

**Review of the
Nursing Homes Act 1988**

**ISSUES PAPER
JUNE 2000**

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EXECUTIVE SUMMARY

The Review of the NSW Nursing Homes Act 1988 (NH Act) arises from the Competition Principles Agreement between the Commonwealth, States and Territories which obliges all Governments to review current legislation to assess its impact on competition and where possible reduce that impact.

The Review is being undertaken in two stages. The first involves: an extensive consultation process and the development of an issues paper which provides an overview of the operation of the Act; an overview of the residential care industry and market; and an examination of the various regulatory mechanisms which may be used to achieve the aims of the Act. Stage Two of the review will involve consideration of submissions received and the production of the Final Report of the Review, which may recommend legislative change. Further consultation will occur during this phase of the Review.

The broad aims of this Review are to determine whether the objectives of the Act remain valid; to assess whether or not the Act imposes restrictions on competition in the residential care industry and whether or not any such restrictions are to the net benefit of the NSW community; and whether the objects of the legislation can be achieved by less restrictive means including non-legislative ones. Part of this process involves determining whether the Act meets the needs of consumers, industry and government.

The fundamental questions that have been foremost in the minds of stakeholders consulted for this initial stage of the Review, and which have become the focus of this Issues Paper, are - should NSW continue to have a regulatory role in the operation of residential care facilities in NSW, and if so what should that role be?

To help answer these questions, the Issues Paper examines the current NH Act and Regulations, including the objectives that underpin the legislation, and the regulatory role of the State authorised through the legislation. It examines the context in which the Act is operating, having particular regard to competition policy reforms, and examines the current validity of those objectives and whether the Act inhibits the effective operation of the residential care market in NSW.

However, although the focus of the Issues Paper is the NSW NH Act, the future of State regulation cannot be considered in isolation from the operation and impact of the Commonwealth Government's Aged Care Act 1997. The Commonwealth Act provides the national legislative framework for Commonwealth funding of residential care services. Some of the fundamental issues that have had to be considered in terms of the future of State regulation have therefore involved an examination of how the Commonwealth Act operates and how the two pieces of legislation, and the respective roles of the Commonwealth and State, interface.

One of the key issues to emerge is that the NSW residential care market is strongly influenced by the interventions of the Commonwealth Government at policy, planning and funding levels. Essentially, the residential care market is not a perfect market ruled by supply and demand where consumers have both unfettered access and free choice of facilities. Rather, there are clear indications of "market failures" which are not the result of how the NH Act operates but which nonetheless impact on the future operation of the Act and the regulatory role of the State.

It is in this context that the Issues Paper examines a broad range of issues related to the operation of the residential care market in NSW. These include issues such as the implications of the Commonwealth's "ageing in place" policy, the rights of consumers in residential facilities, access and choice issues, complaints handling mechanisms and a range of quality related and compliance issues. The Paper asks whether there is a legitimate need for the State to have a role in some of these areas given the nature of the market on the one hand, and the overall regulatory role of the Commonwealth on the other. If the State does have a role, the Paper asks how this can be tailored to complement the role of the Commonwealth, which, as the principal funder of residential care facilities, argues that it will provide an overarching regulatory and quality framework for the industry. While there is a general preference for a single regulatory framework there is an element of concern amongst some groups that the new Commonwealth quality improvement arrangements are untested, or rely too much on self regulation and conciliation and too little on monitoring, investigation and sanctions.

The Paper notes that most other States and Territories have ceased to regulate in this area and outlines a number of alternatives to regulation of the residential care market in NSW.

This Paper does not aim to represent a final position on any issue but is intended to canvas the issues that need to be considered and discussed in order for the NSW community and policy makers to make informed decisions about the future of residential care regulation in NSW.

Submissions

All stakeholders - other government agencies, industry groups, peak bodies, consumer groups and consumers themselves - are encouraged to respond to this paper. Stakeholders are encouraged to express their views freely and openly and to raise any issues relevant to the Terms of Reference, even if they are not covered by the Paper or the questions below. These questions are drawn from the text of the Paper, and additional information on them can be found in the relevant chapter.

When framing submissions, it is important to bear in mind that the underlying premise of the Competition Principles Agreement is that regulation should only exist where the desired policy objectives cannot be achieved in any other way. Therefore when responding to the questions outlined below, submissions which support NSW retaining a regulatory function must provide evidence in support of that view and do so bearing in mind the guiding principles of the Competition Principles Agreement.

For those who need further information about the Act, copies of the Nursing Homes Act 1988 and the Nursing Homes Regulation 1996 are available from the NSW Government Information Service (02 9743 7200) and on the web site of the Australian Legal Information Institute, <http://www.austlii.edu.au>.

DISCUSSION POINTS**Discussion Point 1**

What are the objectives of the Nursing Homes Act and do they remain relevant to the NSW community?

Discussion Point 2

What evidence is there that the decisions of other States to remove state based regulation from the residential care market, in light of the Commonwealth's Aged Care reforms, has had a negative impact on consumers or providers of services?

Discussion Point 3

Is there any evidence that the rights of consumers cannot be protected and enforced through the provisions of the Commonwealth Aged Care Act and other, non-residential care specific, state legislation?

Discussion Point 4

If it is considered that consumer rights can best be protected through State legislation what amendments, consistent with the Competition Principles Agreement, are required and how will they complement the provisions of the Aged Care Act?

Discussion Point 5

Is there evidence that continued State regulation improves consumer choice and access to nursing home services?

Discussion Point 6

Is there evidence that the administration of medication by unregistered staff in residential care facilities causes harm to residents?

If so can the problem be addressed through the Commonwealth Aged Care Act or other regulatory means such as the Poisons and Therapeutic Goods Act?

Discussion Point 7

Is there a role for the State in assessing the quality of the building stock of a residential care facility? If so, can this role be adequately performed outside the context of residential care legislation (eg through the local government building approvals process)?

Discussion Point 8

Is there a role for the State in setting standards for and monitoring the quality of services and care delivered in residential care facilities?

Discussion Point 9

Is there evidence of a continued need for State residential care specific complaint mechanisms in addition to the complaint management mechanisms provided by the Commonwealth Aged Care Act and the NSW Health Care Complaints Act?

Discussion Point 10

As a result of the Commonwealth's aged care reforms is there a continued need for NSW to have a regulatory role in the residential care market?

Discussion Point 11

Which model (whether it is a model outlined in chapter 7 or another model) best achieves the objectives identified for the regulation of residential care facilities in NSW.

Submissions should demonstrate the net public benefits of the preferred option.

Submissions should be directed to:

Legal and Legislative Services – Legal Branch
NSW Department of Health
Locked Bag No. 961
NORTH SYDNEY NSW 2059.

They can also be faxed to the above at: (02) 9391 9604.

The closing date for submissions is Friday 1 September 2000. Inquiries should be directed to the Department of Health Legal Branch above, on (02) 9391 9616.

Individuals and organisations should be aware that submissions may be made publicly available under the Freedom of Information Act 1988. To facilitate the review process the Department may decide to circulate some or all submissions for further comment to other interested parties.

Any information which is considered confidential should be clearly marked.

CHAPTER 1: BACKGROUND TO THE REVIEW

1.1 INTRODUCTION

This Issues Paper is for the purpose of facilitating public consultation on the NSW Department of Health's Review of the Nursing Homes Act 1988 (NSW) (NH Act).

The Review is in part a response to the State's obligations under the Competition Principles Agreement between the Commonwealth, States and Territories which obliges all Governments to review current legislation with the aim of minimising and where possible removing any anti-competitive provisions. The scope of this Review necessarily must consider the impact of the Commonwealth Aged Care Reform process, which also effects the future operation and regulation of residential aged care services in NSW. One of the key aims of the Review is to determine whether in fact the NSW Act is required at all or whether it requires amendment to better meet the needs of Government, the community, industry and consumers in NSW.

The Terms of Reference for the Review are attached at **Appendix A**.

Throughout this paper the term *nursing home* will be used to describe facilities that provide extended care to a wide range of people including the aged; those convalescing following illness, surgery or giving birth; physically disabled people; and people with certain mental illnesses such as dementia. The paper does not focus solely on aged care and the needs of younger residents of nursing homes must be kept in mind in considering the issues that arise for discussion.

1.2 CONTEXT FOR THE REVIEW

1.2.1 Introduction

Following the report of the National Competition Policy Review Committee (the Hilmer Report) the Council of Australian Governments (COAG) endorsed the Competition Principles Agreement which commits all Australian governments to reviewing legislation with the aim of minimising or removing restraints on competition.

1.2.2 Competition Principles Agreement

The review of anti-competitive legislation under the Agreement is aimed at removing unnecessary, cumbersome and costly impediments to conducting business in Australia. The guiding principle of the Agreement is that legislation should not restrict competition unless it can be demonstrated that the benefits to the community as a whole outweigh the costs of restricting competition, and that the objectives of the legislation can only be achieved by restricting competition.

Regulatory initiatives designed to promote the public good may have adverse consequences because they restrict competition. For example, a licensing system may restrict the number of people that can engage in a specific activity by ensuring that only those that hold certain qualifications provide services. In many cases this will be an effective means of protecting consumers from harm. However, restricting the number of people providing services may lead to a reduction in competition with a decline in standards and higher prices for services. It is also possible that regulation may stifle innovation, promote conformity within an industry and encourage maintenance of oligopolies.

However, it must be emphasised that the Agreement recognises that not all legislation which restricts competition will be contrary to the public interest. In many cases it may be necessary to restrict competitive conduct to protect the community, or vulnerable sections of the community, from harm. It is the NSW Government's policy to ensure that review processes take into account the full range of public benefits, including limiting risks to public health and safety, improved information for consumers and protection of consumers from unscrupulous or substandard service providers.

1.2.3 Principles for Best Practice Legislative Review

Legislation should only be used where policy aims cannot be addressed in less regulatory and restrictive ways. Even where legislative intervention is directed at addressing problems that are not a consequence of market failures, it is still necessary to properly assess the reasons for that intervention, and the likely impacts.

To determine what is the most appropriate legislative strategy for any problem, consideration must be given to a wide range of factors to effectively respond to the identified problem. These factors include:

- The objectives of legislative intervention should be clearly specified, and outcome based as far as possible.
- Regulatory intervention through legislation and regulation needs to be appropriately assessed to ensure that it is directed towards correcting real and significant problems in an unregulated environment.
- The effectiveness of existing measures, including non-regulatory and legislative strategies (including general legislation such as fair trading requirements), need to be considered.
- Legislative strategies need to be assessed to ensure that they are appropriate and effective in achieving the objectives of the intervention. This should include an assessment of costs and benefits of the regulatory approach and, in the case of intervention that will impact on a competitive market, an assessment of the impact on competition. Similarly, the impacts on the rights of individuals need to be considered.
- A full assessment should be made of all regulatory options for intervention, including legislative and non-legislative options.

Other factors that should be considered in developing regulatory strategies include: the diversity of the practice, behaviours and commercial activities to be regulated in any situation; the need for transparency and consistency in decision making by those administering the strategies; the need for flexibility so that systems can respond to unforeseen developments and evolving practice and community values; and the response (or penalty) should be commensurate with the materiality of the risk to people or the environment that non-compliance generates.

1.2.4 Identification of Public Benefit Issues

Legislative intervention to achieve public benefit goals will often occur because problems have been identified and failure to address these problems could result in undesirable outcomes for society as a whole. As noted above, legislation will often be directed at protecting the public from harm that may arise in an unregulated market for goods and services. Some examples of where public benefit issues might arise include:

- **Information problems:** Consumers may not have sufficient information, experience or ability to make informed decisions when seeking goods or services. The inability to make informed decisions could lead to physical or financial injury or harm because an unsafe or inappropriate product or service is used. In other cases, the consumer could incur unreasonably high costs in seeking a service provider appropriate for their needs.
- **Impact on third parties or the public generally:** The provision of goods or services may result in a third party incurring costs. For example injuries to a consumer caused by substandard or unsafe products or services may impose costs on the state or other individuals or businesses in providing the injured person with additional welfare or support. This could also have an unintended impact on other carers or family members of the person.

There is a range of other public benefit issues that might arise in circumstances that do not involve the provision of goods and services. These are too extensive to list here but could include:

- individual conduct may expose others to the risk of injury or harm; and
- Government may not be able to obtain sufficient information to assist it in discharging functions or providing services that the public reasonably expects it to provide in an effective manner.

The Competition Principles Agreement explicitly provides for public interest issues to be considered in the review of legislation. To this end the Agreement provides:

- (3) *Without limiting the matters to be taken into account, where this Agreement calls;*
- (a) *for the benefits of a particular policy or course of action to be balanced against the costs of the policy or course of action; or*
 - (b) *for the merits or appropriateness of a particular policy or course of action to be determined; or*
 - (c) *for an assessment of the most effective means of achieving a policy objective;*
- the following matters shall, where relevant, be taken into account:*
- (d) *government legislation and policies relating to ecologically sustainable development;*
 - (e) *social welfare and equity considerations, including community service obligations;*
 - (f) *government legislation and policies relating to matters such as occupational health and safety, industrial relations and access and equity;*
 - (g) *economic and regional development, including employment and investment growth;*
 - (h) *the interests of consumers generally or a class of consumers*
 - (i) *the competitiveness of Australian businesses; and*
 - (j) *the efficient allocation of resources.*

In assessing the need for legislative intervention, it is essential that the problems or rationale for that intervention is clearly identified.

1.2.5 Overview of Regulatory Models

To prevent over-regulation but to ensure the public interest is properly protected a full assessment of appropriate options needs to be made to ensure that any regulatory response is targeted, effective and

measured. It is appropriate to consider both regulatory and non-regulatory options in order to determine the best means of meeting stated goals.

Non-regulatory strategies

The following are some examples of non-regulatory mechanisms that may be used instead of, or in conjunction with, regulatory action.

- **Information campaigns:** Public benefit goals can be achieved using information campaigns or strategies to help inform consumers about options available to them in any given situation or to encourage consumers or the market to operate in a desired way.
- **Provision of information by organisations:** Government can encourage activities by organisations, such as industry associations or community organisations, which focus on providing consumers or individuals with material to assist them to make informed choices.
- **Financial incentives:** Rather than directing individuals, businesses or organisations to take certain measures or comply with standards, an alternative option is to provide financial incentives to encourage such groups to undertake certain steps. The new Commonwealth accreditation requirements for residential aged care facilities are an example of this.
- **Reliance on controls in existing legislation:** Existing legislation can be effective in achieving public benefit goals. In the case of the residential care market this could include reliance on the Commonwealth Aged Care Act and existing state legislation such as the Poisons and Therapeutic Goods Act.
- **Voluntary codes of practice, guidelines and certification:** Rather than requiring that certain standards be met by organisations or business, Government can provide assistance to encourage such organisations to develop and meet standards without legislation, eg through accreditation, certification or benchmarking exercises.
- **Litigation:** In many cases, litigation and its potential financial consequences may be an effective means to prevent people from exposing others to the risk of injury or harm. Government intervention to improve access to such remedies, such as the establishment of advocacy services, facilitation of class actions or broadening standing requirements so that organisations can sue on behalf of individuals may be an effective means of securing public benefit objectives. Equally, there are circumstances where litigation may be an inefficient, costly and ineffective means of achieving these goals.

Regulatory intervention

There are numerous options for regulatory intervention and these are broadly outlined below. It is important to remember that where regulation is utilised the preference is always for the lowest level of intervention required to achieve the stated aims.

- **Mandatory information disclosure to the public:** Requiring service providers to publish information can be an effective means of assisting the public to avoid products that may cause injury or harm or promote awareness of their rights. Examples are requirements to provide people seeking access to residential care with information about the quality of services; to disclose any

interest their medical practitioner may have in the facility; and information about the complaints policy of the organisation.

- ***Information disclosure to government:*** Disclosure of information by service providers may be of little assistance because consumers may lack the skills, knowledge and experience to interpret that information. One regulatory option is to require businesses or organisations to provide certain information to the Government which can then decide whether or not to issue a warning or other information to the public.
- ***General prohibitions on conduct:*** Legislative objectives can be achieved through a prohibition on certain specified conduct. For example nursing homes are prohibited from accommodating more residents than they are licensed for.
- ***Legislative standards:*** The most common form of legislative intervention in response to public benefit issues is the setting of legislative standards that must be complied with. Failure to comply with the standards can result in imposition of a penalty or revocation of a license. Under the current NH Act and Regulations, this approach is used in a number of areas, for example to require nursing homes to have a registered nurse on duty at all times and for there to be a 'Chief Nurse' or Director of Nursing in each nursing home.
- ***Performance based regulation:*** Rather than specifying the manner in which services or businesses are meant to achieve a certain goal or outcome, for example by mandating the process to be used, legislation may set targets or 'performance standards' to be met. The regulatory system is focussed on the end to be achieved, rather than the means. Setting statutory 'outcome standards' such as those in the Commonwealth Aged Care Act is an example of this approach.
- ***Voluntary certification:*** Rather than specifying that all suppliers or service providers must meet certain standards, legislation would establish a system for certifying those that elect to meet the standards. While others can continue to provide the service, those that elect to be certified gain the right to use a specific title or accreditation symbol.
- ***Third party certification:*** Rather than relying on Government to certify that a product meets certain standards, legislation can provide that third parties may conduct the necessary inspections and issue a certificate specifying that the product or service complies. Again, this can be structured so that those that elect to be certified gain the right to use a specific title or accreditation symbol. Accreditation by the Australian Council of Health Care Standards is an example of this.
- ***Negative licensing:*** Under this system, operators are required to meet certain legislative standards. Although no pre-approval is required before operation, where they fail to meet the standards they can be prohibited from engaging in the activity, either permanently or until they meet certain conditions, which may include third party certification.
- ***Registration:*** The requirement to meet certain standards can be supplemented by a requirement that all those wishing to provide the service or product must be registered. Although registrants may not be required to establish that they can meet certain requirements before being registered,

where they fail to meet the standards their registration can be cancelled and they are prevented from providing the service.

