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The Productivity Commission

The Productivity Commission is the Commonwealth's principal review and advisory body on microeconomic reform. It conducts public inquiries and research into a broad range of economic and social issues affecting the welfare of Australians.

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13 January 1999

The Honourable Peter Costello MP
Treasurer
Parliament House
CANBERRA ACT 2600

Dear Treasurer

In accordance with Section 11 of the *Productivity Commission Act 1998*, I have pleasure in submitting to you the Commission's report on *Nursing Home Subsidies*.

Yours sincerely

Mike Woods
Presiding Commissioner

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Abbreviations and explanations

Abbreviations

ACAT	Aged Care Assessment Team
ACHCA	Australian Catholic Health Care Association
ANF	Australian Nursing Federation
ANHECA	Australian Nursing Homes and Extended Care Association
DHAC	Department of Health and Aged Care
DHFS	Department of Health and Family Services
HACC	Home and Community Care
NANHPH	National Association of Nursing Homes and Private Hospitals
RCS	Resident Classification Scale
RN	Registered nurse

Explanations

Responsibility for aged care policy transferred from DHFS to DHAC following restructuring of Commonwealth government departments on 21 October 1998. In this report, references to the 'department' (in the context of the Commonwealth department responsible for aged care policy) should be taken to refer to either DHFS or DHAC as appropriate.

Summary

Around 140 000 Australians are currently in residential aged care. The Commonwealth Government meets most of the cost of that care, paying an estimated $2.9 billion in subsidies to nursing homes and hostels in 1997-98.

Since October 1997, the *Aged Care Structural Reform Package* has introduced major changes to the subsidy regime and to the regulation of residential aged care.

Funding distinctions between nursing homes and hostels have been minimised, with the introduction of a common classification of care needs — the 'Resident Classification Scale' (RCS) — and an alignment of subsidies across nursing homes and hostels for residents having the same care needs.

The structure of nursing home subsidies has also changed significantly. Under the previous arrangements, these subsidies were paid in several components with the largest, the care aggregated module, varying across the States and Territories. This was essentially in recognition of historical differences between jurisdictions in rates of pay for nurses and personal carers. In contrast, subsidies for hostel residents varied only according to care needs, not across jurisdictions.

Under the new arrangements, the previous nursing home subsidy components have essentially been rolled into a single basic subsidy for each care category. At present, the basic subsidies for 'high care' residents (classifications 1 to 4 on the RCS) continue to differ between jurisdictions. However, it was intended that these subsidies move to nationally uniform rates over a period of seven years. The first move towards this coalescence was made in July 1998. Uniform subsidy rates continue to be set for 'low care' residents (now classifications 5 to 8 on the RCS).

This report responds to a request from the Treasurer that the Commission review one aspect of the Reform Package — the proposal to 'coalesce' subsidy rates for high care residents. Specifically, the Treasurer has asked the Commission to report on whether coalescence should proceed and, if not, what would be an appropriate funding methodology.

In this report, the Commission argues that equity of access to quality aged care must be the main criterion for assessing alternative subsidy regimes. The need to

encourage efficient and responsive service provision, to avoid unnecessary administrative costs and to promote transparency are also important considerations.

The equity criterion establishes certain design features for any aged care subsidy regime. In particular, available government funds should support a uniform quality of care across Australia.

This does not mean that all residents should be equally subsidised irrespective of their ability to pay. Indeed, the recent introduction of income tested fees recognises that the targeting of available funding to those people least able to pay for themselves is more equitable than distributing funds equally among all residents.

Nevertheless, equity does mean that the underlying costs of provision need to be taken into account. Thus, if those costs vary significantly across regions then, assuming no significant difference between regions in the financial means of residents, this would require higher subsidies for services in high cost locations.

Such an approach does not automatically rule out nationally uniform *basic* subsidies. If the dispersion in costs between regions is relatively small, then it may well be more efficient to address the needs of the relatively few high cost services through a special needs supplement. On the other hand, if there are widespread differences in costs, then variable basic subsidies may be a more appropriate approach.

In comparing costs across regions, there is a need to net out the effects of inefficiencies in service provision and differences in the quality of service. In the Commission's view, the subsidy regime should not provide ongoing support for inefficiency or quality differences.

Cost comparisons provided by some of the peak industry bodies and major providers netted out such effects. The study based on the widest range of comparisons suggests differences in standardised labour costs across States and Territories of 4 to 6 per cent, or 2 to 3 per cent either side of the national average.

While the standardised labour cost comparisons did not examine the variations within jurisdictions, there is some evidence to suggest that, apart from some smaller rural and remote area services, and homes providing services to some particular social or cultural groups, the variations are not large. Also, although non-labour costs vary across and within jurisdictions, these costs are a relatively small component of total costs.

On the basis of the available evidence, the Commission has concluded that the current variation in standardised costs between jurisdictions is relatively small. For

this reason, the current case for continuing to differentiate basic subsidies is not compelling. However, future cost trends are uncertain, and cost differentials between jurisdictions need to be monitored.

On balance, the Commission considers that an approach based on nationally uniform basic subsidies should be adopted provided that:

- there is adequate special needs funding to ensure equitable access to services in some particular circumstances — for example, in those rural and remote regions where costs are significantly higher than average; and
- the dispersion in regional cost differences is monitored to ensure that uniform basic subsidies continue to remain appropriate in the future.

However, the Commission does not endorse the current coalescence proposal. The national subsidy rates that would emerge from the proposal are the average of the current state based subsidies. Instead, the Commission recommends a subsidy regime which provides a clear link to the standard of care which the Commonwealth is seeking, while not being prescriptive of the actual inputs required to achieve that level of care. Further, the indexing arrangements should be related to movements in the industry's underlying costs. Finally, the arrangements for providing special needs support should be improved.

Such a regime, which could apply to low care as well high care residents, would:

- support a uniform quality of care across Australia at a specified benchmark level;
- establish greater transparency in the link to the cost of providing care to meet those standards;
- address current funding anomalies across jurisdictions;
- improve the resources available to homes catering for special needs, for example those in rural and remote regions;
- provide incentives for improvements in the efficiency of residential aged care service provision; and
- encourage the development of services which are more responsive to the needs of residents.

The Commission is also proposing some interim changes to address anomalies in the current subsidy regime.

The Commission's recommendations are set out below, together with a table which summarises the main features of its recommended subsidy regime using the current

arrangements as a reference point. Details of the proposed methodology are set out in chapter 7.

On the basis of the evidence available for this inquiry, the Commission supports nationally uniform basic subsidies. However, if a subsequent assessment of the cost base were to reveal a case for regionally differentiated subsidies, all of the Commission's recommendations except for the first would remain relevant.

The Commission has taken the opportunity, in chapter 8, to outline some broader issues deserving of further public debate.

Recommendations

1. The Commonwealth Government should adopt nationally uniform basic subsidies (that is, a separate nationally uniform basic subsidy for each RCS category) for high care residents, as part of a package of changes to address deficiencies in the current subsidy arrangements.

2. The Government should specify its intended outcomes in terms of a standard of care benchmark. The purchase price of care outputs from providers by way of subsidy funding, in combination with funding from residents, should be adequate to meet the cost of providing that benchmark standard of care.

3. As a basis for setting the output purchase price, the Government should arrange for a five yearly assessment of the jurisdictional and national average input costs of providing the benchmark level of care using a standardised input mix averaged across a range of efficient facilities (with, say, 40 to 60 beds). These assessments should be set in a broad context taking into account any changes in the residential aged care benchmark and in care expectations, and re-examining the case for nationally uniform basic subsidies. The reviews should be conducted transparently and independently of Government.

4. Basic subsidy rates should reflect nursing wage rates and conditions applicable in the aged care sector, but only to the extent that these do not exceed the rates and conditions applying in the acute care sector.

5. Basic subsidy rates should be adjusted annually according to indices which clearly reflect the changes in the average cost of the standardised input mix, less a discount to reflect changes in productivity. Revised indexation arrangements should be introduced as soon as possible.

6. The pensioner, oxygen, enteral feeding, respite and hardship supplements should be retained in their current form at this stage. The rates should be suitably indexed. The appropriateness and adequacy of these existing supplements, and the justification for any additional supplements, should be re-examined in each five yearly assessment of costs.

7. The concessional supplement should be set at a single uniform daily rate.

8. The current payroll tax supplement should be replaced by a system of cost reimbursement for payroll tax paid by providers for their employees and for contract nursing and personal care staff.

9. The assessment of costs should include a component to reflect the average workers compensation premiums (base tariff plus experience adjustments) incurred by residential aged care providers. This component should be adjusted between the five yearly assessments if indexation of basic subsidy rates fails to cover significant changes in average workers compensation costs.

   In addition, supplementary funding should be made available for individual providers which incur higher workers compensation costs than the amount allowed for in the average cost base, on the condition that those providers bear an excess equal to 30 per cent of that amount.

10. Superannuation charges should be included in the assessment of costs, at rates appropriate for each RCS classification.

11. The current subsidy reduction for government-run homes and those transferred to the non-government sector should be phased out over a five year period.

12. Additional funding support for higher cost homes in special circumstances, such as smaller higher cost nursing homes in rural and remote areas, should come from a special needs funding pool. The Government should add to current outlays to meet this purpose, separate from, and additional to, the funding of the basic subsidy. The new special needs arrangements should be developed and costed in consultation with providers, resident groups and State and Territory Governments.

13. There should be no requirement for providers to acquit subsidy payments.

14. Residential aged care subsidies should continue to be paid to providers rather than to residents.

15. There should be greater opportunity for the provision of extra services to residents who wish to meet the relevant costs. In this regard:

    - an extra service should be any facility or service that exceeds standard care as defined under the benchmark level of care required to be provided to all residents irrespective of financial means;
    - the controls on where in a facility extra services are provided, and the price charged for such services, should be abolished;
    - the current reduction in the basic subsidy for residents receiving extra service should be abolished; and

- the current strict quota on extra service places should be replaced with a lighter-handed approach and a monitoring system aimed at identifying any cases where extra service provision is reducing access to standard care. The Government should also look at the scope to simplify the regional matrix of concessional resident ratios.

16. The Government should work closely with providers and other stakeholders to resolve quickly all outstanding concerns in relation to program administration and transparency of information.

17. The Residential Aged Care Review should undertake the first assessment of average costs as part of its examination of the adequacy of subsidies for residential aged care (as required by its terms of reference). This should be carried out in accordance with the subsidy methodology set out by the Commission in its recommendations and in the body of this report.

18. Subject to any recommendation from the Residential Aged Care Review in relation to the adequacy of funding provided by the Government for residential aged care, funds earmarked for indexing current subsidies should be redirected to progressively increase the basic rates for the low subsidy States until a coalescence (or, if nationally uniform basic subsidies are not adopted, until a revised set of jurisdictional subsidies) is achieved.

[A summary table is given overleaf.]

Summary of the Commission's subsidy proposals

	Current arrangements	*Commission's proposal*
The standard of care	No explicit link between funding rates and required outcomes	Funding for a uniform quality of care
Cost basis for subsidies	Historical costs of provision	Standardised costs that net out the effects of quality differences and promote efficiencies
Regional differentiation in basic subsidies	Based on state and territory borders, but to coalesce to nationally uniform rates	Nationally uniform rates
Relating subsidies to the dependency of residents	Resident Classification Scale	Resident Classification Scale
Indexation of basic subsidy	Use of COPO index — not specifically linked to movements in industry costs	Subsidy rates adjusted on the basis of increases in input prices, less a productivity discount
Supplementary funding	Range of supplements to cater for specific cost circumstances not readily handled through the basic subsidy regime	Continue system but with some changes to individual supplements
	Special funding for small remote and rural homes through the viability supplement	An augmented and extended special needs funding pool to address these requirements
Deductions	Basic subsidy reduced for government-run homes	Phase out differentiation of basic subsidies according to ownership
Acquittal of expenditure against subsidy payments	Not required	Not required
To whom are subsidies paid?	Providers	Providers
Extra service places	Number of places subject to a quota. Also controls on nature and price of extra services	Provide greater opportunity for the provision of extra services to residents who wish to meet the relevant costs
	Reductions in the basic subsidy for residents in extra service places	Abolish reductions

1 Introduction

The Commonwealth Government provided almost $2.9 billion in 1997-98 to subsidise residential aged care. Of this, about $2.3 billion supported high level care, and nearly $0.6 billion low level care. Nursing homes provide most high level care, and more than 75 per cent of their total costs are covered by the subsidy. Low level care is generally provided in hostels, with the subsidy covering a substantially lower proportion of costs.

This inquiry is mainly concerned with the way in which the Commonwealth Government's subsidy for high level care should be distributed. This issue has important equity and efficiency implications.

