-99 (Dr Marinovitch).

2.18 The Committee raised the issue of how such amounts could be raised where an aged care institution has a large proportion of concessional residents who are not required to pay an accommodation bond.[23] Dr Marinovitch conceded that 'there would either have to be an in-built factor in the funding of the concessional patients for depreciation...or it would have to be made up by an increase in the levy on those who are paying an ingoing fee'.[24]

2.19 DHFS stated that although the Aged Care Bill enables the Minister to set a cap on the level of accommodation bonds (Section 57-12(1)(c)), it does not believe 'at this stage' it will be necessary to further regulate or cap accommodation bonds.[25]

2.20 DHFS argued that there are sufficient protections in the Bill to provide safeguards for residents in negotiating payment arrangements with providers. The safeguards include assistance from advocates and access to independent complaints mechanisms. The Department also noted that the prudential requirements will provide security for residents' funds in the event of provider insolvency. The accreditation system will also establish standards for providers to adhere to in negotiating bond amounts and payment arrangements with residents.[26]

2.21 Representatives of the industry were opposed to the capping of bonds, arguing that the bond levels should be left to market forces.[27] In addition, given the variable house prices across Australia the capping of bonds would be difficult.

Recommendation 4: The Committee recommends that the level of accommodation bonds charged be monitored by the Aged Care Standards Agency.

Implications of charging accommodation bonds for access to nursing homes

2.22 Evidence to the Committee suggested that accommodation bonds will provide an incentive for nursing home proprietors to differentiate between prospective residents. APSF argued that currently there is 'no incentive for proprietors to give preference to potential residents with greater income or assets as all fees are standard...The proposed accommodation bond arrangements will introduce an incentive for homes to differentiate between potential residents. This incentive is likely to be most pronounced in the for-profit sector'.[28] The NSW Council of Senior Citizens Associations (COSCA) stated that the imposition of the bonds represent 'an iniquitous and inequitable provision which will discriminate against and disadvantage

23 For a definition of 'concessional' resident see paragraph 2.5.

24 *Transcript of Evidence*, p.191 (Dr Marinovitch).

25 Submission No.94, p.23 (DHFS).

26 Submission No.94, p.23 (DHFS). See also *Transcript of Evidence*, p.241 (DHFS).

27 *Transcript of Evidence*, p.102 (ANHECA) *Transcript of Evidence*, p.6 (NANHPH).

28 Submission No.58, p.8 (APSF).

most seriously, vulnerable frail aged people, needing nursing home care in their final stage of life'.[29]

2.23 A number of groups that could be disadvantaged in terms of access to nursing homes as a result of the imposition of bonds were identified in evidence. These included:

- people with long term needs: the provision of short term care will be relatively more financially rewarding to proprietors, due to the structure of resident fees and draw down arrangements (by contrast, long term residents will find their financial attractiveness to proprietors severely reduced, unless they have paid a substantial bond); and
- people with limited assets, especially those with a low asset base, but who fall outside the concessional resident definition. These people may find their choice of facility limited, their choice of beds limited to multiple bed wards and may have to move away from their home area.[30]

People with dementia

2.24 It was argued in evidence to the Committee that the reform package needed to ensure adequate access to quality residential care for people with dementia and funding safeguards for these people in the new residential aged care system.[31]

2.25 DHFS estimated that some 60 per cent of nursing home and 47 per cent of hostel residents have substantial cognitive or behavioural characteristics associated with dementia. In addition to these residents, it is estimated that in 1996 there were some 135 000 in the community aged 60 and over who had dementia. The number is expected to rise to 177 000 in 2006 and 222 000 in 2016.[32] Alzheimers Australia noted that the growth in the numbers of people suffering from dementia will mean a corresponding growth in the numbers of people needing nursing home care.[33]

2.26 Alzheimers Australia noted that a major concern is the adequacy of the Commonwealth subsidies that will be attached to the Single Classification Instrument (SCI), now called the Resident Classification Scale (RCS), which will be applied to recipients of residential aged care and which will be the basis for allocating Government funds. Alzheimers Australia argued that 'the additional costs of providing

---

29 Submission No.6, p.1 (NSW COSCA).

30 Submission No.58, pp.8-9 (APSF).

31 *Transcript of Evidence*, p.194 (Alzheimers Australia); Submission No.61, p.1 (Alzheimers Australia).

32 Submission No.94, p.28 (DHFS).

33 *Transcript of Evidence*, p.201 (Alzheimers Australia). See also *Transcript of Evidence*, p.79 (Anglicare).

care to people with dementia must be included because of their unusually high and diverse support needs'.[34]

2.27 Alzheimers Australia further noted that the RCS may not deliver the level of funding required to adequately take care of these people –'in terms of a proprietor finding an attractive client group, people with dementia have the potential to be unattractive because the funding is not adequate for their needs'.[35] Anglicare also noted that it had concerns that dementia 'will not be recognised as an area which needs specific and adequate funding'.[36]

2.28 DHFS noted that improved funding for dementia care is a 'major priority' and a specific objective in the development of the new RCS is to better identify the care needs of residents with dementia – 'this will ensure that residents with dementia are appropriately funded irrespective of the type of facility in which they reside'.[37] DHFS noted that under the RCS 'the weighting for dementia has effectively been doubled which will ensure better funding for dementia care'. [38] Under the new funding arrangements, funding for hostel residents with identified dementia care needs increases by over 30 per cent on average.[39] In the 1997-98 Budget $1.5 million was allocated for people with dementia and their carers.[40]

2.29 Alzheimers Australia also noted that the introduction of accommodation bonds in residential care facilities has particular implications for people with dementia, whose impaired cognitive ability means that they may not have the capacity to make decisions for themselves on matters affecting their lives or financial situation, or to enter contractual arrangements with providers – 'provision, therefore needs to be made for the interests of a person with dementia to be adequately represented during negotiations with service providers by an advocate who knows and understands the person'.[41]

---

34 *Transcript of Evidence*, p.195 (Alzheimers Australia).

35 *Transcript of Evidence*, p.196 (Alzheimers Australia).

36 *Transcript of Evidence*, p.79 (Anglicare Australia).

37 Submission No.94, p.29 (DHFS).

38 DHFS, Additional Information, 22 May 1997, p.3.

39 Minister for Family Services, *Media Release*, 'Aged Care Structural Reform Details Announced', 26 May 1997, p.3.

40 Portfolio Budget Statements 1997-98, *Health and Family Services Portfolio*, p.226.

41 Submission No.61, p.3 (Alzheimers Australia).

Sale of the family home

2.30 Some evidence to the Committee suggested that many older people will be forced to sell their homes in order to gain access to nursing homes.[42]

2.31 The Government has, however, argued that this will not be the case. The Minister for Family Services, the Hon Judi Moylan MP has stated that 'there is no compulsion or legal requirement for anyone to sell their home. Entry contributions are essentially a private arrangement between the resident and the nursing home'.[43] DHFS reiterating this argument, told the Committee 'the Minister has said categorically that nobody will be forced to sell their home to gain care and that indeed care will be accessed on need not means'.[44]

2.32 DHFS also noted that entry to a residential care facility represents a permanent move to a new home for the vast majority of residents. DHFS stated that about 50 per cent of people entering nursing homes currently choose to sell their homes – 'this figure is not expected to change significantly with the introduction of accommodation bonds'.[45]

2.33 Some evidence suggested that while admittance to a hostel is like a change of home and therefore a considered decision, entering a nursing home is likely to be a more urgent matter and mainly from acute care. In these circumstances the person is less likely to view it as a change of home but rather as a further step to returning home.[46] DHFS stated, however, that entry to an aged care facility represents a permanent move for the vast majority of residents.[47] Some 60 per cent of nursing homes residents die in the nursing home.[48]

2.34 The NSW COSCA noted that the distinction between nursing homes and hostels needs to be recognised. The Council stated that hostels are an accommodation option 'and there is a choice about the accommodation you undertake – and nursing homes, which provide health care for users and whose entry is usually by prescription and not by choice'.[49]

---

42 Submission No.51, p.2 (Residential Care Rights); Submission No.65, p.4 (COTA); Submission No.17, pp.3-5 (Mr Boyce).

43 Minister for Family Services, *Nursing Homes Residents Safeguards*, 27 August 1996, p.3.

44 *Transcript of Evidence*, p.239 (DHFS).

45 Submission No.94, p.36 (DHFS). See also *Transcript of Evidence*, p.239 (DHFS).

46 Submission No.38, p.8 (ACHCA).

47 Submission No.94, p.36 (DHFS).

48 Submission No.60, p.13 (ACA).

49 *Transcript of Evidence*, pp.29-30 (NSW COSCA).

2.35 The Committee received considerable evidence that the need to sell a home in order to obtain nursing home care may have psychological and other consequences for older people. The Council on the Ageing (COTA) argued that the sale of a home in order to enter a nursing home 'signals to the older person that they will never be able to return to normal life in the community. This may have consequences for the morale and life expectancy of older people'.[50]

2.36 The Office of the Protective Commissioner (OPC), which manages the financial affairs of people with impaired decision-making abilities in NSW, offered further support for this statement arguing that the Office saw 'many people who go into nursing homes and, if the home is sold, they can pass away quite quickly, lose their will to live'.[51] OPC indicated that the general philosophy of the Office is that the sale of a person's home is the 'last resort' option.[52] OPC also noted that 'it is our experience that elderly people often resist the sale of their home in the hope that they may regain the capacity to manage in the community and return home. The knowledge that the former family home may be sold could encourage some residents to return home when they are not able to manage, putting themselves at risk of illness, neglect, injury and premature death'.[53]

2.37 APSF also argued that many older people if compelled to sell the family home will 'lose hope' and may also 'build up a deep resentment if they feel they are, as they see it, "forced" to sell their home against their will'.[54]

2.38 The Royal College of Nursing, Australia (RCNA) stated that 'there is a very robust body of knowledge...that supports the general decline in health, once the person has made a conscious decision to sell their family home in order to enter some level of care, whether it is an independent living unit, a hostel unit or a nursing home'.[55]

2.39 Other concerns were raised in relation to the difficulties older people may face in negotiating the sale of a home.[56] Evidence to the Committee suggested that many aged people have cognitive impairments which result in their inability to make financial and other decisions (with over 50 per cent of people in nursing homes having some form of dementia). OPC suggested that there will be a large increase in applications for formal guardianship as a result.[57] NANHPH argued that for residents

---

50 Submission No.65, p.3 (COTA).

51 *Transcript of Evidence*, p.52 (OPC).

52 *Transcript of Evidence*, p.51 (OPC).

53 Submission No.68, p.3 (OPC).

54 Submission No.58, p.11 (APSF).

55 *Transcript of Evidence*, p.129 (RCNA). RCNA provided an extensive bibliography on these issues.

56 *Transcript of Evidence*, p.48 (OPC).

57 *Transcript of Evidence*, p.49 (OPC).

suffering from dementia, in particular, that the OPC would be available to make arrangements for the sale of the home and to attend to an aged persons financial affairs.[58] OPC argued, however, that the Office already had a heavy workload:

> We have a client load of about 9000 across all disabilities. We are finding at the moment that about 50 per cent is dementia related. There are finite resources, obviously...It is not just our agency but also the Guardianship Board and the Supreme Court who are the legal bodies who make these orders. So there would be a considerable downstream effect there.[59]

2.40 Residential Care Rights also expressed concerns that the various Guardianship Boards may not be able to meet the expected increased demand placed on their services.[60] OPC also noted that in NSW it would take about a month to get an Order through the Supreme Court and with the Guardianship Board four to six months for an exceptional non-urgent matter, such as that relating to a nursing home admission.[61]

2.41 OPC noted the 'burden of the complexity of issues' that will have to be faced by older people in the situation of having to sell the family home.[62] Other evidence raised issues relating to the legal and financial difficulties in selling an aged person's property especially where there are families interested in maintaining the property.[63] APSF also noted that many older people wish to leave their property to their children or other relatives and regard the home more as a 'family' asset and not an individual asset.[64] Some evidence also pointed to the potential for exploitation by real estate agents and/or financial advisers of older people having to arrange the sale of their home.[65] The Committee also raised the possible situation where the principal of a nursing home also operates a real estate agency. NANHPH argued that this would not present a conflict of interest.[66] However, OPC argued that there would be 'an obvious conflict of interest, and we would want to see that principal remove himself or herself from one of those functions'.[67]

---

58 *Transcript of Evidence*, p.11 (NANHPH).

59 *Transcript of Evidence*, p.50 (OPC).

60 Submission No.51, p.9 (Residential Care Rights).

61 *Transcript of Evidence*, p.50 (OPC).

62 *Transcript of Evidence*, p.48 (OPC).

63 Submission No.68, p.5 (OPC).

64 Submission No.58, p.11 (APSF).

65 Submission No.51, p.2 (Residential Care Rights); Submission No.58, p.17 (APSF).

66 *Transcript of Evidence*, p.12 (NANHPH).

67 *Transcript of Evidence*, p.50 (OPC).

2.42 Evidence to the Committee also raised the potential problems of older people having to administer investments and/or income from the sale of the home. APSF noted:

> Most of us had no experience in doing anything of this nature at all. In fact, on retirement, for those of us who have had no such experience it becomes quite a problem if you have got anything left over...to know how to deal with it in terms of getting some sort of income out of it. That is because most of us have had no experience, certainly as far as women are concerned.[68]

2.43 DHFS stated that prospective residents and their families will be able to discuss options available to them through free advocacy services operating in all States and Territories or by contacting the free Financial Information Service (FIS) operated by the Department of Social Security. The Committee notes, however that the substantial reduction in funding for FIS announced in the 1997-98 Budget will reduce the level of services available to aged people.[69] DHFS noted that residents may also approach an independent financial adviser and a financial adviser may be present when prospective residents and providers are negotiating the level and/or payment options for accommodation bonds.[70]

2.44 The APSF, however, questioned the efficacy of financial advisers. APSF stated that:

> We have found, in a lot of areas, that financial advisers are not very good at advising old people. Often their understanding of social security rules are not good...A lot of older people in this sort of situation, perhaps in their 70s or 80s are facing this situation of having to handle money for the first time. They do not know what questions to ask. They do not know how to choose an adviser and how to tell a good adviser from a bad adviser.[71]

Other consequences

2.45 Some evidence suggested that with the possibility that a number of older people and their families will try to avoid entry to residential care, a number of outcomes were possible, including older people not getting the care they need and additional strain on families and carers.

2.46 ACHCA and OPC noted a consequence of families deciding to care for their increasingly dependent and frail aged relatives beyond their coping capacity could result in the potential for elder abuse and neglect and an increase in admissions into

---

68 *Transcript of Evidence*, p.112 (APSF).

69 It was announced in the 1997-98 Budget that funding for FIS officers and Migrant Liaison officers will be reduced by 25 per cent.

70 Submission No.94, p.24 (DHFS).

71 *Transcript of Evidence*, p.113 (APSF).

acute care.[72] There is also a danger to the health and welfare of elderly people, often living on their own and increasingly frail, yet still hesitating to enter a nursing home or hostel due to a reluctance to sell their home.

2.47 Concerns were also raised that additional pressures will be placed on the Home and Community Care (HACC) program.[73] ACHCA noted that 'with the combination of accommodation bonds in the nursing home, income tested charges, residence fees and so on, families will start to look at the economies of it. If the combination of all those elements is going to impact to the tune of, say, $50 to $80 a day on a family, then maybe they will want to look at the HACC program'.[74]

2.48 COTA noted that HACC is already under pressure to provide services for younger people with relatively high care needs rather than providing services for people who have a reasonable capacity for independent living.[75] Moreland City Council commented on the impact at the local government level, arguing that there will be a considerable increased demand for HACC and other community services by older people 'and with Council receiving significantly diminished and diminishing resources to provide these services'.[76]

Negotiating accommodation bond agreements

2.49 Concerns were also raised in relation to the ability of residents and/or their families to effectively negotiate the terms and conditions of accommodation bonds with nursing home proprietors. Evidence to the Committee indicated that nursing home placements generally take place as a result of a health crisis and/or family care breakdown. Some 60 per cent of people entering nursing homes do so from an acute hospital.[77]

2.50 Evidence indicated that most aged people entering nursing homes, and their families, are under great stress. They are often not in a position to negotiate, on an equal basis, the amounts of the bond involved. Many of those entering nursing homes also lack the requisite mental capacity (because of dementia) necessary for negotiation of bonds and, indeed, other contractual issues.[78] Alzheimers Australia noted that this

---

72 Submission No.38, p.7 (ACHCA); Submission No.68, p.5 (OPC).

73 The HACC program is a joint Commonwealth and State funded program which provides services to support frail older people, and their carers, to remain in the community. These services include home help, personal care, meals on wheels and home nursing. See Submission No.65, p.3 (COTA); Submission No.38, p.7 (ACHCA); Submission No.61, p.4 (Alzheimers Australia).

74 *Transcript of Evidence*, p.214 (ACHCA).

75 Submission No.65, p.3 (COTA).

76 Submission No.77, p.3 (Moreland City Council).

77 Submission No.50, p.4 (CPSA of NSW).

78 Submission No.51, p.5 (Residential Care Rights); Submission No.68, pp.4-5 (OPC).

has particular implications for people with dementia by limiting their capacity to enter into contractual arrangements with proprietors.[79] The combination of these factors leaves open the likelihood of exploitation and financial abuse of people entering nursing homes.

2.51 OPC noted that:

> Aged people, particularly people with early onset dementia, are not on equal terms with service providers or nursing home proprietors. They do not have parity in the financial relationship between themselves and the service provider and therefore require assistance in negotiating the placement and payment of the bond.[80]

2.52 Family and friends may be able to fulfil the negotiating role, however, as noted above, entry of a person into a nursing home often occurs at a time when family and friends are distressed at the move. The Combined Pensioners and Superannuants Association of NSW (CPSA) stated that 'given these circumstances, the ability of both the potential resident and their family and friends to negotiate a fair deal has to be seriously questioned'.[81]

Conclusion

2.53 The Committee believes that the reforms ignore the reality of the psychological value of the home on the health and wellbeing of older people and the possible detrimental health effects that the 'forced' sale of the family home may present for many older people. The Committee is of the view that the sale of a person's home should be only an absolute 'last resort' option after all other options are considered.

2.54 The Committee believes that it is important for the Minister's commitment that older people will not be forced to sell their homes to be a genuine component in the implementation of the new aged care reform. The Committee believes that the only way of guaranteeing that older people will not have to sell their home is to exclude the home from the assets test. The Committee considers that DHFS should review all other available options and canvass these options widely with all major stakeholders.

