Looking back with Richard Gray

by Richard Gray / CHA Senior Aged Care Advisor

Catholic Health Australia's Richard Gray, at 80 years of age, retired at the end of August having dedicated more than 22 years with CHA, firstly as Director Aged Care Services and in latter years, Senior Aged Care Advisor. Here he has penned his last article for Health Matters and takes the opportunity to look back at his 27 years immersed in peak body aged care advocacy in Canberra.

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In the Spring of 1991, I strolled into the office of Aged Care Australia (now ACSA) as the organisation's first fulltime CEO to join two other employees. One of the first peak body colleagues I met was Chris Rigby, the CEO of ACHA, the Australian Catholic Healthcare Association (now CHA).

Chris and I shared concerns over the then Minister for Aged Care's plans to legislate for the introduction of a compulsory residents' agreement in nursing homes. The agreement was to force nursing homes to allow residents their doctor of choice. CHA members were concerned about the consequences of euthanasia becoming legalised. Together with ACSA we succeeded in removing the mandate from the agreement.

Residential aged care comprised nursing homes and hostels. Each had distinctly different policy origins. Nursing homes came from a health policy perspective with Commonwealth funding commencing with the introduction of nursing home benefits in 1963.

Hostels came from a welfare policy approach with the first federal government foray into aged care being the *Aged Persons Homes Act 1954*, which allowed for a capital subsidy for approved not-for-profit organisations to provide self-contained hostel accommodation[1].

IN HOME SUPPORT

In 1992, the Commonwealth Government funded more intensive care services for older people living at home through the introduction of Community Aged Care Packages (CACPs) and again in 1998 with Extended Aged Care at Home (EACH) and EACH Dementia packages.

The policy and funding arrangements for nursing home and hostels created inequalities. Hostel buildings were newer and of reasonable quality, owing to the availability of capital funding through capital subsidies, variable fees and entry contributions. In contrast nursing home buildings were generally older and of lower

1 Gibson, Diane, 1998. Aged care: old policies, new problems. Cambridge University Press.

quality, due mainly to constraints on nursing home income that limited the ability of providers to invest in new building stock and in capital regeneration[2].

In 1994, ANU Professor Bob Gregory highlighted the existence of the capital problem in the nursing home industry in his report, *Review of the Structure of Nursing Home Funding Arrangements Stage 2*. He identified a large backlog of capital expenditure requirements due to deferment of refurbishment expenditures in the past.

As nursing homes were not allowed to charge variable fees nor entry contributions, and the CAM and SAM funding arrangements did not provide an adequate return on investment for capital regeneration, over the 10 years of the aged care reform strategy there was a continuing decline in the quality of nursing home stock. The aged care reform strategy had basically run its course when there was a change in government from Labor to the Coalition in March 1996.

In the year leading up to that election, I had been arguing for a change in the way residential aged care was funded. I advised the Shadow Minister for Health and Aged Care, Michael Woodridge that nursing homes and hostels should be treated equally, as residential aged care, under the same subsidy and fee arrangements. Also that there was a need for independent quality management oversight to replace the discredited Standards Monitoring System.

AGED CARE BILL 1997

Coinciding with the change in Government I left ACSA and joined CHA which meant that I was able to represent CHA on the Government's consultative committees for the implementation of the new aged care policies including the drawing up of the *Aged Care Bill 1997* (the Bill) and the creation of the Aged Care Standards and Accreditation Agency.

The Bill was stalled in the Democrat controlled Senate at the last week in June 1997, the last opportunity to pass the legislation in time for its October 1 commencement. CHA CEO, Francis Sullivan, myself and Uniting Care Australia CEO, Libby Davies, spent that last weekend of June negotiating final amendments to the Bill with Aged Care Minister, Judi Moylan, Prime Minister Howard's office, and the Democrats. The amended Bill was duly passed in both Houses during that final week.

The second wave of reform commenced through the introduction of the *Aged Care Act 1997* (the Act). This brought nursing homes and hostels together under the same Act with a single Resident Classification Scale (RCS) determining the government subsidy for residents in either high or low care. In March 2008 the RCS was replaced by the Aged Care Funding Instrument (ACFI).

The Act also introduced;

- income testing of recurrent subsidies thus requiring those with means to contribute to the cost of their care;
- accreditation of residential services based on legislated standards;
- improved complaints resolution processes; and
- certification of building standards.