Box 1.1 summarises background information about high level nursing home care, the people who use it, and the role of government. Much of the information about the role of government also applies to the hostel sector. Chapters 2 and 3 set out more detailed background information.

1.1 Background to the reference

In the past, a number of different funding methodologies have been used to distribute residential aged care subsidies, with important distinctions between the nursing home and hostel sectors.

The *Aged Care Structural Reform Package,* announced in the Commonwealth's August 1996 Budget, maintained different levels of subsidy for residents with different care needs, but sought to remove the funding distinctions between the sectors by providing for:

- a common classification of care needs for all residents (called the Resident Classification Scale — RCS), to replace the different classifications which had applied to nursing homes and hostels;
- an alignment of subsidies across nursing homes and hostels for residents having the same care needs; and
- a process of 'coalescence', under which individual state based subsidy rates for high care residents would gradually move to nationally uniform rates over a

period of seven years, commencing from 1 July 1998. (Nationally uniform subsidy rates for low care (hostel) residents were already in place.)

In jurisdictions with above average high care subsidy rates, providers raised concerns with the Government that coalescence would adversely affect the availability and quality of nursing home care — indeed, even existing rates were considered insufficient. In contrast, providers in jurisdictions with below average subsidies made representations that the seven year phase-in of uniform subsidies would unduly delay improvements in care in those regions.

Box 1.1 **Nursing home care**

Supply

- 1500 nursing homes provide around 75 000 beds:
  - about 36 000 by private for-profit providers;
  - 28 000 by the charitable and religious sector;
  - 11 000 by governments or on behalf of government.
- The proportion of beds provided by the three sectors differs significantly between jurisdictions:
  - private for-profit: from 56 per cent in NSW to 17 per cent in Tasmania;
  - charitable and religious: from 70 per cent in the NT to 25 per cent in Victoria;
  - government: from 28 per cent in Victoria to 5 per cent in SA.
- About half the nursing homes have 40 beds or less:
  - in Victoria and the NT, 70 per cent of homes have 40 beds or less.
- On average, about 70 per cent of homes are located in metropolitan areas:
  - but three-quarters of homes with 20 beds or less are non-metropolitan.
- About 100 000 persons are employed in nursing homes:
  - the majority are nursing and personal care staff;
  - about three-quarters are part time;
  - over 14 000 volunteers work an average of 11 hours each per month.

Demand

- More than 70 per cent of residents are female.
- About 95 per cent of nursing home residents have high care needs (RCS classifications 1 to 4, with classification 1 representing the highest need):
  - but about 10 per cent of those with high care needs are residents of hostels;
  - this proportion may grow with ‘ageing in place’.
- Respite care has grown markedly in recent years, accounting for more than 25 per cent of admissions. But it still makes up less than 1 per cent of total bed days.
- About half of residents stay for one year or less, with about 13 per cent staying for 5 years or more.
- Average waiting time between approval for entry to care and actual entry is about 31 days.

(continued on next page)

Box 1.1 **(continued)**

Residential care subsidy

- The Commonwealth Government provides a basic subsidy to care providers, currently varying from $49 to $110 per resident per day, depending on:
  - the RCS classification of the resident;
  - the State or Territory where the home is located; and
  - whether the care provided is respite or permanent.
- A number of supplements and deductions are made. These include:
  - supplements for concessional residents (those who cannot afford to pay an accommodation bond or charge), a transitional supplement (in respect of those who are exempt from consideration for an accommodation bond or charge), and respite care, oxygen, enteral feeding and payroll tax supplements;
  - deductions for government (or former government) facilities, where a resident receives extra services, or where a home receives a resident's third party or workers compensation payment;
  - a reduction in respect of income tested fees applying to residents who entered residential care on or after 1 March 1998;
  - a pensioner supplement, a viability supplement to support smaller remote facilities and a supplement in respect of residents in financial hardship.

Care fees and accommodation payments from residents

- A number of care fees can apply:
  - pensioners pay a standard resident contribution of $22 per day;
  - non-pensioners pay a higher standard contribution of $27 per day;
  - in addition, new residents entering care from 1 March 1998 may be required to pay an income tested additional fee of up to $38 per day.
- An asset tested accommodation charge of up to $12 per day can also apply to residents entering care from 1 October 1997.

Regulatory arrangements

- The number of subsidised bed places is controlled by the Commonwealth, with a target of 40 high care beds (generally in nursing homes) and 50 low care beds (generally in hostels) for each 1000 of the population aged 70 years and over:
  - a minimum of 27 per cent of places on average need to be allocated to concessional residents. Special needs groups are also provided for;
  - extra service places (for those prepared to pay for a higher standard of accommodation, food and services) are available, but their number is controlled.
- To continue to receive funding after January 2001, services must obtain accreditation as meeting all residential care standards.
- To require residents to pay accommodation charges, a home must obtain certification as meeting specified building and care standards.
- States and Territories may prescribe staff/resident ratios, regulate the dispensing of medication and/or certain medical procedures, occupational health and safety, workers compensation requirements, building standards, fire prevention and fire fighting measures, etc.
- Staff wages and conditions are generally set by jurisdictional based awards.
- Local government by-laws may also apply (eg waste disposal rules).

Sources: DHFS (1997a); AIHW (1998b); Steering Committee (1998) and submissions.

1.2 Terms of reference

The terms of reference require the Commission to examine current and alternative methodologies for setting nursing home subsidy rates, to report whether the proposed coalescence should proceed and to make recommendations on an appropriate funding methodology. It was also asked to report on:

- differences in costs across States and Territories in providing nursing home care, particularly wage costs for nursing and personal care staff;
- future trends in wage costs;
- whether subsidies should vary by State and Territory and, if so, to what extent; and
- if there is a case for differential subsidies, possible methodologies for maintaining appropriate relativities over time.

The terms of reference are set out in full in appendix A. The Commission was asked to submit its final report by 13 January 1999.

1.3 Scope of the inquiry

A narrow interpretation of the reference would imply focusing solely on the distribution of available funding. However, there are important relationships between funding methodology, the overall quantum of funds, the institutional and regulatory framework, and the share of costs paid for by the Government and by residents. For example, it is difficult to develop an appropriate funding methodology without explicitly recognising quality of care objectives. In turn, this leads to consideration of overall funding levels and the shares to be met by the Government and residents.

Thus, the Commission has taken account of wider issues, insofar as they are relevant to the subsidy regime. It notes that broader issues, not directly covered by its inquiry, are being considered by an independent review of the residential care reforms. This review, chaired by Professor Len Gray, is being undertaken over a two-year period with reports to be provided progressively (box 1.2).

Consistent with its terms of reference, the Commission has not limited itself to comparing the existing state based regime with the proposed nationally uniform subsidy arrangement. It has also considered other forms of subsidy which might

give a better outcome for the community. For example, it has considered whether regionally based subsidies might be justified. Further, although the focus of the inquiry is on high level care, the Commission has recognised that an appropriate methodology could encompass funding for low level care. The Commission has also recognised linkages between funding for capital and for recurrent purposes.

Finally, while the coalescence process relates to subsidies for residents with high care needs irrespective of whether they live in nursing homes or hostels, for ease of exposition, this paper generally uses the term nursing home subsidies/services as a proxy for high care subsidies/services. Similarly, the paper uses the term 'residential aged care', even though a small proportion of high care residents are not older people.

Box 1.2 **Independent review of residential aged care reforms — terms of reference**

To assess and report on the extent to which the *Aged Care Act 1997* is achieving its objects and addressing acknowledged deficiencies in the aged care system, including in relation to:

1. *Access*, including equity for different groups within the residential care client group, equity across regions and the balance of care services available within regions;
2. *Affordability*, including ranges of accommodation payments charged and impact on demand for services from residents in different financial situations;
3. *Quality*, including quality of care, having regard to staffing levels, accommodation and user rights;
4. *Efficiency*, including administrative costs and savings for industry and government associated with the new regulatory, funding, classification and income testing arrangements;
5. *Industry viability*, including adequacy of subsidies and the impact of the new fees and capital funding arrangements;
6. *State and territory programs* including usage of acute hospital, housing, community care, assessment and guardianship services;
7. *Choice and appropriateness*, including facilitation of ageing in place; and
8. *Other considerations*, including for example dementia care.

The review will be undertaken over a two-year period, with reports to be provided on a six monthly basis, and a final report on completion.

Source: Information supplied by the Department of Health and Family Services.

1.4 Consultation

The Commission has endeavoured to facilitate participation in the inquiry and to allow the maximum degree of public scrutiny in the six months specified by the Treasurer. Specifically, the Commission:

- held an initial round of informal discussions in all States and Territories with about 50 organisations and individuals with a range of interests and perspectives;
- released an issues paper to assist those wishing to make formal submissions;
- invited written submissions — over 120 submissions were received from providers, peak provider groups, Governments, unions, residents and carers groups;
- released a position paper in October 1998 setting out the Commission's preliminary proposals;
- released a descriptive paper in November 1998 giving an overview of the residential aged care sector and of its funding and regulatory arrangements; and
- conducted public hearings in November 1998 in Hobart, Brisbane, Melbourne, Perth (by video) and Tamworth to receive feedback on the position paper and descriptive material.

Appendix B lists those who have participated in the inquiry.

The Commission expresses its appreciation to all those who provided written submissions to fairly tight deadlines, participated in the public hearings, and/or gave freely of their time to discuss inquiry issues.

1.5 Report structure

Chapters 2 and 3 set out detailed background information about the residential aged care sector, and its funding and regulatory arrangements.

Chapter 4 sets out assessment criteria relevant to the choice of an appropriate funding methodology, and a framework for deciding whether a nationally uniform subsidy regime is appropriate. It concludes that the extent of variability in costs between regions, and the reasons for observed cost differences, are central factors in deciding between uniform and regionally based subsidies.

Chapter 5 looks at available cost information and establishes that the variation in costs between jurisdictions is much less than the variation in current subsidies.

Drawing on this cost information, chapter 6 concludes that a nationally uniform basic subsidy regime should be adopted. However, it also concludes that the previously announced coalescence process is deficient in other ways and should not proceed.

Chapter 7 presents a subsidy regime which the Commission considers would better meet the Government's objectives in supporting residential aged care.

Finally, chapter 8 canvasses some longer term issues which, if addressed, might improve outcomes for residents and for the community generally without detracting from equity in the provision of aged care.

2 Overview of the residential aged care sector

2.1 Aged care environment

The majority of older people care for themselves, or are cared for, in their homes by family members, relatives, friends, charities and benevolent individuals and through government programs such as Home and Community Care. However, a significant number are cared for in residential aged care facilities. At any one time, around 9 per cent of Australians aged 70 years or over live in these facilities, with a much higher proportion doing so at some stage during their lifetimes.

There are two main types of residential aged care facility — nursing homes and hostels. Both provide accommodation and associated support services, such as domestic services (laundry, cleaning) and help with performing daily tasks (moving around, dressing, personal hygiene, eating). Traditionally, the main difference between the two has been that nursing homes have catered for those who have also required ongoing access to nursing care — so-called ‘high care’ residents. Subsidies for high care residents (classifications 1 to 4 on the Resident Classification Scale) are the focus of this inquiry.

The distinction between nursing homes and hostels is becoming less clear. Nearly 10 per cent of high care residents now live in hostels. Moreover, this figure is likely to increase in the future as a result of changes to government policy which will allow ‘ageing in place’ (that is, removing the necessity for residents to move from a hostel to a nursing home as their care needs increase). An increasing proportion of new facilities are catering for both high care and low care residents.

While the majority of nursing home and hostel services are provided by non-government operators, government plays an important wider role in the sector. For example:

- the Commonwealth establishes policy directions and provides significant funding and program administration support. It is also responsible for defining outcomes and monitoring the performance of service providers against those outcomes (current funding and regulatory arrangements are discussed in chapter 3);

- State and Territory Governments monitor compliance with a range of staffing, building, fire, safety and occupational health and safety requirements. They also operate some nursing homes and hostels.

Governments also support a range of non-residential care services for frail older people. Notable amongst these is the Home and Community Care (HACC) Program — a joint program between the Commonwealth and State and Territory Governments — which provides a range of community-based support services, including home help, personal care, home nursing, meals and transport. While the program provides services to younger people with disabilities and their carers, the majority of its clients are 65 years or over. The Commonwealth also provides funding for community aged care packages which support people who prefer to remain at home, but who require care equivalent to that provided in hostels. The continuum of aged care services is illustrated in figure 2.1.