Application of an assets test to the homes of older people living alone

2.55 Under the Bill, the family home will be included as an asset for the purposes of assessing a person's capacity to pay a bond unless there is a spouse or young child still residing in the home, or where a close family member or carer has lived in the home for five years and is eligible for a Commonwealth pension or benefit.[82]

---

79 Submission No.61, p.3 (Alzheimers Australia).

80 Submission No.68, p.4 (OPC).

81 Submission No.50, p.4 (CPSA of NSW).

82 Submission No.94, p.37 (DHFS).

2.56 The amount of the accommodation bond to be paid is a private arrangement between the facility and each incoming resident and is determined as part of the resident/proprietor agreement taking into account the prospective resident's assets. In determining the level of the accommodation bond, the facility operator is obliged only to leave the intending resident a minimum level of assets equivalent to 2.5 times the pension (currently $22 500 for singles and $45 000 for couples).[83]

2.57 Evidence to the Committee raised concerns that older people living alone will be treated differently under the proposed system than married people.[84] COTA stated that while a married person with a spouse remaining at home can enter residential care without payment of a bond, a single person 'could be under pressure to sell the home as it will be identified as an asset. If there are not sufficient other assets which can be converted to cash to pay the bond, the house will have to be sold unless the person can make arrangements for a periodic bond payment'.[85]

Payment options

2.58 The accommodation bond arrangements provide for a number of payment options including payment as a lump sum, or as an equivalent regular fortnightly or weekly payment or, alternatively, a combination of both. If people choose a regular payment option, this will include an interest component. The interest component will be set at the Treasury Note Yield rate applying at the date of entry plus four percentage points.[86] DHFS explained that:

> That is to equate to what the actual value of the bond would be if it were lodged in order to make the incentive completely neutral as to which version is more preferable one way or the other. It is struck as a maximum of an additional four percentage points because a number of the providers said ...that they would actually want an opportunity to compete with some of their counterparts and that they would be able therefore to offer a discount if they thought that gave them an edge.[87]

2.59 If people choose to pay a lump sum, they will have at least six months to pay, although interest and retention may accrue from the time of entry to the facility.[88]

2.60 Pensioner and other groups questioned whether the periodic payments option was realistic for many older people. COTA and APSF argued that few older people would be able to use this option as a regular cash flow will need to be generated.[89]

---

83 Submission No.94, p.36 (DHFS).

84 Submission No.65, p.4 (COTA); Submission No.17, p.6 (Mr Boyce).

85 Submission No.65, p.4 (COTA).

86 Submission No.94, p.24 (DHFS); *Transcript of Evidence*, p.259 (DHFS).

87 *Transcript of Evidence*, p.259 (DHFS).

88 Submission No.94, p.37 (DHFS).

2.61 The Committee raised concerns with DHFS as to what type of secure investments are available for age pensioners that would yield them the equivalent of the full Treasury note yield which is currently 9.6 per cent.[90] DHFS could not supply this information arguing that the rate was set 'being aware of what the costs were and what was a reasonable rate to strike between the needs of consumers and providers'.[91]

2.62 Evidence to the Committee raised concerns about the impact of the payment options on a pensioner's total income levels.[92] APSF argued that:

> It will make a difference to what your income is if you sell your home, or if you rent your home, so immediately your pension is affected by having more money as cash for investment over and above what you might pay as a part of your entry contribution or bond. For example, if it is a question of paying it off weekly or monthly...you will be losing some of your pension, you will be losing your concessions as well and, as a consequence of that, your whole income will be affected...If it is a question of having the cash which you then invest, that becomes another problem in terms of income that will reduce your pension. So, whatever happens, you are going to lose and continue to be losing.[93]

2.63 Renting the house may not provide a sufficient cash flow to meet periodic payments. This will particularly be the case with pensioners or part pensioners. Use of the home to earn rental income will potentially result in:

- a reduction in the pension of $1 for every $2 earned above $49 per week;
- resident fees increasing by 25 cents for every dollar earned above $49 per week;
- an effective rate of tax of 32.5 cent for each dollar earned in excess of $215.10 per week (being the combined result of a loss of the pensioner income tax rebate at the rate of 12.5 cents for each additional dollar and the standard 20 per cent marginal rate); and
- a potential capital gains tax liability proportionate to the period during which the home was not used as a principal place of residence.

---

89 Submission No.65, p.4 (COTA); Submission No.58, pp.12-13 (APSF). See also Submission No.38, p.8 (ACHCA).

90 *Transcript of Evidence*, pp.259-60 (DHFS).

91 *Transcript of Evidence*, p.260 (DHFS).

92 Submission No.58, pp.16-17 (APSF); Submission No.50, p.6 (CPSA of NSW); Submission No.105, p.11 (HRECOC).

93 *Transcript of Evidence*, pp.111-112 (APSF).

2.64 Where a person is a single pensioner living in a home which they own with no other significant income or assets, the Committee agrees that there is little possibility that periodic payment would be a viable option.

2.65 The concept of a 'reverse mortgage' was made known to the Committee.[94] This is where a person borrows against their home, in the form of a lump sum or instalments, and the loan is repaid with interest out of the proceeds of their estate. This was suggested as a means of releasing the value locked up in a property without irrevocably selling it. A subsidised facility of this type was available until 30 June 1996. The point to note however, is that any amount borrowed under the scheme was repayable within 12 months if the borrower vacated the home which secured the loan. Consequently the facility would have been of limited use to a person wishing to borrow against their home for the payment of an accommodation bond.

2.66 The Committee is aware that a comparable subsidised facility is still offered by at least one bank. However, the requirement to repay the loan within 12 months of vacating the home is still a condition of the loan.

2.67 The Committee believes that in the circumstances where a person is a single pensioner living in their own home with no significant other assets, that person will have little practical choice other than to sell their home to raise the amount necessary to pay an accommodation bond.

Asset effects

2.68 CPSA of NSW argued that there was a 'strong possibility' that part pensioners and some maximum rate pensioners will lose access to their pension altogether when the assets test is applied to the family home.[95] APSF noted that many older people worry about losing their pension or part pension – 'people who face this situation for the first time in their late 70s or 80s will be extremely nervous, especially as losing entitlement to the pension also means losing entitlement to concession rate prescription medicines etc'.[96]

2.69 DHFS advised that under the new arrangements the family home will not be treated as an asset for the first two years of a person's residence in the nursing home for age pension purposes. This is a continuation of the current protection. After the two year period, or if the home is sold during this period, the home or the proceeds of the sale are treated as an asset for the purposes of the assets test. The amount of any accommodation bond paid is also treated as an asset for the purpose of the assets test.[97] The most significant impact of this will be felt by single homeowners receiving

---

94 *Transcript of Evidence*, pp.14-15 (NANHPH) and *Transcript of Evidence*, p.25 (Mr Boyce).

95 Submission No.50, p.6 (CPSA of NSW).

96 Submission No.58, p.16 (APSF).

97 Submission No. 94, p.38 (DHFS).

the full rate pension. Upon the sale of their homes, their fortnightly pensions will be reduced by $3 for each $1000 that their assets (including the accommodation bond paid) exceed $212 500 up to a maximum asset level of $331 000 at which point no pension is payable.

Income effects

2.70 Pensioner groups argued that the pensions for many older people may be reduced as a result of people selling their homes to raise funds for a bond.[98] Any income earned from the balance of the sale proceeds (after payment of the accommodation bond) will potentially further reduce the pension, may increase the resident fees which are payable and may result in liability to pay income tax. The balance of the sale proceeds are not accorded any special treatment and will be deemed, by the Department of Social Security, to earn interest.

Conclusion

2.71 The Committee believes that single pensioners who are homeowners, but who have few other assets other than their home should not have their home included as an asset in determining their status as a concessional resident and therefore the requirement to pay an accommodation bond for entry into a nursing home.

Recommendation 5: The Committee recommends that in determining whether a person is a concessional resident:

- **the requirement that a person has not owned a home during the preceding 2 years should be omitted; and**

- **the value of the person's principal place of residence should be disregarded for the purpose of the assets test.**

Guaranteeing equal access to nursing homes for financially disadvantaged people

2.72 The proposed legislation provides that financially disadvantaged persons (concessional residents) will not be required to pay an accommodation bond in order to access aged care facilities. Concessional residents (who will not have to pay a bond) include full or part pensioners who have not owned their own home in the past two years and who have assets of less than two and a half times the single age pension, currently $22 500 for singles or $45 000 for couples.[99]

2.73 In addition, the family home will not be counted as an asset in determining whether a person can pay a bond where a spouse or dependent child is living in the

98 Submission No.58, pp.16-17 (APSF).

99 Submission No.94, p.22 (DHFS).

home, or a carer or close family member has been living in the home for at least five years, and is eligible for a pension or benefit.[100]

2.74 Hardship provisions have been incorporated in the Aged Care Bill (Section 57-14) for people who are unable to pay a bond. Examples include retirees who are not pensioners, and people whose main asset is the family farm and the farm is supporting other family members.[101]

2.75 Two measures are proposed in the new arrangements for financially disadvantaged people to access nursing home care. These are the setting of minimum place requirements for concessional residents and higher Government subsidies for providers who provide places for concessional residents.

2.76 Evidence to the Committee raised a number of concerns with both proposed measures in relation to the extent to which they would ensure access for concessional residents.

Allocation of places for concessional residents

2.77 All aged care facilities will be required to set aside a minimum number of places for concessional residents. The number of places in any individual facility will be based on the proportion of financially disadvantaged people in each planning region.[102] These ratios are calculated by dividing the number of full pensioners aged 70 and over, who have not owned a home in the past two years by the total population aged 70 and over in the particular area of coverage whether that is a planning region or Statistical Local Area.[103]

2.78 On 26 May 1997, the Government announced that 27 per cent of places in nursing homes would be reserved for concessional residents. The quota will not apply to individual facilities but as a national average which would vary across regions depending on the demographic profile of an area.[104]

2.79 Concerns were raised during the hearings that mandating by region a proportion of nursing home beds to concessional residents will not guarantee access in every geographic area across the country. ACHCA argued that:

> Clearly, people are not distributed evenly across this country with regard to socio-economic levels. At this stage we do not have anything definite back from the Government as to the percentage that people will be required to accommodate for financially disadvantaged people....So it is not a clear,

100 Submission No.94, p.40 (DHFS).

101 Submission No.94, p.42 (DHFS).

102 Submission No.94, pp.34,39 (DHFS).

103 Submission No.94, p.39 (DHFS).

104 Minister for Family Services, *Media Release*, 26 May 1997.

> rational, predictable arrangement–simply saying that in a certain area the facilities will have to provide 20 per cent, for example, of places for financially disadvantaged people.[105]

2.80 Some concerns were expressed that the provisions for concessional residents may be insufficient to ensure that those with low to medium income or assets will be able to access adequate and appropriately placed care. The Human Rights and Equal Opportunity Commission (HREOC) argued that the definition of concessional resident is 'very narrow' and there is no clear mechanism of redress or protection for individuals denied access to nursing homes because the concessional resident quota is full.[106] ACA argued that there would be value in applying a socio-economic indicator or index to the regional planning ratios.[107]

2.81 The Committee raised the issue of the possible relocation of people away from their home location. DHFS advised the Committee that, while the level of concessional access would be set on a regional basis it would be implemented flexibly –'if, for example, homes are having difficulty in a particular region...we will talk to them about the application of those requirements'.[108] DHFS also noted that there may be problems 'if a provider who specialises in people who are concessional was at one end of a geographic region and the person wanting to do the deal was at the other end of the geographic region, that potentially disadvantages people who are concessional and who want to be admitted broadly speaking within their own location'.[109]

2.82 ACA also raised some concerns about the appropriateness of the current planning ratios in the light of the rapid growth of the population aged 85 and over. ACA cited an Australian Institute of Health and Welfare study that considered the current planning ratios for residential care facilities had serious shortcomings arguing in particular that the 70 and over planning ratio is not sensitive to the changing internal structure of the population aged over 70, and hence to likely changes in demand for residential care.[110]

2.83 The Committee raised the issue of how the proposed system would monitor access for concessional residents. DHFS advised the Committee that there will be a reporting mechanism based on the payment system as to the numbers of concessional

---

105 *Transcript of Evidence*, p.209 (ACHCA).

106 Submission No.105, p.13 (HREOC).

107 *Transcript of Evidence*, p.148 (ACA).

108 *Transcript of Evidence*, p.281 (DHFS).

109 *Transcript of Evidence*, p.281 (DHFS).

110 Submission No.60, pp.11, 15 (ACA).

residents that are in a facility at any one time. If a facility has not met its target in terms of access a financial penalty will apply to the service.[111]

Recommendation 6: The Committee recommends that the quota system for concessional residents be monitored to ensure equality of access for financially disadvantaged people, particularly to aged care facilities within the prospective residents' locality.

Level of the supplement

2.84 The rate of the concessional resident supplement was announced on 26 May 1997 and was set at $5 per resident per day.[112] During the inquiry, several submissions noted that unless the concessional supplement was comparable with the equivalent income earned from accommodation bonds, ensuring access to nursing home places for financially disadvantaged people would be difficult.[113] ACHCA argued that the supplement should be set at $19.17 per resident per day.[114] APSF noted that the access for concessional residents will only be assured if the concessional subsidy is sufficient to ensure the 'financial attractiveness' of concessional residents. [115]

2.85 ANHECA noted that:

> The main incentive for service providers to admit concessional residents is that the provider will receive the full Government benefit in advance and on time. However, if the amount of the supplement is substantially below the daily dollar equivalent of a reasonable accommodation bond, then the incentive will be considerably reduced and the equity of the entire funding reform package jeopardised.[116]

2.86 Several groups argued that the $5 a day subsidy for concessional residents was inadequate. ACHCA argued that it was 'totally inadequate' and Community Services Australia described the amount as representing 'an act of derision to the work of the charitable sector '.[117] ACHCA argued that while the subsidy would provide $5 a day per bed for financially disadvantaged people, the payment of an accommodation bond would generate an average of $19 per bed per day for other residents, representing a

---

111 *Transcript of Evidence*, p.282 (DHFS).

112 Minister for Family Services, *Media Release*, 26 May 1997.

113 Submission No.38, p.10 (ACHCA); Submission No.62, p.4 (Anglicare Australia); Submission No.58, p.17 (APSF).

114 This figure is based on an average entry contribution of $40 000 'thus reflecting the reality of today's entry contributions averaging closer to the actual capital cost of aged care facility beds'. See Submission No.38, p.12 (ACHCA).

115 Submission No.58, p.17 (APSF). See also Submission No.66, p.10 (CSA).

116 Submission No.56, p.7 (ANHECA).

117 ACHCA, *Media Release*, 26 May 1997; CSA, *Media Release*, 27 May 1997.

$14 per bed per day shortfall in accommodation subsidies for concessional residents. ACHCA argued that this would lead to concessional residents being placed in multi-bed wards in lower quality standard buildings.[118]

2.87 Church groups argued that the subsidy level would make it difficult for homes catering predominantly for concessional residents to maintain and upgrade facilities. The Uniting Church (NSW Synod) stated that:

> This subsidy is supposed to contribute to the capital regeneration of aged care facilities but the amount of the subsidy is totally inadequate. It is hard to see how facilities will be able to be maintained at the appropriate level over the long-term.[119]

2.88 Several organisations noted that the subsidy would only provide $1825 per year for each concessional resident towards the capital costs of aged care facilities, which is considerably less than the allowable annual retention rate from an accommodation bond of $2600. Church groups noted that the subsidy provided for concessional residents is well short of the capital injection provided by a resident paying an accommodation bond.[120]

2.89 ACHCA noted that for some facilities, cross-subsidisation may account for this subsidy shortfall, but it was a concern for the Catholic Church where over 70 of its aged care facilities provide at least 55 per cent of places to financially disadvantaged people. Church based organisations indicated that it would put upward pressure on the amount that they would be obliged to charge for accommodation bonds.[121] CSA noted that 'for church-based facilities with the majority of residents as concessional, it does nothing to meet the current huge capital shortfall'.[122]

2.90 The Committee believes that the amount of the concessional resident subsidy is inadequate and needs to be substantially increased to provide sufficient capital to maintain and upgrade nursing home facilities. The Committee is particularly concerned that the subsidy does not provide any real assistance to the not-for-profit sector who look after the most vulnerable sector amongst the aged – financially disadvantaged aged people. The Committee believes that unless the concessional subsidy is substantially increased it will lead to a two-tiered system where financially disadvantaged people will be accommodated in lower standard accommodation with no real prospect of facilities being upgraded in the future.

---

118 ACHCA, *Media Release*, 26 May 1997.

119 Uniting Church (NSW Synod), *Media Release*, 27 May 1997.

120 CSA, *Media Release,* 27 May 1997; Uniting Church (NSW Synod), *Media Release*, 27 May 1997.

121 ACHCA, *Media Release*, 26 May 1997; CSA, *Media Release*, 27 May 1997.

122 CSA, *Media Release*, 27 May 1997.

Recommendation 7: The Committee recommends that the concessional resident supplement be substantially increased to a level that will provide for the necessary capital injection to maintain appropriately high standards of accommodation in aged care facilities.

Development of a two-tiered system of nursing home care

2.91 Evidence to the Committee suggested that the proposed arrangements may lead to the development of a two-tiered system of nursing homes in terms of quality of, and access to, nursing homes.[123] A notable feature of the current system is its equity – nursing home residents have equal access regardless of income or assets.

2.92 Some evidence suggested that access to nursing homes will increasingly depend on the capacity to pay the accommodation bonds charged by nursing homes. ACHCA argued that:

> This has the potential to result in a two tiered system. Socio-economically deprived suburbs will have lesser quality buildings, whilst within some facilities the quality of accommodation will depend on the residents capacity to pay an entry contribution. In this era of more competition and increased user pays, low income and assets customers will not be as financially attractive to service providers as those who are better off.[124]

2.93 Residential Care Rights also noted concerns that as the system depends on the capacity to pay there will be 'grading' system develop among homes:

> Those homes with the capacity to attract higher bonds, and increased ongoing fees may have more capacity to continue to upgrade and perhaps to staff at a higher level, smaller homes may not, and will become second tier in quality terms.[125]

2.94 Evidence from the churches, in particular, indicated a strong desire to avoid a two-tired system of accommodation standards developing. CSA noted that the Uniting Church 'does not wish to run silver service wings in its nursing homes. Our interest in people's care and how people ought to be treated would make it very difficult for us but it certainly could occur'.[126] Similar views were expressed by ACHCA.[127]

---

123 Submission No.38, p.16 (ACHCA); Submission No.50, p.9 (CPSA of NSW); Submission No.65, p.6 (COTA).

124 Submission No.38, p.16 (ACHCA).

125 Submission No.51, p.6 (Residential Care Rights). See also *Transcript of Evidence*, p.171 (CSA).

126 *Transcript of Evidence*, p.171 (CSA).

127 *Transcript of Evidence*, pp.209-10 (ACHCA).