- **Activity or business licensing:** This is generally considered the most restrictive form of regulation. Those wishing to provide a service must demonstrate to the relevant Government agency that they are capable of meeting the legislative standards. This is generally done by specifying that only certain people may apply, by requiring detailed inspections, or by requiring that certain equipment be used. A variant of this approach would involve recognition of membership of a professional association or standards organisation.
- **Approval processes:** Products or plans are required to be submitted to a Government agency for formal approval before they may be used or marketed.
- **Self-certification and auditing:** Under this arrangement, service providers would certify that their goods or services meet certain standards and provide certain information to Government agencies. The Government agency would then audit this information in appropriate cases to ensure that standards are being complied with.
- **Market based regulation -** Market orientated regulatory strategies place responsibility for the maintenance of standards with those making commercial decisions but establish a proper “market” in which this can occur. It may for example, overcome an information imbalance between buyers and sellers of services, so that a market can operate more effectively, with the aim of promoting cost-effective strategies, creating flexibility and the opportunity for innovation.

1.3 THIS REVIEW

The NH Act provides the basis for State regulation of nursing home services in NSW. The aim of the Act is to ‘prescribe standards’ that relate to the safety, care or quality of life of nursing home residents and thereby protect a section of the community which is amongst the most vulnerable. The Act:

- provides that nursing home owners must be licensed to operate in NSW;
- allows for the specification of standards for the design and construction of premises used as nursing homes, although no such standards are currently specified;
- specifies a range of facilities and equipment which must be available in nursing homes;
- sets some minimum staffing standards;
- sets operational standards including administrative, health care, privacy, safety, hygiene and other support services; and
- sets standards for the content of medical records, confidentiality and residents’ access to their records.

However the environment in which the NH Act operates has changed significantly since its commencement. Not only has there been an increase in demand due to the aging of the NSW population, but there has also been a range of broader structural changes and reforms initiated at the Commonwealth level which have had a significant impact on the environment in which the legislation operates.

The broad aims of the Review first and foremost, are to assess whether or not the objectives of the Act remain valid; to determine whether the Act imposes limitations on competition in the nursing home industry and whether or not any such restrictions are to the net benefit of the NSW community; and to assess whether legislation is the best way of achieving the objects of the legislation. Part of this assessment requires an examination of the nature and impact of the broader environmental changes and to determine whether the Act continues to meet the needs of consumers, industry and government in this context.

The Review is being undertaken in two stages. The first stage involves consultation with key stakeholders and the development of this Issues Paper that provides an overview of the operation of the Act, an overview of the industry and market and examines the various regulatory mechanisms which may be used to achieve the aims of the Act. Enduring Solutions Pty Ltd was engaged to assist in the first stage of the review. This consultancy involved extensive consultation with stakeholders, and research and development which formed the basis of this Issues Paper. The aim of the Issues Paper is to identify and open up for public comment those matters which are of interest to the public generally and stakeholders in particular and to pose questions in a manner which encourages people to respond and put their views to the Department.

Copies of the Nursing Homes Act 1988 and the Nursing Homes Regulation 1996 are available from the NSW Government Information Service (tel: (02) 9743 7200) and on the Internet site of the Australian Legal Information Institute (www.austlii.edu.au).

CHAPTER 2: THE NSW NURSING HOMES ACT 1988 – LEGISLATION AND REGULATIONS

2.1 INTRODUCTION

People with disabilities and frail aged people who are unable to live in their own homes or with their families with community-based assistance need somewhere to live. The residential services for these people include hostel accommodation for people with relatively low level care needs and nursing home accommodation for those who require higher level assistance. With the “aging in place” strategy introduced by the Commonwealth Aged Care Reform process (discussed in Chapter 3), the boundaries between these two types of accommodation are becoming increasingly blurred and the notion of a nursing home in the traditional sense is being lost.

All private sector nursing homes in NSW are licensed under the NH Act. Hostels are not included in the coverage of this Act unless they are providing nursing care. Most, but not all, private for profit nursing homes, private not-for-profit nursing homes and public sector nursing homes and hostels also operate under the Commonwealth Aged Care Act (the Commonwealth Act), so that they can receive Commonwealth accommodation and care subsidies.

There are also a number of other State Acts dealing with different accommodation arrangements, some of which are available to older people only, such as retirement villages covered by the Retirement Villages Act 1989 and the Retirement Village Industry Code of Practice Regulation under the Fair Trading Act 1987. Some of these also cover accommodation for others in need, such as boarding houses and specialised facilities for people with disabilities, which can be regulated under the Youth and Community Services Act 1973.

While all of these arrangements set the context for residential care in NSW, the focus of this Chapter is specifically on nursing homes and the regulatory framework that they are subject to in NSW, ie the Nursing Homes Act 1988 and the Nursing Homes Regulation 1996. The paper describes the legislative arrangements that are currently in place in NSW in order to examine the objectives of the legislation and to consider the validity of these objectives in the context of the Competition Principles Agreement requirements.

Throughout the Paper a number of other Acts that are directly relevant to the operation of the NH Act will be considered. These include for example the Health Care Complaints Act 1993 and the Poisons and Therapeutic Goods Act 1966.

2.2 THE MARKET FOR RESIDENTIAL CARE SERVICES

2.2.1 Features of the Market

In a perfect market people who wish to purchase particular services can choose the service provider they believe provides best for their needs at the best price. Theoretically, this ensures optimal quality of service at the lowest price. Buyers are free to move to a different seller if quality declines, and buyers pay the market price of the service. In a perfect market there are no barriers to entry and where there is a sufficient level of unmet demand service providers will enter the market to satisfy that demand.

By contrast the residential care market is characterised by restrictions on both the demand and supply sides. On the supply side nursing homes must be licensed in NSW and, in order to attract Commonwealth subsidies, must be accredited by the Commonwealth Government. On the demand side government policy of paying subsidies to service operators rather than consumers may have the effect of reducing demand. Furthermore social policies that aim to assist people to live in their own homes and communities for as long as possible also affect demand. In addition to these up front competitive restrictions residents are not readily able to transfer between facilities both because of entry requirements and because of the social and practical difficulties of “moving house” which increase for many people as they get older. Some of these issues are discussed in more detail later in the Paper.

The NSW nursing home industry is described in some detail in **Appendix B**. In Chapter 3, the Commonwealth’s national role is discussed. State governments stand in an interesting position in relation to the residential care market, in that they fund only a minor share of nursing home or hostel accommodation. Funding for such accommodation, and the services provided in these facilities, comes from a combination of Commonwealth and service user funding, except in the case of the relatively small number of beds where the State Government, as service provider, provides some funding.

2.2.2 Impact of Market Features on Service Users and Service Providers

The consultation undertaken to date reveals there are two distinct perspectives on competition and regulation issues for residential care services in NSW. The first is the perspective of the industry and service providers. The other is the perspective of consumers of services and of the community generally.

A key issue for the industry and service providers is the extent to which State nursing home licensing requirements effectively restrict the operation of the residential care market in NSW. There is concern that the market is unnecessarily affected by a range of restrictions imposed by licensing arrangements such as the requirement to satisfy specific entry criteria, the cost of ongoing compliance with the Act and regulations, such as staffing requirements. There is also concern that current licensing arrangements do not recognise hostels, which under Commonwealth funding arrangements can now provide care to residents with both high and low level care needs.

The issues for consumers are broader. Consumer concerns focus on the way the market is structured and how this affects competition, access to services, the quality of services and consumer choice. There are a number of structural issues that concern consumers. These include the tight control of supply of residential places, the disparity between supply and demand for residential care places, the price of a residential place (often in excess of \$30,000) and the high occupancy rates in facilities.

2.3 OUTLINE OF THE NURSING HOMES ACT AND REGULATION

2.3.1 Objectives of the Legislation

The Act does not include an objects clause. However, the key purpose of the legislation can be gleaned from its structure and the contents of its regulations - the regulation of private sector nursing homes, presumably for the protection of those people resident in them, to ensure that they are provided with a safe and comfortable environment and quality services, which meet their needs. In

one sense, the legislative framework reflects the original focus of residential care policy on the “bricks and mortar” of accommodation rather than focussing on the consumer of the services.

This is supported by the second reading speech of the Minister for Health when introducing the legislation with a package of health care institution related Bills in 1988. That speech set out the then Government’s intention for the legislation in the following manner :

... this proposed legislation has four main objectives. The principal objective is the strengthening of standards to ensure patient care and safety; the second objective is the reduction of economic regulation of the private health sector; third, the elimination of arbitrary and trivial bureaucratic interference; and fourth, the provision of a sound legislative base for day procedure centres for the first time.¹

While some of these objectives are clearly related to the other pieces of legislation introduced at the same time, this summary provides a useful insight into the intentions of the Government of the day, particularly in the context of this Review, where the first two objectives are central issues.

2.3.2 Coverage

Section 3 of the NH Act contains the relevant definitions. “Nursing home” is defined to mean:

“premises at which residents are provided with nursing care for fee, gain or reward, being residents:

- (a) who are recuperating from illness or childbirth and who require nursing care; or
- (b) who require nursing care on account of age, infirmity, chronic ill-health or other condition”.^{2,3}

The Act excludes from its purview State run institutions, as well as public hospitals or health services provided by a public health organisation under the Health Services Act 1997, and private hospitals and day procedure centres covered by the Private Hospitals and Day Procedure Centres Act 1988. More importantly the Nursing Homes Act does not cover hostels providing residential care services in NSW. This is a significant issue given the adoption of the “aging in place” philosophy and the Commonwealth’s removal of the distinction between nursing homes and hostels for the purposes of accreditation and funding. Aging in place and the implications for hostel care are discussed in more detail in chapters 3 and 4.

2.3.3 Licensing of Nursing Homes

The NH Act provides a licensing regime for the operation of non-government nursing home facilities with annual licence fees, which are set by regulation. Current licence fees range from \$1,115 where the institution has fewer than 40 residents to \$4,210 where there are 100 or more residents.

¹ NSW Legislative Assembly. *Hansard 29 November 1988*: page 2818 per minister for Health and Minister for Arts, Mr Collins.

² The definition is built on by section 33, which deals with an offence relating to unlicensed nursing homes. It allows a nursing home to be imputed, even where no fee was charged for the nursing care in certain circumstances.

³ This issue needs to be further explored outside the aged care context as clearly the legislation is not only targeted at aged care.

The NH Act provides review and appeal mechanisms for licensing decisions. Section 24 allows the Minister for Health to appoint a person to be Chairperson of Committees of Review. Section 26 requires that a Committee of Review consists of 4 people - the Chairperson of the Committees of Review and 3 other people appointed by the Chairperson. These are to represent the interests of the nursing home industry, health care professions and consumers respectively, but they must have no pecuniary interest in the matter being reviewed. The Committee of Review examines the licensing decision and then makes a written report to the Minister, making recommendations and providing reasons for that recommendation. The Minister can then make a decision having regard to the finding of the committee and any other investigation that the Minister has initiated.

Section 30 states that licences may only be cancelled without notice either on the request of the licensee, where the premises have ceased to be a nursing home or where licence was only a temporary one. Section 31 provides for cancellation of a licence with notice in a range of circumstances, ranging from the failure to pay the annual licence fee, the conviction of the licensee of certain criminal offences, the insolvency of the licensee, and the failure to comply with reasonable standards. There is also a provision, which allows cancellation where the nursing home is conducted in such a manner that the cancellation of the licence is “in the public interest”. The cancellation of licence process in section 31 is subject to the general rules of natural justice relating to the provision of reasons and an opportunity to respond. There is a right of appeal to the District Court for cancellations under section 31.

2.3.4 Conduct of Nursing Homes

The legislation includes a range of provisions about the operation of nursing homes including how and by whom they may be operated, as well as setting out a range of offences. For example, section 33 makes it an offence for unlicensed premises to be used as a nursing home. Section 36 makes it an offence to overcrowd a licensed nursing home. There is also a range of provisions relating to staffing. For example, section 37 requires that there be a “Chief Nurse” responsible for the care of residents and this person must be a registered nurse with certain additional qualifications set out in the Regulations (see clause 11). Section 39 requires that a registered nurse be on duty at all times in a nursing home.

2.3.5 Miscellaneous Provisions

Section 43 requires a medical practitioner to notify a person of any pecuniary interest he/she has in a nursing home, before advising or arranging the person’s admission or treating the person at a facility. “Pecuniary interest” is given a wide meaning under the regulations (see clause 14). The means of making this disclosure are set out in the regulations (see clause 15) - the person must be told, notified in writing and written notice of the interest must be displayed at the premises.

Section 44 provides authorised persons with powers of entry and inspection of any premises that are licensed as a nursing home or where a licence has been sought. Section 45 gives a similar power to inspect registers and records and to take copies of these. Section 46 makes it an offence to obstruct officers performing duties under the Act.

Section 50 sets out the application of offence provisions in the case of a corporation - it allows action to be taken against individual directors.

2.3.6 Nursing Homes Regulation 1996

In addition to those provision discussed above, the Regulations include as Schedule 1, a set of licensing standards, which are central to the operation of the Act and its purpose of protecting the “safety, care and quality of life” of residents of nursing homes. These are set out in parts to reflect the responsibilities set out in section 4 of the Act.

Schedule 1 Part 1 deals very briefly with only two elements to do with the design and construction of premises: that is ambulance access, and a requirement to notify the Director-General of Health of any orders made under section 124 of the Local Government Act 1993. This includes orders in relation to compliance of the premises with that Act and other public health requirements as listed in that section.

Schedule 1 Part 2 covers in some detail the facilities and equipment required to be provided by a nursing home. It covers furnishings; hot-water supply; bedding and bedroom furniture; furnishings and equipment of other rooms, such as the lounge, dining and activities rooms; equipment in the kitchen and servery; medical and nursing equipment; various safety requirements; and the maintenance of all of these.

Schedule 1 Part 3 covers staffing, including a requirement for sufficient staff to provide all the services required, be they nursing, personal care, cleaning or food provision. There is a provision, which gives some guidance on how sufficiency will be judged, but this provision is treated as obsolete operationally as the Commonwealth principles referred to in the provisions no longer exist (see clause 15(2)).

Schedule 1 Part 4 deals with important operational matters, including quality assurance, the provision of health care services to residents and safety issues, including fire safety, infection control and hygiene issues. Administrative issues relating to admission and separation of residents and security of accommodation are also included.

Part 4 (clauses 19-23) also deals with what could broadly be called the “human rights of residents”. There are obligations relating to the fostering of social independence through visiting and personal contact, freedom of movement within and outside the nursing home (restricted only for safety reasons) and through support for religious, cultural and citizen-related roles. A licensee must have written policies, which are developed in consultation with residents, about the freedom of choice of residents in relation to daily activities. There is an obligation on the licensee to ensure that residents are given the opportunity to complain or comment about conditions in the nursing home. The licensee is to provide as home like an environment as is possible, with residents feeling secure in their accommodation. The privacy and dignity of residents is to be respected by staff. There is specific reference to practices at the nursing home supporting “the right of residents to die with dignity”.

There is also a range of provisions covering the identification of residents, measures to assist in their cleanliness and comfort, smoking policies, telephone availability, visiting hours, night time care and overcrowding. Issues to do with food preparation and service are covered, as are the times when meals should be served. There are requirements to report injuries, transfers and deaths of residents in appropriate ways.

The administration of medications and supply of non-prescription drugs are covered in clauses 43-45. Administration of drugs is limited to a number of qualified health professionals and people operating under the authority of the chief nurse, except where otherwise limited by the Poisons and Therapeutic Goods Act.

Schedule 1 Part 5 covers the maintenance and contents of clinical records in relation to residents, as well as residents rights of access to their own records. A resident may seek to look at the record or obtain a copy, subject to a fee. Access can be refused if the medical practitioner in charge of the resident's care advises it should be and the licensee is satisfied that access by the resident or the resident's representative would be prejudicial to the resident's physical or mental health. Where access is refused, the licensee must provide reasons for refusal and an appeal lies to the Director-General of Health from that decision. Clause 52 sets out the confidentiality of resident's personal information.

Discussion Point 1

What are the objectives of the Nursing Homes Act and do they remain relevant to the NSW community?