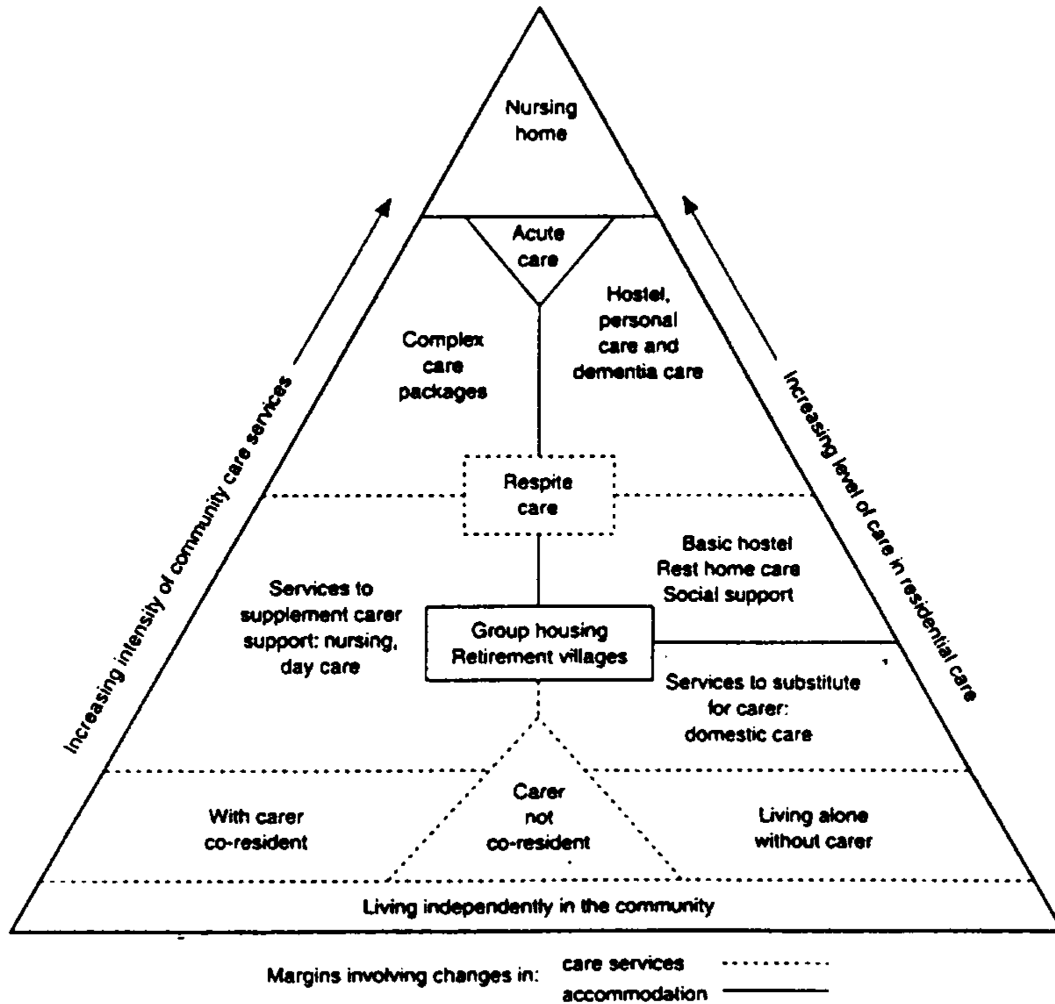
Significantly, this care continuum is evolving over time. For example, over the last decade or so, the Commonwealth has tightened access to subsidised residential aged care places (see chapter 3). This has partly reflected a shift in emphasis towards home based care which has also constrained Commonwealth outlays. One outcome of these changes has been that those entering nursing homes, in particular, are becoming older and more frail. The rationing of residential aged care places has increased demands for community-based services funded by State, Territory and Local Governments.

There has also been a move to rebalance residential care beds between the nursing home and hostel sectors. Until the mid-1980s, nursing homes catered for a wide range of residents, from those requiring intensive nursing care to those needing only minimal supervision. As a result, nursing homes provided the large majority of available residential aged care places. However, over the last decade or so, most of the growth in approved Commonwealth residential care places has been in the hostel sector. As a result, there are now nearly as many hostel beds (65 000) as nursing home beds (75 000). Commonwealth policy is to stabilise this shift to 40 nursing home places, 50 hostel places and 10 community aged care packages per 1000 of the population 70 years and over.

These sorts of changes in the residential aged care sector have had implications for other government supported health and community services which assist the aged. For example, some nursing home patients are treated in acute care hospitals. In this regard the Queensland Government stated that:

> up to 700 beds are occupied at any time in Queensland public hospitals by patients who would qualify for nursing home admission if places were available. (Sub. 10, p. 5)

Figure 2.1 **Hierarchy of the balance of care in Australia**



Source: OECD (1996).

2.2 Supply of residential care services

Nursing homes

There are currently around 1500 nursing homes in Australia providing around 75 000 beds. Around 70 per cent of these homes are located in capital cities or major urban centres. However, the majority of very small homes — less than 20 beds — are located in smaller rural and remote areas (see below).

Ownership

Private for-profit providers supply nearly half (48 per cent) of all nursing home beds, with another 38 per cent provided by religious and charitable organisations (ie private not-for-profit). The remaining 14 per cent of beds are in nursing homes run by, or on behalf of, State or Local Governments (see table 2.1).

Table 2.1 **Nursing home beds, type of home by State/Territory, 30 June 1997**

State	*Private for-profit*	*Private not-for-profit*	*Government and adjusted fees*[a]	*Total*
NSW	16 139	10 623	2 097	28 859
Vic	8 227	4 439	4 856	17 522
Qld	4 675	5 778	1 736	12 189
WA	2 921	2 080	832	5 833
SA	2 989	3 645	294	6 928
Tas	370	1 397	406	2 173
ACT	214	219	86	519
NT	40	146	24	210
Australia	35 575	28 327	10 331	74 233
Australia, 30 June 1993	35 148	26 593	12 724	74 465

a Adjusted fees nursing homes are operated by or on behalf of a State or Territory Government and receive a modified level of recurrent funding from the Commonwealth.

Source: AIHW (1998b).

While the overall share of private sector beds has changed little over the last five years, the charitable and religious sector has increased its share by taking over many of the beds released by State Governments. This trend is expected to continue. As the Victorian Government stated:

> the State intends to divest approximately 1200 residential care beds by 2001 to the private/voluntary sector. (Sub. 60, p. 1)

At the jurisdictional and regional level, the pattern of ownership varies markedly:

- The proportion of beds in private for-profit facilities is highest in New South Wales (56 per cent) and Western Australia (50 per cent) and lowest in Tasmania (17 per cent) and the Northern Territory (19 per cent).
- The proportion of places in religious or charitable institutions is highest in the Northern Territory (70 per cent) and Tasmania (64 per cent) and lowest in Victoria (25 per cent) and Western Australia (36 per cent).
- The proportion of places in facilities operated by, or on behalf of, governments is highest in Victoria (28 per cent) and lowest in South Australia (4 per cent).

- While private for-profit nursing homes provide well over half the nursing home beds in capital cities and metropolitan areas, charitable and religious organisations provide most of the beds in rural and remote areas.

Size

The nursing home sector contains a mix of larger chains and many small, independently run, facilities. Across Australia, half of all nursing homes have 40 beds or less (table 2.2). Only a quarter have 60 beds or more — the size regarded by many as the minimum efficient scale of operation. Southern Cross Homes stated that '41 beds is not viable in achieving any surplus in income. Around 60 beds is, at present, a viable business proposition' (sub. 18, p. 4). Six per cent of nursing homes have more than 100 beds.

Table 2.2 **Number of nursing homes, by size, 30 June 1997**

	Bed size							
State	*1-20*	*21-40*	*41-60*	*61-80*	*81-100*	*101-120*	*121+*	*Total*
NSW	8	129	154	96	46	24	17	474
Vic	65	256	89	17	5	3	9	444
Qld	6	87	50	32	17	11	8	211
WA	2	44	40	10	5	4	5	110
SA	2	89	52	9	3	2	2	159
Tas	9	25	14	4	2	0	1	55
ACT	0	0	2	1	1	1	1	6
NT	3	2	2	0	0	0	0	7
Australia	95	632	403	169	79	45	43	1466

Source: AIHW (1998b).

The proportion of smaller homes is highest in rural and remote areas, where the level of demand is often insufficient to support larger facilities. Over three-quarters of homes with 20 beds or less are located in these areas (AIHW 1998b).

At the jurisdictional level, the concentration of smaller homes is most pronounced in Victoria and the Northern Territory, where over 70 per cent of facilities have less than 40 beds. Tasmania also has a high proportion of smaller homes.

In recent years there has been some rationalisation of smaller homes, particularly in urban areas. AIHW data indicate that, over the last four years, the proportion of facilities with less than 40 beds has declined in all States and Territories other than Queensland and Victoria. Similarly, Aged Care Australia provided data showing that, over the past five years, the proportion of facilities with less than 25 beds has declined by over 40 per cent, with these reductions occurring fairly uniformly

across jurisdictions (sub. 26, appendix 1, p. 2). However, there has also been a decline in the number of facilities of over 100 beds over the same period in a number of States and the ACT. Thus, the average size of nursing homes has remained largely unchanged over the last four years at 50 beds with the median size unchanged at 40 beds. In addition, there has been increasing integration of nursing homes with hostels and assisted living units in order to improve productivity through spreading overheads and administrative costs.

Employment and wage fixing arrangements

A little over 100 000 people are employed in nursing homes (see table 2.3 — but note that this may exclude a significant proportion of employees of government-owned nursing homes). Most are involved in providing nursing and personal care services.

Table 2.3 **Employees in nursing homes**[a]

	For-profit	*Not-for-profit*[b]	*Total*
Number of employees at end June 1996			
Direct service provision	38 300	34 100	72 300
Other[c]	10 400	16 200	26 600
Contract staff	2 700	1 400	4 100
Total employees	51 400	51 600	103 000
Volunteers for June 1996			
Direct service provision	600	6 600	7 200
Other[c]	600	7 800	8 400
Total volunteers	1 200	14 400	15 600
Average hrs. of volunteers during June 1996	8.6	11.4	11.2
Employees at end June 1996 (exc. contract staff)			
Full time	9 900	12 100	22 000
Part time	38 800	38 100	76 900
Total	48 700	50 200	98 900

Note: May not add due to rounding.

a Employment in ANZSIC class 8613, defined as services mainly engaged in providing nursing home or convalescent home facilities (including the provision of nursing or medical care as a basic part of the service). **b** According to the ABS, this excludes government-owned nursing homes classified as 'government organisations', but is likely to include government-owned nursing homes established as separate businesses. **c** Other employees include managerial and administrative support staff (for example, managers, bookkeepers, receptionists, policy and research staff) and others (such as cooks, maintenance workers and cleaners).

Source: ABS (*Community Services, Australia 1995-96*, Cat. no. 8696.0).

Around three-quarters of paid employees work part time and about 90 per cent are female. Contract staff account for about 4 per cent of the paid workforce. There is also some outsourcing of such functions as meal preparation and laundry.

The table shows some significant differences between the employment structures in the for-profit and the not-for-profit sectors. For example, compared with the not-for-profit sector, the for-profit sector:

- utilises a higher proportion of its employees in direct service provision and a lower proportion in administrative and support roles;
- has a higher proportion of contract staff; and
- a lower proportion of full time staff.

There is also a significant volunteer workforce, primarily in the religious and charitable sector. In June 1996, there were almost 14 400 volunteers working an average of 11 hours each.

Wages and conditions for nursing home staff are mainly set by jurisdictional awards. Awards for nursing staff, in particular, are influenced by wages and conditions negotiated in the public hospital sector in the same jurisdiction. In this regard ANHECA said:

> The non-government aged care sector represents only 15 per cent of the wider health care field. As such it is not a price setter and in most cases is forced to follow the lead of the public sector. (Sub. 24, p. 42)

In government-run homes in most States, aged care nurses receive wage parity with nurses in the public hospital sector. However, as noted in chapter 5, there are significant differences between nurses wages in the private nursing home sector and the acute sector.

The Commission understands that over-award payments are not common in the nursing home sector. For instance, the Victorian Employers' Chamber of Commerce and Industry quoted a survey which found that fewer than 1 per cent of Division I and II nurses in Victorian aged care facilities which responded to the survey received over-award payments (sub. D71, p. 2). However, enterprise bargains incorporating over-award payments, and tailored to the specific requirements of individual nursing homes, are replacing awards in some cases. For example, TriCare — one of the largest providers in Queensland — has negotiated an agreement with its nurses. In Western Australia, there are enterprise agreements applying to registered nurses in around 10 per cent of nursing homes (Chamber of Commerce and Industry Western Australia, sub. 49, p. 2).

Other residential aged care services

There are currently around 65 000 hostel beds across Australia, catering mainly for low dependency residents. The charitable and religious sector dominates the provision of hostel places in all States and Territories. The highest proportions of places in government and private facilities are 12 per cent and 9 per cent respectively in Victoria.