2.95 COTA also noted that the introduction of accommodation bonds could mean that well-off older people and their families will be able to access nursing homes more readily than poorer people.[128] ACHCA stated that it was likely that people on low incomes 'will have to accept a bed wherever they can afford one, this may be within their local area, or outside it even if this means a move away from their local area, friends and family'.[129]

2.96 Evidence also suggested that facilities that focus their service on financially disadvantaged persons and special needs groups will not be able to plan for capital upgrading and replacement in the same way as those facilities charging accommodation bonds or periodic payments.[130]

2.97 DHFS stated that access to facilities for financially disadvantaged people is addressed through the concessional resident quotas. This will mean that these people will have 'access to the same proportion of places irrespective of their location or capacity to pay an accommodation bond'.[131] DHFS also noted that all facilities will be required to set aside a proportion of places for concessional residents.

2.98 It was also put to the Committee that the introduction of accommodation bonds may also give rise to different standards of accommodation within nursing homes.[132] For example, a person paying a high accommodation bond may get a single room while people paying a low bond or a person designated as financially disadvantaged and unable to pay a bond will have to share a four or six bed ward or accept lower quality services generally.[133]

2.99 The ACTU argued that the imposition of accommodation bonds will result in a two-tiered system of aged care 'with the standard of quality care dependent upon capacity to pay'.[134]

2.100 DHFS stated that the fact that people will pay according to their means 'does not mean that people who cannot afford to pay more, will receive a lower standard of care or accommodation. The accreditation framework will ensure that all residents benefit from improved facilities and good quality care'.[135] The Department noted that the accreditation standards address the issues of quality of accommodation and care considerations that must be met by facilities that wish to charge accommodation

---

128 Submission No.65, p.6 (COTA).

129 Submission No.38, p.17 (ACHCA).

130 Submission No.50, p.9 (CPSA of NSW); Submission No.38, p.16 (ACHCA).

131 Submission No.94, p.46 (DHFS).

132 Submission No.50, p.9 (CPSA of NSW); Submission No.79, p.4 (ACTU).

133 Submission No.65, p.6 (COTA).

134 Submission No.79, p.4 (ACTU).

135 Submission No.94, p.47 (DHFS).

bonds. DHFS noted that the Aged Care Standards Agency will monitor standards 'to ensure that all residents benefit through improved care outcomes'.[136]

2.101 Concerns were also expressed in relation to the Government's intention to allow an increase in the provision of exempt status homes (to be known as Extra Service arrangements). These homes provide higher level services for residents who pay additional charges. Evidence suggested that this will encourage further market segmentation for consumers and will lead to distinctions in service levels within facilities.[137] ACA argued that the Government should exercise caution in granting exempt status to ensure that this does not disadvantage access to aged care facilities by financially disadvantaged people or people in rural and remote areas.[138]

2.102 Other concerns were expressed that non-accredited services (that is, services not certified as of sufficient standard to be allowed to charge accommodation bonds) will become the last resort for people who would not be eligible for a concessional subsidy, nor able to pay a significant accommodation bond. ACHCA stated that 'there is a risk that poor quality building stock will end up being used to accommodate older people with low income and low assets in services which fail to meet accepted community and industry standards'.[139]

2.103 The Committee believes that a two-tiered system of nursing home care in relation to the quality of, and access to, nursing homes may develop as a result of the proposed changes. The Committee considers that access to nursing homes will increasingly depend on a person's capacity to pay. Access for financially disadvantaged people may also be compromised given the inadequate level of the concessional supplement. The Committee considers that it is would be unacceptable if, as a result of the reforms, different standards of care within nursing homes were to develop and believes that the accreditation framework must ensure that this does not occur.

Role of the market in determining the level of accommodation bonds to be paid

2.104 Contributors to the inquiry generally recognised that market forces would play an important role in determining the level of bonds charged.[140] ACA identified a number of market forces that will apply with respect to bonds. These include:

- what potential residents can afford and are willing to pay;

---

136 Submission No.94, p.47 (DHFS).

137 Submission No.60, p.16 (ACA); Submission No.65, p.6 (COTA).

138 Submission No.60, p.16 (ACA). See also Submission No.65, p.6 (COTA).

139 Submission No.38, p.18 (ACHCA).

140 Submission No.9, p.5 (NANHPH); Submission No.58, pp.18-20 (APSF).

- what other service providers are charging;
- the nature and type of the residential aged care facility;
- the range and standard of services provided;
- the location of the residential aged care facility and the real estate values and saleability of properties in the area; and
- the criteria for entitlement to the pensioner supplement will continue to place some constraint on what residents are prepared to pay and what the market is prepared to ask.[141]

2.105 ANHECA noted that market forces will play a role in determining the level of bond payable, both between facilities and within the one facility. ANHECA stated that:

> Socio-economic variations will result in regional differences in the amount of accommodation bonds and the quality of "PC items" evident in aged care facilities. It is not unreasonable to expect that the fabric of nursing home buildings will reflect regional variations in housing in the community.[142]

2.106 ANHECA also stated that market forces would most likely result in aged care facilities offering a range of accommodation bonds for the different types of accommodation available – for example, a single room with its own bathroom will almost certainly attract a higher accommodation bond than a twin room with a share bathroom.[143]

2.107 Evidence to the Committee questioned whether market forces are an appropriate way of determining the level of entry fees given the severe imbalance in the market between supply and demand for nursing home places.[144] CSA noted that the supply side is characterised by strict Government regulation of the number of places offered at any time and the price at which supply can be made is fixed by Government – 'thus prices will, in an imperfect market like this where demand substantially exceeds supply, be inclined, without the moderating presence of the not-for-profit sector, to be what the market will bear'.[145]

---

141 Submission No.60, p.16 (ACA).

142 Submission No.56, p.7 (ANHECA).

143 Submission No.56, p.7 (ANHECA).

144 Submission No.58 p.18 (APSF).

145 Submission No.66, p.12 (CSA).

2.108 Pensioner and resident advocacy groups expressed concerns that pensioners would be vulnerable in a competitive market environment.[146] APSF argued that older people who need residential care are limited in their ability to take advantage of the market – 'older residents are among the most vulnerable groups in our community. Their ability to exercise choice and explore options or to "vote with their feet" is limited by their frailty and/or illness'.[147]

2.109 Residential Care Rights also noted:

> Most of those entering nursing homes, and their families, are under great stress. They will often not be in a position to negotiate, on an equal basis, the amounts of fees involved. Many of those entering nursing homes will also lack the requisite mental capacity (because of dementia) necessary for negotiation of fees and, indeed other contractual issues. The combination of these factors leaves open the likelihood of exploitation and financial abuse of people entering nursing homes....In addition, it is apparent that few, if any, potential nursing home residents have any real market choice as to the nursing home they eventually enter, or as to the quality and level of care that they receive. In such a circumstance, it is...untenable and inequitable that pure market forces should operate in relation to the level of accommodation bond payable.[148]

2.110 Many groups argued that it was important that that the impact of market forces in determining the level of accommodation bond be monitored to ensure equitable access to nursing home places for older people.[149] COTA argued that this monitoring role be carried out by DHFS in consultation with peak organisations.[150]

2.111 The Committee believes that the simple solution of market oriented 'user-pays' to the growing demand for aged care services is misinformed and misguided. The Committee does not believe that access to essential services, such as aged care facilities, should be left to the vagaries of the market and considers that the Government has a responsibility to provide equality of access to these services for the aged sector of the population. The market and the user pays principle both ignore the needs of those individuals who are not recognised by the market – those without the financial resources to become a market participant or who because of acute need must access the market with little option to exercise real choice.

---

146 Submission No.58, pp.18-19 (APSF); Submission No.51, pp.5-6 (Residential Care Rights); Submission No.67, pp.2-4 (ADACAS).

147 Submission No.58, p.19 (APSF).

148 Submission No.51, p.5 (Residential Care Rights).

149 Submission No.65, p.5 (COTA); Submission No.66, p.12 (CSA); Submission No.60, p.16 (ACA).

150 Submission No.65, p.5 (COTA).

Recommendation 8: The Committee recommends that the Government ensure equality of access to aged care facilities is provided for all aged people and that the provision of aged care services not be left to the vagaries of a market user-pays system.

Rural and remote areas and areas of socio-economic disadvantage

2.112 A number of submissions and other evidence argued that under the proposed system there is a risk that significant differences will develop in regard to the quality of facilities between different geographical areas.[151] APSF stated that:

> The differences in levels of investment that facilities in different parts of the country may be able to attract are likely to be considerable, thus creating differences in the quality of buildings across the country. Poorer socio-economic areas will continue to have poorer quality homes, while those in richer areas may be able to develop much better standard facilities.[152]

2.113 The Commonwealth Government will continue to provide $10 million capital program over the next four years to assist facilities that are unable to generate sufficient capital funds because of their location in country areas or because they target Aboriginal or Torres Strait Islanders or financially disadvantaged people.[153]

2.114 DHFS argued that the capital program 'acknowledges the difficulties faced by facilities in country Australia in serving their communities because of limited funding for building and upgrading as well as higher building costs arising from their remoteness'.[154]

2.115 Evidence from numerous groups suggested that this capital grants program was inadequate to meet the needs of rural Australia and the financially disadvantaged and that the funding for this program needed to be substantially increased.[155] Concerns were expressed by several churches, in particular, because of their emphasis on providing places for concessional residents. CSA stated that most Uniting Church facilities in the hostel sector take in excess of 60 per cent of residents as concessional residents and some in rural and remote areas are 99 per cent concessional residents. [156] ACHCA noted that 55 per cent of Catholic aged care facilities provide over 50 per

---

151 Submission No.66, p.13 (CSA); Submission No.62, p.5 (Anglicare Australia).

152 Submission No.58 p.19 (APSF).

153 Submission No.94, p.45 (DHFS).

154 Submission No.94, p.30 (DHFS). See also *Transcript of Evidence*, pp.266-67 (DHFS).

155 Submission No.66, p.13 (CSA); Submission No.58, p.20 (APSF); Submission No.62, p.5 (Anglicare Australia); *Transcript of Evidence*, p.210 (ACHCA).

156 *Transcript of Evidence*, pp.171-72 (CSA);

cent of their accommodation to financially disadvantaged people and 15 per cent cater for 100 per cent of this group.[157]

2.116 Several organisations, including ACA and CSA stated that as accommodation bonds will not generate significant income in the short term, the $10 million capital funding per annum will not provide sufficient flexibility to meet urgent needs or to cater adequately for the capital development of aged care facilities which cater predominantly or exclusively for financially disadvantaged residents.[158] CSA stated that:

> We would argue that $10 million will basically cover two facilities of around 30 beds based on $100 000 per bed, taking into account additional costs associated with remoteness. In Australia, the ability of the church to provide those beds of course has been because of capital grants available. For under $10 million, you cannot provide or meet those services at the current level of demand in rural and remote areas.[159]

2.117 ACA also noted that the current capital funding will not address the 'catch 22' situation which may arise where aged care facilities do not meet building standards for certification and hence are unable to charge accommodation bonds but do not have access to sufficient capital funding to undertake the upgrading required in order to be certified.[160]

2.118 ACA stated that the $10 million capital funding would provide for only the capital cost (excluding land) of only 150 new beds a year.[161] ACHCA stated that the capital funding would provide for the construction of only two nursing home facilities per year.[162]

Recommendation 9: The Committee recommends that funding for the $10 million capital grants program directed to rural and remote areas and for financially disadvantaged people be substantially increased.

Impact of the reforms on hostels

2.119 During the inquiry, issues were raised in relation to the impact that the withdrawal of hostel variable fees and the removal of hostel care level subsidies would have on hostel residents and the viability of some hostels.

---

157 *Transcript of Evidence*, p.204 (ACHCA).

158 Submission No.60, p.15 (ACA); *Transcript of Evidence*, p.172 (CSA).

159 *Transcript of Evidence*, p.172 (Community Services Australia).

160 Submission No.60, p.15 (ACA).

161 Submission No.60, p.15 (ACA).

162 *Transcript of Evidence*, p.211 (ACHCA). See also *Transcript of Evidence*, pp.267-68 (DHFS).

Withdrawal of hostel variable fees

2.120 Hostel variable fees for new residents will be abolished from 1 October 1997. Currently, some hostels charge residents variable fees. Under the system, they can take, in addition to the base fee charged, up to half of a resident's first $49 of private income above the pension plus almost all income they earn above this level, provided they leave the resident with at least a minimum amount. Under the proposed reforms, variable fees will be replaced by income testing. The Government's subsidy to the provider will be reduced by the amount of the income tested fees.[163]

2.121 The existing arrangements will be 'grandparented' during the transitional period to the new system. Under the grandparenting of variable fees, existing hostel and exempt nursing home residents who already pay an agreed higher amount than under income testing will continue to pay the same amount. Their subsidies will be reduced by the amount of any income tested charge, and the provider will be able to keep the difference.[164]

2.122 Some evidence suggested that the withdrawal of hostel variable fees will have serious implications for the viability of many hostels, particularly in rural and remote areas. ACA argued that the decision will effectively mean that service providers will have no discretion to generate additional income to offset reductions in the recurrent care funding due the new requirements (accreditation, prudential arrangements) and indexation mechanisms which undercompensate for cost increases.[165]

2.123 ACHCA argued that the measure may mean the loss to hostels of between $15 and $35 million a year that is currently spent on care. ACHCA noted that critical to calculating the real potential loss will be the funding levels set for the new RCS and how this impacts on hostel residents and their dependency levels.[166]

Removal of hostel care level subsidies

2.124 Under the aged care reforms, hostel care level subsidies will be withdrawn from 1 October 1997. Hostel providers currently receive a subsidy of between $2.95 and $3.55 a day for financially disadvantaged residents. DHFS noted the Government decided to withdraw the subsidies because residents classified at this level have primarily social and housing needs, rather than care needs and that their numbers decline each year as hostels increasingly focus on care needs, rather than social or lifestyle needs.[167]

---

163 DHFS, *Fact Sheet 6: Variable Fees.*

164 DHFS, *Fact Sheet 6: Variable Fees.*

165 Submission No.60, p.10 (ACA).

166 Submission No.38, p.28 (ACHCA).

167 DHFS, *Fact Sheet 16: Hostel Care Subsidy.* See also *Transcript of Evidence*, p.296 (DHFS).

2.125 DHFS advised that Hostel Care level residents will remain part of the new system with security of tenure. These residents will not have to pay an income tested charge. Residents classified at the Hostel Care level will, however, have there income assessed and may later pay an additional income tested charge should their care needs increase and they become eligible for a care subsidy. They may also be required to pay an accommodation bond, subject to the same conditions that apply to other residents.[168]

2.126 Evidence from several groups raised concerns about the Government's failure to provide a new program of funding for appropriate housing and support services for people who previously sought accommodation for social reasons, and particularly for the existing 5000 hostel residents who are financially disadvantaged.[169]ACA stated that if no action is taken, it is 'inevitable' that there will be an increase in the numbers of 'vulnerable homeless elderly people'.[170]

2.127 Anglicare also noted that:

> If these people did not receive care within the residential facility, they would move into a world where we know there are going to be cuts to public housing...We already know again that the costs of some basic services like home care delivered meals in the HACC program are going up....So when you take away a hostel level of care but do not devise a system to pick up those people in its place, you create quite a problem that we do not believe has been addressed.[171]

2.128 The Committee also raised the issue of the need to ensure access to hostel care for people with very low level or 'social' care needs.[172] The Committee believes that although these people are in hostels for largely social reasons the social isolation faced by many people living alone can be debilitating and hostel care of this type will often ensure that these people maintain a better state of health and are provided with a safer lifestyle than when living outside a hostel setting. In the long term, providing this type of accommodation may also reduce expensive medical or nursing home costs in the future.

2.129 The Government stated that under the new funding arrangements hostels that cater for people with low level or 'social' care needs 'can expect their total funding to at least be maintained, if not increased. The new classification scale is a much better

---

168 Submission No.94, p.15 (DHFS).

169 Submission No.60, p.21 (ACA); *Transcript of Evidence*, p.78 (Anglicare Australia); *Transcript of Evidence*, p.135 (ACA).

170 Submission No.60, p.21 (ACA).

171 *Transcript of Evidence*, p.78 (Anglicare Australia).

172 For a discussion see *Transcript of Evidence*, pp.296 -97 (DHFS).

measure of care needs, including social needs, and some Hostel Care level residents move up the scale'.[173]

Financial viability of hostels

2.130 As noted above, some concerns were raised as to the effect the withdrawal of hostel variable fees and the removal of hostel care level subsidies would have on the financial viability of some hostels.[174]

2.131 ACA noted that of the three major components of capital funding for hostels – entry contributions, variable capital funding and variable fees, the Government has 'only applied one part of the tri-partite system of capital funding for hostels, and that, in doing so, it has dismantled the other two components of capital funding for hostels'.[175] ACA noted that the financial viability of many hostels will be threatened and argued that there needed to be greater provision for capital funding to ensure their continued viability.

2.132 The Gregory report also stated that, while the combination of variable capital funding and variable charges would enable the majority of hostels to access sufficient income to maintain and upgrade their building stock, 'the Government will need to continue to give significant capital support to those hostels which provide for a high level of Financially Disadvantaged residents'.[176]

2.133 DHFS argued that the net impact of the changes on hostels will not be as severe as some hostels claim. The Department noted that 'a good number of particularly HC residents, to wit, those who either receive a very small amount of funding or who indeed no funding is attracted to, will actually move up into the funded category. That means that for a good proportion of those hostels their position is going to be a better one'.[177]

Conclusion

2.134 The Committee believes that the withdrawal of hostel variable fees and the removal of hostel care level subsidies may effect the viability of some hostels. The Committee is also concerned that the removal of hostel care level subsidies may adversely those residents of hostels who are financially disadvantaged, especially in the absence of other measures to address their needs.

---

173 Minister for Family Services, *Media Release*, 26 May 1997, p.4.

174 Submission No.60, p.10 (ACA).

175 Submission No.60, pp.9-10 (ACA).

176 Gregory, *op.cit.*, p.57.

177 *Transcript of Evidence*, p.295 (DHFS).

Recommendation 10: The Committee recommends that the Government monitor the impact of the proposed funding changes to hostels, especially in relation to the financial viability of hostels; and that capital funding be provided to hostels that cater for a high proportion of financially disadvantaged residents.

Recommendation 11: The Committee recommends that the Government provide appropriate funding for the Home and Community Care program and other community services and housing programs to address the needs of financially disadvantaged Hostel Care level residents that may be affected by the withdrawal of Hostel Care level subsidies.