CHAPTER 3: THE COMMONWEALTH CONTEXT: THE AGED CARE ACT

3.1 INTRODUCTION

The environment in which the NH Act operates has changed significantly since its commencement in 1988. While this partly reflects a changing social context, other forces have also been at work. Advances in technology, changes in the community and community expectations, demographic shifts and changes in the way services have been funded have had a significant impact on how services to nursing home residents are being delivered. Some of the more significant of these changes include:

- the shift from institutional models of care for people with disabilities and frail aged people to expectations that these people should live in the community;
- the ageing of the population;
- advances in technology and changing hospital early discharge policies;
- changes to the provision of residential care services;
- a focus on consumers - meeting their needs and recognising their rights; and
- the shift to the purchaser/provider model for delivering services and to the practice of competitive tendering.

One of the single biggest ‘drivers’ of change in the residential care area has been the Commonwealth Government’s Aged Care Reform process. The changes brought about by this process have significant implications for the operation of residential care services for older people, who comprise the vast majority of nursing home residents in NSW, and therefore for all users of nursing homes in NSW. This Chapter describes these changes and the Commonwealth legislative arrangements that have brought them about.

3.2 THE COMMONWEALTH AGED CARE ACT 1997

The Commonwealth’s Aged Care Act 1997 (Commonwealth Act) commenced operation on 1 October 1997. This legislation replaced the National Health Act 1953 and the Aged or Disabled Persons Care Act 1954. The Aged Care Act signalled significant reform to the way residential services are delivered to older Australians and the standards and quality of care that consumers can expect from services. On the introduction of the legislation to the Commonwealth House of Representatives, the then Minister for Family Services, the Hon. Judi Moylan, said in her second reading speech, that the legislation had both social and financial objectives. The reforms heralded:

“ . . . a new era in the provision of residential aged care in this country, based on dignity, comfort and security for all.”⁴

This important social objective was part of a package which was designed to address the potential burgeoning costs of residential aged care services where the over 65 group was expected to exceed 5 million people within 30 years.

⁴ House of Representatives Hansard 26 March 1997 page 3193

It also clarifies that for those permanently entering residential care this is their new home. As is the case in society more broadly, there is an expectation that those who have an ability to provide for their accommodation costs should do so.

3.2.1 The Objectives of the Commonwealth Legislation

The objects of the Commonwealth Act are set out in Division 2 which describes a set of philosophical aims, with some practical, financial balances included to recognise the interests of the Commonwealth as funding provider. The objects of the Act as set out in section 2-1 of the Act are:

- (a) to provide for funding of aged care that takes account of:
 - (i) the quality of the care; and
 - (ii) the type of care and level of care provided; and
 - (iii) the need to ensure access to care that is affordable by, and appropriate to the needs of, people who require it; and
 - (iv) appropriate outcomes for recipients of the care; and
 - (v) accountability of the providers of the care for the funding and for the outcomes for recipients;
 - (b) to promote a high quality of care and accommodation for the recipients of aged care services that meets the needs of individuals;
 - (c) to protect the health and well-being of the recipients of aged care services;
 - (d) to ensure that aged care services are targeted towards the people with the greatest needs for those services;
 - (e) to facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location;
 - (f) to provide respite for families, and others, who care for older people;
 - (g) to encourage diverse, flexible and responsive aged care services that:
 - (i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and
 - (ii) facilitate the independence of, and choice available to, those recipients and carers;
 - (h) to help those recipients to enjoy the same rights as all other people in Australia;
 - (i) to plan effectively for the delivery of aged care services that:
 - (i) promote the targeting of services to areas of the greatest need and people with the greatest need; and
 - (ii) avoid duplication of those services; and
 - (iii) improve the integration of the planning and delivery of aged care services with the planning and delivery of related health and community services;
 - (j) to promote ageing in place through the linking of care and support services to the places where older people prefer to live.
- (2) In construing the objects, due regard must be had to:
- (a) the limited resources available to support services and programs under this Act; and
 - (b) the need to consider equity and merit in accessing those resources.

These objectives are translated into the following broad principles in the Residential Care Manual, which provides that the intentions of the legislation are to:

- promote a high quality of care and accommodation and protect the health and well-being of residents;

- help residents enjoy the same rights as all other people in Australia;
- ensure that care is accessible and affordable for all residents;
- plan effectively for the delivery of aged care services and ensure that aged care services and funding are targeted towards people and areas with greatest needs;
- encourage services that are diverse, flexible and responsive to individual needs;
- provide funding that takes account of the quality, type and level of care;
- provide respite for families, and others, who care for older people; and
- promote ‘ageing in place’ through the linking of care and support services to the places where older people prefer to live⁵.

3.2.2 Structure of the Legislation

The aged care reforms are implemented by a comprehensive piece of legislation and set of principles, which have statutory force and operate like regulations. Much of the detail is included in the principles.

Chapter 1 Division 3 contains an overview of the Act. In section 3-1, it states that:

This Act provides for the Commonwealth to give financial support:

(a) through payment of subsidies for the provision of aged care; and

(b) through payment of grants for other matters connected with the provision of aged care.

Subsidies are paid under Chapter 3 (but Chapters 2 and 4 are also relevant to subsidies), and grants are paid under Chapter 5.

In the Act’s dictionary, “aged care” is defined as residential care, community care or flexible care, with an “aged care service” being any undertaking providing these services. Residential care is defined in the following manner in Paragraph 41-3:

(1) **Residential care** is personal care or nursing care, or both personal care and nursing care, that:

(a) is provided to a person in a residential facility in which the person is also provided with accommodation that includes:

(i) appropriate staffing to meet the nursing and personal care needs of the person; and

(ii) meals and cleaning services; and

(iii) furnishings, furniture and equipment for the provision of that care and accommodation; and

(b) meets any other requirements specified in the Residential Care Subsidy Principles.

Perhaps the most important Chapter of the legislation for the purposes of this paper is Chapter 4, which covers the responsibilities of approved providers in the areas of quality of care (Part 4.1); user rights for the people to whom they provide care (Part 4.2); and accountability for the care that is provided (Part 4.3). The importance of these responsibilities is stressed early in the Act in Paragraph 3.4, which states that:

⁵ Commonwealth Department of Health and Aged Care. Residential Care Manual. 1997. Last updated April 1998. Aged and Community Care Division. Chapter One. The resource can be located at <http://www.health.gov.au/acc/manuals/rcm/>

Failure to meet these responsibilities can lead to the imposition of sanctions that affect the status of approvals and similar decisions under Chapter 2 (and therefore may affect amounts of subsidy payable to an approved provider).

These parts are discussed in more detail in the relevant chapters later in this Paper, as are some of the administrative provisions in Chapter 4.

3.3 NATURE AND SCOPE OF AGED CARE REFORMS

Essentially, the reform program is based on the alignment of the previous hostel and nursing home programs and introduces new funding, new user charging and accountability arrangements across Commonwealth funded residential care services. Major elements of the reform are listed below but are also discussed in more detail throughout the Paper, particularly in terms of how they intersect with regulatory arrangements in NSW.

3.3.1 A uniform approach to the funding and operation of hostels and nursing homes

The key philosophy that underpins the Aged Care Reform process is ageing in place. Unlike the previous separation between nursing homes and hostels which required people to physically move accommodation depending on their care needs, ageing in place gives facilities the flexibility to offer a range of different services and allows residents to remain in the same ‘place’ even though their care needs change. Former hostels can provide care to residents as they become more dependent without having to discharge them to a nursing home. Former nursing homes can accommodate people with low care needs and charge bonds. Unlike former arrangements, couples with different levels of care needs can be cared for in the same facility.

Ageing in place recognises the importance of stable, homely and familiar environments, particularly as people get older and as far as possible, focuses on residents enjoying a ‘home like’ rather than a hospital type environment. While the “homelike” environment is also an important issue in the NH Act, the current legislative separation between nursing homes and hostel facilities in NSW limits the capacity to implement this theory as a person’s care needs change.

3.3.2 A new funding framework

Linked to removing the distinction between hostels and nursing homes, is the introduction of a single funding and classification instrument designed to distribute funding equitably across the aged care sector.

The key element of the funding structure is the Residential Classification Scale (RCS) which aims to match funding to the care needs of residents, irrespective of where they are located in a hostel or nursing home. A key feature of the RCS is that it is designed to recognise the costs of caring for people with dementia and, as mentioned above, to remove the differential funding system, which prevents ‘ageing in place’.

3.3.3 A new user charging framework

A system of daily care fees and income tested fees has been introduced so that all residents make a contribution towards the costs of their care. The level of contribution is determined by what individual residents can afford and the additional funding raised to offset Government subsidies.

All facilities which meet the appropriate standards in quality and care are able to seek a capital contribution from those residents who can afford to make one. Previously this capacity only existed in hostels. Under the new arrangements, there are two types of accommodation payments:

- accommodation bonds; and
- accommodation charges.

People who require hostel type care can be asked to pay an accommodation bond and people who require nursing home type care can be asked to pay a capped daily accommodation charge.

3.3.4 A new accountability framework

The Commonwealth Act establishes the Aged Care Standards and Accreditation Agency which has responsibility for:

- managing accreditation for all Commonwealth funded residential aged care services;
- monitoring standards of care for services which have not yet been accredited;
- liaising with the Commonwealth Department of Health and Family Services about services which present a serious risk to residents' wellbeing and safety;
- promoting best practice within the care industry;
- encouraging overall improvement in the quality of care being provided; and
- education and training.

The aim of the Agency is that all residential care services across Australia will be accredited by 1 January 2001.

3.4 THE TWO YEAR REVIEW – PROGRESS SO FAR

An initial Review of the new arrangements is already under way. The aim of the Government's Two Year Review of Aged Care Reforms is to evaluate:

- the impact of the reforms on the aged care system;
- their success in overcoming acknowledged deficiencies in the aged care system; and
- the extent to which the objectives of the reforms, and the Aged Care Act 1997, are being achieved⁶.

The Review commenced in 1998 and will extend over a two year period, reporting to the Government every six months. The focus of the analysis will be on eight areas related to the aged care system including access, affordability, quality, efficiency and industry viability.

The results from the early stages of the Review indicate that most participants think that the reform process has been necessary and they are very supportive of particular principles underlying the changes such as ageing in place, resident contributions and quality and continuous improvement. This was particularly evident amongst industry participants. However, concern has also been raised about elements of the reform process and its implementation, including the pace of change.

⁶ Gray, Len. *Two Year Review of Aged Care Reforms. Report of the First Six Months*. Produced by Professor Len Gray. January 1999. Professor Gray's Report informed the content of this section of the Paper.

Some of the key findings to emerge from community consultations so far include:

- improved access to services for some groups including people with dementia and people who are financially disadvantaged;
- the need for consumers to have access to information about the range of services available and their costs;
- support for certification and accreditation, which are seen as mechanisms to force poor performers out of the residential care industry;
- concern about the potential dislocation of residents who may be affected by poor providers leaving the market and the need for this to be carefully considered in advance; and
- a view that state or local governments should no longer have any role in residential care and that their inspectorial functions such as in the areas of nursing home licensing, food services, occupational health and safety and fire regulations should be removed.

Issues for the NH Act which arise from this reform process are discussed generally in the following chapters.

CHAPTER 4: THE INTERACTION BETWEEN STATE AND COMMONWEALTH REGULATORY ARRANGEMENTS

4.1 INTRODUCTION

The introduction of the Commonwealth Aged Care Act 1997 and the obligations for legislative review under the Competition Principles Agreement bring into sharp focus the relevance, appropriateness and effectiveness of State based regulation in the area of residential care services. This Chapter examines how the Commonwealth and State regulatory regimes interface with each other and identifies the key issues that are currently or will potentially, impact on the operation of the residential care system in NSW.

4.2 THE ROLE AND FUNCTIONS OF THE COMMONWEALTH

4.2.1 Commonwealth Objectives

The Commonwealth government has put in place a flexible residential care system which aims to meet the needs of older people in the most appropriate setting. The aims of the Commonwealth are inherent in the overall principles that underpin the Aged Care Act. These were briefly outlined in Chapter 3 of this Paper.

To help achieve these objectives, the Commonwealth accepts responsibility for the subsidisation of residential aged care in both nursing home and hostel services. It is estimated that Commonwealth subsidies translate to an average of about \$30,000 per year per resident and for residents with the highest levels of needs, about \$40,000 per year. Residents contribute about \$9,000 to \$10,000 each per year. For many, this comes directly from their pension income but more and more, residents are being asked to make additional contributions from their own resources, where these exist. Table 4.1 shows the amount of government funding per annum by RCS score. Table 4.2 shows the total amount of Government and resident funding per annum.

Table 4.1: Government funding per annum by RCS score.

RCS Level	Government funding per resident per annum \$
RCS 1	40,210
RCS 2	36,536
RCS 3	32,018
RCS 4	23,588
RCS 5	15,980
RCS 6	13,843
RCS 7	11,436
RCS 8	3,528 ⁷

⁷ Source: Aged and Community Care Program Data Summary No 1 July to October 1998. Department of Health and Aged Care, Aged and Community Care Division. Section 2.6

Table 4.2: Total amount of Government and resident funding per annum

RCS Level	Total Government and resident funding per resident per annum \$
RCS 1	50,342
RCS 2	46,683
RCS 3	42,147
RCS 4	33,636
RCS 5	26,130
RCS 6	23,953
RCS 7	21,550
RCS 8	13,847 ⁸

In addition to residential subsidies, Commonwealth investment in residential care services includes the subsidisation of State and Territory based advocacy and visitor support services, the establishment of State and Territory aged care complaints processes and the development of the certification and accreditation quality improvement frameworks.

In the context of this commitment, the Commonwealth has an interest in:

- controlling the supply of residential care services to ensure it in line with available resources;
- the appropriate targeting of services to meet the needs of older people;
- restricting eligibility;
- containing and controlling costs; and
- the delivery of appropriate and quality services.

4.2.2 Funding and Regulatory Arrangements

The Commonwealth implements its objectives by:

- controlling the allocation and distribution of subsidised residential places;
- approving providers of services;
- determining eligibility and access to services; and
- overseeing a quality framework - delivered through the certification and accreditation processes.

The Commonwealth oversees only those services which it funds. It does not regulate the quality of services or the number of places available in facilities that do not receive funding, except in a very broad sense by establishing a defacto benchmark for the delivery of aged care residential services.

⁸ Source: Aged and Community Care Program Data Summary No 1 July to October 1998. Department of Health and Aged Care, Aged and Community Care Division. Section 2.6

4.3 THE ROLE AND FUNCTIONS OF THE STATE

4.3.1 NSW as a provider of services

The NSW Government currently operates 28 nursing homes – some 2,000 beds - across NSW. A further 2 facilities are under construction. It is reported that these facilities generally operate at costs in excess of Commonwealth funding levels and industry benchmarks. In addition they are only eligible to receive a reduced residential care subsidy fee – the residential care subsidy less \$8.93 per resident, per day. This reflects a previous agreement between the Commonwealth and the State in which the Commonwealth agreed to continue to subsidise State funded nursing homes but at a reduced rate. It also required the State to reduce the number of State run beds and to take full responsibility for the capital funding and maintenance of all State Government nursing homes. State run nursing homes do not require a licence under the NH Act.

4.3.2 Regulatory and Licensing Arrangements

The NH Act has been outlined at Chapter 2. It covers, amongst other things:

- testing that proprietors are fit and proper to operate nursing homes;
- approving the suitability of premises, alterations and extensions;
- equipment requirements;
- staffing levels;
- a range of operational matters including care standards; and
- the maintenance of clinical records.

Currently there are some 460 nursing homes licensed by the NSW Department of Health. Each is charged a prescribed once-only license fee, currently \$610.00, on application and based on the number of beds in a facility, an annual licensing fee. Table 5.3 shows the scale of annual license fee charges.

Table 4.3: Annual Licensing Fees for NSW nursing homes

Number of Beds	\$
< 40	1,115
40 – 49	1,550
50 – 59	1,995
60 – 69	2,440
70 – 79	2,905
80 – 89	3,324
90 – 99	3,755
100 or more	4,210

Source: NSW *Nursing Homes Regulation 1996*

Licenses are held in perpetuity subject to meeting the prescribed licensing conditions and paying the annual fee. They can be transferred, amended or cancelled with the approval of the Director-General of Health. A monitoring and complaints investigation process is in place to oversight the licensing process and facilities are subject to inspections by officers of the Department of Health.

4.4 TENSIONS BETWEEN THE COMMONWEALTH AND STATE REGULATORY ROLES

There are perceptions that a number of system wide tensions exist between the operation of the Aged Care Act and the NH Act. These relate to:

- the scope of the different pieces of legislation;
- removal of the distinction between nursing homes and hostels;
- requirements under the respective Acts and the implications in terms of the Building Code of Australia; and
- duplicate regulatory regimes.

4.4.1 Issues of scope

To the extent that the Commonwealth Act extends beyond nursing home care its application is broader than the NSW legislation. While the Commonwealth Act deals with a range of aged care services including residential care, community care and flexible care, the NH Act is confined to the licensing of nursing homes, although given the expansion of high care places in facilities, it can be argued that the definition of a “nursing home” would also cover many hostels in NSW. It has been suggested that the scope of the Aged Care Act effectively renders the NH Act obsolete.