In addition, there are around 30 multipurpose services operating in small rural communities lacking the population to support stand-alone facilities. They provide a range of aged care services, including nursing home and hostel care, palliative care, community nursing, home care and meals on wheels. Under the Multipurpose Services Program — a joint Commonwealth-State initiative — funding for residential care is pooled with funding for a range of other programs. In its 1998-99 Budget, the Commonwealth made provision for an extra $24 million over 4 years to extend the coverage of multipurpose services. Thirty new multipurpose services will be established with 800 new residential aged care places being made available.

2.3 Demand for residential aged care

At the end of June 1997, there were around 72 500 people in nursing homes. There were a further 60 000 people in hostels (table 2.4). The data suggest a vacancy rate of approximately 7 per cent for hostels compared with only 2 per cent for nursing homes. The ratio of nursing home residents to hostel residents was highest in New South Wales, Tasmania and the Northern Territory. In Queensland and the ACT, there were more hostel residents than nursing home residents.

Table 2.4 **Residents in nursing homes and hostels by State/Territory, 30 June 1997**

	Nursing homes		*Hostels*	
State	*Residents*	*%*	*Residents*	*%*
NSW	28 400	39	18 900	32
Vic	16 800	23	15 000	25
Qld	12 000	17	12 100	20
WA	5 600	8	5 500	9
SA	6 800	9	6 100	10
Tas	2 100	3	1 500	3
ACT	500	1	800	1
NT	200	<1	100	<1
Australia	72 500	100	60 000	100

Note: May not add due to rounding.

Sources: AIHW (1998a, 1998b).

Access and admission arrangements

The Commonwealth prescribes target ratios of 40 nursing home and 50 hostel beds per 1000 persons aged 70 or more. Entry to facilities is controlled through the Commonwealth Aged Care Assessment Teams (ACATs). These teams assess whether people require residential care and, if so, whether their care needs are likely to be high care or low care. In 1996-97, the average waiting period between approval and entry into care was 18 days for nursing homes and 58 days for hostels (DHFS 1997b). In 1997-98 this had increased to 31 and 108 days respectively (DHFS 1998a).

The majority of new entrants to nursing homes apply for admission from acute hospitals. While most admissions are for permanent care, respite care admission is growing. Of the nearly 45 000 admissions to nursing homes in 1996-97, over one-quarter were for short term respite. This compared with a figure of 8 per cent in 1991-92. The quadrupling of respite care admissions over this period contrasted with a decline in admissions for permanent care of 16 per cent (table 2.5). That said, respite residents still account for only 1 per cent of total bed days in nursing homes (AIHW 1998b).

Table 2.5 **Nursing home admissions by type of care, 1991-92 and 1996-97**

	1991-92		*1996-97*	
Type of care	*No.*	*% of total*	*No.*	*% of total*
Permanent care admissions	38 397	92	32 252	72
Respite care admissions	3 191	8	12 612	28
Total admissions	41 588	100	44 864	100

Sources: AIHW (1997, 1998b).

There is a general yearly limit of 63 days of respite care for each individual. However, ACATs can grant extra days depending on such factors as carer stress, the severity of the resident’s condition, or the absence of a carer.

Characteristics of residents

Sex and age

More than 70 per cent of nursing home residents are female (table 2.6). This is mainly because females tend to live longer than males and are less likely to have a partner to act as a carer. Female residents are older on average than male residents and tend to stay longer. Over half of female residents are 85 years or older, compared with 30 per cent of male residents.

Table 2.6 **Nursing home residents by age and sex, 30 June 1997**

	Females		*Males*		*Persons*	
Age	*No.*	*%*	*No.*	*%*	*No.*	*%*
<70	3 300	6	3 400	16	6 700	9
70-85	21 500	42	11 200	54	32 600	45
85+	27 000	52	6 300	30	33 200	46
Total	51 800	100	20 800	100	72 500	100

Note: May not add due to rounding.

Source: AIHW (1998b).

Dependency

As noted, most high care residents live in nursing homes. However, with ageing in place there is likely to be an increasing proportion of high care residents in hostels.

For subsidy purposes, high level care is classified as categories 1 to 4 on the 8 level Resident Classification Scale (RCS). These classifications take into account a wide range of factors and involve a detailed scoring system (see chapter 3). Of the 76 000 or so high care residents across Australia, the majority are classified as categories 2 and 3 on the RCS. The highest proportions of RCS 1 and 2 residents are in Victoria and the Northern Territory, while the highest proportion of all high care residents are in the Northern Territory and New South Wales (table 2.7).

Table 2.7 **Estimated May 1998 RCS distribution by State and Territory, number of residents**

	High care				*Low care*	
State	*RCS 1*	*2*	*3*	*4*	*5-8*	*Total*
NSW	3 541	11 882	10 260	2 814	19 266	47 763
Vic	2 712	8 230	5 671	1 285	14 245	32 143
Qld	1 904	5 678	4 532	1 408	10 764	24 286
WA	416	2 567	2 162	595	5 481	11 221
SA	668	3 076	2 826	699	5 862	13 131
Tas	191	790	867	267	1 547	3 662
ACT	105	229	206	108	661	1 309
NT	12	124	82	20	107	345
Total	9 549	32 576	26 606	7 196	57 933	133 860

Source: DHFS (1998b).

A simpler perspective on dependency is provided by an AIHW survey of residents' care needs over the period 1994 to 1996. This revealed that virtually all nursing home residents required at least some help with washing and dressing (90 per cent required total help), 90 per cent required at least some help with eating (one-third

needed total help) and 95 per cent at least some help with mobility and transfers (63 per cent total help) (AIHW 1997). The AIHW (1998b) also notes that the dependency level of newly admitted permanent residents during 1996-97 was, on average, higher than for current residents. Similarly, new residents entering residential care since October 1997 are, on average, more dependent than people already living in care (table 2.8).

Further, recent research commissioned by the Department of Health and Family Services indicates that around 60 per cent of nursing home residents and 28 per cent of hostel residents have dementia.

Table 2.8 **Distribution of RCS scores of all residents of aged care facilities and of new residents, October 1997 to June 1998**

per cent

	RCS1	*RCS2*	*RCS3*	*RCS4*	*RCS5*	*RCS6*	*RCS7*	*RCS8*
All residents	6.6	23.1	18.0	4.9	8.3	11.1	22.7	5.3
New residents	8.3	26.0	23.6	5.8	7.6	9.0	17.1	2.6

Source: DHFS (1998a).

Pension status

Full pensioners comprise around 65 per cent of residents, part-pensioners comprise around 25 per cent of residents while the remaining 10 per cent of residents are non-pensioners (DHFS 1997a, p. 7-5).

Greater encouragement of self-provision in retirement through occupational superannuation, particularly in the last decade, may see these pension dependency rates decline in future years. Larger numbers of self-funded retirees may also have implications for the demand for extra service places.

Length of stay

Estimates of the length of stay of residents indicate that, in 1995-96, one in six permanent admissions left in the first month and over half within the first year (table 2.9). A small proportion (13 per cent) stayed for 5 years or more. Despite the increasing dependency of residents, permanent admissions per bed have dropped from 0.52 in 1991-1992 to 0.43 in 1996-97.

Separations

The vast majority of separations from permanent nursing home care were due to death (table 2.10). In 1996-97, only 5 per cent of those leaving returned to the community, with a further 2 per cent moving to a hospital. In contrast, nearly 60 per cent of residents leaving respite care returned to the community.

Table 2.9 **Cumulative expected length of stay distribution of permanent nursing home admissions, 1995-96**

Length of stay	*Admissions* *Per cent*
1 month	17
2 months	25
3 months	30
4 months	34
6 months	40
1 year	50
2 years	64
3 years	74
5 years	87
>5 years	100

Source: Steering Committee (1998).

Table 2.10 **Separations of permanent and respite nursing home residents, 1996-97**

	Permanent residents		*Respite residents*	
	No.	*%*	*No.*	*%*
Death	28 529	88	686	5
Return to community	1 570	5	7 265	57
To hospital	651	2	657	5
To hostel	504	2	258	2
To other nursing home	564	2	2 050	16
Other	443	1	1 775	14
Total separations	32 261	100	12 691	100

Source: AIHW (1998b).

Future demand

Projecting future demand for residential aged care services is far from simple. Prima facie, the ageing of Australia's population suggests that there will be a significant increase in demand for these services. Current projections indicate that, over the next 50 years, the proportion of Australians aged 70 and over will more than double, while the proportion of those aged 80 years and over will triple. Based on 1993 age

and sex-specific usage of residential care, the AIHW examined the impact of these demographic changes on future demand for nursing home and hostel beds. It projected, for example, that even if nursing homes were to cater only for the most dependent residents (RCS levels 1 to 3), an extra 12 500 beds would be required by 2011 (reported in Gibson 1998, p. 60).

However, such projections must be qualified in the light of other factors that will influence future demand for residential care services. For example, the increases in life expectancy that partly explain the projected ageing of Australia's population are likely to be accompanied by later onset of frailty. Similarly, the availability of a wider range of community care options is likely to further offset the impact of the ageing of the population on demand for residential care. Social changes will also have an impact on future demand. For instance, the increased rate of female work-force participation in recent years, higher rates of divorce and the increase in single-person households will affect both the structure and functioning of informal support networks and the availability of volunteers in the welfare service industry.

3 Funding and regulatory arrangements

The residential aged care sector is heavily controlled by governments. Nursing home providers depend on a government subsidy for the majority of their income, recurrent and capital contributions from residents are regulated, the supply of available (subsidised) places is controlled, eligibility for residential care is restricted, there are controls over staffing, minimum ratios are set for concessional residents together with differential subsidy incentives, extra service places and extra service fees are controlled, and there are regulated care and accommodation standards. Much of this control stems from the Commonwealth Government, but the States and Territories, and local government authorities, are also involved.

This chapter provides background information about the funding and regulatory environment for residential aged care and about recent changes to those arrangements. It focuses on the provision of high level care (RCS 1 to 4, predominantly in nursing homes), but relevant information about the provision of low level care is also given.

3.1 Subsidies

The Commonwealth Government accepts responsibility for the subsidisation of residential aged care in both nursing homes and hostels. The department advised that, on average, the Commonwealth provides about 78 per cent of nursing home income and a somewhat lesser proportion of hostel income. Residents provide most of the remainder, with some income from charitable sources and from donations. State and Territory Governments financially support the facilities they operate, as these homes receive lower Commonwealth subsidies than other nursing homes. They also provide support for some charitable facilities, particularly those operating in rural and remote regions. Table 3.1 shows total Commonwealth expenditure on residential aged care services from 1991-92 to 1997-98, while table 3.2 shows the average annual subsidy per resident from 1994-95 to 1996-97, by State.

Nursing homes

A number of subsidy arrangements for nursing homes have applied since recurrent subsidy payments commenced in 1963. Box 3.1 sets out a brief history. The more recent arrangements are described in the following sections.

To control the cost escalation occurring under the previous subsidy arrangements, the basis of funding was changed in stages from 1987, to provide nursing homes with a fee paid per resident/day, comprising:

- a standard aggregated module (SAM) common to all nursing homes to reflect costs such as food, laundry, cleaning, electricity, building maintenance, non-care staff salaries, and a return on investment. SAM funding was coalesced to a single national rate over the five years to 1992;

Table 3.1 **Commonwealth expenditure on residential aged care, 1991-92 to 1997-98**

$ million in 1996-97 dollars

Year	*Nursing homes*	*Hostels*	*Total*
1991-92	1 748	255	2 003
1992-93	1 806	295	2 101
1993-94	1 812	332	2 144
1994-95	1 900	382	2 282
1995-96	2 048	427	2 475
1996-97	2 171	474	2 645
1997-98[a]	2 280	584	2 864

[a] Figure for 1997-98 is nominal expenditure.

Source: Steering Committee (1998), Commonwealth of Australia (1988), DHFS (Sub. 52).

Table 3.2 **Average annual Commonwealth subsidies per utilised place — nursing homes, 1994-95 to 1997-98[a]**

$

State	*1994-95*	*1995-96*	*1996-97*	*1997-98*
New South Wales	24 482	27 994	31 047	30 093
Victoria	28 410	29 335	30 922	30 334
Queensland	20 654	23 480	26 413	27 208
South Australia	25 358	27 775	28 828	29 931
Western Australia	23 998	27 774	29 101	28 916
Tasmania	27 088	29 962	31 838	32 522
Northern Territory	28 802	31 071	31 442	28 793
Australian Capital Territory	27 164	25 911	30 102	33 866
Australia	24 896	27 580	29 917	29 648

[a] Differences in average annual subsidies between States reflect differences in subsidy rates between jurisdictions as well as differences in dependency of residents.