CHAPTER 3

THE NEED FOR USER RIGHTS

3.1 Contributors to the inquiry emphasised the need for effective user rights (residents rights) protections to be in place in the reform package. The Australian Pensioners' and Superannuants' Federation (APSF) stated that the current user rights protections 'are extremely important and have helped facilitate a positive change in the culture of many nursing homes'.[1]

3.2 The Australian Council of Social Service (ACOSS) argued that strong and effective mechanisms to protect the rights of users is essential particularly in the area of aged care where consumers 'are likely to be more vulnerable to exploitation, abuse or benign neglect...This will require even stronger measures than in the past given the shift towards a more market-driven model of service provision'.[2]

Current arrangements

3.3 The current arrangements for user rights protections comprise a Charter of Residents Rights, resident agreements, a complaints mechanism, advocacy services and outcome standards and associated monitoring system.[3] These arrangements are outlined below.

Protection of rights

3.4 The current arrangements include a Charter of Residents Rights which covers amongst other things the right of residents to quality care, to be treated with dignity and respect, to live in a safe and secure environment, to continue cultural and religious practices, to have access to information about their rights and to have access to advocates and other avenues of redress.[4]

3.5 In addition, nursing home residents may sign an agreement which sets out the rights and responsibilities of the resident and the provider. Matters covered include security of tenure, arrangements for fees and charges and services provided. The rights of nursing home residents are also protected by section 40AA(bc)(ii) of the *National Health Act 1953* where a resident is unable, or chooses not, to sign an agreement. As applied, this requires the nursing home to extend to the resident all the protections in the standard agreement.[5]

---

1 Submission No.58, p.23 (APSF).

2 Submission No.80, p.10 (ACOSS).

3 Submission No.94, pp.51-52 (DHFS); Submission No.58, p.23 (APSF).

4 Submission No.94, p.51 (DHFS).

5 Submission No.94, p.51 (DHFS).

Standards

3.6 The existing arrangements provide for assessment of compliance by providers against defined outcome standards for nursing homes and hostels.[6]

Complaints mechanism

3.7 Complaints about nursing homes and hostel care are investigated by the Department of Health and Family Services (DHFS) and dealt with in the context of compliance with standards. Independent, community-based advocacy services are also available to deal with complaints. There is, however, no independent external complaints mechanism to address residents complaints.[7]

Advocacy program

3.8 The Advocacy Program provides funding to independent agencies which use trained advocates to represent residents and focus on the needs, preferences and rights of the person.

Community Visitors Scheme

3.9 The Community Visitors Scheme provides socially isolated residents with regular contact with trained visitors. The Scheme is managed by independent agencies funded by the Department.

Proposed arrangements

3.10 Under the proposed arrangements all the elements of the existing user rights strategy have been retained. DHFS stated that, in combination, the Aged Care Bill, the User Rights Principles in the subordinate legislation, and the draft standards provide the 'same protections for residents as are provided in the existing arrangements'.[8] DHFS also noted that some elements of the user rights strategy will be 'strengthened', such as the complaints resolution arrangements (that is, the establishment of an external complaints mechanism and the requirement for providers to have a complaints resolution process in place).[9] These proposed arrangements are outlined below.

Charter of Residents Rights

3.11 Under the new provisions, the Charter of Residents Rights is set out in the User Rights Principles to guide the provision of care and service for residents. The Charter is reproduced, without the existing Preamble, and with one additional 'right', taken

---

6 Submission No.94, p.51 (DHFS). See also Chapter 4.

7 Advice from DHFS, 21.5.97.

8 Submission No.94 (DHFS), Appendix 2, p.1.

9 Submission No.94, pp.28, 53 (DHFS).

from the existing Preamble, which is 'to full and effective use of his or her personal, civil, legal and consumer rights'.[10]

Resident agreements

3.12 The Aged Care Bill requires approved providers to offer a resident agreement to all care recipients (Division 56-1 (g)). The Bill (Division 59-1) further specifies requirements for resident agreements to include:

- level of care and services to be provided;
- policies and practices relating to fees;
- circumstances in which the resident can be asked to leave;
- extent of assistance to be provided in obtaining alternative accommodation;
- the complaints resolution mechanism; and
- the care recipient's responsibilities.

3.13 The Bill also provides for an accommodation bond agreement which must be agreed if a bond is to be paid (Division 57-2). This must cover, *inter alia*, the amount of the bond, date of entry, how the bond will be paid and the conditions relating to periodic payment if applicable, when the bond is payable and the amount of any retention amount. This agreement may be part of the resident agreement. Residents are able to use an advocate of their choice or have family members involved in discussions about agreements if they wish.[11]

Standards

3.14 The existing outcome standards for nursing homes and hostels will be replaced by new residential care standards and accreditation standards. The accreditation standards will cover four categories – health and personal care, resident lifestyle, the physical environment, management systems and staffing and organisational development. The residential care standards will be the first three categories which cover issues addressed in the current outcome standards. The fourth category will establish new standards which will relate to management practices.[12]

Complaints mechanisms

3.15 As noted above, currently complaints about nursing home and hostel care are investigated by DHFS and dealt with in the context of compliance with standards.

---

10 Submission No.94 (DHFS), Appendix 2, p.1.

11 Submission No.94, pp.52-3 (DHFS). See also Appendix 2 to the Submission.

12 Submission No.94, p.53 (DHFS).

3.16 The proposed arrangements have provision for a tiered approach to the handling of complaints through:

- the requirement that approved service providers must have in place a complaints resolution mechanism to address complaints made by or on behalf of a resident and must also advise residents of other complaints mechanisms that are available;
- provision for the Department to investigate and assist in the resolution of any complaint; and
- provision for the complainant to be informed about the outcome of a complaint.[13]

3.17 In addition, the accreditation standards will provide for assessment of how well a service provider embraces the concept of encouraging and acting on resident feedback and concerns.

3.18 In addition, an independent external complaints process will be established. DHFS advised the Committee that a working group (which is a sub-group of the Quality Assurance Working Group) which includes industry and consumer representatives is currently developing a model for such a complaints mechanism.[14] It is expected that the sub-group will put a package of reforms to the Quality Assurance Working Group in late May. After this Group has considered the draft proposals, a final draft package will go the Minister.[15]

Advocacy program

3.19 DHFS advised the Committee that there are no changes to the arrangements for advocacy services under the reforms.[16] Access by residents to advocacy services are provided for in the Aged Care Bill under Division 56-1(k). Access to other advocates is provided for in the Bill under Division 56-1(j).

Community Visitors Scheme

3.20 DHFS advised that under the new arrangements the Community Visitors Scheme will continue as at present.[17] Access by residents to visitors is provided for in the Bill under Division 56-1(k).

---

13 Submission No.94 (DHFS), Appendix 2, p.3.

14 Submission No.94, p.53 (DHFS).

15 Additional Information, Residential Care Rights, 12 May 1997, p.4.

16 Submission No.94, pp.52-3 (DHFS); and Appendix 2.

17 Submission No.94, pp.52-53 (DHFS); and Appendix 2.

Issues

3.21 A number of issues were raised in evidence to the Committee in relation to user rights and these are discussed below.

User Rights Principles

3.22 In a number of submissions, including those of Aged Care Australia (ACA), Community Services Australia (CSA) and the APSF, it was argued that the User Rights Principles should be embodied in the principal legislation rather than in the subordinate legislation.[18] APSF in arguing that the User Rights Principles be included in the principal legislation, noted that 'this would be an important and transparent demonstration of the Government's commitment to supporting residents rights and would foster public confidence in aged care'.[19] The Committee supports the proposal that the User Rights Principles be incorporated in the principal Act.

External complaints mechanism

3.23 Evidence to the Committee, including evidence from advocacy and pensioner groups, argued that there is a need for an external independent complaints mechanism to be established.[20]

3.24 The Australian Law Reform Commission (ALRC), in a review of Commonwealth aged care legislation published in 1995, argued that older people or their representatives 'should be able to complain to a body outside the service if the complaint has not been resolved or dealt with effectively by the service's internal mechanism or if they do not feel comfortable approaching the service with a complaint'.[21] The Human Rights and Equal Opportunity Commission (HREOC) argued that internal complaints mechanisms 'are not likely to be suitable for all complaints and are unlikely to assure older people of fair resolution in matters over which there is dispute'.[22]

3.25 Several groups, including Residential Care Rights and the Combined Pensioners and Superannuants Association of NSW (CPSA) argued that the external

---

18 Submission No.60, p.17 (ACA); Submission No.66, p.16 (CSA); Submission No.58, p.24 (APSF).

19 Submission No.58, p.24 (APSF).

20 Submission No.105, p.22 (HREOC); Submission No.51, p.12 (Residential Care Rights).

21 ALRC, *The Coming of Age: New Aged Care Legislation for the Commonwealth*, Report No. 72, 1995, p.208.

22 Submission No.105, p.22 (HREOC).

complaints body should have the powers to investigate complaints, enforce a range of sanctions and have a negotiation, conciliation and arbitration role.[23]

3.26 The ALRC stated that the complaints body should have the power to obtain information and documents and question parties to a dispute; seek advice from and refer matters to relevant bodies; and make recommendations to DHFS, to service providers and to the complainant that certain action be taken. The Commission also argued that the body needed to handle complaints quickly, informally and in a non-legalistic way; be affordable for users; encourage older people and service providers to resolve disputes between themselves in the first instance; and have an emphasis on, and be staffed by people skilled in, investigation, mediation and dispute resolution policy and procedures.[24]

3.27 Residential Care Rights noted that in terms of its powers 'it needs to be able to investigate, negotiate and conciliate, but also to make binding decisions when matters have not been resolved. Over the past few years we have been involved in some very difficult situations that have not been able to be resolved through investigation, negotiation and conciliation...That is a very difficult situation for service providers, consumers and everyone else involved'.[25]

3.28 APSF noted that an external complaints mechanism is important as many residents and their families feel hesitant in complaining to their facility management fearing reprisals. The ability to lodge grievances anonymously is an important safeguard in protecting residents rights.[26] Residential Care Rights noted that older people living in nursing homes 'are one of the most disempowered groups...One of the greatest fears of residents and their relatives is the fear of speaking up about their concerns, needs and complaints. There is a high level of fear of reprisal'.[27]

3.29 As noted above, a working group is currently developing a model for an external complaints mechanism. Full details of the model are not available, but DHFS advised the Committee that the new arrangements will focus on resolving disputes as they arise. Where systemic issues are identified, they will be referred to the Aged Care Standards Agency for consideration in the context of compliance with the accreditation criteria. Where a complaint indicates a serious health or safety issue, it will be referred to the Department for appropriate action.[28]

---

23 Submission No.51, p.12 (Residential Care Rights); Submission No.50, pp.15-16 (CPSA of NSW)

24 ALRC, *op.cit.*, p.209.

25 *Transcript of Evidence*, p.223 (Residential Care Rights).

26 Submission No.58, p.25 (APSF).

27 Submission No.51, p.13 (Residential Care Rights). See also Submission No.75, p.14 (TARS).

28 DHFS, Additional Information, 22 May 1997, p.2.

3.30 Residential Care Rights stated that an effective complaints mechanism needed to have a number of features including visibility, accessibility, transparency, a high profile in the aged care industry, provide a strong voice for consumers within the aged care system, recruit qualified staff with specialist skills in investigation, conciliation and arbitration and have sufficient independence to avoid the possibility of perceived or actual conflicts of interest.[29]

3.31 Several advocacy groups and the ALRC argued that the independent complaints unit should not be located within DHFS.[30] Residential Care Rights noted that the complaints unit within DHFS has failed to meet the needs of consumers – 'it has a very narrow focus and, because of constraints like the secrecy provision, people have not been able to get a personal and timely response in relation to the matter'.[31]

3.32 Residential Care Rights also expressed concerns about the possible siting of the complaints unit in the proposed Aged Care Standards Agency. The organisation noted that as the primary focus of the Agency is on quality assurance and accreditation of facilities –'if a complaints mechanism is placed within this agency, conflicts of interest will inevitably arise in regard to effective handling of complaints. The lack of consumer confidence in [the Agency's] ability to remain independent, and serve both industry and consumers, would also mitigate against effective outcomes'.[32]

3.33 Residential Care Rights further noted that:

> What we want to see as advocates, is a mechanism that is independent of all the stakeholders, including the Department. We would like to see it set up as an incorporated body and we would like to see the structure and functions of that taking into account the benchmarks that are still in draft stage but that had been done by the federal Bureau of Consumer Affairs as benchmarks for all industries in terms of setting up mechanisms. Those are under consideration in the current working group.[33]

Need for a residents' rights agency?

3.34 A number of advocacy groups and others argued that a specific agency needed to be established to deal with the complaints process and other broader issues of concern to the aged.[34]

---

29 Submission No.51, pp.13-14 (Residential Care Rights).

30 Submission No.51, p.14 (Residential Care Rights); Submission No.75, p.14 (TARS); ALRC, *op.cit.*, p.208.

31 *Transcript of Evidence*, p.222 (Residential Care Rights).

32 Submission No.51, p.22 (Residential Care Rights).

33 *Transcript of Evidence*, p.223 (Residential Care Rights).

34 Submission No.51, pp.21-24 (Residential Care Rights); Submission No.65, p.8 (COTA).

3.35 As noted above, Residential Care Rights proposed the establishment of a statutory body to be known as the Aged Care Consumer Agency with a Commissioner for Aged Care responsible for its functions. This Agency would, in addition to dealing with complaints, have responsibility for ensuring the User Rights Principles are upheld, and for the functions of funding independent advocacy services and the Community Visitors Program.[35]

3.36 Residential Care Rights argued that the establishment of the Consumer Agency, headed by an independent commissioner would 'ensure a real capacity to articulate issues arising from advocacy and complaints. This could, in turn, reflect the strengths and weaknesses of the accreditation process, providing for a system of checks and balances. It will enable consumers to act in an empowered relationship with service providers'.[36] The Council on the Ageing (COTA) also proposed the establishment of a specific residents' rights agency to, *inter alia*, oversee the complaints mechanism, quality assurance system and the dissemination of information to consumers.[37]

3.37 The Committee strongly supports the establishment of an independent complaints body, although it does not favour one kind of external body over another. However, the Committee believes that the body established should be independent of all stakeholders, including DHFS and should be given the powers to deal with disputes quickly and effectively.

Advocacy services

3.38 Advocacy services provide confidential information, advice and referral services to residents of nursing homes and hostels. The services, which are funded by the Commonwealth Government, act as advocates and promote awareness of residents' rights through information and education strategies. Evidence suggested that advocacy services are a crucial component in the user rights program by assisting individuals who cannot or do not have a representative to speak for themselves.[38] HREOC stated that:

> Complaints processes are most effective where advocates and advisers are involved with residents and service providers. Advocates assist to overcome the barriers that exist where people affected seek to address issues surrounding treatment by those on whom they are either financially, emotionally or physically dependent. Advocates are uniquely placed to assist individuals to raise their concerns [and] run their complaints.[39]

---

35 Submission No.51, pp.21-24 (Residential Care Rights).

36 Submission No.51, pp.21-22 (Residential Care Rights).

37 Submission No.65, p.8 (COTA).

38 Submission No.65, p.8 (COTA); ALRC, *op.cit.*, pp.171-72.

39 Submission No.105, p.22 (HREOC).

3.39 HREOC argued that the Commonwealth should recognise to a greater extent than at present the important role of advocates in the internal and external complaints handling process, and support this role by adequate funding.[40] The ALRC also suggested that the Commonwealth Government should consider more funding to existing advocacy services because of the crucial role they play in helping older people in protecting their rights. The ALRC argued that the level of resourcing should be adequate to provide for any new responsibilities expected of services and to ensure services can manage their existing workloads.[41]

3.40 The Committee recognises the important role advocacy services play as a means of ensuring that older people, often in a vulnerable position, have a better chance of ensuring that their rights are not infringed. The Committee believes that this advice should be independent and objective. Family and friends, while often an important source of advice, often lack the necessary expertise or detachment from the particular situation to effectively represent the interests of residents. The Committee believes that the role of advocates needs to be properly recognised and that advocacy services should be funded at a level sufficient to ensure that they can fulfil their important role in protecting residents' rights.

Residential care agreements

3.41 As noted above, the Aged Care Bill requires approved providers to offer a resident agreement to all care recipients. The ALRC, in its 1995 review of the aged care legislation, recommended 'a scheme in which the new legislation sets out implied legislative terms covering the same types of matters that are now dealt with by written agreements. These implied terms would be terms of the contract which already exists between the service provider and the consumer (whether written or oral)'.[42]

3.42 The Commission argued that this a better option than imposing statutory obligations directly on service providers because it gives consumers individual rights which they can, in theory at least, enforce in the courts. Where a service breaches implied terms, consumers and their representatives would also be able to take complaints to DHFS or to the independent complaints body. Any breach of the implied terms would also be a breach of provider obligations and subject to sanctions under the Bill.[43]

3.43 HREOC and Residential Care Rights also recommended that implied contractual terms be incorporated in all residential care agreements.[44] Residential Care Rights argued that the implied terms should cover the areas listed in the current

40 Submission No.105, p.22 (HREOC).

41 ALRC, *op.cit.*, p.172.

42 *ibid.*, p.169.

43 *ibid.*

44 Submission No.105, pp.22-23 (HREOC); Submission No.51, p.11 (Residential Care Rights).

nursing home agreement. These core standard protection terms cover such items as the grounds on which the agreement can be terminated, temporary leave provisions, resident's bed location, the right to complain, access to financial information and information on fee increases.[45]

3.44 In addition, HREOC argued that standard form agreements that outline the implied terms and a model agreement that incorporates fundamental rights should be developed. The Commission argued that these measures would safeguard the rights of older people, especially during the often difficult negotiation period. The Commission also argued that entitlements to basic human rights, such as the right to be treated with dignity and respect, the right to adequate medical treatment, non-discrimination between concessional residents and other residents and non-discrimination on the grounds of race, gender or disability should be included.[46]

3.45 The Committee believes that, to enhance the rights of older people, the implied contractual terms should be incorporated in all residential care agreements and that standard form agreements that outline the implied terms and a model agreement that incorporates fundamental rights should be developed.

Conclusion

3.46 The Committee believes that an effective user rights system needs to be in place to protect the rights of residents in aged care facilities. Considerable progress has been made in this area in recent years and it is of critical importance that the proposed arrangements continues this progress. Given the emphasis in the reforms towards a more market-driven model of service provision this will require stronger measures to protect residents' rights than in the past. The Committee considers, therefore, that user rights protections would be enhanced by the incorporation of the User Rights Principles in the principal Act. The Committee also believes that the user rights protections need to be underwritten by access to an independent complaints mechanism and that implied contractual terms should be incorporated in all residential care agreements.

Recommendation 12: The Committee recommends that the User Rights Principles be embodied in the principal legislation.

---

45 Submission No.51, p.11 (Residential Care Rights).

46 Submission No.105, p.23 (HREOC). See also Submission No.51, p.11 (Residential Care Rights). See also Submission No.48, p.7 (Aged Rights Advocacy Service).