However, the Commonwealth only has jurisdiction over those services it funds. The Act has no application to a facility, which is established and operated without Commonwealth funding. Unlike most other States and Territories, NSW still requires these facilities to be licensed under the NH Act and they are thus subject to State licensing requirements. To the extent that the NH Act requires all non-government sector providers of high level care in NSW to be licensed, its regulatory scope is broader than the Commonwealth’s.

4.4.2 Removal of the distinction between nursing homes and hostels

One of the most significant features of the 1997 aged care reforms is the removal of the distinction between nursing homes and hostels. This has enabled facilities to provide a range of services and allow residents to remain in the one facility rather than having to move accommodation because their care needs change. While in practice some facilities will continue to operate exclusively as nursing home accommodation and others as hostels, there is no legislative barrier to facilities offering both kinds of services and policy discussions indicate a clear intention that, over time, facilities will more and more incorporate both types of places in one institution, which is the philosophy of “ageing in place”. This poses a significant legislative dilemma for NSW, in those instances where hostels wish to provide services to residents with high care needs. This issue has in the past been addressed by negotiations with a number of hostel operators resulting in facilities becoming nursing homes or having their high care beds licensed under the NH Act.

4.4.3 Prevailing models of care

Linked to the above issue is balancing clinical and nursing models of care with models that are more holistic and focused on meeting ‘all’ the needs of individuals. One of the aims of ageing in place is to achieve a model of care, which recognises that people have a range of needs and that these can be met in different ways – a move strongly supported by industry groups.

Industry groups and service providers are concerned that the current NH Act is premised on a medical model of care and that this undermines the fundamental objectives of the Aged Care Reform process which encourages facilities to be more home like and less 'clinical'. It is argued that the medical model is out of step with contemporary care models, which are more flexible and focus on consumer outcomes and quality of life issues for residents.

While a broad range of groups support the need for more flexible models and agree with the need to move away from the medical model of care, some groups are concerned that the balance has tipped too far back the other way. It has been suggested that the strong emphasis on the residential model of care fails to recognise the increasing dependency of many high care residents who require intensive clinical intervention.

Concerns have also been expressed about 'mixing' high care and low care need residents, particularly where some people are very sick and frail or where residents who suffer from dementia are mixed with non dementia residents. It has been suggested that many people do not like being accommodated with people who are in the advanced stages of illness or ageing and there is a question about whether it is possible to meet such diverse needs within a single residential service. It has been suggested that more rigorous regulation is necessary to ensure the care needs of all residents are appropriately and adequately addressed.

It is also worth noting that nursing homes do not only cater for the frail aged. While they are only a relatively small proportion of residential facility residents, people with brain injury, chronic psychiatric conditions, paraplegia, quadriplegia and people with social and alcohol related conditions, are also residents in nursing homes. In terms of funding arrangements, these residents are treated in the same way as aged residents and have all their care needs funded. The same issues as noted above exist for these residents. Essentially there is concern that any model of care that is put in place in nursing homes must have regard to the special care needs of some of these groups of residents. There is a view that a care model needs to be developed, which is sufficiently flexible, appropriate and responsive to the needs of a wide range of different types of residents, including people who are not aged but who need support in a residential care facility.

4.4.4 'Bed block'

The issue of 'bed block' particularly in relation to hostel beds, has emerged. It has been reported that because former hostels can care for high care residents and because high care residents attract a higher subsidy, residential services prefer to take on these residents rather than people with low care needs. It has been suggested that the financial incentive to care for high care residents is focussing services on this end of the market and as a result, there is a shortage of low care beds and growing waiting lists for low care residential services.

It has also been reported that former hostels are moving old residents out of their accommodation in order to attract new residents who can pay an accommodation bond.

These issues have been raised because of reported concern that the operation of the market and financial imperatives can compromise endeavours to meet the needs of consumers. Furthermore there is concern that some operators in the market are operating in an unscrupulous way and there appears to be no regulatory intervention to protect the interests of residents and potential residents.

4.4.5 The Building Code of Australia 1996

The Building Code of Australia 1996 (BCA96) outlines the design and construction standards that buildings and other structures throughout Australia must meet. These standards are met by following technical provisions relating to, among other things, the structure of a building, the fire resistance of building elements and materials, access and egress, services and equipment, health and amenity and maintenance of services and equipment.

The BCA96 is the responsibility of the Australian Building Codes Board (ABCB) on behalf of the Commonwealth Government and each State and Territory Government. Each State and Territory has its own building legislation that references the BCA96. This legislation generally covers administrative issues and does not contain technical requirements.

In NSW all building work must be carried out in accordance with the BCA96 which is referenced in the Environment Planning and Assessment Act 1979 and The Local Government Act 1993 and administered by the Department of Urban Affairs and Planning.

In the BCA96 there are 10 building classifications each of which relates to a particular kind of building use. A residential care facility will usually be classified as either a Class 3 building or a Class 9a building.

Generally a low care facility is classified as a Class 3 building. These facilities accommodate residents who are generally able to move about freely in their daily activities and who require some personal care but do not require nursing care. Residents of these facilities are likely to score between 5 and 8 on the Residential Classification Scale.

A high care facility is generally a Class 9a building. These facilities accommodate residents who require nursing care and/or medical treatment and require assistance to carry out their daily activities or evacuate the building in an emergency. Residents of these facilities are likely to score between 1 and 4 on the Residential Classification Scale.

It is also possible for a residential care facility to be given a ‘combined classification’. This means that different ‘parts’ of the facility can be built in accordance with either Class 9a or Class 3 requirements and the facility used to accommodate residents with both high and low level care needs.

The concept of ageing in place however goes one step further. Its aim is to accommodate people not just in the same facility but in the same *place* – ie in the same room or in the same ‘bed’ without having to move them to a different ‘part’ of the facility. It is because of this that a Review of the BCA is currently under way. The purpose of the review is to simplify the regulatory requirements of the BCA 1996 and to enable greater flexibility in the design of residential care buildings to facilitate ageing in place. The aim is to develop a building classification for residential care facilities that enables residents to literally stay where they are even though their care needs change. The new classification would allow for the design and building of facilities that can accommodate residents with the full range of dependency scores on the RCS, ie from RCS 1 to RCS 8.

It is understood that that review is in the final stages of preparing a ‘Draft Regulation Document’ for public consultation. The document will set out the changes that are proposed to the BCA96 and why they are needed. The public will have three months to make submissions in response to the Regulation Document before amendments are finalised and introduced.

The BCA96 and the NSW Nursing Homes Act

As mentioned above, currently in NSW provision of nursing home care somewhere other than in *premises* licensed to provide that care is an offence. If a hostel wants to provide high level care, they are required to be licensed and are technically in breach of the NH Act if they are not. The issue is further complicated because once a hostel is licensed to be a nursing home, it is technically also required to comply with the BCA96 and under that legislation nursing care (of the type that is provided in a nursing home) must be provided in a Class 9a building. Concern has been raised because generally hostels do not satisfy this building classification requirement and therefore are technically also in breach of the Local Government Act.

4.4.6 Duplicate regulatory regimes

Given the operation of both the Aged Care Act and the NH Act providers of high care residential services in NSW are required to comply with two separate regulatory regimes. This raises a number of concerns.

(i) Costs

One concern expressed by proprietors of nursing homes is that they do not see any return on their licensing fee other than a legal sanction to operate. There is a belief that fees should be commensurate with the service that is provided and that this is currently not believed to be the case in the industry. It has been suggested that if the current licensing role of NSW is to continue with the same cost regime, nursing homes should receive a range of extra services. These could include for example, access to a range of information relevant to the operation of services and possibly also a risk management mechanism to support the licensing requirement. Alternatively some suggest the scaling back or removal of the State licensing system.

The view of some consumer groups is that the licensing cost is a legitimate cost given the primary objective of the Act is ensuring patient care and safety. Licensing fees cover the costs of administering the legislation and as both industry and the Government have a responsibility to ensure that quality services are provided to those residents of NSW who require nursing home care it is considered appropriate that industry contribute to the cost of monitoring.

The other cost issue, which will be brought into sharp focus when the Commonwealth accreditation process commences, is the very significant cost NSW proprietors will have to bear to be certified, accredited and licensed. It is likely that a significant number of facilities will incur combined fees of close to \$15,000 every 2 or 3 years and smaller amounts each year depending on the frequency of accreditation and certification assessments.

(ii) Compliance

The other area of concern is duplication of effort in having to comply with two different regulatory regimes. Although it is claimed that requirements under the Commonwealth Act and the NH Act basically cover many of the same areas, proprietors argue they are sufficiently different to require them to deal with each process separately. This view is not uniform across the industry or shared by consumers. Proprietors express concern that such duplication reduces their ability to meet the specific standards required by the legislation. It has also been suggested that if nothing else, the overlap between the two regulatory processes is confusing to service providers.

4.5 OTHER JURISDICTIONS⁹

A number of consumer, advocacy and industry groups from other States have been consulted about issues that have emerged in other jurisdictions relating to the regulatory role of the State in the residential care area.

The views of various stakeholders within the different States are mixed. On the one hand there is concern about duplication of Commonwealth and State regulatory arrangements and over-regulation. On the other, there is concern that a reduction of regulation could have adverse effects for residents, and the experiences of other states may provide evidence to support this view. While there is a general preference for a single regulatory framework there is also concern that the Commonwealth quality improvement framework has not been tested as yet and that the legislation may be deficient in some areas.

In some jurisdictions, such as South Australia, the regulatory role of the State was never considered adequate by some, and the introduction of the Aged Care Act has been welcomed as a much more effective piece of legislation.

In Victoria however, where very prescriptive regulations relating to nursing homes and hostels were in place, the exiting of the State from any legislative control has raised conflicting views. While some think that the State regulations that used to apply to nursing homes and hostels were restrictive – ie they stipulated staff levels, mix and qualifications, room sizes, requirements for specific equipment etc – others argue that State regulation offered residents more protection in terms of quality of care than is currently the case. At the same time there is also a view that it was nonsensical for both the State and Commonwealth to have a regulatory and monitoring role when scarce health resources could be better directed to other priority areas such as public health.

Concerns have been raised that the lack of specificity of the Commonwealth legislation in some areas means there has been a shift away from prescribing standards of quality to an onus on proprietors to self-regulate. Some groups are wary of this approach and question the rigour of the Commonwealth complaints process as a mechanism to address quality issues and identify poor performing facilities at a service level. Recent publicity surrounding allegations of poor treatment in a Victorian nursing home has highlighted those arguments and may be evidence of shortcomings in the Commonwealth's standards monitoring and complaints systems, which rely largely on conciliation and complaints management rather than investigation and the imposition of sanctions.

Like NSW, Western Australia has had an active role in licensing nursing homes on a regular basis. As part of this process nursing homes have been subject to regular licensing audits and licenses cancelled where facilities breach the *Hospitals and Health Services Act 1927 (WA)*. A review of these arrangements having regard to changes introduced by the Aged Care Reform process and the Commonwealth's quality improvement framework, has just been completed.

⁹ See list of organisations consulted for development of the Issues Paper at Appendix C.

That review concluded that duplication did exist between the Commonwealth and State regulatory roles and that two tiers of regulation could not be justified given the scope of Commonwealth requirements and the cost of maintaining a virtually identical State based system. However, rather than recommend that the State exit completely, the review suggested that facilities should still be licensed by the State but that any service that received Commonwealth certification or accreditation would automatically also satisfy the licensing criteria. It also recommended that the period of a licence be linked to the period of accreditation. This approach enables the State to retain an active role in licensing facilities that do not receive Commonwealth funding and means they also have a role in monitoring facilities that fail accreditation. That review also recommended that in accordance with ageing in place the same provisions should apply to hostels. Previously hostels did not need to meet these licensing arrangements. Finally the review recommended that the Commissioner of Health could re-implement the State licensing assessment process should that become necessary from a public policy perspective. While some groups are concerned about possible ‘gaps’ in the Commonwealth legislation, overall stakeholders seem to regard this as a sensible approach.

Discussion Point 2

What evidence is there that the decisions of other States to remove state based regulation from the residential care market, in light of the Commonwealth’s Aged Care reforms, has had a negative impact on consumers or providers of services?

CHAPTER 5: CONSUMER ISSUES

5.1 INTRODUCTION

In its current form, the NH Act is often criticised as having an insufficient focus on the rights of service users and little focus on consumer outcomes. There is a view that the Commonwealth legislation takes a more outcomes oriented approach and should be relied upon, in preference to the NH Act, if the system is to be truly consumer focussed. Equally there are those who say that, from a consumer perspective, the Commonwealth Act is largely untested, in terms of ensuring good outcomes for consumers and has tipped the balance too far towards conciliation of complaints and away from monitoring and investigation.

The aim of this Chapter is to consider some of the key consumer issues, quality of care and compliance issues that are relevant to the current and future operation of the NH Act. It covers issues such as the rights of consumers in residential facilities, access and choice issues, quality of care and workforce issues.

5.2 THE RIGHTS OF CONSUMERS

5.2.1 Current position

Consumer groups claim that nursing home residents are seldom aware of their rights and are unlikely to be assertive or complain when their rights are infringed. One of the explicit aims of the Commonwealth Act is to promote and protect the civil, human and legal rights of people living in subsidised residential care services. User rights and meeting the needs of residents is an integral part of the Commonwealth Act and Principles and of the accreditation process. Included in the User Principles is the “Charter of Residents’ Right and Responsibilities” which specifies the rights of residents in residential care services funded by the Commonwealth and their responsibilities in relation to other residents. These include the right to quality care appropriate to their needs, the right to be treated with dignity and respect, and to live without exploitation, abuse or neglect and responsibilities such as respecting the rights and needs of other people within the residential care service.

These rights are further protected by:

- resident agreements which ensure that both the resident and management are aware of and agree about what is expected from the service;
- complaint resolution mechanisms, including requirements for service based procedures for dealing with complaints and State and Territory based external complaints resolution processes;
- advocacy services based in all States and Territories which promote the rights of consumers and advocate on behalf of individuals ; and
- the Community Visitors Scheme which provides support to residents who have limited family and social contact and may be at risk of isolation from the community.

The NH Act has no explicit focus on consumers and their rights. However the former Commonwealth Outcome Standards are incorporated in the Nursing Home Regulation. The aim of the Standards was to regulate the quality of life of residents and the quality of care they receive. The

NH Regulation incorporates all 31 Outcome Standards developed by the Commonwealth. These are grouped into the following seven broad categories.

- Health care, including the right to choose a doctor, individualised care, informed choice of treatment;
- Social independence, including freedom to come and go, to maintain friendships and receive visitors, religious and cultural freedom;
- Freedom of choice including, choosing bedtime and rising time, bath time and clothing;
- Homelike environment including having personal possessions and security;
- Privacy and dignity including preference in relation to modes of address, the right to private space, privacy in bathing and toileting;
- Variety of experience including organised activities and freedom not to participate; and
- Safety including the right to take risks, the design of the building, minimal use of restraints, fire standards and emergency procedures.

While inclusion of the Outcome Standards is a clear signal that the State is keen to assume a role in safeguarding consumers' rights, the Standards are not as broad in scope as the Commonwealth rights framework and there is a strong view that the Charter of Residents' Rights and Responsibilities combined with the new accreditation framework renders the Standards redundant.

5.2.2 Security of tenure and fair trading issues

The NH Act does not overtly protect the security of tenure of residents but requires, among other things, that the provider assist in finding alternative accommodation for a resident if requested, while under the Commonwealth Act the onus is on the resident to appeal and defend an eviction decision. It has been suggested that this shift of onus by the Commonwealth fundamentally undermines the security of tenure of residents of residential care facilities and therefore raises a range of fair trading issues.

5.2.3 The right to equipment, appliances and materials

Part 2 of the NH Regulations and Schedule 1 of the Commonwealth's Quality of Care Principles 1997 specify the facilities and equipment that must be provided to residents of nursing homes and aged care facilities respectively. Some advocacy groups have suggested that residents of some facilities are charged for these items even though they are a mandatory part of the care that is supposed to be provided. There is concern that this demonstrates a lack of compliance scrutiny under both regulatory regimes.

5.2.4 Access to clinical records

Schedule 1 of the NH Regulations enables a resident, or their representative, to access his or her clinical records. There is no similar explicit statement about access to clinical records in the Commonwealth Act, although the User Rights Principles indicate that residents 'have access to information about his or her rights, care, accommodation and any other information that relates to the resident personally'. It is unclear if this includes clinical records.

Resident advocacy groups in NSW have expressed concern that the right that nursing home residents currently have to access their clinical records under State legislation will not be replaced if the NH

Act is repealed. The High Court has determined that medical records belong to individual practitioners or service providers¹⁰ and that a patient has no enforceable right of access. The Commonwealth legislation provides that the onus for proving a right to access clinical records is on the resident rather than the facility operator demonstrating why records should not be provided.

It is acknowledged that access to medical records is part of a broader State, Commonwealth and health industry issue.