Source: DHFS (1998a).

- a care aggregated module (CAM) for nursing and personal care staff costs. Each resident was classified into one of five care levels. Each level attracted a specified number of nursing and personal care hours, and a 'standard hourly rate' specific to each State. These rates were based on a notional mix of staff categories (for each level of care), and the award rates for those categories in each State. In contrast with SAM, any unspent funds below a 1 per cent tolerance were recovered by the Government following an acquittal process. Conversely, if a nursing home spent more on direct care than the amount funded, beyond a 1.5 per cent tolerance, it had to meet the extra cost; and

Box 3.1 **Brief history of nursing home subsidies from 1954 to 1987**

The Commonwealth Government first became directly involved in supporting residential aged care in 1954, when it began providing subsidies to charitable and religious bodies toward the cost of constructing homes for the aged. In 1963, in an attempt to free up hospital beds for acute care patients, the Government began paying 'nursing home benefits' to nursing home residents in approved nursing homes. The subsidies resulted in rapid growth of the number of nursing homes and nursing home beds.

In 1970, a review found that almost 25 per cent of nursing home residents did not need to be there on medical grounds. In an attempt to stem the expansion of nursing home beds, the Government introduced growth and admission controls, and fee control arrangements (the Participating Nursing Home Scheme). The construction of hostels for aged people who needed personal care rather than medical care was also encouraged. The new measures proved to be effective in curbing the excessive growth of nursing home beds.

In 1975, the Government introduced the Deficit Financed Nursing Home Scheme. This scheme provided recurrent funding for nursing homes operated by non-profit religious, charitable or benevolent organisations.

Both the Participating Nursing Home Scheme and the Deficit Financed Nursing Home Scheme remained in place until 1987. However, problems remained, as both schemes were based essentially on cost reimbursement, providing little incentive for proprietors to seek efficiencies. As long as the nursing homes could show that their expenses had risen, the Commonwealth contribution was increased to cover the additional cost. There were also problems in respect of: quality of care; lack of uniformity in staffing, funding and care; and administrative intrusiveness.

Source: Based on DHFS (sub. 52).

- other cost reimbursed expenditure (OCRE) applied to staff overhead costs such as long service leave, superannuation for nursing and personal care staff, payroll tax and workers compensation. OCRE was originally fully cost-reimbursed, but funding for the workers compensation cost component was later amended in an effort to encourage owners to provide a safer working environment for staff. From 1995-96, nursing homes were paid an amount equal to the state average workers compensation cost percentage of payroll (with transitional arrangements for the highest cost homes).

The actual Commonwealth subsidy paid was equal to the sum of these three components, *less* a standard contribution made by the resident, equivalent to 87.5 per cent of the single pension plus rent assistance.

Eligible nursing homes also received one or more of the following extra assistance payments:

- 24-hour-top-up funding, a form of 'floor funding' designed to prevent government support from dropping below the minimum level deemed necessary to ensure 24-hour nursing cover;
- designated home funding, for homes more than 50 km from another nursing home or caring for residents in a special needs group; and
- isolated home funding, for homes in remote locations.

Initially, no additional funding was available for costs associated with enteral feeding and oxygen requirements. However, in the 1991-92 Budget, the Government provided such funding in the form of supplementary payments.

In 1993, the Government commissioned Professor Bob Gregory to undertake a review of the structure of nursing home funding arrangements (Gregory 1993). This was later extended to include the interaction between nursing home and hostel funding and their different fee arrangements, and the issue of the maintenance of the quality of nursing home buildings and the replenishment of capital stock (Gregory 1994). Gregory's findings are summarised in box 3.2.

Hostels

From 1954, Commonwealth funding — both capital and recurrent — was available to provide suitable accommodation for aged or disabled people so that they might reside in conditions approaching as closely as possible normal domestic life. This early support was largely a housing initiative for those who did not have families with whom to live (DCSH 1986).

In 1969, personal and hostel care subsidies were introduced. These were intended to meet costs which could not be met from the resident contribution of 85 per cent of the pension plus rental assistance. Hostels could admit any persons they wished, but the personal care subsidy was only payable for those residents assessed as needing hostel care.

From 1972, additional capital funding became available for expanding the number of hostel beds. Capital funding also became available for upgrading of existing facilities.

Box 3.2 **Gregory review of the structure of nursing home funding arrangements — summary of main findings**

Stage 1 findings

- The requirement to acquit the CAM component of funding meant there was no flexibility in the allocation of staff between nursing and personal care duties, and domestic duties.
- The requirement to use all of the CAM component of funding for nursing and personal care meant that efficiencies in the nursing and personal care budget would not increase profits.
- In conjunction with the non-recognition of over-award payments in the CAM formula, the acquittal system reduced nursing home proprietors' incentives to participate in enterprise bargaining.
- Because indexing was based on movements in the relevant nursing awards, it was not possible to take account of enterprise agreements.
- The funding system did not provide sufficient incentive for the maintenance of the quality of nursing home buildings and the replenishment of nursing home capital stock over time.

Stage 2 findings

- There were financial disincentives for private investment in nursing home stock, because:
  - homes would gain no extra income as a result of that investment; and
  - the number of nursing homes was closely regulated, resulting in nearly all homes operating at near to full capacity, regardless of the state of their buildings.
- The hostel capital system was working reasonably well, through targeted use of capital funding and the hostels' ability to charge variable amounts according to residents' income and assets.

Source: Gregory (1993, 1994).

From 1986, hostels were required to ensure that 20 per cent of persons admitted were financially disadvantaged (that is, in receipt of the full pension plus some rental assistance). These residents could not be charged more than 85 per cent of the standard rate of pension plus rental assistance, and were exempt from what were sometimes known as 'donations' (capital bonds or outright capital contributions). Fees and donations paid by the remaining 80 per cent of residents were negotiated between the hostel and the prospective resident.

The current system

In its 1996-97 Budget, the Commonwealth Government announced major changes in its residential aged care policies. The changes were intended to:

> address major structural problems with the existing residential aged care system in order to make it more sustainable and to make the system more responsive to the needs of frail older people. (Commonwealth of Australia 1996, p. 215)

These changes were included in the Aged Care Structural Reform Package. Amongst other things they provided for an end to the funding distinctions between nursing homes and hostels. The key element of the aligned funding structure is 'a single funding and classification system, designed to distribute funding equitably across the residential aged care sector' (DHFS 1997a, p. 1-2). The new arrangements are also designed to ensure that access to residential care is based on need rather than capacity to pay. The Residential Care Manual states:

> This system ensures that funding is properly matched to the care needs of residents and provides appropriate support for dementia care, wherever residents are in the system. It provides improved flexibility and choice for residents and providers, including greater opportunities for 'ageing in place'. (DHFS 1997a, p. 1-2).

The Package (as subsequently amended) also introduced significant changes to resident charges. These include an income tested fee for people entering after March 1998. This is to ensure that wealthier residents make a fair and reasonable contribution to the cost of their care (Commonwealth of Australia 1996, p. 216). The package, as originally introduced, also included a uniform system of accommodation bonds across the residential aged care sector. This system was subsequently amended on 6 November 1998, so that different arrangements for accommodation payments again operate for high care residents compared to low care residents. Individual aspects of the current system are described in more detail below.

The residential care subsidy

Under the new funding arrangements, from 1 October 1997 nursing home income consists of a residential care subsidy from the Government, *plus* care fees and accommodation payments from residents. The residential care subsidy consists of a basic subsidy (current rates are given in table 3.3), which is subject to additions or reductions in respect to particular categories of resident. Details of how the residential care subsidy is calculated are given in box 3.3.

Table 3.3 **Basic subsidy rates for residential aged care**
$ per resident per day as at 1 July 1998

Resident classification	*National*	*NSW*	*Vic*	*Qld*	*SA*	*WA*	*Tas*	*ACT*	*NT*
1		104	109	90	97	100	110	100	106
2		94	98	81	88	91	100	91	95
3		81	84	70	76	78	86	78	82
4		57	60	49	54	55	62	56	58
5	34								
6	28								
7	22								
8	0								

Source: DHFS.

Some features are worth a mention:

- for the time being, different basic subsidy rates for high care continue to apply for different States and Territories (subject to coalescence — see below);
- the not-for-profit sector, while exempt from payroll tax for its own staff payroll, may be eligible to claim the payroll tax supplement where it employs contract labour;
- provision to pay a higher subsidy to higher cost homes is limited; and
- there is no provision for a higher subsidy for any additional costs incurred by particular facilities in providing better accommodation, for example, in single rooms.

The indexation arrangements which applied at the end of the CAM/SAM system have continued under the new arrangements. The basic subsidy rates are indexed annually on 1 July using the Commonwealth Own Purpose Outlays (COPO) index formula. The particular COPO index used is Wage Cost Index 9 (WCI9) which is weighted 75 per cent for wage costs and 25 per cent for non-wage costs. WCI9 uses the Safety Net Adjustment for indexing wage costs and the Treasury Measure of Underlying Inflation for non wage costs. For 1998-99, the WCI9 was 1.014. All

other payments, other than the oxygen and enteral feeding supplement, are also indexed using the WCI9. The oxygen and enteral feeding supplements are indexed using the TMUI, which was 1.015 for 1998-99.

Box 3.3 **Calculating the Residential Care Subsidy**

[Note: some transitional arrangements apply — see text.]

The basic subsidy amount is determined first (see table 3.3).

A number of supplements may be added:

- the concessional and assisted resident supplement (for residents unable to afford to pay an accommodation bond or charge);
- the respite supplement (for residents receiving respite care);
- the oxygen supplement (for residents in need of oxygen treatment);
- the enteral feeding supplement (for residents in need of enteral feeding);
- the payroll tax supplement (where providers care for high dependency residents (categories 1 to 4) and are liable for state based payroll tax);
- the transitional supplement (for residents in nursing homes and hostels as at 1 October 1997, who therefore cannot be assessed for concessional resident status and who do not receive the concessional resident supplement);
- the pensioner supplement (this replaces the contribution previously made by pensioners out of their rent assistance, and is payable for all residents who receive an income support payment, have a dependent child, or are respite residents);
- the viability supplement (where a provider is operating in circumstances which might otherwise be financially non-viable, assessed against a range of criteria including remoteness, whether a facility is co-located with another service, and any special resident needs); and
- the hardship supplement (for residents for whom the fee as assessed under the income test (see below) would cause financial hardship).

A number of reductions may apply:

- the extra service reduction (applies where residents receive care on an extra service basis. The amount of the reduction is equal to 25 per cent of the fee for the extra service);
- the adjusted subsidy reduction (for residents of state owned and operated facilities, and ex-government facilities);
- the compensation payment reduction (where residents receive a lump sum or a continuing payment for compensation under a judgment or settlement); and
- the income tested reduction (where a resident is liable to pay an income tested fee — see text).

Source: DHFS (1997a).

The Resident Classification Scale

Before the introduction of the Aged Care Reform Package, different care need classification schedules applied to the hostel and nursing home sectors. Assessment in nursing homes was based on the Resident Classification Instrument, and in hostels on the Personal Care Assessment Instrument. As part of the Aged Care Reform Package, a single classification system was introduced, one of its objectives being to:

> break down the distinction between different types of residential care — that is, nursing homes and hostels — leading to funding being based on level of care need rather than on the type of facility and [encouraging] ageing in place. (DHFS 1998b, p. 5)

Under the new Resident Classification Scale (RCS), there are eight care levels. RCS1 represents the highest dependency level, and RCS8 the lowest. As a first step towards admission, an Aged Care Assessment Team may assess a potential resident as eligible for admission, classifying the resident as requiring either high level care or low level care. The more detailed classification is undertaken after admission, when the care provider assesses the person against the RCS. The provider determines an RCS category on the basis of 22 questions covering such areas as clinical needs, ability to do various daily tasks, major areas of personal care need, communication or sensory assistance, and the need for social or emotional support.

Apart from unifying the nursing home and hostel sectors, another intention of the Aged Care Reform Package in general, and the RCS in particular, was to redistribute funds towards the hostel sector where hostels cared for high dependency residents. It was also intended to provide better support for residents suffering from dementia. A review of the RCS (DHFS 1998b) found, inter alia, that the RCS had resulted in an increase in total recurrent funding for all residential care facilities, with total funding for hostels increasing by 10 per cent, and total funding for nursing homes increasing by 1 per cent.