Recommendation 13: The Committee recommends that:

- **an independent complaints mechanism be established as a matter of priority to deal with complaints made by older people or their representatives about aged care facilities;**

- **in formulating the model for such a mechanism, the Quality Assurance Working Group take into account the comments made by organisations and groups referred to in this chapter to enhance the functioning of the complaints mechanism; and**

- **the complaints mechanism be independent of all stakeholders, including the Department of Health and Family Services.**

Recommendation 14: The Committee recommends that the independent complaints body be given the powers necessary to deal with disputes expeditiously and effectively.

Recommendation 15: The Committee recommends that the role of advocates and advocacy services be encouraged and expanded and that advocacy services be supported by guarantees of recurrent funding sufficient for the services to fulfil their role and responsibilities.

Recommendation 16: The Committee recommends that implied contractual terms be incorporated in all residential care agreements; and that these implied terms relate to national standards of care and that any breach be legally enforceable.

Recommendation 17: The Committee recommends the development of standard form agreements that outline the implied terms and a model agreement that incorporates fundamental rights.

CHAPTER 4

ENSURING QUALITY OF CARE

4.1 A large number of organisations during the inquiry expressed concerns that the aged care reforms have the potential to compromise the standards of care in aged care facilities.[1] The NSW College of Nursing told the Committee that if the Bill passes in its current form 'we cannot guarantee that residents of aged care facilities...will receive care of the standard that they require or that they will be safe'.[2] The Australian Nursing Federation (ANF) stated that the Bill 'does little to reassure the... Federation that it directs itself to preserving quality of care to the elderly residents in nursing homes and hostels'.[3]

Current arrangements

4.2 The present arrangements for ensuring quality of care in nursing homes and hostels involve assessment of compliance by providers with defined outcome standards. This involves Standards Monitoring Teams visiting homes and assessing services against agreed minimum standards (Outcome Standards). If a home is seen to be not performing, the Standards Monitoring Team will present a report to the home requiring action against particular standards. If the home continues to breach the standards the Government has the power to stop funding, either in part or in full. Nursing homes are also required to acquit a portion of their funding – called the Care Aggregated Module (CAM) – against expenditure on direct care staff and duties. CAM's intention was to give nursing homes more flexibility in setting staffing levels.[4]

Proposed arrangements

4.3 Under the Reform Package it is proposed to introduce from 1 January 1998 a new quality assurance system based on accreditation. The Department of Health and Family Services (DHFS) stated that the aim of the accreditation based system is to 'promote continuous improvement and higher levels of quality'.[5] The Department noted that the new system will balance the enforcement of minimum standards with recognition and encouragement of higher quality in aged care facilities.[6] DHFS also noted that it 'reflects a shift from sole Government responsibility to ensure quality to a

---

1 Submission No.34, p.9 (ANF & NSW Nurses Association); Submission No.66 p.13 (CSA); Submission No.24, p.6 (NSW College of Nursing and Geriaction–NSW); Submission No.79, p.2 (ACTU); Submission No.68, pp.3-4 (OPC).

2 *Transcript of Evidence*, p.121 (NSW College of Nursing).

3 Submission No.34, p.9 (ANF & NSW Nurses Association).

4 Submission No.94, pp.48-49 (DHFS); Submission No.58, p.21 (APSF).

5 Submission No.94, p.49 (DHFS).

6 DHFS, Additional Information, 22 May 1997, p.5.

shared responsibility for ensuring quality among providers, consumer representatives and Government'.[7]

4.4 The accreditation arrangements will be overseen by an independent Aged Care Standards Agency, the board of which will comprise individuals with a representative range of aged care and management experience. The role of the Agency will be to promote quality management within facilities, oversee the accreditation process, and identify any facilities not meeting minimum requirements. DHFS, in association with the Agency, will have the power to take action against facilities which are substandard and whose operators have themselves taken inadequate action to achieve a sustained improvement in the situation.[8]

4.5 Under the reforms it is also proposed that nursing home operators will receive a single non-acquitted payment for each resident instead of the existing funding structure based on CAM, Standard Aggregated Module (SAM) and Other Cost Reimbursed Expenditure (OCRE). As noted above, CAM provides funding to meet the costs of nursing and personal care (essentially nursing and therapy staff wages). SAM provides funding to meet such costs as food, electricity, building maintenance and the salaries of the administrators and domestic staff, while OCRE provides cost reimbursement for staff superannuation, workers' compensation, payroll tax and long service leave.[9]

Becoming accredited

4.6 To become accredited all residential aged care services will be assessed against an agreed set of accreditation standards. The accreditation standards, which are set out in the draft Principles (Schedule 1), cover four categories – health and personal care, resident lifestyle, physical environment and safe practice and management systems, staffing and organisational development. The first three categories largely cover standards addressed in the current outcome standards. The fourth establishes new standards relating to management systems, including the employment of skilled staff.[10]

Transitional period (to December 2000)

4.7 During the transition period services will continue to be assessed by DHFS (to December 1997). After January 1998 those services not yet accredited will be assessed against their capacity to meet the residential care standards (that is, the first three categories of the accreditation standards) by the Aged Care Standards Agency.

---

7 Submission No.94, p.49 (DHFS).

8 Submission No.94, pp.26,49 (DHFS).

9 Professor R.Gregory, *Review of the Structure of Nursing Home Funding Arrangement:Stage 1*, August 1993, p.8.

10 Submission No.94, pp.49-50 (DHFS).

Services will be identified against risk factors, such as complaints, to ensure that they meet present requirements. Regulatory action will be taken against those facilities identified as not complying with those standards.[11]

4.8 Following a transition period of three years from 1 January 1998 only accredited services will be eligible to receive Commonwealth funding to provide residential care services. DHFS noted that 'full details' of the new arrangements are being developed in consultation with stakeholder groups.[12]

Resident Classification Scale

4.9 Under the reforms, the Resident Classification Scale (RCS), formerly called the Single Classification Instrument, is designed to assess the care needs of residents irrespective of whether they reside in a nursing home or a hostel. The funding rates attached to the RCS were released on 26 May 1997.[13]

4.10 The aim of the RCS is to ensure that residents are funded according to their needs no matter what kind of facility they are in, and will allow facilities to meet residents' care needs as they change over time. One of the purposes of the new Instrument is to ensure better funding for dementia care. DHFS noted that the new RCS 'brings better recognition and weighting of dementia care needs. Together with the new funding scale, this means funding for hostel residents with identified dementia care needs increases by over 30 per cent on average'.[14]

4.11 The existing nursing home Resident Classification Instrument and hostel Personal Care Assessment Instrument will be phased out gradually over a 12 month period in nursing homes, and over a six month period in hostels. All residents entering care after the commencement of the new arrangements will have their care needs assessed using the new Instrument. The RCS is linked to a new single scale of subsidy levels that will apply across both nursing homes and hostels. The Minister announced on 26 May 1997 that there will be eight funding categories reflecting the range of dependency levels.[15]

---

11 Submission No.94, p.50 (DHFS).

12 Submission No.94, p.50 (DHFS).

13 Minister for Family Services, *Media Release*, 'Aged Care Structural Reform Details Announced', 26 May 1997.

14 Minister for Family Services, *Media Release*, 26 May 1997, p.2. See also Submission No.94, p.14 (DHFS); DHFS, Additional Information, 22 May 1997, p.3.

15 Minister for Family Services, *Media Release*, 26 May 1997. See also Submission No.94, p.14 (DHFS); DHFS, Additional Information, 22 May 1997, p.3.

Issues

4.12 A number of issues were raised in relation to ensuring that the quality of care is maintained in nursing homes under the new arrangements and these are discussed below.

Abolition of CAM funding

4.13 Many organisations, including the ANF and NSW Nurses Association, expressed concern at the proposed abolition of CAM funding and the adoption of a single non-acquittable payment system.[16] The ANF and the NSW Nurses Association stated that the use of CAM ensured that public money provided to nursing homes by the Government was used for its intended purpose – 'this meant that providers were accountable for funds and, importantly, it meant that this money was spent on the provision of care for residents. The system was transparent and allowed the community to have some certainty about staffing levels in nursing homes'.[17]

4.14 The NSW Nurses Association argued that:

> With the CAM system of assessing needs and delineating whether registered nursing hours are needed or enrolled or assistant nursing hours are needed, the measured hours guaranteed care levels [which meant] that 97 per cent – the 1450 nursing homes – are operating at a good level, a great level, and are providing the type and level of nursing care that is needed.[18]

4.15 The NSW Nurses Association further noted that under the current system:

> There is an integrated system of funding, which delivers specific standards of care and, with that, skilled nursing staff and other trained allied health staff....The RCI gives us the funding at a guaranteed level, guarantees thereby the care level and the acquittal process–the auditing process–gives us certainty. It is definitely a circle. If the system of the quality circle single-payment is dismantled, then we believe we can give no guarantee as nurses...for that standard to be maintained.[19]

4.16 The ANF argued that under the proposed system there is a real danger that proprietors will attempt to maximise their profits by deskilling their workforce and thereby compromising the care given to residents.[20]

---

16 Submission No.34, p.10 (ANF & NSW Nurses Association); Submission No.82, p.3 (ANF-Victorian Branch); Submission No.85, p.3 (Victorian Nurse Executives Association).

17 Submission No.34, p.10 (ANF & NSW Nurses Association).

18 *Transcript of Evidence*, p.155 (NSW Nurses Association).

19 *Transcript of Evidence*, p.153 (NSW Nurses Association).

20 Submission No.34, p.10 (ANF & NSW Nurses Association).

4.17 The ANF and the NSW Nurses Association noted that the collapsing of specific funding for skilled workers, particularly trained nurses, will have a detrimental impact on skilled employment in the nursing sector. The ANF and NSW Nurses Association argued that employers have already foreshadowed their intention to reduce and retrench staff as a consequence of the introduction of the new arrangements. The ANF also noted the 'great uncertainty' amongst the workforce as a consequence of the proposed changes.[21]

4.18 The Gregory report noted that a system of non-acquittable grants is attractive as a response to the rigidities and administrative costs imposed by the requirement of the current funding system that separate CAM and SAM expenditure and demand an acquittal of CAM funding. The system would allow proprietors to keep as a profit, or surplus, savings they can make on the cost of nursing and personal care staff and so provide a strong incentive for cost savings in that area.[22]

4.19 The Gregory report noted, however, that this option has potential disadvantages, especially relating to the ability of the funding system to ensure proper levels of care. The report noted that neither the current standards monitoring system, nor any alternatives considered, would be able to prevent the diversion of funding from nursing and personal care to profit.[23]

4.20 DHFS argued that the removal of CAM acquittal would not undermine the quality of care in nursing homes. The Department noted that CAM acquittal 'occurs some three or so years on average after the money is spent'.[24] DHFS also noted that there is not a direct correlation between CAM expenditure and the quality of care that is provided – 'it goes far more to the attitudes and approach of the staff than as to whether you actually spend 100 per cent of CAM'.[25]

4.21 The Committee considers that any system that claims to be concerned about the quality of care in nursing homes must ensure that public money provided for nursing care is spent for this purpose. The Committee therefore considers that funding provided to meet the costs of nursing and personal care should continue to be acquitted against expenditure.

Appropriately qualified nursing staff

4.22 Many concerns were expressed that the proposed reforms would be unable to ensure adequate levels of care will be delivered by appropriately skilled and trained

---

21 Submission No.34, p.10 (ANF & NSW Nurses Association).

22 Gregory, *op.cit.*, p.21.

23 *ibid.*, pp.32, 79.

24 *Transcript of Evidence*, p.286 (DHFS).

25 *Transcript of Evidence*, p.287 (DHFS).

staff and that neither the Bill nor the Principles contain sufficient assurance on this matter.[26]

4.23 The importance of maintaining highly qualified nursing staff in nursing homes was underlined by the NSW College of Nursing who stated that there are increasing numbers of people being admitted to nursing homes with severe multisystem disorders and illnesses that require the equivalent of services that are provided by acute medical units in teaching hospitals.[27] The College estimated that about 30 to 40 per cent of patients in nursing homes are acute care patients.[28]

4.24 As a result of comments provided on the exposure draft, the Aged Care Bill as introduced (Division 54) was amended to include responsibilities for approved providers to:

- maintain an adequate number of appropriately skilled staff to ensure that the needs of care recipients are met; and
- provide care and services of a quality that is consistent with any rights and responsibilities of care recipients that may be set out in User Rights Principles.[29]

4.25 The NSW College of Nursing stated, however, that it was of concern that the Bill made so much use of the words 'adequate' and 'appropriate' in relation to the use of qualified staff in nursing homes but with no definition of these terms. The College added:

> Without those terms being defined we simply cannot guarantee the safety and high standard quality care that is dictated by their needs, because not only do they require qualified registered nurse care to a great extent ...but it cannot be given without those nurses being employed, and more so, without nurses who also have specialist qualifications in the area.[30]

4.26 The Royal College of Nursing, Australia (RCNA) also noted that, in terms of staffing, the Bill says very little about the kind of care that needs to be given or the kinds of medical illnesses that nurses have to deal with in nursing homes, especially in the area of dementia.[31]

---

26 *Transcript of Evidence*, pp.121-22 (NSW College of Nursing/Royal College of Nursing); *Transcript of Evidence*, p.212 (ACHCA); Submission No.50, p.11 (CPSA of NSW).

27 *Transcript of Evidence*, p.120 (NSW College of Nursing).

28 *Transcript of Evidence*, p.124 (NSW College of Nursing).

29 See also Submission No.94 (DHFS), Appendix 1, p.7.

30 *Transcript of Evidence*, p.121 (NSW College of Nursing).

31 *Transcript of Evidence*, pp.121-22 (RCNA).

4.27 Other concerns were expressed that increasing numbers of non-nursing trained staff will be required to undertake nursing tasks under the proposed reforms.[32] The ANF and the NSW Nurses Association stated that 'nursing staff numbers, skills, and the level of experience and expertise will be systematically reduced, that non-nursing staff will be forced to carry the role of nurses, and that, in the end care for residents will suffer'.[33]

4.28 The NSW Nurses Association noted that the current system stipulates the number of registered nursing hours and the number of other nursing hours required for the care of residents in nursing homes –'we would hold grave fears that if the situation was such that the level of regulation of nursing standards was not there, and if it was replaced by an unregulated standard with no statute and regulations attached to the personnel that would replace nurses, nursing homes would be heading for a pretty disastrous time in terms of care standards'.[34]

4.29 The Combined Pensioners and Superannuants Association of NSW (CPSA) suggested that the Aged Care Standards Agency should consider the appropriate ratio of trained staff to the number of residents in nursing homes, as well as monitoring the level of trained staffing levels in nursing homes. In addition, the CPSA suggested that trained staffing ratios to residents become an integral part of accrediting nursing homes.[35]

4.30 The Australian Catholic Health Care Association (ACHCA) stated that in the absence of an acquittal process 'the only way Government, consumers and the community will be satisfied that care standards are being performed by appropriately trained staff will be through the accreditation standards and the quality assurance system'.[36]

4.31 DHFS stated that the RCS will indicate in a number of cases where particular functions would have to be performed by a person who is appropriately qualified. The Department added:

> The instrument [RCS] cross-refers...to the relevant requirements of State legislation and to relevant requirements in terms of professional standards, best practice, et cetera...In essence, the current requirements of making sure that you meet State requirements and the tasks are performed by appropriately qualified people are continued. There are particular references in the single classification instrument. The bill itself talks about the provision of high

---

32 *Transcript of Evidence*, p.166 (NSW Nurses Association); *Transcript of Evidence*, p.167 (ACTU).

33 *Transcript of Evidence*, p.154 (NSW Nurses Association/ANF).

34 *Transcript of Evidence*, p.166 (NSW Nurses Association).

35 Submission No.50, p.11 (CPSA of NSW).

36 *Transcript of Evidence*, p.213 (ACHCA).

> quality care. The standards arrangements will continue in the interim...to have a particular focus in the new accreditation arrangements. That will go to the qualifications, experience and capacity of staff to deliver the care that people need.[37]

4.32 The Committee considers that as nursing care is the essence of residential aged care, the reforms need to guarantee that the quality of nursing and other care will be available in nursing homes and that this nursing care will be delivered by appropriately skilled and trained staff. The Committee believes that the accreditation standards and quality assurance system needs to ensure that skilled and trained nursing staff levels are maintained in aged care facilities and that these levels should be monitored by the Aged Care Standards Agency.

Resident Classification Scale

4.33 A number of concerns were expressed during the inquiry in relation to the Resident Classification Scale (formerly referred to as the Single Classification Instrument) especially as regards its application and the funding implications that will arise from its introduction.

4.34 DHFS stated that the RCS 'will ensure that care needs are assessed and residents are funded according to their care needs no matter what kind of facility they are in, and will allow facilities to meet residents' care needs as they change over time'.[38] As noted above, there are eight care categories reflecting the range of dependency levels. The care categories are divided into a high and a low level reflecting the existing distinction between nursing homes and hostels.[39]

4.35 ACHCA explained that the RCS is essentially a 'resource allocation tool' designed to redistribute a given subsidy pool–which is the subsidy pool that exists now–to suit the Government's wish to increase funding for dementia care and for high dependency people in hostels –'it is of concern to us that that pool is being asked to perform tasks through the single classification instrument in terms of increased funding levels without increased dollars being apportioned'.[40] ACHCA noted that the demand for relevant care will not be achieved unless the RCS as a relative resource allocation tool is supported by the appropriate funds.[41]

4.36 The NSW College of Nursing raised criticisms of the study methodology that led to the development of the RCS arguing that 'the results are that the tool is fairly

---

37 *Transcript of Evidence*, p.287 (DHFS).

38 DHFS, Additional Information, 22 May 1997, p.3.

39 Minister for Family Services, *Media Release*, 26 May 1997, pp.2-3. See also DHFS, Additional Information, 22 May 1997, p.3.

40 *Transcript of Evidence*, p.212 (ACHCA).

41 Submission No.38, p.19 (ACHCA).

meaningless and we are highly critical of that'.[42] Concerns were also raised that the delay in finalising the Instrument posed problems for providers in terms of training staff in its use and also raised funding implications.[43]

4.37 The Committee regrets that details of the Resident Classification Scale were not available during the Committee's hearings. While the RCS was released on 8 May the funding rates were only announced on 26 May 1997.

Role of the Aged Care Standards Agency

4.38 Evidence to the Committee suggested that ensuring quality of care in nursing homes will be a major challenge for the new Aged Care Standards Agency, to be established from 1 January 1998.[44] As noted above, the Agency will oversee the accreditation arrangements and monitor compliance with these arrangements.