5.2.5 Dementia

The number of people with dementia is increasing and will continue to increase as the population of ageing Australians grows and as more people live to an age where the prevalence of dementia is highest.

In 1996 it was estimated that about 6% of the population over the age of 65 suffered from dementia¹¹. It is currently estimated that the average rate of moderate to severe dementia amongst Australians is about 1 in 15 for people aged over 65; about 1 in 9 for people aged between 80 and 84; and about 1 in 4 for people aged over 85. This does not include people who show early signs of dementia¹². Between 1995 and 2041 the number of people with dementia in Australia is expected to increase by 254%. Nearly half of the people with moderate to severe dementia live in a residential care facility. While there is a steady increase in the proportion of people with dementia in residential facilities in 1996 only about 5.9% of beds were dementia specific¹³.

Concern about the increasing prevalence of dementia and appropriate ways to treat and manage the illness is growing. Changes introduced through the Commonwealth Aged Care Act have been important in achieving quality improvement in dementia management but a range of concerns remains. These concerns include the reported reduction of qualified staff in facilities and the inappropriate use of psychotropic medications and physical restraints. It is argued that the NH Act with its more prescriptive approach provides a better framework for managing this issue.

5.2.6 Restraint

In 1996 a NSW Ministerial Taskforce considered concerns about the use of restraint, both physical and chemical, as a solution to managing people with dementia. The Taskforce was the result of concerns expressed by the Private Health Care Branch of the NSW Department of Health and the Health Care Complaints Commission about what appeared to be a systemic problem with the prescribing, administration and reviewing of psychotropic medication in aged care facilities¹⁴. The scope of issues considered by the Taskforce included the use of physical restraint in nursing homes.

The Taskforce confirmed the widespread use of psychotropic medications in nursing homes and that physical and chemical restraint is regarded as an 'easier' and less expensive way of managing difficult

¹⁰ *Breen v Williams* (1996) 70 ALJR 772

¹¹ Australian Institute of Health and Welfare. *Older Australians at a Glance. Dementia and Older Australians*. See <http://www.aihw.gov.au/publications/welfare/oag/oag-c09.html>

¹² Australian Dementia Facts at See <http://www.alznsw.asn.au/library/demfact.htm>

¹³ See note 11.

¹⁴ Department of Health NSW. *Psychotropic Medication Use in Nursing Homes*. Report of the NSW Ministerial Taskforce, May 1997. See <http://www.health.nsw.gov.au/public-health/psymed.html>

behaviour than appropriate behaviour management strategies. This is the case even though such practices breach the rights of residents and have potentially harmful, even dangerous consequences for them. The Taskforce acknowledged the therapeutic uses of psychotropic medication but found evidence that in nursing homes they are used mainly to control residents and their behaviour rather than to help them. This is especially the case in the management of residents with dementia. It also found that the administration of psychotropic medications occurred without the consent of residents and that nursing staff play a prominent role in administering the medication ‘when it is needed’.

Claims have been made that the use of restraint continues to be a major problem in residential care facilities throughout NSW. A number of reasons are suggested for this, including:

- the difficulty of managing dementia residents, particularly where facilities have a diverse mix of residents and are not physically set up to provide care to people with dementia;
- pressure to contain staffing costs that has led to a reduction in staffing levels and a reduction in qualified nursing staff;
- the inappropriate mix of staff and the use of unqualified staff who are not trained to manage difficult behaviour or qualified to administer medication;
- inadequate regulatory and monitoring arrangements; and
- a focus on improving the efficiency of the sector, ‘profits’ and cost cutting rather than meeting the needs of consumers.

Some consumer and some professional groups believe these issues are not adequately addressed by the Commonwealth accreditation standards. There is concern that accreditation outcomes and criteria are too broad and a view that standards relating to a restraint free environment should be more defined and prescriptive. These groups think that the NH legislation offers residents protection against inappropriate restraint practices. The NH Regulations specifically safeguard residents against inappropriate physical and ‘other forms’ of restraint, require restraint of any resident to be documented and for the medication of all residents to be reviewed every three months. The requirement for the regular review of medication was a direct result of the recommendations of the Review of Psychotropic Medication in Nursing Homes. Industry groups acknowledge these are sensitive issues but point out that the accreditation standards are as yet untested.

Discussion Point 3

Is there any evidence that the rights of consumers cannot be protected and enforced through the provisions of the Commonwealth Aged Care Act and other, non-residential care specific, state legislation?

Discussion Point 4

If it is considered that consumer rights can best be protected through State legislation what amendments, consistent with the Competition Principles Agreement, are required and how will they complement the provisions of the Aged Care Act?

5.3 ACCESS, CHOICE AND COMPETITION

5.3.1 Current position

Supply of residential services is tightly controlled and demand appears to outstrip supply many times over. In most cases people do not ‘plan’ to go into a nursing home and consumers are usually reluctant to think about the need for residential care until it is absolutely necessary. As a result consumers are reported to ‘take what they can get’ - which is usually the next available bed. It appears that there is no opportunity for a potential resident to take a temporary or short-term placement to see if it is suitable. When a person is placed in one facility they are not regarded as a priority in terms of access to another service and will have difficulty in accessing another position.

While consumer groups appreciate that resources are limited, there is concern that the large gap between supply and demand reduces choice for consumers and means that some people miss out entirely. It has been suggested that, until the gap between supply and demand is at least reduced, it is impossible to have a truly competitive residential care market in NSW. On the other hand it has been reported that, because there are fewer options to get people into residential care, more effort needs to go into investigating alternatives, such as home based care, which often achieve better outcomes for consumers.

5.3.2 Multi-Purpose Services

It has been suggested that lack of access and choice is exacerbated for people who live in rural areas. Lack of critical mass and the fact that it is not financially viable to establish small residential care facilities mean that people in these areas cannot readily access services and if they can obtain a place it is in a larger centre which requires them to move away from their community. The result is isolation for the resident and difficulties for members of their family who often need to travel long distances to visit.

Multi-Purpose Services (MPS), managed by NSW Area Health Services, provide a range of health care related services under the one roof. They aim to provide viable health and residential care services to smaller towns and, in particular, small rural communities where there is an ageing community profile; there are difficulties sustaining stand alone health, community and residential care services; and there are no, or limited, residential care services.

This is done by pooling Commonwealth and State funding and management of services that would otherwise be separate, eg health, nursing homes, hostels and HACC services. Services that can be part of an MPS include:

- acute and emergency beds;
- x-ray services;
- outpatient clinics for dressings, asthma, diabetes and immunisation;
- residential care services such as nursing homes, hostel and respite services;
- community health services such as home nursing, physiotherapy, podiatry, mental health, drug and alcohol services and psychology;
- ambulances; and
- meals on wheels.

It is claimed that the benefits that are derived by MPSs include:

- increased capacity to sustain a range of services by integrating health and residential care services and their associated funding;
- increased flexibility in the use of funds to meet community needs;
- improved coordination between services and targeting of services to meet local needs;
- increased ability to respond to the changing health status of the community;
- provision for appropriate residential care services;
- reduced need for older people to move outside their community for residential care;
- streamlined service delivery and a reduction in service duplication; and
- potential improvement in the recruitment and retention of qualified staff.

There are currently some nine MPS' in rural NSW with an additional three services near completion.

Discussion Point 5

If there evidence that continued State regulation improves consumer choice and access to nursing home services?

5.4 WORKFORCE ISSUES

One of the most contentious issues to arise in the context of the Review is staffing. This includes issues to do with staffing levels and the mix of staff and professional qualifications needed to deliver quality care to residents in residential care facilities. There is concern that unlike some of the provisions in the NH Act, the requirements set out in the Commonwealth Act and Principles are not prescriptive enough in some areas to guarantee the delivery of high quality care in all residential care facilities. Industry groups do not share these concerns and contend that there is no evidence that quality of care will suffer by a less prescriptive regulatory environment.

5.4.1 Staffing Issues

A direct result of the Aged Care Reform process is that service providers have more flexibility to determine the number of staff and the mix of staff they use in residential care facilities. Under the new arrangements more onus is put on service providers to make staffing decisions based on the care needs of residents having regard to residents' RCS scores and accreditation requirements. The Act requires that approved providers maintain adequately skilled staff to ensure the care needs of residents are met. The Classification Principles 1997 and Quality of Care Principles 1997 describe instances where specific nursing expertise, ie registered nurse expertise, should be used. They also defer to respective State and Territory legislative requirements in some areas such as in the performing of some clinical duties and the administration of medication.

While greater flexibility has been welcomed by industry providers and some consumer and professional groups, others express concern that the Commonwealth Act does not provide sufficient regulation over staffing issues to ensure that quality care will be delivered to residents. The view of consumer groups is that the NH Act provides greater protection both in terms of requiring nursing home facilities to have registered nurses and for them to be available 24 hours a day.

There is also concern among some consumer and professional groups that there has been a reduction in registered nursing staff and that this is reflected by both the reduction in absolute numbers as well

as in the hours that registered nurses provide direct care. It has been reported that in some instances registered nurses are diverted from direct care to undertake management duties and to prepare for accreditation assessments. There is concern that this has directly led to a reduction in the level of supervision and direction provided by registered nurses to other less qualified staff in residential facilities and that this is a very a high risk approach given that residents of facilities have increasingly high care needs.

Industry argues that prescriptive staffing standards, such as those in the NH Act, fail to recognise the diverse needs of residents and that they don't all need clinical support. They are also concerned that the legislation is rigid and fails to appreciate contemporary care models that have moved away from clinical and medical models of care. Industry supports the increased use of trained but less qualified staff such as Assistants in Nursing (AIN) and Personal Care Assistants (PCA) and argue that these workers are sometimes better placed to meet the 'holistic' needs of a resident than 'qualified' nurses who have a more narrow focus.

5.4.2 Medication and drug administration

Concerns about the administration of medication in residential services have also emerged. Under Commonwealth legislation the regulation of drug administration is deferred to State law.

The Nursing Homes Regulation covers the administration of medications. Clause 44(1) provides :

Medications must not be administered to a resident otherwise than by the resident or by a person authorised by subclause (5) to administer medications to residents.

Subclause (5) of the NH Regulations provides that:

Subject to any restrictions imposed by the regulations under the Poisons and Therapeutic Goods Act 1966, the following persons are authorised to administer medications to residents of a nursing home :

- (a) any duly qualified medical practitioner, dentist, pharmacist or nurse; or*
- (b) any other person who is authorised by the chief nurse of the nursing home to administer medications to residents.*

The Poisons and Therapeutic Goods Act 1966 allow the supply of both Schedule 4 and Schedule 8 drugs by a "person who has the care of, or is assisting in the care of another person" to the other person consistent with a written prescription¹⁵.

The Poisons and Therapeutic Goods Regulation 1994 also includes some specific regulations covering the administration of prescription medications and drugs of addiction. Under these Regulations, "hospital" is defined as including a nursing home. The Regulations cover administration of a restricted substance and drugs of addiction respectively by a person employed at a hospital and both are fairly consistent in requiring the written direction of a medical practitioner for the administration of that medication.

¹⁵ See Poisons and Therapeutic Goods Act 1966, section 10(4)(c1) and section 23

It is claimed that, in practice, this means that medications are generally only given by registered nurses in nursing homes. The legislative provisions operate concurrently with standards promulgated within the relevant professions, for example acceptable nursing practice prevents enrolled nurses from giving these medications in many cases. In theory, at least, a chief nurse could delegate administration to someone without nursing training, but a chief nurse may well believe such an action is not consistent with proper professional conduct.

Because the Poisons legislation allows administration by a carer, it is quite legal for a non-nurse carer to administer these drugs consistent with the written authority of the prescribing doctor and this is reported to occur widely in hostels. It is reported that PCAs and AINs in hostels are effectively handling and administering medications in hostels, which enrolled nurses are not permitted to administer in nursing homes. This anomaly is partly the result of a NSW Department of Health 1991 ‘best practice policy’ that limits enrolled nurses to administering Schedule 2 and Schedule 3 medications but also the broader lack of regulation of drug administration in hostels. It has been argued that if it is regarded as clinically unsafe for enrolled nurses to administer certain medications in a nursing home, the same should apply to less qualified PCAs and AINs in hostels. The converse argument could also be raised – if PCAs and AINs are able to safely administer medications and indeed such medications are administered by family and other carers in domestic situations, the restricting of medication administration to registered nurses cannot be clinically justified.

Discussion Point 6

Is there evidence that the administration of medication by unregistered staff in residential care facilities causes harm to residents?

If so can the problem be addressed through the Commonwealth Aged Care Act or other regulatory means such as the Poisons and Therapeutic Goods Act?

5.5 QUALITY FRAMEWORKS

The Commonwealth certification and accreditation processes are designed to work together to oversight quality service and quality care in residential care facilities. The issue of duplication between these processes and the regulatory role of the NSW NH Act and Regulation is central to this Paper and the future role of NSW in this area. Some argue that the issue is not so much one of duplication but that the Commonwealth framework supersedes regulatory arrangements in NSW.

The NSW Act and regulations approach quality of service issues in a manner which tends to be prescriptive about what is to be provided rather than by looking at outcomes for consumers. It assumes that if certain conditions and systems of care are in place, this will automatically translate to quality of care for residents. Industry groups argue that the NSW legislation is outdated and inconsistent with contemporary management practices.

While the Commonwealth quality framework is much broader and comprehensive in scope it is less prescriptive than State licensing requirements. The Commonwealth has made it clear that it believes that resident needs vary from resident to resident and service to service and that quality systems will vary accordingly. It advocates the need for more flexibility in achieving quality of care and puts significant onus on providers to self regulate in achieving this.

The Commonwealth has adopted a systemic approach to quality. The overt focus of the quality improvement framework including certification and accreditation, is the need to ensure quality ‘systems’ are in place and that these provide a framework for the delivery of quality at a resident level. An advantage of getting the ‘system right’ is that regulators are able to maintain overall control over the system and clear lines of accountability are usually in place. At the same time however, such a focus can divert attention away from monitoring care at an individual level, at least until something goes wrong. While there is arguably a strong focus on ‘process’ it is asserted that there is a much weaker focus on actual outcomes for individuals. This is the concern about the accreditation process overall.

Accreditation is by nature very process driven - it usually only requires optimal performance over a very short period of time, often only a day or few days. A major concern of some groups is that there is too much focus on process rather than outcomes and there is no guarantee that quality is maintained between accreditation assessments. Although the ‘system’ is notionally in place there is concern that there is no mechanism to monitor quality practises on a regular basis or to ensure and measure quality outcomes. There is concern that this is exacerbated by the complaint process that has no investigatory function.

The criteria against which accreditation standards are assessed are broad and allow for flexibility in the delivery of care. While the need for flexible approaches is supported there is a view that standards of care and quality should be specified in some instances. For example, there is concern that standards relating to medication dispensing and administration, staffing levels and staffing mix and best practice care for special needs groups should be more specific and prescriptive and that providers should be compelled to comply. There is a view that there are some areas where a more prescriptive and directive approach would result in better outcomes for residents.

5.6 CERTIFICATION

Certification of residential premises is an initiative of the Commonwealth Aged Care Reform process. The aim of certification is to encourage improvements in the physical quality of residential care buildings. The process involves the inspection of residential care buildings, using a Certification Assessment Instrument, which assesses and scores various aspects of building quality. The specific areas that certification covers includes safety – with an emphasis on fire safety, resident privacy and occupational health and safety.

Certification is not mandatory and it does not guarantee accreditation but a facility cannot be accredited unless it is also certified. Certification is not a one off assessment. Facilities need to be re-certified on a regular basis. This is linked to the accreditation cycle of the facility but is an additional expense to accreditation. Fees for certification range from \$150 for facilities with less than 10 care places, \$700 for facilities with up to 46 care places and for any other service \$15 for each place allocated to the facility. Assuming that the average capacity of a residential service is 60 places, this translates to a certification fee of \$910.

Services that receive certification can ask residents to make accommodation payments and are eligible to receive concessional resident supplements. Accommodation payments cannot be requested until a service has met the specified certification standard. The aim is to encourage services to upgrade their capital stocks to attract the additional income stream from residents.

5.6.1 Building trends and new building standards

As part of the move to improve the quality of residential home stock, new privacy and space requirements have been introduced. All new buildings will be required to comply with the new standards. Upgrades of existing buildings that are required under State and Territory building regulations to comply with the Building Code of Australia, will also have to meet the new standards.

The standards for new buildings relate to the number of residents per room, access to toilets and showers and resident sleeping space. It is expected that over time (ie by 2008) all facilities, including existing facilities, must meet prescribed standards in these areas.

A recent analysis of stock undertaken by the Commonwealth Department of Health and Aged Care shows that the requirements for privacy and space are already being met or exceeded by the majority of facilities that have been built in the last five years. Over the five years from 1993 to 1998 some 10,762 new rooms have been added to residential care building stock either through completely new construction or substantial renovation. The majority of these are either single room or double occupancy accommodation. Of the 7,239 low care rooms built or renovated, 99% are single rooms and of the 3,523 new high care rooms, 80% are single rooms and 18% are doubles. Only 2% of all high care rooms added to the building stock since 1993 are for three or more residents¹⁶.