Coalescence

As part of the new funding arrangements, a 'coalescence' process was proposed, and indeed commenced. DHFS provided a rationale:

> hostel rates had always been national, nursing home infrastructure [SAM] rates had already been coalesced to a single national rate over five years and personal and care salaries [reflected in CAM] were coalescing themselves [through reduction of interstate wage differentials] in the period before structural reform. Given these developments, and

> the desire of the Commonwealth to purchase consistent outputs rather than to fund inputs, the strategy of coalescence was the natural progression of funding policy. (Sub. 52, p. 22)

Under the proposed coalescence arrangements, the jurisdictional differences in basic subsidy rates for high care residents (RCS 1 to 4) were to be phased out over seven years. The phasing program specified a 2 per cent adjustment — up or down towards the national average — on 1 July 1998, followed by adjustments in subsequent years of 4, 8, 14, 24, 24 and 24 per cent respectively. The payroll tax supplement was also to be coalesced over seven years.

The first step in the coalescence process took effect as proposed. However, further coalescence has been deferred pending the outcome of the Commission's review. Box 3.4 provides a notional example of how coalescence was to work (see also appendix D).

Clearly, there would be winners and losers from coalescence, with providers in some States and Territories receiving relatively more, and some relatively less, than if separate jurisdictional subsidies and current indexing arrangements were to continue. Those States benefiting would be Queensland, South Australia, Western Australia and the ACT (except for RCS 4). The biggest losers would be Tasmania and Victoria (see table 3.4).

Table 3.4 **Differences in basic subsidy rates per bed/day**

Compared with the 1998-99 national average

Category	*NSW*	*Vic*	*Qld*	*SA*	*WA*	*Tas*	*ACT*	*NT*
	$	$	$	$	$	$	$	$
1	-1.82	-6.76	12.03	4.74	1.42	-8.26	1.61	-3.73
2	-1.82	-6.20	10.85	3.91	1.15	-7.82	1.07	-3.62
3	-1.24	-4.96	9.76	3.48	1.39	-6.68	0.88	-2.74
4	-1.14	-3.62	6.88	1.75	0.91	-5.50	-0.29	-2.07

Source: Derived from DHFS information.

Capital funding

Since 1954, various arrangements have been in place to provide government support for investment in new facilities and the upgrading of existing facilities. Different provisions have operated in the hostel and nursing home sectors. Within the nursing home sector, capital grants have been more readily available to charitable and not-for-profit homes. Some funding has been available to private for-profit operators

through 'additional recurrent funding' (ARF). This provided a subsidy for replacement or upgrading of facilities, paid monthly over a 10-year period.

Box 3.4 **Coalescence — an illustration of how it works**
(Notional example based on Queensland 1997-98 RCS1 rate — see also appendix D)

The proposed coalescence program phases out jurisdictional differences in basic subsidy rates over seven years. It does this by reducing the difference between individual state rates and the national average, commencing on 1 July 1998, with a 2 per cent adjustment, followed in subsequent years by adjustments of 4, 8, 14, 24, 24 and 24 per cent respectively.

The actual calculations involve multiplying the differences from the national average (after indexation), each year, by a fraction arrived at by dividing the relevant percentage by the proportion of the difference yet to be coalesced. In the first year that fraction is 2/100, in the second year it is 4/(100-2) =4/98, in the third year it is 8/(100-2-4) = 8/94, in the fourth year 14/(100-2-4-8)=14/86 and so on until in the seventh year the fraction is 24/(100-2-4-8-14-24-24) = 24/24. The amounts so found are added to those individual state rates where they are lower than the national average, and subtracted from the individual state rates where they are higher than the national average. The table below shows how this process would change Queensland RCS1 rates each year (using the relevant COPO indexation index for 1998-99 for the whole period).

Year	*Prev. year's nat. av.*	*Nat. av. indexed*	*Prev. year's Qld RCS1*	*Qld. rate indexed*	*Diff. from nat. av.*	*Coales. fraction*	*Adj. required*	*Current rate*
1998-99	99.86	101.26	87.74	88.97	12.29	2/100	+0.25	89.21
1999-00	101.26	102.68	89.21	90.46	12.22	4/98	+0.50	90.96
2000-01	102.68	104.11	90.96	92.24	11.88	8/94	+1.01	93.25
2001-02	104.11	105.57	93.25	94.55	11.02	14/86	+1.79	96.35
2002-03	105.57	107.05	96.35	97.69	9.36	24/72	+3.12	100.81
2003-04	107.05	108.55	100.81	102.22	6.33	24/48	+3.17	105.39
2004-05	108.55	**110.07**	105.39	106.86	3.21	24/24	+3.21	**110.07**

Source: Based on methodology advised by DHFS.

From 1 October 1997, the Government introduced accommodation payments (see below) for eligible nursing home residents. While the Government ceased most of its other capital funding, a capital program of $10 million a year over four years has been made available to target services in rural and remote areas and those with

special needs. When accommodation payments were first introduced, those providers in receipt of ARF at October 1997 who elected to continue to receive these payments, would not be eligible to charge accommodation payments nor to receive the concessional supplement. In December 1998 the Minister announced that the legislation would be changed to enable current holders of ARF to both continue to receive ARF (but phasing down as the proportion of residents living in the home prior to 1 October 1997 declines) and to receive accommodation payments and concessional supplements.

3.2 Residents fees and payments

Until the introduction of the CAM/SAM system, nursing home proprietors were largely free to determine residents fees. With the advent of CAM/SAM, the resident contribution was fixed at 87.5 per cent of the single pension plus rent assistance (a supplement received by those who lived in rental accommodation), irrespective of their care needs or the quality of the service provided. There was no additional income tested fee. Thus, there was no direct link between the costs of providing care in nursing homes and fees paid. As noted above, hostels continued to be able to negotiate fees with the majority of their residents.

With the changes implemented since 1997, there are now two main types of fees which may be charged to nursing home and hostel residents — care fees and accommodation payments, both based on the financial circumstances of the resident. Care fees (consisting of standard fees and income tested fees) are a contribution towards the recurrent cost of providing care. Accommodation payments are primarily intended as a contribution towards capital costs, although in practice they too may be used for recurrent purposes.

Care fees

Residents entering care since March 1998 have been liable to pay both a standard resident contribution plus an income tested compulsory fee if private income exceeds $50 per week. The Government's subsidy is reduced by the amount of any such income tested payment. However, the majority of residents (see chapter 2) are full pensioners and do not pay any income tested fee. Further, 'higher income' residents in care before 1 March 1998 do not have to pay any income tested fee, even if they move from one service to another.

Care fees currently payable by eligible residents are:

- full pensioners: $22 per bed/day (85 per cent of the basic pension);

- part pensioners: up to $34 per bed/day (a standard fee of $22, plus an additional fee of 25 cents for each dollar of private income above $50 a week up to a maximum of $12 a day); and
- self-funded retirees: up to $65 per bed/day (a standard fee of $27 plus an additional fee of 25 cents for each dollar of private income above $50 a week up to a maximum of $38 a day).

DHFS estimates that by 2007 income testing will provide around 2.5 per cent of total residential care income.

Extra service places (see below) are subject to additional charges. As the government subsidy is reduced by an amount equivalent to one quarter of the extra service fee, the resident may be asked to make up the loss of subsidy in addition to paying the fee for the extra service (see DHFS 1997a, p. 15-15).

Accommodation payments

Since the 1950s, hostel operators have been able to levy capital contributions (bonds or outright contributions) from (most) new residents as a condition of entry. The department indicated that these entry contributions averaged about $26 000 per resident in 1993. No similar arrangements existed for nursing homes. Under the current system there are still differences in the accommodation payments payable by high care and low care residents.

High level care residents — the accommodation charge

The accommodation charge is an additional daily fee which residents with assets above a specified minimum, who enter permanent high level care (RCS 1 to 4) *may* be asked to pay by the provider, once a facility has achieved certification (see below).

Residents living in a nursing home prior to 1 October 1997 cannot be asked to pay an accommodation charge as long as they remain in the same home. If they move to another service, an accommodation charge may be levied if they are otherwise eligible. Residents who enter an extra service place may be asked to pay an accommodation bond (see below).

The amount of the charge is agreed between the resident and the provider, subject to an indexed maximum of $12 per day (or $4380 a year), depending on the resident's assets at time of entry. A resident with assets less than 2.5 times the annual age pension (around $23 000) cannot be asked to pay an accommodation charge. A

resident's home is not included as an asset if the resident' partner or dependent child is living in it, or if a carer of the resident has been living there for at least two years, and is eligible to receive an income support payment. It is also excluded if a close relative, who is eligible to receive an income support payment, has been living there for at least five years.

An accommodation charge cannot be levied for more than 5 years.

Low level care residents — the accommodation bond

Low level care residents, and high level care residents entering extra service places, may be asked to pay another form of accommodation payment — an accommodation bond, the balance of which must be refunded if the resident dies or leaves the facility. The provider can take $2600 (indexed) annually for five years out of the capital amount, and retain the interest earned on the full amount of the bond for the full period of care. Prudential requirements are in place which providers must observe when charging accommodation bonds. To generate revenue from a bond broadly equivalent to that generated by the accommodation charge for high level care residents, with an interest rate of 5 per cent, a bond of around $35 000 would be required. The department indicated that the average bond is around $54 000 (late 1998).

For the purposes of determining whether a resident is potentially liable for an accommodation bond or a charge, only the resident's classification (of high level care or low level care) at the time of entry to a facility is relevant. Thus, for example, residents who originally entered low level care and paid an accommodation bond, and who are later reclassified as needing high level care, and who remain in the same facility, do not lose their status with regard to the accommodation payment. The service provider retains the bond until permanent separation from the facility.

As is the case for high level care residents, low level care residents cannot be charged an accommodation bond if it would leave them with less than the minimum permissible asset value of 2.5 times the annual pension. Apart from that provision, there is no ceiling on the amount of accommodation bond which can be charged. However, where a pensioner resident pays an accommodation bond of more than ten times the pension (currently $92 000), the pensioner supplement is not payable in respect of that resident. That loss would be equivalent to $1825 a year, or the earnings (at 5 per cent) on $36 500. Hence, the loss of the pensioner supplement would mean the bond would have to be larger by at least that amount to compensate for the loss.

3.3 Controls over bed numbers

Planning targets

In the period following the introduction of nursing home benefits in 1963, there was rapid growth in nursing home beds as well as a significant expansion of hostel accommodation. According to the *Nursing Homes and Hostels Review* conducted in 1986, this was the direct result of government intervention, and its consequences were largely unseen, unplanned and uncoordinated (DCSH 1986). The review concluded that, if beds were available, they were likely to be filled. It suggested that the focus should be on the provision of alternatives to nursing home care, with greater emphasis on maintaining people in their own homes rather than in institutional or residential care. The review recommended that the overall ratio for general purpose hostel places and nursing home beds should be 100 per 1000 persons aged 70 years or over, with 40 of those beds reserved for people over 70 with high care needs.

These targets were subsequently adopted, and have been carried through to the present arrangements, the current targets being 40 high level care places, 50 low level care places and 10 community care places per 1000 of the population 70 years and over, by 2011 (DHFS 1997b). For Aboriginal and Torres Strait Islander people, the target is 100 places for every 1000 indigenous Australians over 50 years and over. However, the total number of aged care places has fallen short of these targets (see table 3.5). A recent Auditor-General's report (ANAO 1998) was critical of this shortfall, saying that to meet the target planning ratio immediately, an addition of nearly 10 100 places would be needed. It attributed the decline in part to time lags inherent in the system (see below) and recommended that DHAC:

> conduct a review of its planning process to put in place appropriate action to achieve reduction in the time between estimation of the need for new places and the actual provision of these places. (ANAO 1998, p. 20)

Table 3.5 **Provision ratios of nursing home, hostel and care package places[a]**

	1985	*1990*	*1998*	*Target 2011*
Nursing homes	67	59	47	40
Hostels	33	37	41	50
Care packages	na	na	6	10

na: not applicable; community care packages were introduced in 1992.

a Provision ratios are number of places per 1000 persons aged 70 and over. These ratios are based on operational places at 30 June.

Source: DHFS (1998a).

Allocation of places

The process of allocating new places commences with an estimation of the number of new places needed to cater for increases in the target population. Aged Care Planning Advisory Committees in each State or Territory then consider how the new places should be distributed between regions and special needs groups, and advise the Secretary (of the department) on the most appropriate allocation and distribution of new places. The Secretary then invites applications from approved providers. Applications are assessed against the criteria in the *Aged Care Act 1997* and the *Allocation Principles 1997*. These include whether the applicant has the necessary expertise and experience, whether the premises used, or intended to be used, are suitably planned and located, and the provision of appropriate care for people with special needs. In May 1998, 2007 new residential aged care places were allocated to providers who had applied for places in advertised target areas of identified need (DHFS 1998a, p. 167).

Once new places are allocated, providers can proceed to make them operational. This can involve additions to an existing facility or the construction of a new facility. The ANAO (1998) said it can take from one to three years or more from the time of the estimation of the need for new places before those new places are operational.