4.39 DHFS stated that an essential role of the Agency will be to promote quality management and the accreditation process to services and assist them through skills development, education, training and other support services. The Agency will also take responsibility for low quality services and work with the Department to ensure such services either improve and reach accreditation requirements or, where necessary, are removed from the system.[45]

4.40 ACHCA noted that the elimination of nursing and personal care funding acquittals in nursing homes will remove considerable regulatory requirements from providers but may lead to some providers cost cutting in the areas of care to the detriment of residents.[46]

4.41 The Australian Pensioners' and Superannuants' Federation (APSF) stated that the success of the accreditation process will be compromised if there is insufficient input from consumer representatives to provide a consumer perspective into policy and management issues. Furthermore, APSF argued that there may be a conflict of interest in the Agency having a role of both encouraging quality assurance and monitoring and applying sanctions. APSF argued that the Agency's role should be to encourage the industry to achieve optimum quality, while the Government should focus on monitoring and applying sanctions where facilities do not meet the required standards.[47]

---

42 *Transcript of Evidence*, p.127 (NSW College of Nursing).

43 *Transcript of Evidence*, p.151 (ACA).

44 Submission No.38, p.19 (ACHCA); Submission No.58, p.22 (APSF).

45 DHFS, Additional Information, 22 May 1997, p.6.

46 Submission No.38, p.19 (ACHCA).

47 Submission No.58, p.22 (APSF).

4.42 Residential Care Rights also noted that there is a strong perception among consumers and their representatives that 'a significant focus of the Agency will be the needs of service providers' to the detriment of consumer interests.[48]

4.43 Other evidence suggested, however, that the Agency could fulfil the roles of maintaining quality assurance and monitoring compliance. ACHCA suggested that the Agency needed to be supplied with the necessary investigative powers comparable with other Government agencies that have similar responsibilities for protecting consumers and safeguarding their rights. The ACHCA also argued that the Agency must be established with a Chairperson and Board of Directors with the skills and competence to ensure that the quality of care in residential aged care facilities is protected.[49] The Australian Council of Social Service (ACOSS) argued that the amount of funds committed to the Agency needed to be sufficient to facilitate its work.[50]

4.44 The Committee believes that quality of care needs to be protected and enhanced in aged care facilities. The Committee notes that full details of how the proposed new Aged Care Standards Agency will operate are not available and therefore it is difficult to determine the exact role it will play in monitoring standards of care. The Committee believes, however, that the new Aged Care Standards Agency should play an important role in this regard and needs to have adequate monitoring and enforcement mechanisms in place to ensure industry compliance with care standards and be adequately funded.

Transitional period

4.45 Concerns were expressed during the inquiry at the length of the transitional period (to December 2000) to implement accreditation of aged care facilities.

4.46 The ANF and NSW Nurses Association and the APSF argued that there should be a shorter timeframe for proprietors to achieve accreditation in respect of care standards. The ANF and the NSW Nurses Association argued that this would minimise the potential for the development of 'three tiers' of care standards – extra services facilities, accredited facilities and non-accredited facilities.[51] The APSF argued that accreditation should be brought forward one year (to 1 January 1999).[52] The ANF also argued that the Government should apply pressure on the industry to ensure that all homes meet accreditation by 'declaring what it intends for those which

48 Submission No.51, p.21 (Residential Care Rights).

49 Submission No.38, p.19 (ACHCA).

50 Submission No.80, p.9 (ACOSS).

51 Submission No.34, p.13 (ANF & NSW Nurses Association).

52 Submission No.58, p.22 (APSF).

don't measure up within the required time'.[53] The ANF also argued that accreditation should be a requirement of approved provider status.

4.47 DHFS indicated that during the transitional period, services will continue to be assessed and that 'there would be no reduction in the level of effort applied to standards monitoring' during this period.[54]

Conclusion

4.48 The Committee believes that that the Government's aged care reform proposals have the potential to compromise the standards of care in aged care facilities. The present arrangements for quality of care in nursing homes and hostels has achieved a substantial improvement in residents' quality of care and quality of life. The Committee regrets that the full details of the new quality assurance system based on accreditation is not yet available.

4.49 The Committee also has particular concerns at the proposed abolition of CAM funding and the introduction of a single non-acquittable payment system and the fact that the proposed reform package does not contain adequate provisions to ensure that proper levels of care will be delivered by appropriately skilled and trained staff to residents of aged care facilities.

Recommendation 18: The Committee recommends that nursing homes continue to be required to acquit that proportion of their funding expended on nursing and personal care.

Recommendation 19: The Committee recommends that the accreditation standards and quality assurance system provide for the employment of appropriately skilled and trained nursing staff to ensure that quality of care is maintained in aged care facilities.

Recommendation 20: The Committee recommends that the Aged Care Standards Agency monitor the ratio of trained nursing staff per resident in nursing homes through a transparent reporting procedure which would signal significant change in the ratio.

Recommendation 21: The Committee recommends that the Aged Care Standards Agency be established with the necessary investigative powers to ensure that the quality of care and rights of residents are maintained and protected.

Recommendation 22: The Committee recommends that the Aged Care Standards Agency have monitoring and enforcement mechanisms in place to ensure industry compliance with care standards and be funded to meet those objectives.

---

53 Submission No.34, p.13 (ANF & NSW Nurses Association).

54 Submission No.94, p.50 (DHFS).

CHAPTER 5

PRUDENTIAL ARRANGEMENTS

Introduction

5.1 The Department of Health and Family Services (DHFS) has estimated that by the fourth year after implementation of the accommodation bond scheme, the scheme will generate about $125 million each year.[1] Clearly, it is anticipated that there will be a significant pool of funds if the combination of retentions and interest are to generate that amount.

5.2 DHFS expressed its commitment to ensuring the protection of accommodation bonds as follows:

> The prudential arrangements for accommodation bonds will provide an unconditional guarantee that residents will not be disadvantaged where an individual facility is unable to refund amounts owed within the two months or shorter period as set out in Section 57-21 of the Aged Care Bill.[2]

5.3 The Aged Care Bill provides that the prudential requirements may be specified in the User Rights Principles. The User Rights Principles in respect of prudential arrangements have not been drafted at this stage because they are still the subject of consultation with industry and consumer stakeholders.[3]

Appropriate prudential arrangements

5.4 The Committee received evidence as to some of the risks associated with the payment of an accommodation bond to a nursing home. These included:

- insolvency of the proprietor of the facility;
- fraud on the part of the proprietor, operator or an employee of the facility;
- a sudden loss of residents resulting in an obligation to repay more accommodation bonds than the liquid assets of the facility could satisfy; and
- closure of the facility.[4]

5.5 As noted in Chapter 1, following the announcement of the reforms to residential aged care in the 1996-97 Budget, four working groups were established to provide

---

1 *Transcript of Evidence*, p.249 (DHFS).

2 Submission No.94, p.56 (DHFS).

3 *Exposure Draft – Aged Care Bill 1997 Principles*, p.278.

4 Submission No.58, p.28 (APSF); Submission No.65, p.11 (COTA).

advice on the implementation of the new system. The role of the Funding and Other Implementation Issues Working Group was twofold:

- identify issues outside the scope of the other groups which need to be resolved in implementing the package, in particular those related to entry contribution and income testing arrangements and funding matters generally, and
- advise the Minister on possible approaches and their implications.

5.6 That Group reported to the Minister in January 1997. The following issues were raised when considering the various options for prudential arrangements:

- the desirability of avoiding duplication or conflict with state retirement village legislation;
- the extent of access to capital sums and interest provided by the arrangement;
- the adequacy of security for residents;
- the costs to government and providers;
- the ease of administration;
- the impact of the arrangements on the willingness of financial institutions to lend funds for capital improvements;
- the capacity to apply the arrangements to leasehold or other situations where the providers have limited equity in the property; and
- the implications for current funds held by hostels.[5]

5.7 Submissions to the Committee demonstrated almost universal acceptance of the need for prudential arrangements to ensure protection for resident contributions against the risks outlined above.[6] However, a number of operators of homes expressed concern at the proposed prudential measures. Reference was made to the apparent lack of any problems in relation to the protection of hostel entry contributions since their introduction in the late 1980s, and the potential cost of the measures for operators. In particular, it was suggested that the likely rise over time in the cost of insurance would result in the erosion of capital funding.[7]

---

5 Funding and Other Implementation Issues Working Group, *Initial Report*, January 1997, pp.9-10.

6 As examples, Submission No.24, p.7 (NSW College of Nursing); Submission No.9, p.9 (NANHPH); Submission No.56, p.24 (ANHECA); Submission No.65, p.11 (COTA).

7 Submission No.54, p.5 (Resthaven); Submission No.55, p.4 (SCH –Tasmania); Submission No.60, pp.19-20 (ACA).

5.8 The Committee agrees that complete protection of the balance of accommodation bonds is critical to the confidence of prospective nursing home residents in the accommodation bond scheme. It is therefore imperative that prudential arrangements which are developed gain the absolute confidence of the older people whose bonds the arrangements are designed to protect.

Current developments

5.9 The Funding and Other Implementation Issues Working Group also considered and rejected a number of possible prudential models:

- trust funds – the Group concluded that these would place significant limitations on the use of the bond for capital purposes and thus would not achieve the intended purpose of the arrangements;

- bank guarantees - these would be difficult to obtain in circumstances where there is no property against which to secure the guarantee (eg. where premises are leased) or where there was not sufficient equity in the property to support the guarantee; and

- providing residents with a first charge on the value of the assets in the event of insolvency, as occurs with retirement villages in some States - this again results in problems where the value of the asset is less than the amount charged against it.[8]

5.10 A number of organisations referred to State and Territory retirement village arrangements which is provided in some State legislation. However, whilst provisions exist in a number of States, they are not uniform and some States do not have any legislative provisions at all.[9]

5.11 The Minister, in responding to the Working Group report, stated that 'work in progress suggests that a mandatory prudential scheme will best meet the objective of ensuring strong protection of older people's financial investments in their own care'.[10] The Minister convened a new working group of providers and consumers to undertake more detailed development work and to provide her with further recommendations on how such an arrangement could best be implemented.

5.12 The Department engaged a consultant with expertise in financial and risk management to undertake the first stage of the developmental process to specify the

---

8 Funding and Other Implementation Issues Working Group, *op.cit.*, p.10.

9 Submission No.56, pp.24-5 (ANHECA).

10 *Steps to Better Care: Implementation of the Government's Residential Aged Care Structural Reform Package*, Statement by the Minister for Family Services, 10 February 1997, p.7.

features of the scheme as a prelude to seeking tenders from organisations able to construct and manage it.[11]

5.13 The consultant is developing a proposed arrangement for the prudential scheme. DHFS has advised that the scheme is comprised of three tiers:[12]

- A liquidity requirement for every service provider to ensure that the provider has the capacity to repay 3 or 4 bonds in a very short space of time. This requirement need not be satisfied by a pool of money but could take the form of access to a line of credit.

- There will be an industry owned pool of funds to be used in the event of some catastrophic event. If there is some difficulty and someone cannot pay in the time required by the Act, those funds would be drawn. The creation of the industry owned pool will require a diversion of funds from service providers for a period until the desired level of funds is accumulated. When that level is reached the need to draw further from providers would cease. The amount of the industry owned pool is still unknown.

- There will be a policy of 'stop-loss' insurance to cover the event that the aggregate of the pool is exhausted. The Committee has been made aware that the cost of this cover will be met on a flat dollar amount per bed basis.

Exemptions to prudential arrangements

5.14 Church groups have argued that their record of ensuring the protection of entry contributions in the hostel sector coupled with their ability to provide a guarantee of accommodation bonds backed by their substantial resources means that they should be exempted from any insurance scheme.[13] It is not clear whether they would object to being required to contribute to the industry owned pool.

5.15 The Committee understands that requiring church groups to take part in the insurance arrangements will reduce the overall risk and consequently lower the premium payable by all service providers.

5.16 Anglicare Australia felt that it would be wasteful for church based bodies to take part in a system where they would be financially penalised for doing so.[14] Anglican Community Services (SA) commented as follows:

---

11 Submission No.94, p.57 (DHFS).

12 *Transcript of Evidence*, p.291 (DHFS).

13 Submission No.62, p.7 and *Transcript of Evidence*, p.78 (Anglicare Australia); *Transcript of Evidence*, p.172 (CSA); and Submission No.38, pp.26-27 (ACHCA).

14 *Transcript of Evidence*, p.78 (Anglicare Australia).

> Given that the cost of the prudential arrangements will have to be met from monies currently available and used for the provision of care, Anglican Community Services believes that residents currently in organisations which are rated as having low or virtually nil risk in regard to their financial structure and their ability to guarantee the return of refundable amounts should not be disadvantaged by having to share the costs of the higher levels of risk found in other elements of the industry.[15]

5.17 Community Services Australia (CSA) expressed the view that if the charitable sector was the one which posed the greatest risk there may be some justification for spreading the risk across the industry as a whole. However, they could see no justification for imposing an added burden on the charitable sector in order to improve the profits of the private sector.[16] The Committee has sympathy with that argument but believes it needs to be balanced by the recognition that smaller non-profit operators (who are not resourced to give the same guarantees as the larger churches) will also be subject to higher premiums as a result of the churches not participating in the scheme.

5.18 CSA said that the Uniting Church was prepared to guarantee absolutely all monies received as accommodation bonds and, on that basis, felt that it should not be forced to pay a premium to insure against risk to the monies.[17]

5.19 The Australian Catholic Health Care Association (ACHCA) submitted that a precedent for exemption by the Catholic Church from an industry-wide prudential system already exists in the Class Exemption granted by the Australian Securities Commission with respect to the prospectus provisions of the Corporations Law.[18]

5.20 The Committee received evidence from Anglicare as to a possible compromise under which church groups would take part in the insurance scheme but would not be financially penalised for doing so. This would involve the insurance premium for each service provider being assessed on the basis of real risk factors such as differential management capacities, gearing levels, capital adequacy and liquidity ratios.[19] The Committee is unsure of the administrative cost of such an arrangement or its impact on the very small non-profit facilities many of which may be located in rural areas.

5.21 The Committee received further evidence from Anglicare that its facilities are separately incorporated and have differing arrangements with their respective dioceses.[20] Additionally, not all facilities are backed by the Anglican Church.

---

15 Submission No.57, p.5 (Anglican Community Services – SA).

16 Submission No.66, p.20 (CSA).

17 *Transcript of Evidence*, p.172 (CSA).

18 Submission No.38, p.26 (ACHCA).

19 *Transcript of Evidence*, p.76 (Anglicare Australia).

20 *Transcript of Evidence*, p.81 (Anglicare Australia).

5.22 The Committee has been made aware that nursing homes and hostels run by the Uniting Church through CSA are backed by the respective assets of the Synod of each State/Territory except South Australia where facilities are separately incorporated.

5.23 ACHCA described the more complex structure of the Catholic Church run or approved nursing homes and hostels.[21] There are three classes of owners or sponsors – Diocesan based, Congregation based or lay organisations such as Southern Cross Homes (SCH) and St Vincent De Paul. In simple terms, the Diocesan sponsored organisations are backed by the assets of the Church whereas the Congregation sponsored and lay organisations are not. However, the Church advised that it may be prepared to back those organisations if appropriate arrangements were put in place – for example, the granting of a mortgage in favour of the Church over the assets of the facility.

5.24 The potential uncertainty as to which facilities would or would not be covered by a guarantee by the Church would mean that a blanket exemption from the major churches would not be appropriate.

5.25 The Department has not ruled out the prospect of exemptions. The Bill does provide a power for the Minister to make exemptions and to provide principles on which the Minister would base decisions in relation to exemptions. The Minister has publicly stated that those exemptions will be tightly administered and would be granted only in a case where the exemptee has precisely the same obligations as a person covered by the prudential scheme in terms of obligations on repayment and liquidity.[22]

5.26 The Committee agrees with the view expressed by CSA and does not believe that the large church groups capable of providing sufficient assurance in respect of their facilities should effectively subsidise the for-profit operators. At the same time, the Committee acknowledges that smaller non-profit homes may be forced to pay higher premiums as a result of the absence of the church groups from the scheme.

5.27 The Committee agrees with the exemption of facilities run by church organisations from the compulsory insurance arrangements. However, the Committee believes it will be necessary to separately consider the relationship between each church based facility and the church to ensure that the facility is properly backed by the church.

Timing of implementation

5.28 Based on the Government's original intention that the accommodation bond scheme would commence on 1 July 1997, concerns were expressed as to whether the

---

21 Submission No.38, pp.26-27 (ACHCA).

22 *Transcript of Evidence*, p.292 (DHFS).

prudential arrangements would be in place by that date and if so, whether they would be compromised as a result of the haste.[23] The Minister subsequently announced that the implementation of the Bill will commence on 1 October 1997. The Committee believes that the prudential arrangements need to be in place by the commencement date – failure to do so will result in great uncertainty for prospective care recipients. As noted earlier, the Committee believes that it is imperative that older people have complete confidence in the prudential arrangements that are implemented. It is not certain whether, if the prudential arrangements are not in place by the date on which the Act commences, the payment of bonds will be somehow delayed or suspended until those arrangements are in place.

5.29 The Committee understands that the User Rights Principles relating to prudential arrangements will not be released until June. The Committee's ability to comment more fully on the proposals for prudential arrangements has been limited by the lack of detail on anything other than the most bare framework of the proposed arrangements.

Conclusion

The Committee believes that prudential arrangements are essential to ensure the complete protection of accommodation bonds which is critical to the confidence of care recipients in the accommodation bond scheme.

Recommendation 23: The Committee recommends that the requirement for prudential arrangements relating to accommodation bonds, as contained in the User Rights Principles, should be incorporated into the principal legislation.

Recommendation 24: The Committee recommends that the prudential arrangements should:

(i) provide an unconditional assurance that the balance of the accommodation bond is able to be refunded in accordance with the provisions of the Aged Care Bill 1997 when enacted;

(ii) be able to be complied with at the least cost to providers as possible, so as to ensure that as much of the amount received by way of accommodation bonds can be used for the intended purpose of capital improvement;

(iii) be mandatory for all providers of aged care who receive accommodation bonds, subject to the recommendation in respect of church run and church associated facilities;

---

23 *Transcript of Evidence*, p.134 (ACA); *Transcript of Evidence*, p.170 (CSA).

(iv) be reasonably straightforward and easily understood by residents and their families; and

(v) be in place at the commencement date of the Aged Care Bill 1997.

Recommendation 25: The Committee recommends that while a blanket exemption for church run or church associated facilities is not appropriate, exemptions should be permitted for these facilities in certain circumstances. The relationship between each church-based facility and the relevant church will need to be considered to ensure that the facility is properly backed by the church before any exemption from the prudential arrangements is granted.

Recommendation 26: The Committee recommends that a review of the prudential arrangements including the mechanism for granting exemptions should be undertaken every 12 months for the first 4 years. The review should incorporate an actuarial assessment of claims records.