5.6.2 Certification compliance

Of the 406 facilities originally identified at risk of not meeting certification requirements, only some 70 facilities currently remain in this category. While this means that a lot of services have improved their premises, it also means that some facilities have already closed down in anticipation of not meeting certification and not being able to afford to upgrade. The aim is to improve the overall stock of residential facilities and there is already an indication that the certification process is having an affect with the occupancy rate of facilities that are not certified reported to be falling.

The following Tables relate to the period to 31 August 1998. Although the actual figures are different to the numbers provided above it is useful to see the certification performance of NSW facilities relative to other jurisdictions¹⁷.

¹⁶ Commonwealth Department of Health and Aged Care. *Certification Procedures for Residential Aged Care Services Background Paper*. 1999. Department of Health and Aged Care Canberra. Pages 6-9

¹⁷ There is a slight variation in the number of services that are not yet certified because the most recent information on numbers provided in the introductory paragraph to this section has been provided verbally whereas the Table relates to data collection and analysis undertaken in August last year.

Table 5.1: Certification passes and failures by State and Territory

State	Assessed	Pass	Fail	% Pass
NSW	959	937	22	98
VIC	849	723	126	85
QLD	494	484	10	98
SA	317	311	6	98
WA	294	285	9	97
TAS	103	98	5	95
ACT	22	22	0	100
NT	13	13	0	100
AUST	3,051	2,873	178	94

Table 5.2: Certification Passes and Failures by State by Type of Facility

State	High Care			Low Care		
	Pass	Fail	% Pass	Pass	Fail	% Pass
NSW	457	20	96	480	2	100
VIC	332	111	75	391	15	96
QLD	211	7	97	273	3	99
SA	157	5	98	154	1	99
WA	109	4	96	176	5	97
TAS	51	3	94	47	2	96
ACT	7	0	100	15	0	100
NT	7	0	100	5	0	100
AUST	1,331	150	90	1,542	28	98¹⁸

As can be seen from the Tables above, given the number of facilities in NSW the State has performed well in terms of the number and percentage of facilities attaining certification.

5.6.3 Certification and the Nursing Homes Act

The Commonwealth certification process has implications for the NH Act and Regulation. In the areas that are covered, the Commonwealth's certification requirements are more specific and set more rigorous expectations than the equivalent in the existing State legislation. Unlike the existing State legislation the certification requirements are also more likely to bring about change in the quality of the NSW residential care building stock as there is a clear financial incentive for services to upgrade.

Discussion Point 7

Is there a role for the State in assessing the quality of the building stock of a residential care facility? If so, can this role be adequately performed outside the context of residential care legislation (eg through the local government building approvals process)?

¹⁸ Source: Aged and Community Care Program Data Summary No 1 July to October 1998. Commonwealth Department of Health and Aged Care, Aged and Community Care Division. Section 2.8

5.7 STANDARDS OF CARE AND ACCREDITATION

Accreditation is the evaluation process which residential care facilities must go through to be recognised as approved providers under the Commonwealth Act and to continue to receive Commonwealth funding. It is a requirement that all services must be accredited by January 2001. The aim of accreditation is to improve the quality of facilities and the standard of care delivered in residential care services. The system is based on quality improvement principles and a quality improvement framework. Accreditation also provides a mechanism for consumers to access information about the comparative quality of services. The aim is to encourage services to improve their performance and to compete on the basis of quality – it is argued to be a way of addressing one of the “market failures” inherent in the residential care market.

5.7.1 The accreditation framework

Accreditation involves assessment in relation to five key elements. These are:

- The Accreditation Standards:
 - Management Systems, Staffing, and Organisational Development (Standard 1)
 - Health and Personal Care (Standard 2)
 - Resident Lifestyle (Standard 3)
 - Physical Environment (Standard 4);
- User rights;
- The quality of buildings;
- Concessional and assisted resident ratios; and
- Prudential arrangements.

5.7.2 The Accreditation Standards and process

The focus of the four accreditation standards (Management Systems, Staffing and Organisational Development, Health and Personal Care, Resident Lifestyle and Physical Environment) is on the quality of care and the quality of life delivered to residents. They are gazetted in the Quality of Care Principles 1997 and are the corner stone of the accreditation process.

Under each standard a range of expected outcomes has also been gazetted. There are some 44 expected outcomes, which express the desired result for each of the standards and which services are rated against.

Based on the accreditation outcome a service can be accredited for a maximum of three years. It is envisaged that even services that perform well during accreditation will receive at least one support contact from the Agency during this period. Additional support will be provided to services that perform badly or who require additional assistance in some areas.

It is a requirement that the Agency publish an executive summary of all audits along with the accreditation decision. It has been indicated that these reports will also be available on the Internet and that this information should be made available to prospective residents prior to entry.

5.7.3 The Aged Care Standards and Accreditation Agency

The Aged Care Standards and Accreditation Agency oversees the accreditation process and is responsible for administering the accreditation process in residential care facilities. It is entirely independent from the Commonwealth Department of Health and Aged Care but liaises with the Department about poor quality services. It also provides assistance to services to improve the quality of services and care through education and training, information dissemination and identification of best practice.

The cost of accreditation will depend on the numbers of care places in a facility, not whether those places are occupied. At the moment the pricing schedule for accreditation is different depending on whether a facility applies for accreditation before 1 November 1999. Where an application for accreditation is made before 1 November 1999 the fee is a flat rate of \$2,500 plus \$95 per care place or a maximum of \$9,500. Where an application is made after 1 November 1999 the flat rate increases to \$3,500 plus \$95 per care place or a maximum of \$10,500. New services (ie new constructions) are only required to pay 20% of the accreditation fee and are not required to undergo a site audit. However they are only accredited for one year.

Discussion Point 8

Is there a role for the State in setting standards for and monitoring the quality of services and care delivered in residential care facilities?

CHAPTER 6: COMPLAINTS, INVESTIGATION AND COMPLIANCE

6.1 INTRODUCTION

As discussed above in relation to consumer and quality issues, sometimes regulation is required to facilitate the operation of a competitive market. The increased ability for residents and potential residents to compare the accreditation assessments of different facilities is one example of seeking to address a market failure associated with lack of information.

Equally a statutory consumer complaints system is a means of resolving power and information imbalances within the market. However, there are different approaches to complaints management. Those who favour light-handed regulatory approaches often see such complaints as essentially private matters for resolution and disposal as quickly and efficiently as possible. Others see complaints as events, which need investigation to determine whether they are private matters or incidents in which there is a public interest, such as poor quality care or a breach of consumer rights.

6.2 COMPLAINTS HANDLING

Residents of residential care facilities in NSW have three formal mechanisms they can use to make a complaint about a facility or the care they receive. These are the:

- Commonwealth Aged Care Complaints Resolution Scheme;
- NSW Department of Health, Private Health Care Branch Complaints Team; and
- NSW Health Care Complaints Commission (HCCC).

These are described briefly below.

6.2.1 Commonwealth Aged Care Complaints Resolution Scheme

The Commonwealth Aged Care Complaints Resolution Scheme involves 2 levels of complaints resolution. These are the:

- internal complaints resolution system; and
- external complaints resolution system.

Under the Commonwealth Act, all providers of residential services are required to establish a process to deal with complaints at the service level. There is an assumption that the best way to resolve a complaint is to deal with it at the local level. It is expected that service providers will develop appropriate mechanisms to deal with complaints and that residents are aware that they can make a complaint and have recourse to an external complaints system. Complaint handling procedures developed at the local level will be assessed as part of the accreditation process.

Residents also have access to the Commonwealth's external complaints resolution process. There is a Complaints Unit in every State and Territory and an Aged Care Complaints Resolution Committee oversees each of these. The service provided by the Units is free and independent so far as its role is not to defend either the complainant or the provider of services. Complaints may be made in writing or verbally and can be about anything that affects a person who is receiving or is eligible to receive residential care services.

The complaints resolution process involves 3 main steps - negotiation, mediation and determination. Each step is required by law even where it is clear that resolution is only likely to occur after a determination has been made.

Where negotiation and mediation fails, the matter is heard by the Complaints Resolution Committee. The outcome of this process is a decision about what needs to happen for the complaint to be resolved. This can involve requiring either the service provider or the resident to take a course of action. Where a provider does not act upon the Committee's decision this is regarded as non-compliance with the Act and the matter is referred to the Commonwealth Department for action. The matter is concluded when resolution is achieved and all parties are informed of the outcome.

For a complaint to be recorded as a complaint, it is a requirement that the service provider is advised that a complaint has been made.

The focus of the system is on *resolving* the complaint through negotiation and mediation. It is not the role of complaints units to substantiate a complaint or to take investigatory action. The approach that has been adopted is based on analysis of former complaints handling mechanisms that show that in most cases an outcome of a complaint can be achieved through negotiation and mediation. However, where it is clear that a serious incident or problem has occurred, Units will refer the matter either to the Department of Health and Aged Care or another relevant authority for action. This could include for example, referring a matter to the HCCC, the Accreditation Agency, the NSW Private Health Care Branch or to the police. Recent developments in relation to a Victorian facility have led some people to suggest that this system does not provide a sufficiently speedy and effective means of dealing with complaints that concern urgent treatment and care issues.

Units can accept anonymous complaints but these are hard to resolve where only one of the parties is identified. The Unit aims to resolve urgent complaints within 7 days, minor complaints within 30 days and complex matters within 90 days.

6.2.2 NSW Department of Health, Private Health Care Branch

The NSW Private Health Care Branch (PHCB) complaint process focuses on complaints about standards of service and care in licensed facilities. These include issues about staffing, the quality of premises, equipment, furniture and facilities in the service and instances where residents are concerned that quality of care does not reflect the standards contained in the regulations. Like the Commonwealth, the PHCB aims to promote and support the local resolution of issues between facilities, residents and their relatives and regularly refers complaints back to a facility for resolution if this avenue has not been explored.

The NSW PHCB has the power to investigate complaints including the ability to enter facilities, examine, and, if necessary, remove relevant records and documents. They cannot however, compel staff to talk to them as part of the investigation. NSW Health is not required to forewarn services before they enter a facility.

The purpose of the NSW Health process is to investigate incidents, to find out what has happened and whether a breach of the Act or licensing requirements has occurred. It will investigate and act upon anonymous complaints.

The PHCB Complaints Team has a similar turn around time to that of the Commonwealth. It should be noted that this team has managed a number of complaints referred to it from the Commonwealth where it has been found that the resolution scheme was not able to achieve the desired outcome.

6.2.3 NSW Health Care Complaints Commission

The NSW Health Care Complaints Commission (HCCC) has the power to investigate any complaint about a health service provider, which includes residential care facilities providing health services. The HCCC deals primarily with complaints relating to the professional misconduct of health care practitioners and the clinical management or care of individuals by health service providers. The HCCC has the power to investigate complaints, to refer complaints to the Health Conciliation Registry for conciliation, and to refer complaints to registration boards, practitioners and their employers for investigation.

The HCCC will not act on an anonymous complaint unless there is clear evidence of a systemic problem that needs to be investigated. During 1998/99 the HCCC received 38 complaints relating to nursing homes. This represented 4.5% of total complaints received by the Commission for that period.

6.2.4 How existing mechanisms intersect

There is a high degree of cooperation and referral between complaint mechanisms in NSW and recognition that each has a role in addressing concerns raised by residential care consumers. However it is also clear that in some instances consumers have to negotiate a complex system, that there is duplication between some arrangements and that the demarcation lines in terms of who does what are not always clear.

Prior to the Aged Care Act the Commonwealth had an investigatory role, though this was primarily in relation to breaches of the Outcome Standards. Under the new arrangements the scope of issues that can be heard by complaints units is much broader but the action that can be taken much narrower. Concern has also been raised about the capacity of the Commonwealth scheme to deal with complaints/concerns arising from accreditation, particularly as it has no investigatory powers.

6.2.5 The nature of complaints relating to residential care facilities

On the basis of complaints data provided by each of the complaints mechanisms outlined above it is difficult to say anything conclusive about trends in complaints in NSW in recent years. Nevertheless, data provided by the NSW PHCB and the HCCC does indicate that quality of care is the major area of concern of residents and their families.

Of the 222 complaints received by the NSW PHCB for the period July 1998 to 10 July 1999, 158 (71%) related to concerns about quality of care. Data also showed that there has been a reasonably steady increase in the number of quality of care complaints raised with the PHCB since October/November 1998.

Of the 38 complaints received by the HCCC for the period 1 July 1998 to 30 June 1999, 23 (60.5%) related to quality of care and 9 (23.6%) to clinical standards. The period showed an overall increase in complaints in these areas compared with previous years.

The Commonwealth Department of Health and Aged Care reported that the majority of complaints raised with them in NSW relate to matters of care, finance, the environment, catering, safety and choice.

6.2.6 The role of consumer advocacy groups

Consumer advocacy groups play an important role in assisting people exercise and protect their rights. As part of strategy to ensure user rights are upheld, the Commonwealth funds advocacy groups in each State and Territory. Proprietors of services are required to allow advocacy groups to access residential services during normal working hours or at any time if a resident or their representative has asked the advocacy service to call.

6.2.7 Issues for consumers

Given the breadth and power of the complaints mechanisms described above, it appears that consumers potentially have access to a very extensive and robust complaints framework. Nevertheless, a number of issues have emerged that reflect how difficult it is for consumers to complain about the services they receive.

Consumer groups report that many residents are fearful of complaining about the service they receive or the people who deliver it because they fear retribution and because of the nature of the market they have few, if any, accommodation options. In addition residential care consumers tend to be cared for by the same staff on most days and are unlikely to go home. While this is important to ensure caring and supportive relationships are established between residents and carers, when things go wrong the situation is very difficult for both parties. It has been suggested to the Review that many old people are so grateful for any care they receive and so afraid of not having it, that they will tolerate intolerable situations and treatment. This argument is used to stress the vulnerability of residents and the need to ensure mechanisms are in place to protect their interests, even if they are reluctant to raise issues themselves.

It has been reported that there is too great a reliance by regulating agencies on the cooperation of, and conciliation with, facilities the subject of complaints, even where the complaints raise pressing issues about the adequacy and safety of care and treatment of residents. It is argued that whilst the complaints mechanisms are broad and powerful in their range and flexibility, in practice regulators have confined themselves too much to the "soft" end of complaints resolution and have been unwilling to wield the more coercive powers of investigation and sanction.

6.3 INVESTIGATION AND COMPLIANCE

6.3.1 Investigation

The NSW NH Act clearly gives the NSW Department of Health the power to investigate breaches of the Act and of licensing conditions. The PHCB plays an active investigatory role in relation to complaints about facilities and actively monitors and investigates compliance with licensing requirements across all facilities.

The Commonwealth Act has a number of investigation powers set out in it, each of which are covered by different rules. These cover:

- investigation of complaints;
- investigation by representatives, eg people working on accreditation or certification; and

- investigation by authorised officers.

So far as complaints are concerned, the Act and Principles provide that an approved provider must allow people authorised by the Secretary access to a service that is necessary “to investigate and assist in the resolution of the complaint”.¹⁹

While some service providers argued that the investigatory role of the State duplicates the compliance arrangements put in place by the Commonwealth Act, the approach adopted by the PHCB has been supported and praised by a range of groups consulted for the development of this Paper. It has been suggested that the PHCB’s approach has been both pragmatic and successful in terms of achieving improvements in facilities and monitoring the practices of poor performers.

A range of consumer, advocacy and professional groups are concerned that, in the absence of this State investigatory function, there would be no routine, ‘on the ground’ mechanism to investigate complaints and to protect the interests of residents on an ongoing basis. It is the view of these groups that the Commonwealth compliance framework is deficient because it has determined its complaints role will not include the investigation of issues raised by residents but instead will refer these complaints to other bodies.

Service providers and the Commonwealth do not support this view and argue that there is broad scope in the Commonwealth Act to address breaches of standards and quality and that the ability to investigate serious issues is deferred to an appropriate area as required, ie the police, the Commonwealth Department of Health and Aged Care and the Health Care Complaints Commission.

6.3.2 Sanctions and penalties

Under the NH Act prosecution of licensees for a breach of the Act or licensing conditions is one of the few legal sanctions the state has available to it short of license revocation. It has been suggested to the Review that in reality prosecution is a ‘paper tiger’ and that there should be a more comprehensive range of sanctions and penalties in place which better reflect the degree of non-compliance in a particular instance. It has also been suggested that on-the-spot fines would be useful as a means of applying an immediate sanction as well as in providing leverage to broker improvements. It is understood that the NSW WorkCover Authority has adopted an approach along these lines.

The Commonwealth also has a sanctions framework in place. Service providers can be sanctioned in a range of areas including non-compliance relating to quality of care, user rights, accountability requirements and the allocation of places. The sanctions that can be applied include for example, revoking or suspending approval as a provider, denying approval for new premises or places, denying funding for new residents and prohibiting the charging of accommodation bonds.

Where an issue of non-compliance arises the Commonwealth Department is notified and follows the issue up with the provider in writing requiring them to respond to the issues raised. The onus is on the provider to show that either appropriate action will be taken to remedy the situation and to follow this through or that the claim of non-compliance is unfounded.