Allocations are provided without charge, but conditions apply. Amongst the general conditions is a requirement that a specific ratio of places be available for concessional residents. (Essentially, a concessional resident is someone who is unable to afford to pay an accommodation bond or charge.) Currently this ratio is set at an overall 27 per cent of places nationally; but it is specified on a regional basis, ranging from around 16 per cent in some metropolitan areas to 40 per cent in Alice Springs and some remote areas. According to the RCS review, about 38 per cent of residents nationally are concessional residents (DHFS 1998b, p. 19).

Those wishing to provide care for special needs groups must apply in response to a formal invitation by the Secretary. Special needs groups include people:

- from Aboriginal and Torres Strait Islander communities;
- from culturally and linguistically diverse backgrounds;
- who live in rural and remote areas; and/or
- who are financially or socially disadvantaged.

Government policy is that places should go to those who need it most and for whom it is appropriate. The ANAO (1998) said inequities found by the *Nursing Homes*

and Hostels Review (DCSH 1986) to exist in access to aged care places had been reduced but regional inequities remained significant. In particular, it said:

> the disproportionate numbers of places in some metropolitan areas persists and rural and remote areas remain underserviced. (p. 15)

As noted earlier, under the current system, an ACAT assesses a person seeking to become an approved care recipient and, after admission, the care provider assesses the new resident's RCS classification. The average waiting period in 1996-97 between an ACAT approval for entry into care and actual entry was 18 days for nursing homes and 58 days for hostels (DHFS 1997b). In 1997-98 this had increased to 31 and 108 days respectively (DHFS 1998a).

Transferring places

All transfers of places between providers must be approved. Approval is generally given, provided the transfer results in no significant changes to the distribution of places, and the new provider continues to fulfil any obligations imposed on the original provider. Transfers between regions may be approved when the move is towards regions with greater need. Although, as noted earlier, the department allocates bed licences without charge, once allocated, they can be traded. DHFS said that in 1997 bed licences could be purchased on the open market for $27 000 (sub. 52, p. 22).

Transfers of places often occur as a result of the sale of a facility. The seller must give the department at least 90 days notice of the sale of a home. The buyer also has certain obligations with regard to informing the department of the purchase, including the purchase price, the address where the sale will be finalised, and the proposed time and day of completion of the sale.

Extra service places

Care recipients prepared to pay for 'a significantly higher standard of accommodation and services' (DHFS 1997a, p. 15-1) can elect to enter an extra service place, if one is available. Maximum extra service fees must be approved by the department, and must average at least $10 a day.

The subsidy for the recipient of the extra service is reduced by 25 cents for each dollar of extra service fee approved. The provider may require this extra service subsidy reduction to be paid by the resident in addition to the extra service fee.

The number of extra service places is controlled. The current limit is 12 per cent of places, and this applies on a regional basis. However, the Commission understands the number of residents currently in extra service places is well below that limit.

From time to time, the Government invites applications for the provision of new extra service places. To be approved, certain conditions need to be satisfied. For example, they must be in a 'distinct part' of the service that:

- is physically identifiable as separate from the rest of the premises (although it may be in the same building);
- includes sufficient living space to provide residential care for all the places in the area;
- includes dining and lounge areas (located together or separately) for the exclusive use of care recipients living in the area; and
- has at least five places.

In addition, the service (or distinct part) must offer a significantly higher standard of accommodation, food and services than the average standard.

Non-approved places

Under the *Aged Care Act 1997* it is possible to have places in a service which are additional to the number of allocated places. Providers can use these places to provide other compatible services, such as rehabilitation or hospice care. However, these places are not subsidised by the Commonwealth. PJ Pusey (sub. D97, p. 1) said the 81 bed facility operated by his family company contains 51 beds which do not attract a subsidy and which are entirely resident funded.

3.4 Specified care and services

Commonwealth and state government regulations influence the nature of care services provided in nursing homes and hostels. They cover a number of aspects ranging from the supply of necessary equipment, specification of services, the qualifications of staff, and building design. Regulations governing the quality of care are covered in section 3.5.

Commonwealth Government

A brief summary of the care and services specified by the Commonwealth Government is given in box 3.5.

Previously, the Commonwealth required 24 hour on site care by a 'qualified' nurse if there were eight or more high care residents. Less stringent requirements applied where there were less than eight residents requiring nursing care. However, since August 1998, a less prescriptive requirement has been in place, which allows homes themselves to determine staffing arrangements based on their assessments of resident needs.

Box 3.5 **Specified care and services — Commonwealth**

Specified care and services are those basic services a facility must provide to residents, based on their level of care needs, at no extra cost. Some need to be provided only to high care residents. Where a low care resident (category 5 to 8 of the RCS) requires any services specified only for high care level residents (category 1 to 4), they may be charged for the provision of these additional services. The list of specified care and services consists of three components:

- Part 1, 'hotel' or accommodation related services, to be provided for all residents who need them. These include furnishings, bedding, general laundry, toiletry goods, cleaning services, meals, maintenance of buildings and grounds and the provision of staff on call to provide emergency assistance.
- Part 2, personal care services, to be provided for all residents who need them. These include assistance with the activities of daily living such as bathing, toileting, dressing, and eating; support for rehabilitation; assistance in obtaining health and therapy services; and support for people with cognitive impairments.
- Part 3, nursing and personal care services and equipment to be provided for all high care level residents (RCS levels 1 to 4) who need them. These include equipment to assist with mobility, incontinence aids, basic pharmaceuticals, provision of nursing services and procedures, administration of medications, provision of therapy services and the provision of oxygen.

Source: DHFS (1997a).

State and Local Governments

The States generally have their own legislation governing aged care and nursing homes. For instance, in New South Wales, there is the *Nursing Home Act 1988 and Regulations 1996*. Under that legislation, all nursing homes pay an annual licence fee to the New South Wales Private Health Care Branch. The fee ranges from $1110

for homes with fewer than forty beds to $4195 for homes with one hundred beds or more. Further, the legislation prescribes the minimum qualifications that a Director and Deputy Director of Nursing must possess.

Legislation may prescribe that particular categories of qualified nurses perform certain functions. For example, in New South Wales, medications must be distributed by a registered nurse. In addition, there is a New South Wales Department of Health protocol which requires certain medical procedures to be carried out by registered nurses. Similar requirements exist in other States. Further, requirements in some States provide that enrolled nurses work under the direction of a registered nurse.

While the staffing profile for an individual facility is to a large extent determined by resident needs, specific staffing requirements are prescribed in some States. For example:

- In Victoria, a staff/resident ratio, previously prescribed by the state legislation, has been incorporated into the nurses' industrial award. The Queensland Nurses Union has lodged a claim for a staff/resident ratio similar to that in place in Victoria.
- In New South Wales, nursing homes must employ a Deputy Director of Nursing if the home has more than 40 beds. A registered nurse must be on duty 24 hours a day regardless of the number of beds. This requirement also applies in South Australia.
- The Federal Nurses Award in Tasmania requires each nursing home to have 25 per cent of their nursing establishment at least at Level 2.

Workers compensation is governed by state government legislation. The requirements differ from State to State, as do the basic premiums — from nearly 4 per cent of wage costs in Victoria and Queensland to 7 per cent of wage costs in Tasmania.

While the Building Code of Australia (BCA) applies to residential aged care facilities in all jurisdictions, various state and local government building legislation and regulation also impact on the industry. These relate to such matters as building standards (lighting, stairs, lifts, bathroom and toilet facilities, wheelchair access etc), the provision and accessibility of fire prevention equipment, fire escapes, and evacuation procedures. The board of the BCA, in consultation with the industry, is currently undertaking a review of the building code as it applies to residential aged care facilities. This review is to address state and local variations to ensure that a national regulatory framework for new residential aged care facilities is put in place (Aged Care Australia, sub. 26, appendix 4, p. 3).

3.5 Quality of care

The underlying aim of much of the regulation surrounding residential aged care is to enhance quality of life and care, and to ensure the safety of residents. Concerns about quality of care in some nursing homes during the early 1980s led to the development of outcome standards and a standards monitoring program. As part of the Aged Care Reform Package, a set of Residential Care Standards has been developed.

Residential Care Standards

The aim of the Residential Care Standards, effective from 1 October 1997, is to ensure that the individual needs of all residents are met, including those of residents from rural and remote areas, those with culturally diverse backgrounds, and Aboriginal and Torres Strait Islander people. The requirements are categorised into three standards:

- The Health and Personal Care Standard refers to the promotion of residents' physical and mental health. It includes outcomes such as appropriate clinical and nursing care, medication management, pain management, palliative care, dental care, adequate nourishment, continence management, meeting the needs of residents with challenging behaviours, and achieving optimum levels of mobility and dexterity for all residents.
- The Resident Lifestyle Standard refers to the rights of residents to retain their personal, civic, legal and consumer rights, and assistance to residents to achieve and maintain active control of their own lives. It is concerned with the social, cultural and spiritual aspects of residents' lives, and includes emotional support, achieving maximum independence, privacy and dignity, participation in leisure activities, participation in decisions about the services received by residents and security of tenure.
- The Physical Environment and Safe Systems Standard refers to the rights of residents to live in a safe and comfortable environment. It is concerned with outcomes which enhance the residents' quality of life, such as regulatory compliance, the minimisation of fire, security and emergency risks, infection control and catering, and cleaning and laundry services.

Each standard also includes provision for continuous improvement, and education and staff development.

It is the responsibility of the Aged Care Standards and Accreditation Agency to assess facilities against the Residential Care Standards. Standards Monitoring

Teams are made up of at least one nursing officer and one clerical/administrative officer. An extra team member may be added where appropriate, for instance an interpreter, or an expert in a particular area of a facility's operation. The teams will visit facilities and speak to residents, relatives of residents, staff and other persons who may be involved in the running of the facility. For routine assessments, 24 hours' notice will generally be given, but unannounced assessments will be made where concerns exist, or complaints have been made, and reassessments may occur at any time, unannounced. Failure to comply with the Residential Care Standards may result in sanctions. Meeting those standards is also a requirement of accreditation. As discussed below, non-accredited facilities will not be eligible for subsidies after January 2001.

Two mechanisms are available to residents and non-residents who want to make a complaint about an aged care service. Service providers must have in place a process for addressing complaints, as well as ensuring that people are aware that they can complain to the department.

Certification

Facilities which are assessed as meeting specified building and care standards may ask residents to make accommodation payments and receive concessional resident supplements. The process of assessing these standards is called certification. A service may apply for certification at any time. Certification is not mandatory.

The physical standard of a facility is measured against a 'benchmark' set by the Certification Instrument and Guidelines. Points are awarded for each standard. Inspections focus on:

- safety — with emphasis on fire safety;
- hazards;
- resident privacy;
- occupational health and safety;
- lighting and ventilation; and
- heating and cooling.

To obtain certification, residential facilities must score 57 points for safety, occupational health and safety, and fire standards. Requirements will be progressively tightened. For example, with regard to privacy and space, new facilities will need to satisfy a mandatory standard of a maximum average of 2 residents per room (or up to 4 where cultural preferences would make this

appropriate). For existing facilities, a mandatory standard of a maximum of 4 residents in any room must be met by 2008.

Aged Care Australia said that, during the initial inspection process, 370 services were refused certification, with the highest incidence of failure being in Victoria. As a result of a review process, the number of failures has since been reduced (sub. 26, appendix 4, p. 4). However, the Victorian Government said 33 per cent of Victorian nursing homes remain uncertified (sub. 60, p. 5).

Accreditation

To continue to receive Commonwealth Government funding after January 2001, all services must be accredited. To obtain accreditation, facilities must meet the Accreditation Standards incorporating the Residential Care Standards, the building and care standards required for certification at the time of accreditation (although a service does not have to be certified), and a Management Systems, Staffing and Organisational Development Standard.

The latter standard is aimed at ensuring that management systems are responsive to the needs of residents, their representatives, staff and other stakeholders, and the changing environment in which they operate. As well as requiring continuous improvement and staff education and development similar to the Residential Care Standards, this standard requires that residents have adequate access to internal and external complaints mechanisms, and that facilities employ appropriately skilled and qualified staff. Other elements of the Accreditation Framework are the Prudential Arrangements in place (if a facility holds accommodation bonds) and the Concessional and Assisted Resident Ratios, both specified by the Department.

The Aged Care Standards and Accreditation Agency will manage the accreditation system, which will involve a self-assessment process followed by a desk audit and a site audit. The agency will also carry out regular supervision of facilities to ensure that they continue to satisfy the accreditation standards. If the agency is concerned that an accredited service is not complying with the Accreditation Standards, it may arrange for the service to be audited.