CHAPTER 6

IMPLICATIONS OF POSSIBLE TRANSFER OF AGED CARE TO THE STATES AND TERRITORIES

Rationale for devolution of aged care to the States/Territories

6.1 At its June 1996 meeting, the Council of Australian Governments (COAG) agreed that there was an urgent need to shift the focus of health and community services from programs to people, through a partnership between the Commonwealth and the States. COAG suggested that this would involve building a system that:

- provides quality care responsive to peoples' needs;
- provides incentives for preventive health and cost effective care;
- gives better value for taxpayers' dollars;
- provides more clearly defines roles and responsibilities; and
- retains the benefit of universal access to basic health services through Medicare.

6.2 Specifically, in respect of aged care, COAG agreed that interim steps to consolidate and rationalise a number of existing arrangements, including consideration of the transfer of responsibility for managing aged care programs to the States, are to be developed in parallel with work on the longer term approach.[1]

6.3 COAG further stated that the specific measures proposed as interim steps were:

> Developing new aged care agreements under which States would have responsibility for managing aged care programs, including nursing homes, hostels and the aged care component of HACC, and with the Commonwealth's interests being met by the agreements having a greater focus on outcomes for consumers.[2]

6.4 An increased potential for States to achieve flexibility between related programs, with flow-ons in efficiency and tailoring to individual need was cited as an advantage of this measure.

6.5 In its submission to the Committee, the Department of Health and Family Services (DHFS) outlined the proposal as follows:

> The approach envisages a realignment of roles and responsibilities with the States taking responsibility for the management of aged care programs. The

---

1 Council of Australian Governments, *Communique*, 14 June 1996, p.3.

2 *ibid.*, p.6.

> Commonwealth would have a continuing role in jointly setting objectives, priorities and strategic directions as well as defining outcomes and monitoring performance.
>
> Administrative arrangements, including in relation to funding, access and quality assurance measures would be addressed in bilateral agreements. The agreements would be predicated on a National Aged Care Strategy that would guide the national development of aged care into the next century.[3]

6.6 COAG was to consider a draft public discussion paper at its November 1996 meeting. However, it was subsequently agreed not to release this paper and instead develop further proposals for reform. The further proposals are to focus on options for achieving flexibility which do not involve a major transfer of funding and do not impinge on current concerns on broader Commonwealth–State financial arrangements.[4] Specifically, the reforms would include addressing duplication and overlap, improving co-operation and creating more consistent management between levels of government.

Commonwealth position

6.7 The Department claims that the reforms will potentially offer more flexibility for providers, improved outcomes for clients and greater efficiencies and improved effectiveness.[5] The Government's view is that there is considerable scope for development and improvement in the aged care sector but it would only agree to reforms if it was confident that:

- frail older people will get better services,
- the Government's Medicare commitments are upheld, and
- Australian taxpayers will get a fairer deal.[6]

6.8 The Aged Care Bill 1997 makes provision in clauses 4-2 and 4-3 for the transfer of the responsibility for aged care to the States. The stated aims behind the transfer of responsibility have been supported by various organisations. Potential advantages were seen with the responsibility of aged and community care resting with one level of government. Duplication of effort by State and Federal governments could be reduced and the capacity to provide a flexible mix of services to suit particular situations would be assisted by a clearer delineation of responsibilities

---

3 Submission No.94, p.54 (DHFS).

4 Submission No.94, p.54 (DHFS).

5 Submission No.94, pp.54-55 (DHFS).

6 Submission No.94, p.55 (DHFS).

between the Commonwealth and the States and Territories.[7] While these potential advantages were recognised, there were significant concerns and reservations expressed over the proposed transfer of responsibility.

Access to services and national standards for service delivery

6.9 A number of submissions expressed the concern that a transfer of responsibility could result in differing standards for the provision of aged care services across Australia.[8] The Australian Council of Social Service (ACOSS) summarised this concern submitting that past experience has indicated that, in practice, it is extremely difficult following the devolution of programs for the Commonwealth to retain a strong role in the establishment and maintenance of enforceable national standards. ACOSS believes:

> This is one reason why there is widespread scepticism in the community services sector that such a devolution of responsibilities (especially in the context of reduced public monies) will actually lead to better outcomes for consumers.[9]

6.10 Many organisations identified a number of issues and problems that could arise from devolution and which should be given further consideration before any transfer takes place.[10] These included:

- the far from successful results of the transfer of other programs to the States, eg. immunisation and Commonwealth funded disability services, which were regarded as an indication of what could occur with aged care;
- equal accessibility to nursing home/hostel beds across Australia. Community Services Australia (CSA), for example, expressed the concern that the range, quality and amount of aged care services available may become varied, as State governments take on different 'priorities';
- the possibility of Special Purpose Payments (earmarked for funding of hostels and homes) being subsumed into general purpose payments by cash strapped States,

---

7 Submission No.31, pp.5-6 (NCOSS); Submission No.24, p.7 (NSW College of Nursing and Geriaction–NSW); Submission No.57, p.5 (Anglican Community Services–SA).

8 Submission No.15, p.3 (Catholic Care of the Aged); Submission No.34, p.15 (ANF); Submission No.49, p.6 (Older Persons Advocacy Service); Submission No.62, p.7 (Anglicare Australia).

9 Submission No.80, p.9 (ACOSS).

10 Submission No.50, pp.16-17 (CPSA); Submission No.56, pp.19-20 (ANHECA); Submission No.67, p.6 (CSA); Submission No.80 (ACOSS), Appendix 1. CSA and ACOSS appended to their submissions a copy of *The Risks of Devolution: A Joint Statement of Concern*, issued by the National Consumer and Community Service Organisations following the June 1996 COAG meeting.

with the potential that funds could be diverted to other programs thereby compromising the provision of aged care services;

- the effect on the continuity and uniformity of consumer protections and user rights, and care standards with the possible development of an inconsistent aged care system nationally; and

- the impact for the Home and Community Care program (HACC) through the possible further restructure of services to older people.

6.11 The Australian Catholic Health Care Association (ACHCA) referred to the importance of the Commonwealth's continued role, commenting that:

> ACHCA recognises some benefits in the transfer to the States of day to day responsibility for management of programs with the Commonwealth retaining control of funding through a national payment system, equity of access to services, affordability for consumers through national income security measures and national quality standards.[11]

6.12 The Committee received evidence from Dr Marinovich, a consultant physician/geriatrician from Western Australia, who identified antagonism between the State and Commonwealth health departments as a major problem where Commonwealth programs are handed to State departments with the Commonwealth retaining higher level policy control.[12]

Shortcomings in State/Territory administration of health care

6.13 A number of groups pointed to the allegedly poor record of States and Territories in the area of health administration as an argument against devolution.[13] The Australian Nursing Homes and Extended Care Association (ANHECA), in particular, referred to the inability of States to 'effectively deliver expected outcomes, despite rigorous Commonwealth oversight in the following areas: the public hospitals system, the disabilities services programs, the home and community care program, and the children's immunisation program'.[14]

6.14 As an example, reference was made in a number of submissions to the Commonwealth/State Disability Agreement (CSDA), which represented an effort on the part of Federal and State levels of government to develop a coordinated, rationalised and integrated approach to disability services in Australia. Professor Anna

---

11 Submission No.38, p.23 (ACHCA).

12 *Transcript of Evidence*, p.188 (Dr Marinovich).

13 Submissions No.25, p.3 (ANF–WA Branch); No.32, p.6, (APSL–Qld); No.43, p.5 (RSL); No.56, pp. 20-22 (ANHECA); No.66, p.19 (CSA); *Transcript of Evidence*, p.187 (Dr Marinovich).

14 Submission No.56, p.20 (ANHECA).

Yeatman, who reviewed the CSDA in 1995, produced some highly critical findings arising out of the implementation study. These included:

- a variation across jurisdictions of State Government readiness and capacity to implement the CSDA;
- inconsistent patterns and mixes of service types across jurisdictions and these imbalances have been perpetuated to some extent by the CSDA (for example, the proportion of day activities varied from State to State); and
- inconsistencies occurred between States in the service components which were included in the calculation of base funding levels.[15]

6.15 Not all views on transferred responsibility were negative. The ACT Disability, Aged and Carer Advocacy Service (ADACAS) submitted that an advantage of the State/Territory governments becoming responsible for aged care 'is that the relationship between aged care and other social services will become more apparent and could result in more seamless service delivery'.[16]

6.16 The Accommodation Rights Service (TARS) felt that the principal advantage of devolution of power to the States was the ability of the States to establish complaints mechanisms and tribunals with the power to give binding orders between consumers and their representatives and service providers. TARS also said that the enactment of binding and effective consumer protection laws for residents by the States should be a proviso to the transfer of any power over the aged care system to any State.[17]

6.17 TARS expressed the concern that the residential care model is disliked by forces within some State government departments and professional associations which see the residential rights which are incorporated into that model as a threat to entrenched power structures.

Conclusion

6.18 The Committee shares the concerns which have been expressed about the transfer of responsibility for aged care to the States and believes that before any transfer is to occur further consultation is required to ensure that the concerns held by the various parties involved are satisfactorily resolved.

---

15 *CSDA Evaluation - The Implementation Study: Supporting Paper 1* - January 1996, pp.ix-x. Reference was made to this review by ANHECA, ACOSS and APSF in their submissions.

16 Submission No.67, p.6 (ADACAS).

17 Submission No.75, pp.15-16 (TARS).

Recommendation 27: The Committee recommends that further consideration of the implications of the transfer of responsibility to the States and Territories on the provision of aged care services needs to be undertaken by all parties involved before the transfer is to occur.

Recommendation 28: The Committee recommends that before any transfer of responsibility occurs it needs to be demonstrated that improved outcomes for providers, residents and staff will result from such a transfer, and that adequate protection for all parties involved has been put in place. In addition, there needs to be certainty that transferred funds will be used for aged care services and not diverted to alternative programs.

Senator Mark Bishop
Chairman

June 1997

MINORITY REPORT: ORIGINAL INTENT OF INQUIRY VERSUS EVENTUAL OUTCOME RE LEGISLATION

It is worth noting that this inquiry was held against a back drop of a massive decline in nursing home funding during the last five years of the Labor Government. Funding for capital stock dropped from $47 million in 1991-92 to $10.7 million in 1995-96. This represents a 77% decrease in funding which needed to be redressed.

A minority report is essential given that the Labor dominated majority report condemns all the initiatives created by the Government following the above decline in funding.

While the terms of reference for the inquiry were very wide the emphasis in both the submissions and the evidence provided at the hearings clearly revolved around he *Aged Care Bill 1997*. Given the emphasis on the legislation it could be easily argued that the hearings should have been conducted by the Legislation Committee and not the References Committee.

This Report reflects the views of the Government Members of the Committee.

It seeks to rebut the many distortions, misinformation and inaccuracies that have formed the basis of the views expressed by Labor Party Committee Members.

It contends that the passage of the Government's *Aged Care Bill 1997* represents the best chance this Parliament has had to implement meaningful change to a sector long deserving of better service and care.

And a sector that for thirteen years had been miserably treated by the former Labor Government.

It contends that all the Government is seeking to do with its Aged Care Reform package is to build on existing measures as they have been successfully applied to the hostel sector for the last decade by Labor. It is therefore perplexing to note Labor's opposition to the extension of their own initiative with added protection for those affected.

During the hearings of this inquiry, Committee Members heard about a whole raft of concerns, worries, apprehensions and anxieties. While some of these concerns are understandable given the nature of the sector of the community that will be subject to the Government's reforms, many, this Report argues were "politically inspired", borne of an apparent unwillingness by many people giving evidence to accept existing government assurances on a whole range of issues and/or a total lack of understanding of the detail of the Bill.

It was apparent to the Government members of the Committee that many people giving evidence had a very cursory understanding of the government's reform package

and in some cases had not even read the draft exposure bill. The many consultative processes conducted by government on the proposed new measures have sought to include as many of the stakeholders as possible.

Indeed, some of the evidence given during the Committee's hearings seemed to adopt the rhetoric of the irresponsible political campaign waged by Labor Party members across the country.

While it is not the role of this Minority Report to respond to each and every complaint made against the Government's Aged Care Reform package, it is its intention to respond and rebut the key concerns (and in some cases "furphies") spread about the Government's intentions in this important area of public policy.

Allegation: 'Consultation Has Not Been Extensive Enough'

By any measure, consultation has been very extensive but the Government has had to strike a balance between consultation and meeting industry and consumer expectations of action to address serious problems. Despite this, the implementation process has been carefully structured to enable industry and consumer groups to be involved in each and every step of the process.

It should be remembered that the Government produced and distributed an exposure draft Bill so as to allow as much community feedback and industry and consumer input as possible into the final legislative product.

Four working groups were established to better focus the consultation process. These were:

1. The Funding and Other Implementation Issues Working Group which concentrated on issues including: measures to protect the financially disadvantaged; ensuring flexibility in the payment of the accommodation bond; prudential arrangements; residents agreements; viability funding in rural and remote areas; coalescence of rates and many other issues relating to funding.

This Group has met ten times since September 1996 and includes organisations such as Aged Care Australia; Alzheimers Association; Australian Catholic Health Care Association; Australian Council of Trade Unions; Australian Nursing Home and Extended Care Association; Council on the Ageing; Australian Pensioners' and Superannuants' Federation and the National Association of Nursing Homes and Private Hospitals.

2. The Certification Steering Committee

This Committee is overseeing the work of a consultant who is developing a design to assess the quality of construction of nursing homes before individual operators are allowed to charge accommodation bonds.

This Committee has met five times since October 1996 and includes many of the groups mentioned above.

3. The Quality Assurance Working Group

This Committee considered models for devising new standards for residential care facilities. It has already met five times and includes, apart from organisations already mentioned, the Australian Association of Gerontology; Carers Association of Australia; Federation of Ethnic Community Councils of Australia; Geriaction Inc.; and the University of Newcastle Faculty of Medicine and Health Science.

4. Technical Reference Group

This Committee focused attention on developing a new Single Classification Instrument (SCI) to apply to both nursing homes and hostels. It has met five times since November 1996.

Extensive consultations have been held on the Government's aged care reforms across the nation with over 1,000 industry and consumer representatives.

As well, the Government has committed to an information strategy which it believes will provide the very best advice to all interested parties on the Governments' Aged care reforms.

Allegation: 'Pensioners Will Be Forced to Sell Their Homes'.

This particular "furphy" has been a favourite of those that are determined to see the Government's aged care reforms defeated, particularly those in the Labor Party who started this rumour soon after the budget last year but did not make the same claim when the same measure relating to hostels was introduced by Labor.

Nobody will be forced to sell their home to get into a nursing home or to access quality care.

Already over fifty percent of nursing home residents choose to sell their home prior to entering a nursing home.

For individuals choosing to enter a nursing home while leaving their spouse, relative or partner in their principal place of residence, there will be protections to ensure that there will be no financial penalty for retention of the home as the principal asset. For those who either wish to not pay or defer payment of an Accommodation Bond, the option of periodic payments exists.

For those financially disadvantaged individuals who cannot afford to pay an accommodation bond, the Government will legislate to impose a quota on nursing home operators which will ensure that around thirty percent of total residents are "concessional" or financially disadvantaged individuals.

The Government's aged care reforms will focus on the needs of the individual and not the means.

Allegation: 'Accommodation Bonds Must Be Capped Or Else Only The Wealthy Will Access Nursing Homes'

This particular political line has been one of the cornerstones of the Opposition's scare campaign.

As stated before, Accommodation Bonds are an extension of the system introduced by the then Labor Government to the hostel sector nearly ten years ago.

Although the Bill allows for the Minister to set a cap on the level of accommodation bonds, the Government believes it not necessary to involve itself in the setting of Accommodation Bond levels – these arrangements will be decided by private agreement between the nursing home provider and the individual seeking care, as is the structure put in place by Labor in the hostel sector.

The Government is not relying solely on so-called "market forces" to determine the levels of accommodation bond. Rather a combination of strategies involving regulation, incentives and consumer pressure will, we believe, keep accommodation bonds to realistic levels.

For those who can afford to pay an accommodation bond, there will be limits based on their assets to ensure that nobody will be asked to pay what they don't have. No-one paying an accommodation bond will be left with less than $22,500 (single) or $45,000 (married). To state otherwise is to wilfully misinform.

And despite what some critics claim, this does not mean that an accommodation bond will be the total of a person's assets less $22,500 (single) or $45,000 (married). The exact same system with the exact same limits, which was introduced by the Labor Party for the hostel sector, has not resulted in such outcomes and indeed has managed to keep average hostel contributions down to a very reasonable level.

As well, it is important to remember that over ninety percent of the accommodation bond is refundable – with only a portion (a maximum of $2,600 per year) being retained by the provider in each of the first five years of a stay. The balance is refunded to the individual or their estate when the resident leaves.

Allegation: 'Financially Disadvantaged Persons Will Miss Out Under The Government's New Scheme'.

As we all know, Residential Care is costly. Currently, the Government pays around $29,000 for each nursing home resident. The Government now believes that it is appropriate for those who can afford to, to make a small contribution towards their nursing care via an accommodation bond.

But there will be adequate protections for the financially disadvantaged to ensure that access to nursing home care is based on need and not means or capacity to pay.

Under the current hostel system, many hostel operators accept more than their apportioned share of financially disadvantaged persons in need.

Under the Government's Aged Care Reforms a certain percentage of residents of each nursing home will be classified as financially disadvantaged or "concessional". While there will be a set concessional quota for each nursing home there will also be additional factors taken into account in rural and remote areas to ensure that financially disadvantaged persons are adequately catered for.

What this concessional quota will mean is that financially disadvantaged people and those better off will all have access to quality care regardless of their financial circumstances or location.

Given that the Government will provide financial incentives to providers to take on concessional residents, this will act as a further incentive for nursing home operators to take on their fair share of financially disadvantaged persons in need of care.

Allegation: 'Standards Of Care Will Deteriorate Under The New System'

This is a completely fallacious argument with no basis in fact and is designed to frighten the aged.

Facilities which are not accredited under the new arrangements will continue to be assessed against the Residential Care Standards by the Department until January 1998 and then by the new Aged Care Standards Agency.

This will ensure that the present standards of care will be maintained. To suggest otherwise is simply untruthful.

Where facilities are identified as being of poor quality they will be required to improve or lose their access to funding. They will not be protected.

Under the new system, all residential care facilities must be accredited by January 2001. The new accreditation arrangements will require all facilities to demonstrate their quality against a more comprehensive set of standards than the current set of standards require.

The new accreditation system will also recognise the higher quality facilities, providing encouragement for all facilities to improve. This is in stark contrast to the present system which makes no provision for better facilities.

In other words, the current system put in place by Labor discourages "best practice".