¹⁹ *User Rights Principles 1997*, section 23.5; see also *Aged Care Act 1997*, section 56-4 (d).

6.3.3 Implications for residents

The major policy and practical issue in implementing any sanction, which involves cancellation of a license, closure or cessation of subsidy, is the impact it will have on residents. There are few vacant places for residents of a closed service to move to and unless the issue of non-compliance is managed appropriately residents of a facility will inevitably suffer the consequences of a dispute. This has been an issue for both the State and Commonwealth.

Discussion Point 9

Is there evidence of a continued need for State residential care specific complaint mechanisms in addition to the complaint management mechanisms provided by the Commonwealth Aged Care Act and the NSW Health Care Complaints Act?

CHAPTER 7: REGULATORY OPTIONS

7.1 INTRODUCTION

This Chapter draws together some conclusions about the current position of the residential care market in NSW. It provides an overview of the key issues and themes to emerge and outlines the range of issues that need to be considered to determine the appropriate regulatory framework for residential care services in NSW. It considers a number of alternative regulatory options/models for NSW.

7.2 KEY ISSUES TO EMERGE

The underlying question for the Review is whether the State needs to retain any regulatory role in relation to the operation of residential care facilities in NSW and if so, precisely what that role should be.

Some of the key themes and issues to emerge, which have been discussed throughout the Paper, include:

- duplication and inconsistency between existing Commonwealth and State regulatory arrangements and the implications this has for service providers and consumers of services;
- the legislative implications for NSW of ageing in place with the associated removal of the distinction between nursing homes and hostels;
- the cost to the State of maintaining a regulatory role, the cost to service providers of having to comply with a dual regulatory regime and the implications this potentially has on the delivery of services and competitive pricing;
- whether the Commonwealth accreditation process will be an effective mechanism to ensure the quality of residential care services and whether this is an appropriate mechanism to prevent market failure in this area;
- the impact of the aged care reform process on State based services and the implications for the State if the quality of residential care is adversely affected in any way;
- the disparity between the supply and demand of residential care places and the impact this has on the operation of the market and the lack of consumer choice, in other words the extent to which the residential care market is truly competitive; and
- adequate consumer/residential protection issues.

Supporters of reduced regulation make the point that the NSW legislation is out of date and out of step with other States and Territories and that it endorses an approach that is inconsistent with community expectations about appropriate and preferred models of care. There is also concern that current State regulatory arrangements perpetuate an ‘input’ focus rather than the more contemporary ‘outcomes’ and quality improvement focus that is being widely adopted in business and management, although this ignores the possibility of updating the State legislation.

Support for the continuing role of the State is based on concerns about how the current market is structured and whether it actually operates in the best interests of the consumer or the NSW community. There is a view that the residential care market is structured in a way that reduces competition and as a result limits access to services and choice for consumers.

7.3 REGULATORY OPTIONS

Bearing in mind the broad range of issues raised in this Paper, the following outlines the range of regulatory options for the future of residential care facilities in NSW. Each option contains a brief description and suggests the possible strengths and weaknesses of each model. The strengths and weaknesses that have been identified are not intended to be exhaustive and submissions to the Review are invited to raise additional comments and views. Submissions which advocate adoption of any regulatory model, whether described in this paper or not, should provide evidence which demonstrates the net benefit to the community from the preferred model.

7.3.1 Option 1: NSW withdraws from regulation

Adoption of this model would involve repeal of the Nursing Homes Act with the specific regulation of nursing homes being left to the Commonwealth which has introduced a comprehensive system for accrediting and monitoring the performance of facilities that receive Commonwealth funding. It is important to remember that while NSW would no longer licence facilities there are a number of legislative instruments that can be used to enforce standards. Legislation that could be used to enforce standards includes:

- health professional registration Acts such as the Medical Practice Act 1992 and the Nurses Act 1991, which relate to professional standards of individual practitioners;
- the Poisons and Therapeutic Goods Act 1966, which controls the prescribing and dispensing of dangerous medications;
- the Local Government Act 1993 and the Environmental Planning and Assessment Act 1979 which apply the provisions of the Building Code of Australia; and
- the Health Care Complaints Act 1993 which provides that the Health Care Complaints Commission can investigate a complaint about any health service provider (including residential care service providers).

It is also important to note that the State Government could utilise a number of alternative non-legislative means to assist consumer choice or influence the market to comply with practice and service standards. Those alternative means include:

- **Provision of information by organisations** – The Government could encourage industry and consumer groups to publish information designed to assist residents and potential residents in understanding and enforcing their rights and in making informed choices about the need for care and the type of care available.
- **Voluntary codes of practice** – The Government could publish codes of practice or guidelines on appropriate practice which could set a voluntary standard for the market. The NSW Department of Health already publishes a wide range of standards and guidelines to be observed in public health facilities and these are often considered to set an appropriate standard to be observed in the private sector. This approach could apply to nursing home facilities.

Advantages

- There would be a single regulatory system thereby removing possible sources of confusion and inadvertent breaches of regulation by providers.
- There would be a significant reduction in costs (both compliance costs and fees) to industry which may flow into cheaper or better services for residents and more profitable businesses for providers which could have the benefit of encouraging more service providers into the market.

- The potential for consumers to be confused about which regulatory system applies will be reduced.
- There would be a reduction in costs to the State in establishing and maintaining licensing and compliance enforcement bodies.
- Reduction of regulation is consistent with moves to rely on competitive forces to encourage markets to operate effectively.
- The existing distinction between hostels and nursing homes would be removed thereby removing an impediment to the implementation of aging in place strategies.

Disadvantages

- The existing complaints mechanism involving the NSW Private Health Care Branch would be removed and consumers have expressed concerns about the Commonwealth's complaints management process.
- There will be an increased onus on facility operators to self regulate, especially between accreditation assessments, and there are concerns that self-regulation will significantly disadvantage consumers.
- The system relies on the effective operation of the Commonwealth accreditation process, which is as yet untested, to protect the interests of residents.

7.3.2 Option 2: Negative Licensing

The term negative licensing describes a system that erects no barriers to entry to a market although in certain instances individuals or organisations can be prohibited from continuing to operate in the market. The circumstances in which the system could operate include where there have been serious complaints made under the Commonwealth Aged Care Act, or where a service provider has been convicted of offences which establish that they are not fit to operate a residential care facility.

The advantages and disadvantages of a negative licensing system are similar to those detailed under option 1 with the following additions:

Advantages

- There are more effective sanctions to protect consumers from sub-standard operators.
- A negative licensing system would complement the role of the HCCC in investigating complaints from consumers.

Disadvantages

- In some cases providers who have been subject to complaints under the Aged Care Act or been convicted of offences may be excluded from the market in NSW notwithstanding the fact that the Commonwealth Government considers it appropriate to maintain their accreditation and fund them to provide residential care services.

7.3.3 Option 3: Licensing and exemptions for Commonwealth regulated facilities

Under this model the Commonwealth would have the major role in regulating residential care facilities with the State regulating only those facilities which are not accredited, and therefore funded, by the Commonwealth. It is important, when considering the practical effect of this model, to remember that the overwhelming majority of facilities will seek Commonwealth accreditation and that those facilities which fail accreditation will not receive funding and are therefore unlikely to remain in the market.

The advantages and disadvantages of this model are the same as those for option 1, no regulation at state level, with the addition of the following:

Advantages

- The State will have a role in monitoring and regulating the performance of facilities which are not regulated by the Commonwealth and this could include those facilities which are the poorest performers.

Disadvantages

- Additional costs will be imposed on those providers that fail accreditation.
- The State will be required to establish and maintain licensing and regulatory systems for a very small number of facilities.

7.3.4 Option 4: Registration of residential care facilities

This model assumes that services and standards in the market would be regulated at a Commonwealth level. The State would not assume a regulatory role or have any regulatory powers and the only complaints handling functions at State level would be those provided by the Health Care Complaints Commission.

The model involves the State maintaining a register of residential care facility operators in NSW. Services would be required to provide certain information, which could then be made available to consumers and possibly to competitors, but would not have to satisfy any entry criteria or minimum standards. Such a system would also need to be self-funding and providers would be required to pay registration fees of some type.

Advantages

- To a large extent registration addresses the current issue of duplication of regulatory arrangements between the Commonwealth and the State.
- There will be a lower administrative and compliance burden on providers.
- The residential care industry would incur lower costs than under the current dual regulatory system .
- A registration system would impose lower costs on the State Government as the system would be largely administrative and not require the establishment and maintenance of inspection and monitoring functions.
- There would be a central updated register that could help inform residents and potential residents about the range of services that are available, and it could be used by service providers to help in targeting the establishment of services to those areas with unmet demand.

Disadvantages

The disadvantages of this model are the same as for option 1 with the addition of the following:

- There are administrative costs to service providers associated with registration.
- The State Government will be required to administer a registration system which, even if it is self funding, will involve some costs to government.

7.3.5 Option 5: Dual regulatory arrangements with amendments to the Nursing Homes Act

This option would see the retention of the Nursing Homes Act with a range of amendments designed to update its operation to take account of the changing regulatory environment, changing community expectations and developments in regulatory techniques. If this option were adopted the State could enter into a collaborative arrangement with the Commonwealth to ensure that there is no duplication of effort and that any regulation is targeted to ensuring that it delivers enhanced outcomes for stakeholders.

Possible amendments, which could be considered for the NH Act include:

- introduction of a statement of objectives;
- recognition of the removal of the distinction between nursing homes and hostels;
- replacement of prescriptive regulation with performance based regulation;
- explicit adoption of a quality improvement framework;
- development of a regulatory regime that complements the Commonwealth framework; and
- introduction of an enhanced complaints management and investigation regime.

A slight variation on this model would involve the NSW Government conducting a further review of the legislation after the Commonwealth accreditation and certification processes are fully operational to determine if there remains a need for State regulation.

Advantages

- This model could employ elements of the existing administrative framework which has been refined over a number of years and in which resides a great deal of expertise.
- The regulatory system could be refined so as to take into account changes in the residential care environment and thereby ensure minimal duplication of regulatory activities and therefore minimal administrative and compliance burdens on providers.
- It ensures that services that do not receive Commonwealth funding are subject to an active regulatory regime.
- It ensures the existence of a mechanism with a continuing ‘hands on’ monitoring role in respect of residential care services in NSW.
- The current complaints handling system could be refined to complement the Commonwealth’s complaints resolution mechanisms and the Health Care Complaints Commission.
- This model addresses concerns that have been expressed by a number of consumer groups about the Commonwealth’s complaints handling systems.

Disadvantages

- It perpetuates dual regulation and therefore the cost of regulation to service providers and those costs may require service providers to direct resources away from direct care for residents of facilities or to increase charges for services in order to meet the regulatory burden.
- The State will continue to incur the costs of maintaining the regulatory system.
- It may not adequately address areas of regulatory duplication notwithstanding amendments to the legislation.
- Future amendments to the Commonwealth Aged Care Act may have significant implications for the NH Act and the State would be required to continually monitor developments at a Commonwealth level to ensure that the operation or objects of the Act are not frustrated and that

service providers are not inadvertently placed in a position where they find themselves unable to comply.

- It is out of step with most other States and Territories which have exited from State Government regulation in this area.

7.3.6 Option 6: Retain the status quo

Under this model the dual regulatory regime that currently exists will remain and the NH Act will continue to be administered in its current form.

Advantages

- The model retains the dual regulatory framework that is claimed to provide additional protection to high care need residents in nursing homes in NSW.
- There is a regulatory framework for those residential facilities that do not receive Commonwealth funding.
- This model provides a cautious and conservative ‘wait and see’ approach while the effectiveness and implications of the Aged Care Reform process are tested.

Disadvantages

- It perpetuates dual regulation and therefore the cost of regulation to service providers and those costs may require service providers to direct resources away from direct care for residents of facilities or to increase charges for services in order to meet the regulatory burden.
- There are cost implications for the State in terms of having to retain a licensing role.
- It fails to address major areas of overlap and duplication between Commonwealth and State regulatory arrangements.
- It fails to recognise that the NH Act and Regulations are out of date and that the approaches they adopt are not recognised as best practice from a policy, clinical standards or operational perspective.
- It fails to address the “amalgamation” of nursing homes and hostels under the ‘ageing in place’ strategy and means that NSW is effectively out of step with arrangements in other States and Territories.
- It is out of step with most other States and Territories which have exited from State Government regulation in this area.

Discussion Point 10

As a result of the Commonwealth’s aged care reforms is there a continued need for NSW to have a regulatory role in the residential care market?

Discussion Point 11

Which model (whether it is a model outlined in chapter 7 or another model) best achieves the objectives identified for the regulation of residential care facilities in NSW.

Submissions should demonstrate the net public benefits of the preferred option.

APPENDIX A : TERMS OF REFERENCE

1. The Review should:
 - (a) clarify the objectives of the legislation and their continuing appropriateness;
 - (b) identify the nature of the restrictive effects on competition, including any restrictions on competition between providers of nursing home care and hostel care and/or between public and private providers of aged care;
 - (c) analyse the likely effect on the economy generally of any identified restriction on competition;
 - (d) assess and balance the costs and benefits of any restrictions identified;
 - (e) consider strategies to ensure that the interests of residents and their families are adequately represented and protected in nursing home management; and
 - (f) consider alternative means of achieving the legislation's objectives, including non legislative approaches.

2. When considering the matters in (1) the Review should also:
 - (a) identify any areas of market failure, their nature and extent, which are being addressed or which need to be addressed by regulation;
 - (b) consider whether the effects of the legislation contravene the competitive conduct rules in Part IV of the Trade Practices Act 1974 (Cth) and the NSW Competition Code.

3. The Review will consider and take account of relevant regulatory schemes in other Australian jurisdictions, and any recent reform proposals, including those relating to competition policy in those jurisdictions. In particular, the Review will examine the extent to which it is possible to rely on the Commonwealth Aged Care Act 1997 as the principle means of achieving the objectives of the NH Act and options for minimising any duplication or inconsistency in the regulation of aged care services.

4. During the course of the Review there will be consultation with and submissions accepted from all sectors of the industry, residents, consumers groups, health professions, government agencies and other interested parties.

APPENDIX B: THE AGED CARE RESIDENTIAL SERVICE INDUSTRY

This Appendix gives a broad overview of the residential aged care industry nationally and in NSW.

While traditionally the Australian system of residential care for older Australians has comprised two levels of care – nursing homes for higher dependency residents and hostels for lower dependency residents, as a result of the Aged Care Reform process, this distinction has been removed. Therefore, in order to capture a current picture of the overall residential aged care facilities market, data has been drawn from separate available analysis relating to nursing homes and hostels, as at 30 June 1997. This is the most up to date, reliable data available at this time and has been produced by the Australian Institute of Health and Welfare (AIHW)²⁰.

A National Overview

As at 30 June 1997, there were 1,466 nursing homes and 1,547 hostels in Australia, providing a total of 139,058 beds across Australia. Over 74,000 of these were provided in nursing homes and 64,825 in hostels²¹.

Between 30 June 1996 and 30 June 1997, the number of nursing home beds Australia wide declined from 75,004 to 74,233 beds. The ratio of beds to persons aged over 70 years also declined from 50 beds per 1,000 people aged 70 and over at 30 June 1996 to 48 beds per 1,000 aged 70 and over at 30 June 1997. Over the same period, the number of nursing homes fell by 6²². Almost half (48%) of the beds in nursing homes were run by private for-profit organisations, 38% in nursing homes run by not-for-profit organisations (including church and charitable groups) and 14% in nursing homes run by State or local governments. While the number of beds in both the not-for-profit and government nursing homes decreased, there was a growth in the number of beds provided by the private for-profit sector²³.

As at 30 June 1997, there were 64,825 hostel places in Australia providing accommodation services to some 58, 046 residents aged 65 years and over, who make up 96.5% of the total hostel population²⁴. This is equivalent to 41.6 places per 1,000 persons aged 70 and over and is significantly more than the situation in the mid 1980s where the level of provision was 32.5 places per 1,000

²⁰ See Australian Institute of Health and Welfare and Department of Health and Family Services. *Nursing Homes in Australia 1996-97: A Statistical Overview*. 1998. Aged Care Statistics Series. AIHW Cat. No. AGE 9 and Australian Institute of Health and Welfare and Department of Health and Family Services. *Hostels in Australia 1996-97: A Statistical Overview*. 1998. Aged Care Series. AIHW Cat. No. AGE 10. Both reports can be located at <http://www.aihw.gov.au/publications/welfare>

²¹ See note 20

²² Australian Institute of Health and Welfare and Department of Health and Family Services. *Nursing Homes in Australia 1996-97: A Statistical Overview*. 1998. Aged Care Statistics Series. AIHW Cat. No. AGE 9. Page 1. See <http://www.aihw.gov.au/publications/welfare>

²³ See note 22. Page 1

²⁴ Australian Institute of Health and Welfare and Department of Health and Family Services. *Hostels in Australia 1996-97: A Statistical Overview*. 1998. Aged Care Series. AIHW Cat. No. AGE 10. Tables 1.1 and 1.2. See <http://www.aihw.gov.au/publications/welfare>

persons aged 70 and over²⁵. Over the last decade the ratio of hostel places to older people has progressively expanded and while hostels traditionally cater to a lower dependency clientele, the range of resident dependency has steadily increased in recent years.²⁶

Nursing Home accommodation in NSW

There are a total of 28,859 nursing home beds across NSW. This is significantly more than in other States or Territories (Victoria, for example, at the time had 17,522 beds and Queensland 12,180). For NSW, the ratio of nursing home beds per 1,000 people aged over 70 years was 52.2 at June 1997. This compared to a national average at the time of 47.6 and was a significantly higher ratio than most other States and Territories. Since this AIHW data was released, the ratio for NSW has been reduced to 46.6.