Entry payments, subject to an assets test, were also permitted for persons entering all residential care, for the first time allowing providers to charge an entry contribution for access to nursing home care.

LUMP SUM ENTRY ABANDONED

CHA led a sustained media campaign that exposed a move by the Federal Government to introduce a 'contribution' for entry into a nursing home, which would require the pensioner to sell the family home. The Government abandoned the 'lump sum' entry contribution for a high care nursing home and substituted it with a daily accommodation charge (still subject to an assets test) of up to $12 per day.

Accreditation of residential services replaced the former Standards Monitoring of nursing homes and commenced late 1999. All 3,050 residential aged care services were required to be accredited for one to three years by 1 January 2001 to be able to retain care subsidy payments.

Richard Gray retires after 27 years of advocacy for providers and consumers of aged care services.

2 Gray, Richard, 1999. The Third Wave of Aged Care Reform, Health Matters, October & December 1999.

To better understand the process and to assist CHA's Catholic Aged Care members through accreditation, I became a Certified Quality Assessor and undertook site audits for the Aged Care Standards and Accreditation Agency of non-Catholic services. In 2006, Federal Cabinet appointed me as a Director on the Board of the Agency for a period of three years.

The second wave of reform introduced a measure of competition in aged care with nursing homes able to accept hostel residents and a hostels' nursing home residents. The ageing in place of residents in hostels changed their character akin to nursing homes.

In 2000, Jill Iliffe, National Secretary of the Australian Nursing Federation (now ANMF) suggested to me and the CEO of Uniting Care, Libby Davies, that our three organisations jointly host and sponsor a meeting of provider, consumer, union and professional peak bodies to discuss the issues of concern in aged care. The subsequent meeting between 16 organisations formed the National Aged Care Alliance which now has 50 members.

THE THIRD WAVE OF AGED CARE REFORM

The 2012 introduction of the Living Longer Living Better ten year package heralded the next era of aged care reform increasing the supply of services, introducing Consumer Directed Care in Home Care Packages, and introducing the choice of fully refundable lump sum payments or rent for all aged care facility residents.

CHA had influenced much of the home care package direction but continued to argue against places being rationed and allocated to providers through an annual allocation round. Some parts of Australia had waiting lists for access to services, other areas had empty places. In February 2017, the Government transferred all Home Care Packages from providers to consumers and introduced allocations of future packages direct to ACAT assessed consumers. This transferred control of the package to the consumer and overnight created competition, a major step in moving to a more market driven system that empowers the consumer to choose the type of care they are (assessed at) entitled to, where that care is delivered, and the provider.

The last hurdle yet in this reform is the freeing up of residential places, allocating them to the consumers to enable them to choose their provider, and from the providers' perspective, allowing them to choose where to build residential aged care and the number of beds. The current Government will be assessing the implications of this in due course.

On looking back over my 27 years in aged care 22 with CHA, I have been impressed with the quality and commitment of the Catholic aged care sector to the reforms. The number of Catholic owners may be declining but the number of beds and packages in the sector continues to grow with successes in allocation rounds and acquisition of place approvals from existing Catholic and non-Catholic providers taking place.

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OUR STRENGTH IN CORE VALUES

A basic principle underpinning care delivery is the protection and promotion of the dignity of the person. This obliges the community to accept shared responsibility to ensure the wellbeing of all its members. This shared responsibility for all members of the community requires a mutual distribution of available resources. Access to essential aged care is a right, which should be universally maintained. Maintaining that universality and accessibility to appropriate aged care must remain a prime objective of government and a shared commitment of the Australian community.

This shared responsibility for care of the sick, the vulnerable and the dying requires access to essential services to be based on entitlement rather than a welfare scheme. Furthermore, central to Catholic social teaching is the preferential option for treating the poor, disadvantaged and the vulnerable in society. This is what motivates the Catholic sector to play a central role in alleviating economic disparity and threats to wellbeing posed by illness, disability and the frailty of old age. Society's new poor are the very frail dependent older people who may not be economically poor, but who are marginalised from community participation by their frailty, dependence, disability and, in many cases, their cognitive dysfunction.

The Church has an important role to play in caring for the 'new poor' and in protecting them from any changing societal values that would want to cast them on to the human 'scrap heap' and devalue them as non-contributors to the economic wealth of the community. The strength of the Church's presence in aged care will be fundamental to meeting these challenges and in protecting the single uniqueness of the life of every human being.