The new accreditation system will ensure that quality care is delivered by appropriately qualified staff. That is, facilities that do not employ appropriately

qualified staff will undoubtedly be penalised and if they do not change their ways they will be defunded.

Allegation: 'The New Single Classification Instrument Will Encourage Lower Standards Of Care In Nursing Homes'.

Indeed, the Government's absolute commitment to ensuring quality of care is maintained and where possible improved is evidenced by the exhaustive research that has been undertaken in devising the Single Classification Instrument (SCI). 400 facilities across the country and over 20,000 residents made up the sample.

By bringing nursing homes and hostels under the one funding classification that Labor introduced for hostels, the Government believes that:

- residents will be funded more appropriately according to their relative care needs;
- for the first time, providers will receive funding based on requirements dictated by their state of health rather than the geographical criteria of where a person may have resided prior to entering the nursing home;
- different gender couples will not have to be separated; and
- most importantly, funding for dementia care will be substantially improved.

The quality of care will not be compromised.

Nursing home staff will also benefit from the new funding Instrument.

The current nursing home funding system has substantially prevented the development of innovative staff management practices in nursing homes. It has prevented effective enterprise bargaining and played a part in restricting the capacity of nursing home staff to develop flexible work practices and training opportunities with their employers.

The Government's reforms to aged care will bring opportunities for staff to benefit from a simpler, less bureaucratic approach to funding and regulation. They will also enjoy broader career opportunities as providers take the opportunity to deliver care to a more diverse range of residents.

Extensive consultation took place with the Australian Nursing Federation (ANF) and agreement was reached in relation to accreditation, setting of standards etc and the Single Classification Instrument. The Department ensured that the ANF concerns about staffing requirements were resolved to their agreement.

Allegation: 'The Government's Proposals Will Lead To A Two Tier System of Care'.

It has been the current system that has encouraged a two-tiered approach to the hostel and nursing home sector, with two different sets of funding rules and different arrangements as they apply to capital.

The new funding arrangements will do away with the two classes of care that currently apply to the hostel and nursing home sector.

It will introduce a much fairer system of funding, with all residents funded according to the level of care needed.

The new funding arrangements will also allow people access to services closer to their preferred location than has been reliably assured in the past.

The new accreditation system will recognise quality residential care facilities as well as promoting ongoing improvement of the physical facilities and standard of care.

The bottom line is that something must be done to replenish capital stock of nursing homes given that successive Labor governments had not made any investment in replacement or upgrading for six to seven years.

The fact is that (as mentioned earlier) under a Labor government, funding for nursing home capital stock shrank at ever increasing rates from an already inadequate base.

In 1992-93, funding in the area totalled $45 million, by 1993-94, it was reduced to $26.5 million, in 1994-95 it reduced to $15.7 million and by 1995-96, funding was down to $10.7 million.

Allegation: 'Prudential Provisions Won't Be Enough To Protect An Individual's Accommodation Bond'.

The Government is strongly committed to robust prudential arrangements to protect the refundable portion of accommodation bonds.

It should be noted that when the Labor Government introduced contribution fees for hostels in 1987, there were no such accompanying prudential provisions to protect individual contributions.

The extension of accommodation bonds to nursing homes will provide both private and charitable sector providers with a significant new stream of income to meet capital costs. It is not unreasonable that a proportion of such resources are directed to ensuring that all residents in nursing homes are able to have confidence that their bond moneys will be refunded to them or their estate on departure from a nursing home facility.

The details of the prudential arrangements will be spelled out in subordinate legislation to be released in the near future.

Conclusion

This report considers many of the misleading statements concerning the *Aged Care Bill 1997.*

Aged Care in Australia cannot afford to have the Government's package defeated or delayed.

It is tragic for so many ageing Australians that they have been subjected to such a scurrilous and deliberate misinformation campaign.

Hundreds of nursing homes across the country are in need of substantial capital upgrade. The Government's package of reforms represents the best opportunity to achieve such an outcome.

The Government's package again represents the best opportunity to implement improvements throughout the nursing home sector and to ensure that thousands of elderly Australians live out their frail and declining years with access to proper care and improved facilities.

At the end of the day, the major concern for the Parliament should be the quality of care Government can deliver to the aged and frail in our community. Playing politics and embarking on scare campaigns with the most vulnerable in our community should be condemned by all fair minded Australians.

Senator Sue Knowles	Senator Alan Eggleston	Senator Helen Coonan
(LP, Western Australia)	(LP, Western Australia)	(LP, New South Wales)

DISSENTING REPORT BY THE AUSTRALIAN DEMOCRATS

The Australian Democrats agree with many of the recommendations contained in the Majority Report. However, the Australian Democrats disagree in part or in full with a number of the recommendations and make the following amendments, or variations to the recommendations contained in the Majority Report.

Chapter 1

Recommendation 1

The Australian Democrats recommend that the commencement date for the aged care structural reforms be delayed until information concerning all the issues is available, outstanding problems and concerns have been resolved and the impact of the proposed reforms have been fully explored and debated, but no later than 1 January 1998.

Recommendation 2

The Australian Democrats recommend that:

(i) the Aged Care Bill 1997 be amended to require the setting up of an Independent Review Committee to review the first two years operation of the Act. The Committee should include representatives of consumers and providers and elect its own Chairperson. Funding for the Committee should be provided as part of the Provisions attached to the Bill.

The brief of the Committee should be:

- taking evidence from and receiving submissions from all parties involved in the reform process;

- making six monthly reports to the Parliament on the implementation of, and problems with, the new legislation;

- making recommendations to the Parliament on amendments to the legislation, including changes to the funding levels set out under the Principles.

(ii) Should the amendment to establish an Independent Review Committee fail to pass, the Australian Democrats recommend that the Community Affairs References Committee monitor the operation of the Aged Care Bill 1997 following its enactment and review the implementation of the aged care structural reforms 12 months after the commencement of the Bill.

Chapter 2

Recommendation 3

The Australian Democrats recommend that:

- the payment of accommodation bonds for entry to nursing homes should be introduced only if the Majority Report's other recommendations as amended by the Australian Democrats are implemented.

Recommendation 5

The Australian Democrats recommend that in determining whether a person is a concessional resident:

- the Government should review the evidence presented in Chapter 2 of this report about the difficulties experienced by persons who will be forced to sell their homes and move amendments to the Bill to take account of these concerns.

Should the Government fail to amend the Bill adequately the Australian Democrats will agree to the following in determining whether a person is a concessional resident:

- the requirement that a person has not owned a home during the preceding 2 years should be omitted; and

- the value of the person's principal place of residence should be disregarded for the purpose of the assets test.

Recommendation 11

The Australian Democrats recommend that the Government continue appropriate funding for the Home and Community Care program and other community services and housing programs to address the needs of financially disadvantaged Hostel Care level residents that may be affected by the withdrawal of Hostel Care level subsidies.

Chapter 3

Recommendation 17

The Australian Democrats recommend the development of standard form agreements that outline the implied terms and a model agreement that incorporates fundamental rights. Such agreements should take into account the wide diversity of comprehension amongst residents and the difficulty of imposing too rigid agreements on proprietors.

Chapter 4

Recommendation 18

The Australian Democrats do not agree with this recommendation – that nursing homes continue to be required to acquit that proportion of their funding expended on nursing and personal care.

Senator John Woodley
(AD, Queensland)

APPENDIX 1

ORGANISATIONS AND INDIVIDUALS WHO PRESENTED WRITTEN SUBMISSIONS AND ADDITIONAL INFORMATION TO THE INQUIRY

Submission No.

1 Concerned Citizens' Action Group (WA)
2 Maroba Nursing Home Inc (NSW)
3 Mr Trevor O Wilks (TAS)
4 Ms Brenda Bailey (NSW)
5 Ms Margaret Wickham (TAS)
6 NSW Council of Senior Citizens Associations (NSW)
7 Miss Mavis Wigley (NSW)
8 Mr Dean Davidson (WA)
9 National Association of Nursing Homes and Private Hospitals Inc (NSW)
10 Ainslie House Association Inc (TAS)
11 CEPU Retired Members Association (NSW)
12 Huon Valley Council (TAS)
13 Rosemont Nursing Home (NSW)
14 NSW Retired Teachers Association (NSW)
15 Catholic Care of the Aged, Diocese of Maitland-Newcastle (NSW)
16 Ms Jean Maertin (TAS)
17 Mr Neville Boyce (NSW)
– Revised submission and Additional Information received at public hearing 23 April 1997
18 Churches of Christ Retirement Services Inc (SA)
19 Mr Thomas M Wyatt (NSW)
20 Older Women's Network WA Inc (WA)
21 CPSA – Central Coast Outreach Network Branch (NSW)
22 Mr R A Walker (WA)
23 Public Service Association of NSW – Retired Associates' Group (NSW)
24 The New South Wales College of Nursing, and Geriaction Inc. NSW (NSW)
25 Australian Nursing Federation – WA Branch (WA)
26 Huon Districts Eldercare Home Association Inc (TAS)
27 Australian Nursing Homes' & Extended Care Association SA Inc (SA)
28 Ms Christine Crofton (VIC)
29 M Curtis (NSW)
30 Morcartonio Rositono (SA)
31 Council of Social Service of New South Wales (NSW)

32 Australian Pensioners' & Superannuants' League, Qld Inc (QLD)
33 Geriaction (NSW)
34 Australian Nursing Federation and NSW Nurses Association (NSW)
35 Pensioners' Action Group Inc (WA)
36 Ashfield Baptist Homes Ltd (NSW)
37 Manning Valley Senior Citizens' Homes Ltd (NSW)
38 Australian Catholic Health Care Association (ACT)
39 Wesley Uniting Mission (SA)
40 Women with Disabilities Australia (ACT)
41 ACROD Ltd (ACT)
42 Doncaster & Templestowe Nursing Home and Day Centre (VIC)
43 The Returned & Services League of Australia Ltd (ACT)
– Additional Information received at public hearing 23 April 1997
44 Dr N Marinovich (WA)
45 Catholic Women's League (ACT)
46 Australian Community Health Association (NSW)
47 Alzheimer's Association NSW (NSW)
48 Aged Rights Advocacy Service Inc (SA)
49 Older Persons Advocacy Service Inc (QLD)
50 Combined Pensioners & Superannuants Association of NSW (NSW)
51 Residential Care Rights (VIC)
– Additional Information, dated 12 May 1997
52 Alexandra Private Nursing Home (VIC)
53 Central Coast Community Care Association Ltd (NSW)
54 Resthaven (SA)
55 Southern Cross Homes (Tasmania) Inc (TAS)
56 Australian Nursing Homes & Extended Care Association Ltd (NSW)
– Additional Information, dated 28 April 1997
57 Anglican Community Services (SA)
58 Australian Pensioners' & Superannuants' Federation (NSW)
59 National Seniors Association (QLD)
60 Aged Care Australia (VIC)
61 Alzheimers Australia (ACT)
62 Anglicare Australia (VIC)
63 Brotherhood of St Laurence (VIC)
64 Royal College of Nursing, Australia (ACT)
– Additional Information, dated 1 May 1997
– Additional Information, dated 13 May 1997

65 Council on the Ageing (VIC)
66 Community Services Australia – Uniting Church (ACT)
67 ACT Disability, Aged & Carer Advocacy Service (ACT)
68 Office of the Protective Commissioner (NSW)
69 Mrs F E Chegwidden (NSW)
70 Mr Peter Boardman (VIC)
71 Australian Law Reform Commission (NSW)
72 Eldercare (SA)
73 Over Fifties Focus (VIC)
74 Darebin City Council (VIC)
75 The Accommodation Rights Service Inc (NSW)
76 NSW Aged Care Alliance (NSW)
– Additional Information dated 9 May 1997 including Resolutions of a Public Meeting called by the Alliance on 7 April 1997
77 Moreland City Council (VIC)
78 The Returned and Services League – Northcote Sub-Branch (VIC)
79 Australian Council of Trade Unions (VIC)
80 Australian Council of Social Service (NSW)
81 Mrs Aileen Pereira (NSW)
82 Australian Nursing Federation – Victorian Branch (VIC)
83 The Centre On Ageing, Benevolent Society of NSW (NSW)
84 Older Women's Network Australia Inc (NSW)
85 Victorian Nurse Executives Association Inc (VIC)
86 Social Work Department, Prince Henry Hospital (NSW)
87 Tricare Limited (QLD)
88 Lindsay G Rittberger (SA)
89 Aged and Disability Support Program (Southern Region) (TAS)
90 Mrs B Small (NSW)
91 Mr James G Campbell (WA)
92 Mr Ian McDonald (SA)
93 Ms Glenys E Jackson (NSW)
94 Commonwealth Department of Health and Family Services (ACT)
– Additional Information on user rights, dated 21 April 1997
– summary of the Draft Aged Care Principles, dated 22 April 1997
– Additional Information, dated 5 May 1997
–Additional Information, dated 22 May 1997
95 Aged Care Victoria – Barwon Regional Branch (Confidential) (VIC)
96 Mr Clive John Arnold (NSW)

97 The Combined Pensioners and Senior Citizens Associations of Newcastle, Lake Macquarie, and Hunter Regional Council (NSW)
98 Central Australian Advocacy Service Inc (NT)
99 R van Schie (TAS)
100 Crowley Retirement Village (NSW)
101 S D Lean (SA)
102 Council of Pensioner and Retired Persons Associations Inc (SA)
103 Health Consumers' Council (WA)
104 Council of Retired Union Members Association of New South Wales (NSW)
105 Human Rights and Equal Opportunity Commission (NSW)
106 Ms Judith Williams (VIC)
107 Mr Ross Barnett (VIC)
108 Mr William Bostock (NSW)
109 Community Care (VIC)
110 Consultative Committee on Ageing (NSW)
111 D E Harris (NSW)
112 Ms Helen Cook (NSW)
113 Nambucca Valley Care Limited (NSW)
114 Combined Pensioners & Superannuants Association of NSW – St Georges Basin & Districts Branch (NSW)
115 G M Connell (QLD)
116 CAPAH Association Inc (NSW)
117 Dougherty Apartments Residents' Association (NSW)
118 South Australian Government (SA)

APPENDIX 2

WITNESSES WHO APPEARED BEFORE THE COMMITTEE AT PUBLIC HEARINGS

Wednesday, 23 April 1997, Charterbridge House, Sydney

National Association of Nursing Homes and Private Hospitals Inc

Mr Arthur Brotherhood, Chief Executive Officer
Ms Natasha Chadwick, National Executive Officer

Mr Neville Boyce

New South Wales Aged Care Alliance

Ms Trish Benson, Member
Ms Isobel Frean, Member
Ms Catherine Moore, Member

Older Women's Network (Australia)

Ms Betty Johnson, National Convenor
Mrs Hedi Roggeveen, Assistant Secretary

New South Wales Council of Senior Citizens Associations

Mr William Weston, President

Office of the Protective Commissioner (New South Wales)

Mr Mark Robinson, Director of Strategic Planning/Deputy Protective Commissioner
Mr Hamilton Steel, Manager, Accommodation Support Team
Ms Robin Turnham, Specialist Disability Adviser (Social Worker)

Returned and Services League of Australia

Mr Barrie Lindsay, Aged Care Committee Representative
Mr John O'Brien, State Pensions Manager (New South Wales)
Mr Godfrey 'Rusty' Priest, RSL State President (New South Wales)

Tricare Ltd

Mr Peter Toohey, Executive Chairman

Anglicare Australia

Mr James Longley, Chief Executive Officer
Mr Mark Caldwell, Executive Director, Operations
Ms Lesley Dredge, Member, National Executive

Australian Nursing Homes and Extended Care Association

Mr Warren Bennett, Chief Executive Officer
Mr William Bourne, Administration and Research Manager
Mrs Susanne Macri, Executive Director

Australian Pensioners' and Superannuants' Federation

Mrs Edith Morgan, National Secretary
Ms Betty Johnson, Assistant Secretary
Ms Sarah Fogg, Executive Officer
Ms Mary Banfield, Policy Officer

New South Wales College of Nursing

Associate Professor Debora Picone, Executive Director
Ms Julienne Onley, Acting Director, Professional Services

Geriaction Inc

Mrs Pauline Pallister, New South Wales State President
Mrs Kathryn Hurrell, Executive Member of State Council

Royal College of Nursing Australia

Professor Heather Gibb, Member
Professor Irene Stein, Chairperson, Greater Sydney Chapter

Thursday, 24 April 1997, Parliament House, Canberra

Aged Care Australia

Ms Maureen Lyster, Chief Executive Officer
Mr John Ireland, National President

New South Wales Nurses Association

Ms Sandra Moait, General Secretary
Mr Glen Fredericks, Industrial Officer

Australian Nursing Federation

Mr Denis Jones, Assistant Federal Secretary

Australian Council of Trade Unions

Ms Jennifer Doran, Senior Industrial Officer

Community Services Australia – Uniting Church

Ms Elizabeth Davies, Executive Director
Rev Harry Herbert, Chairperson

Council on the Ageing (Australia)

Mr Denys Correll, National Executive Director
Mrs June Healy, National President

Dr Norman Marinovich

Consultant Physician/Geriatrician, Fremantle Hospital, WA

Alzheimers Australia

Mrs Maureen Keating, National President
Ms Merran Newman, National Secretary

Australian Catholic Health Care Association

Mr Francis Sullivan, Executive Director
Mr Richard Gray, Director, Aged Care Services

Residential Care Rights Advocacy Service

Ms Catherine Brophy, Senior Advocate
Ms Mary Lyttle, Acting Director

ACT Disability, Aged and Carer Advocacy Service (ADACAS)

Ms Colynne Gates, Manager/Coordinator
Ms Judy Phillips, Advocacy Worker (Aged)
Mr Gabriel Savas, Secretary

The Accommodation Rights Service Inc (TARS)

Ms Wendy Fisher, Principal Solicitor
Ms Leisa Simmons, Education/Policy Worker

Department of Health and Family Services

Ms Jane Halton, First Assistant Secretary, Aged and Community Care Division
Ms Lisa Paul, Assistant Secretary, Residential Program Management
Ms Jennifer Bryant, Assistant Secretary, Policy and Evaluation Branch
Mr Conor King, Assistant Secretary, Accountability and Quality Assurance Branch
Mr David Learmonth, Director, Strategic Development Section

Monday, 5 May 1997, Parliament House, Canberra

Department of Health and Family Services

Ms Jane Halton, First Assistant Secretary, Aged and Community Care Division
Ms Lisa Paul, Assistant Secretary, Residential Program Management
Ms Jennifer Bryant, Assistant Secretary, Policy and Evaluation Branch

Department of Social Security

Ms Glenys McIvor, Director, Means Testing Policy Section, Retirement Programs
Mr Stuart Kennedy, Project Officer, Means Testing Policy Section