Of the nearly 30,000 beds in NSW, 16,139 (55.9%) are in the private for-profit sector, 10,623 (36.8%) in the not-for-profit sector and 2,097 (7.3%) run by State or local governments. With the exception of Western Australia, NSW has a much higher proportion of beds in the private for-profit sector than any other State or Territory.

On average nursing homes in NSW have 61 beds per facility. This is relatively large compared to the size of nursing homes in other States and Territories but is consistent with the national trend towards the “rationalisation” of smaller homes. Over 28,000 people were using nursing homes in NSW at 30 June 1997. Of these, 20,296 were female and 8,115 were males. This predominance of women is most evident at older ages²⁷.

Between 1 July 1996 and 30 June 1997 NSW these residents occupied a total of 10,442,022 bed days. People over the age of 75 accounted for over 80% of these days and people under the age of 65 occupied less than 6% - marginally more than the national average. Almost 70% of occupied bed days were provided throughout the Sydney suburbs. Table A1 shows the number of bed days in nursing homes by broad geographic area.

Table A1: Number of bed days in nursing homes by geographic area

	Capital cities	Other metro centres	Large rural centres	Small rural centres	Other rural centres	Remote zones	Total
No.	7,223,858	1,182,231	513,137	621,463	881,931	19,402	10,442,022
%	69.2	11.3	4.9	6.0	8.4	0.2	100.0

Source: Australian Institute of Health and Welfare and Department of Health and Family Services. *Nursing Homes in Australia 1996-97: A Statistical Overview*. 1998. Aged Care Statistics Series. AIHW Cat. No. AGE 9. Table 1.11

Data shows that almost 30% of residents in NSW high care facilities were in care for less than 12 months²⁸ and that residents of nursing homes have high dependency levels (see Table A2).

²⁵ See note 24. Table 1.3

²⁶ See Australian Institute of Health and Welfare. *Older Australians at a Glance: Hostels*. 1998. http://www.aihw.gov.au/publications/w_online/oag/page29.htm and note 20

²⁷ See note 22. Table 2.1

²⁸ See note 22. Table 2.2

Table A2: Levels of dependency for residents of NSW nursing homes at 30 June 1997

	High dependency			Low dependency		Total
	1	2	3	4	5	
Number	2,711	13,130	9,360	2,501	44	28,142
%	9.6	46.7	33.3	8.9	1.6	100.0

Source: Australian Institute of Health and Welfare and Department of Health and Family Services. *Nursing Homes in Australia 1996-97: A Statistical Overview*. 1998. Aged Care Statistics Series. AIHW Cat. No. AGE 9. Table 6.1

Hostel accommodation in NSW

As at 30 June 1997, there were 474 hostels in NSW offering a total of 20,371 hostel places providing care to 18,909 residents. Of these 96.6% of places were in the not-for-profit sector and 3.4% in the Government sector. Prior to the aged care reform process, there was no hostel accommodation managed in the private for-profit sector in NSW²⁹.

The above roughly translates to 36.8 hostel places per 1,000 people aged 70 and over in NSW. This is less than any other State – most of which have ratios in the mid 40s³⁰.

While the size of hostels varies from under 20 to over 121 beds, the highest proportion of hostels in NSW have between 21 and 40 beds. Table A3 shows hostels by size in NSW.

Table A3: Hostels by size in NSW, 30 June 1997

Number of beds	%
1 - 20	19.4
21- 40	38.4
41- 60	24.5
61- 80	9.5
81-100	4.4
101-120	1.7
121+	2.1
Total	100.0

Source: Australian Institute of Health and Welfare and Department of Health and Family Services. *Hostels in Australia 1996-97: A Statistical Overview*. 1998. Aged Care Series. AIHW Cat. No. AGE 10. Tables 1.6

In the period 1 July 1996 to 30 June 1997, the total number of occupied bed days in hostels was 6,854,754. People over the age of 65 accounted for 6,638,656 of these days – over 96.8%. Nearly 72% were occupied by people over the age of 80, the majority of which were women (see Table A4).

²⁹ See note 24. Table 1.2

³⁰ See note 24. Table 1.3

Table A4: Total number of occupied bed days in hostels for the period 1 July 1996 to 30 June 1997 by age

Age	Number	%
Under 65	216,098	3.2
65-69	263,740	3.8
70-74	504,522	7.4
75-79	975,915	14.2
80-84	1,793,695	26.2
85-89	1,867,566	27.2
90+	1,233,218	18.0
Total	6,854,754	100.0

Source: Australian Institute of Health and Welfare and Department of Health and Family Services. *Hostels in Australia 1996-97: A Statistical Overview*. 1998. Aged Care Series. AIHW Cat. No. AGE 10. Table 1.9

The overall occupancy rate of hostels for the period was 92.9% - in line with the national average. Over 55% of people stayed in a hostel for 2 years or more and over 22% of these for more than 5 years³¹.

Nearly 80% of hostel residents as at 30 June 1997 were classified as requiring some level of assistance with personal care activities. Dependency categories are based on a resident's dependency level and care needs. These ranged from the highest level of assistance – Personal Care High (PCH), to Personal Care Intermediate (PCI) to Personal Care Low (PCL) and Hostel Care (HC), the lowest level of dependency. Ranges PCH to PHL reflect the need for some level of personal assistance. Table A5 shows dependency levels in hostels at 30 June 1997.

Table A5: Dependency levels in hostels at 30 June 1997

	PCH	PCI	PCL	PCH to PCL	HC	Total
Number	3,005	4,827	6,796	14,628	3,725	18,353
%	16.4	26.3	37.0	79.7	20.3	100.0

Source: Australian Institute of Health and Welfare and Department of Health and Family Services. *Hostels in Australia 1996-97: A Statistical Overview*. 1998. Aged Care Series. AIHW Cat. No. AGE 10. Table 6.1

Data also shows that almost 70% of residents admitted to hostels in NSW between 1 July 1996 to 30 June 1997, had a dependency level of between PCH and PCL – this is consistent with claims that the dependency levels of hostel residents is also increasing.

Extra Service Places

Extra Service Places replace the former Exempt Nursing Homes scheme. To be approved for extra service status a service or a distinct part of a service must offer a significantly higher standard of accommodation, food and services than the average standard of care in a mainstream residential service. In return, residents are charged higher fees. The scheme is designed to offer residents who can afford it, a higher standard of residential service on the basis that they will pay for that extra service. These services receive reduced assistance from the Commonwealth.

³¹ See note 24. Table 2.2

At 31 October 98 there was 37 extra service facilities nationally offering some 1,949 extra service places. Most of these were offered in high care accommodation facilities³².

There is currently 13 extra service facilities offering 757 extra service places to residents requiring a high level of care in NSW. All 13 facilities offer entirely extra service care. It is understood that residents pay some \$90 a day compared to residents in mainstream services that pay about \$40 a day. An additional 11 facilities (395 places) have been approved for extra service accommodation in NSW over the next twelve months. This includes facilities that are entirely for extra service accommodation and those where only part of the facility will provide extra service care.

Planning and Projections

In terms of planning for residential aged care places, the Government has set a target of 100 residential and community care places per 1,000 people over the age of 70. This 'benchmark' comprises 40 high care places (nursing home type accommodation), 50 low care places (hostel type accommodation) and 10 community care places per 1,000 of the population over 70 years.

For aged care planning purposes, NSW is divided into 16 planning regions. These are roughly based on groupings of Statistical Local Areas (SLAs) and as far as possible, also linked to State Government planning regions. These regions are:

- Central Coast
- Illawarra
- New England
- South East Sydney
- Central West
- Inner West
- Northern Sydney
- South West Sydney
- Far North Coast
- Mid North Coast
- Orana/Far West
- Southern Highlands
- Hunter
- Nepean
- Riverine/Murray
- Western Sydney

Currently, 10 of these regions are identified as having aged care services in excess of the planning ratio of 100 places/services per 1,000 people over the age of 70. Of these the Central West, Inner West, Northern Sydney and Western Sydney are the most significantly over serviced regions – the Inner West currently carrying a ratio of 161.09 places per 1,000 people. While over time, it is expected the ratios in some areas will reduce naturally as a consequence of the growing population in regions, areas such as the Central West, Inner West and Northern Sydney already have services in excess of their projected growth over the next 6 to 7 years.

Six regions currently have services less than the planning benchmark of 100 places/services per 1,000 people over the age of 70. These include the Southern Highlands, Mid North Coast, Central Coast, Far North Coast, Illawarra and South East Sydney – all of which are expected to also be below this benchmark by 2006. This does not mean however, that the ratio for each of the service types is right. For example, while South East Sydney is below ratio overall, it still has too many high care places and will continue to have too many of these places even by 2006. While areas such as the Southern Highlands, the Central Coast and Illawarra currently have too many high care places this is expected to even out within the next 6 to 7 years in line with population growth. In fact it is likely

³² Commonwealth Department of Health and Aged Care. Aged and Community Care Program Data Summary No 1 July to October 1998. 1998. Department of Health and Aged Care, Canberra. Table 2.1

these regions will need more high need places over time to cater for the needs of their growing and ageing populations.

Currently 13 of the 16 regions have ratios of more than 40 high care places per 1,000 people over the age of 70. It is projected that 8 of these regions (Central West, Hunter, Inner West, Nepean, Northern Sydney, South East Sydney, South Western Sydney and Western Sydney) will continue to be in excess of this ratio in 2006. The most significant of these will be the Inner West and Northern Sydney where it is projected that the ratios in these areas will be as much as 108.09 and 63.93 respectively by 2006.

In broad terms it is likely that the growth of services in NSW will be in low care and community care services. Only Northern Sydney and Orana/Far West are projected to need fewer low care places and South East Sydney fewer community care services by 2006.

Needs differ between regions but in general terms NSW is over bedded in the area of high care beds. Currently the NSW ratio of 46 beds exceeds the national benchmark ratio by 6 beds per 1,000 over the age of 70. The allocation of these services is therefore likely to be tightly controlled in the near future and emphasis placed on expanding the low care and community care service market.

The 1999 Regional Distribution Plan

The situation outlined above is reflected in the latest aged care allocation round announced in March this year. At that time, 91 high care places were allocated across the whole of NSW, 672 low care places and 1,448 community care packages.

Allocations for high care residential places were only given to the Far North Coast, the Mid North Coast and some 30 places spread across a wide range of regions specifically targeted for people from non-English speaking backgrounds.

Low care places were targeted for the Central Coast, Central West, Far North Coast, Hunter, Illawarra, Nepean, Orana/Far West, Riverina, South East Sydney, South West Sydney and the Southern Highland regions. A number of places were also allocated across regions for people from non-English speaking backgrounds.

Community Care packages were allocated in the Central Coast, Central West, Far North Coast, Hunter, Illawarra, Inner West, Mid North Coast, New England, Northern Sydney, Orana/Far West, Riverina/Murray, South East Sydney, South West Sydney, Southern Highlands and Western Sydney regions. Community care allocations were also targeted at people from non-English speaking backgrounds, people from Aboriginal and Torres Strait Islander communities and people who are financially disadvantaged.

An estimate of the value of the market

On the basis that there are nearly 50,000 aged care places in NSW and that the conservative cost of providing care to residents is on average about \$100 a day (it is assumed this includes the cost of care, the cost of accommodation plus capital costs), it is estimated that the value of the aged care residential market in NSW is some \$1.825 billion a year. In cases where high levels of care are provided it is reported that this daily amount can be significantly more.

It should be noted that the cost per day of caring for a resident is not what the Commonwealth subsidises, but rather what industry reports is the overall cost of care, inclusive of all the components listed above. The Commonwealth Government currently provides more than \$3 billion a year for the care and accommodation of aged Australians.

The ageing cohort

There is already a clear indication that the type of people in aged care facilities is likely to change over time. For example, the population is not only ageing but the ageing population is getting older, ie the number of very old people is increasing. The implications of this include a more dependent and frail aged population and given that the likelihood of dementia increases as people get older, a much higher proportion of dementia affected people. This could have significant implications in terms of the types of care models and services that residential services need to develop to meet the care needs of older people in the future. It could also have implications for the type of market that needs to be in place and the type of protection that consumers of services need to have to ensure they receive the best possible care.

Supply and demand in the NSW nursing home market

Anecdotal evidence to the Review suggests that demand for residential care exceeds supply in most regions across NSW. The few exceptions to this appear to be generally in the lower socio-economic areas where it has been reported that people are reluctant to seek out residential care because they believe they cannot afford it. A consequence of this is that these places are either not filled or are offered to people from other regions who often have to move away from where they have been living and away from their familiar community to access a place. In some cases people have no choice but to accept these places if they need residential care.

Tables A6 and A7 show waiting periods for nursing homes and hostels from the time the ACAT assessment is undertaken to placement in an aged care service.

Table A6: Waiting periods for nursing homes from the time the ACAT assessment is undertaken to placement in an aged care service.

	Average days	2 days % placed	30 days % placed	60 days % placed	90 days % placed	120 days % placed
NSW	26	31	73	87	95	97
VIC	30	20	70	86	94	96
QLD	38	23	62	80	90	93
SA	29	23	72	85	94	96
WA	25	25	76	89	96	97
TAS	29	27	68	85	93	96
ACT	31	18	65	86	94	96
NT	32	30	58	81	90	97
AUST	29	26	71	85	94	96

Source: Aged and Community Care Program Data Summary No 1 July to October 1998. Department of Health and Aged Care, Aged and Community Care Division. Section 2.5

Table A7: Waiting periods for hostels from the time the ACAT assessment is undertaken to placement in an aged care service.

	Average days	2 days % placed	30 days % placed	60 days % placed	90 days % placed	120 days % placed
NSW	78	11	39	56	71	78
VIC	82	10	41	57	69	76
QLD	99	10	35	51	62	71
SA	88	6	33	52	66	74
WA	75	8	42	60	73	80
TAS	109	8	34	47	59	65
ACT	90	4	31	50	64	73
NT	64	27	54	65	73	83
AUST	85	10	38	55	68	76

Source: Aged and Community Care Program Data Summary No 1 July to October 1998. Department of Health and Aged Care, Aged and Community Care Division. Section 2.5

NSW is performing reasonably well compared to other States and Territories and is below the national average in terms of getting people into residential aged care accommodation. It should also be noted that the entry into low care facilities usually takes longer because people are often not in urgent need of accommodation and need time to arrange their affairs prior to entering a facility.

Industry Viability

High demand for services, high occupancy rates and the high bed values suggests that the residential aged care service market is both robust and profitable and is likely to remain so. Although it has been reported that since the Aged Care Reform process some services in NSW have experienced a decline in their occupancy rates – from 100% to an average of about 98% - this has not seriously affected the profitability of the sector. It has been suggested that this result is probably a short term issue and the result of confusion surrounding the introduction of the reforms.

The particular characteristics of the market should also be noted. For example, unlike most other kinds of business the aged care residential market is generally a very low risk and reasonably good cash business. It is one of the only areas where income is guaranteed (ie through Government subsidies), payment is in advance and there is a very low risk of bad debt. Supply is controlled and demand is high. Larger providers have opportunities to achieve economies of scale in areas such as shared administrative and management structures as well as through shared laundry, linen and food services. There is also increasing opportunities for economies of scope as residential services diversify into the aged care package market.

APPENDIX C: CONSULTATIONS UNDERTAKEN BY ENDURING SOLUTIONS PTY LTD

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Ms Geraldine Garvan State President Geriation	Ms Patricia Reeve COTA Victoria
Ms Carol Allen Anglicare	Ms Wendy Sitch COTA Queensland
Mr Rex Leighton Illawarra Retirement Trust	Ms Marlyn Crabtree Advocacy Service of South Australia
Ms Janet Ma, Ms Stephanie Sheen, Ms Kate Adams NSW Nurses Association	Ms Jill Clutterbutt ANF Victoria
Mr Michael Keats COTA NSW	Ms Maureen Lister Aged Care Australia
Mr Lewis Kaplin Alzheimers Association NSW	Ms Chris Smith State President Geriation Western Australia
Mr James Hayman, Mr John Hartigan Ms Leanne Rowe Moran Group NSW	NSW Aged Care Alliance Convened by NCOSS Attended by range of organisations with interest in Aged Care issues
Ms Wendy Fisher The Accommodation Rights Services NSW	Ms Mary Little Residential Rights Centre Victoria
Ms Julienne Onley NSW College of Nursing	
Mr Kel Nash Senior Policy Officer NSW Department of Fair Trading	

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