During the three year period between 1998 and 2001, it will be up to each provider to decide when to apply for accreditation. Accreditation will be for a period of up to three years, depending on the overall assessment of the service against the standards. Providers will then need to re-apply for accreditation.

State government controls on quality

Some State Governments also have quality controls. This appears to result in some duplication of the Commonwealth requirements. For instance, the Aged Services Association of NSW & ACT said:

> nursing homes need to have written procedures in order to establish the quality of care provided ... This ... is a duplication of the requirements of the Accreditation Standards, but is more prescriptive than is required by the Commonwealth legislation. (Sub 35, p. 23)

Baptist Care - WA (sub. 5) raised similar concerns, saying there is duplication between the care standards imposed by the Western Australian State Health Department, and those required by the Commonwealth's accreditation process. It said this creates confusion and additional costs.

4 Assessment criteria and implications

4.1 Criteria

For the Commission, a starting point for determining appropriate assessment criteria is the general policy guidelines set out in the *Productivity Commission Act 1998*. Amongst other things, these require the Commission to have regard to the need to improve the productivity and economic performance of the economy, reduce unnecessary regulation, encourage the development of efficient and internationally competitive industries, facilitate adjustment to structural change, recognise the interests of the community generally and all those likely to be affected by its proposals, and promote regional employment and development. Collectively, the guidelines require the Commission to give due regard to social, regional and environmental concerns as well as to economic performance.

As well as its own policy guidelines, the Commission has also had regard to the objectives of the *Aged Care Act 1997.* These objectives (see box 4.1) underpin the new Residential Aged Care Program arising from the Aged Care Structural Reform Package.

Box 4.1 **Objectives of the *Aged Care Act 1997***

- 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 the 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
- Promote ‘ageing in place’ through the linking of care and support services to the places where older people prefer to live

Source: As summarised in DHFS (1997a, p. 1-1).

Several participants recognised that explicit assessment criteria could help resolve the coalescence issue. For example, Aged Care Australia outlined three key principles, as well as criteria for evaluating funding approaches (see box 4.2).

Box 4.2 **Aged Care Australia's criteria**

Guiding principles

Access — older people assessed as needing care in a residential aged care facility should be able to receive care appropriate to their needs on a timely basis, within their local community wherever possible, and irrespective of their financial status.

Quality — older people should be able to receive the same quality of residential aged care throughout Australia; and the quality of care provided should be consistent with the standards for accreditation.

Viability — residential aged care facilities must be able to operate as ongoing viable concerns.

Criteria for evaluating funding approaches

Funding adequacy: will the funding approach deliver funding adequate to provide quality care outcomes for consumers? Does it take into account the extent to which services are able to control and manage their costs and income?

Funding equity: will the funding approach enable services with different inescapable costs to provide the same standard of care for residents? Will it maintain funding over time as cost relativities change?

Universal access: will the funding approach ensure universal access by people assessed as needing residential care irrespective of their location or ability to pay? Will it ensure that a high quality of care, consistent with accreditation, is provided to all residents who are financially disadvantaged?

Incentives for quality and efficiency: is there scope within the funding approach to encourage and reward quality and efficiency? Does it provide flexibility to manage the funding to achieve quality and efficiency improvements?

Administrative efficiency: will the transaction costs of the funding approach be efficient and affordable? Will the funding arrangements be easy for consumers to understand? Will implementation costs be funded and will they be justified by ongoing overall improved outcomes from the funding arrangements?

Source: Sub. 26, pp. 3, 19.

The emphasis given to different criteria is important, as is their interpretation. In general, participants placed greatest emphasis on equity, in the sense that overall funding and its allocation should be sufficient to support an adequate standard of care throughout Australia.

The Commission would agree that in examining funding methodologies, *equity* is the core criterion. Equity has at least three aspects:

- ensuring that the necessary physical and human resources are available in a suitable location — ie *equity of physical access*;
- ensuring that the care provided always meets an acceptable standard of care benchmark that addresses the individual needs of each person — ie *equity of care*; and
- ensuring that access to care is not denied through inability to pay — ie *equity of financial access*.

Providing equity of care does not necessarily rule out allowing people to pay for extra services over and above the acceptable quality standards. Similarly, providing equitable financial access does not imply that all residents should be equally subsidised irrespective of their ability to pay. Indeed, targeting available funding to those people least able to pay for themselves is more equitable than distributing funding equally among all residents. The recent introduction of income tested care fees recognises this principle.

Subject to a funding methodology meeting this core criterion of equity, a number of other criteria are relevant to the assessment process. As far as possible, the funding methodology should:

- enhance incentives for the efficient delivery of care. For example, subsidies should not indefinitely underwrite inefficient arrangements in management or staffing;
- avoid creating incentives for the wasteful consumption of care. For example, the methodology should not create incentives to use residential care, if non-residential aged care services would be more appropriate;
- encourage diversity and provide choice wherever possible. Those from particular social or cultural groups, for example, should be able to choose care appropriate to their needs;
- provide flexibility, to facilitate adjustment over time to changes in the aged care system with minimum disruption; and
- minimise administrative and compliance costs.

Program design principles are also relevant. For example: the objectives of funding should be clearly spelt out; as far as practicable, methodology should be simple, stable and predictable; incentives for fraud should be minimised; and transparency should be maximised.

4.2 Implications for funding methodology

Funding to a standard of care

As noted above, equity means that, ideally: residential aged care would be available to all Australians needing such care, in a suitable location; that care would be of an acceptable quality; and that access to that care would not be constrained by ability to pay.

A few participants considered that the differentiation of basic subsidies for aged care on the basis of regional costs runs counter to the national uniformity principle underlying a range of social support payments. For example, unemployment benefits, pensions and the like do not vary according to differences in the regional cost of living.

However, major social programs such as health and education are provided across Australia irrespective of differences in regional costs. Hence, the underlying subsidy varies across regions. More broadly, the operations of the Commonwealth Grants Commission (CGC) ensure that Commonwealth funding for the States takes account of differences in the costs of service provision. As Aged Care Tasmania stated:

> The CGC recognises that there are very clear and significant differences between the six States and the two Territories in their social, economic, demographic and geographic make-ups. These differences give rise to marked cost differentials, a fact widely recognised, and specifically taken into account in Commonwealth-State funding arrangements. (Sub. 40, pp. 5–6)

The Productivity Commission's view is that two important implications for funding methodology arise directly out of this equity principle.

- Variability in care needs should be recognised. As some residents have higher needs than others, providing an equal subsidy to all would not be equitable.
- Differences in the cost of delivering care cannot be ignored. Some cost factors are largely beyond the control of nursing home operators, and differ between jurisdictions and between regions. If no allowance is made for *significant* regional cost differences, equity of care could not be achieved across Australia.

Standardised costs

While funding should be adequate to meet an efficiently delivered standard of care Australia wide, the subsidy arrangements should not indefinitely underwrite cost differences that reflect inefficient management or work practices. Nor should they

remove incentives for productivity gain and cost control. For example, providing higher subsidies to all smaller operators, irrespective of location, could reduce incentives for providers in the cities and the larger towns to expand or amalgamate to provide quality care at lower cost.

For this reason, the Commission considers that subsidies should not directly reflect variations in the actual costs incurred by providers in delivering services. Rather they should only reflect significant regional variations, if any, in the 'standardised' cost of providing the benchmark standard of care. This is discussed in more detail in chapter 5.

Netting out the impact of differences in input quantities means that, where higher costs in a particular jurisdiction reflect the use of more inputs to provide a standard of care above the benchmark, the Commonwealth would not contribute towards this quality premium. That is, funding for the quality premium would have to come from higher resident charges and/or efficiencies achieved by providers. State and Territory Governments might also have a role to play in providing top-up funding if they require the employment of more staff than provided for in the benchmark level of care, impose higher building standards and the like.

The Commission recognises that, without adequate quality assurance arrangements, providers may attempt to increase returns by reducing the quality of their care or the standard of their premises, thus putting the well-being of some residents at risk. However, the certification and accreditation requirements are aimed at preventing this. Achieving a balance between encouraging efficiency and safeguarding resident well-being is addressed in chapter 7.

Maintaining care quality

To maintain equity of outcomes over time, the funding methodology must make allowance for changes in the price of inputs. If the costs of providing residential aged care run ahead of increases in subsidy rates, then the objective of ensuring access to an acceptable quality of care could be compromised. Similarly, an increase in the required standard of care (at the direction of the Government, or through changes in community expectations) will be difficult to achieve unless subsidies are increased.

However, this raises the issue of how to compensate providers for cost increases, without removing incentives for improvements in efficiency. In turn, this focuses attention on the basis for indexing subsidies (see chapter 7).

4.3 Implications for coalescence

As noted above, the Commission considers that some allowance needs to be made for significant regional differences in (standardised) costs faced by nursing home providers in providing a benchmark standard of care. Thus, coalescence cannot be accepted as an equity principle in its own right — it becomes an empirical question about the significance and stability of cost variations.

This view was shared by the vast majority of participants. With only one or two exceptions, they considered that the particular nature and extent of cost differences between homes in different jurisdictions or regions was fundamental to the funding methodology.

Allowing for cost variation

In principle, there are two broad approaches to dealing with regional cost differences:

- implementing variable basic subsidies; or
- augmenting a basic uniform subsidy with supplementary funding for high cost services.

In practice, the current funding arrangements reflect a mixture of these two approaches. They combine a jurisdictionally variable basic subsidy with a viability supplement for services in more remote high cost locations.

Nonetheless, the in-principle distinction is useful because it focuses attention on the importance of the regional dispersion in the costs of providing care when choosing between funding methodologies.

The narrower the dispersion in (standardised) costs around the average, the stronger is the case for nationally uniform basic subsidies to be augmented with supplementary funding for services which face significantly higher costs. Administratively, it is likely to be less complex to cater for a relatively small number of facilities requiring above average support through targeted arrangements, than to have a more complex basic subsidy scheme to fund the majority of homes.

However, if there is wide dispersion in regional costs, nationally uniform basic subsidies will lead to two types of problem.

- There may be a relatively large number of high cost facilities that warrant supplementary funding support. Catering for these needs through supplementary funding arrangements could impose significant administrative costs on both

providers (through the need to apply for additional funding) and the Government (through the need to process those applications).

- The extent of over-funding of providers operating in relatively low cost regions is also likely to be higher.

The relative significance of these two problems will depend on the level at which the uniform subsidy is struck. If it is based on the lower end of the cost scale, then the problem of processing a large number of claims for supplementary funding will predominate. Conversely, if it is based on the higher end of the cost scale, then over-funding will dominate. In either case, however, the existence of significant cost dispersion increases the justification for implementing regional/jurisdictional variations in the basic subsidy.

To assist in resolving these issues, chapter 5 examines variations in nursing home costs. Chapter 6 follows with a discussion on which of the two broad approaches is the more appropriate.

5 Nursing home costs and their determinants

As discussed in chapter 4, the extent and nature of (standardised) cost dispersion between different regions is central to whether nursing homes subsidies are funded nationally or regionally. Expected future changes in cost variation are also relevant in choosing the most appropriate funding methodology.

In accordance with the terms of reference, this chapter outlines the factors influencing nursing home costs as well as a method for comparing cost information across jurisdictions. Using this methodology, the chapter compares costs across States and Territories, and examines recent wage trends and likely future directions. To undertake this analysis, the Commission has relied primarily on information provided by participants.

The chapter does not attempt to present a complete analysis of the costs of providing nursing home care. Rather, the emphasis is on discovering whether there are significant cost differences that may inform choices between alternative funding methodologies.

5.1 Factors influencing unit costs

A wide range of factors can influence the costs of delivering nursing home care, not the least of which is the expertise of management in efficiently running a facility in a caring manner. Other factors include:

- *Resident mix*: The resident mix has an important influence on costs as care needs of residents increase with the level of dependency. The present arrangements recognise this by providing different funding for each RCS classification — subsidies for RCS category 1 residents are more than 80 per cent higher than those for RCS category 4 residents.
- *Quality of care*: Better facilities or better personal care often cost more to provide, though not always (see below). The cost premium for better personal care may reflect the use of more staff, or alternatively more experienced, and more costly, staff.

- *Home size*: Larger homes have greater opportunity to reduce costs through spreading overheads (such as the costs of the Director of Nursing, and administration), and taking advantage of scale economies for services, such as meals and laundry services. Homes that are part of a larger group can also reduce unit administrative costs.
- *Service integration*: Co-location of a nursing home with hostel accommodation and/or independent living facilities offers further opportunities to spread fixed costs and reduce unit variable costs.
- *Ownership*: Government and not-for-profit operators are exempt from certain taxes on inputs levied on for-profit homes. Some would argue that the profit motive gives for-profit homes an incentive to operate more efficiently than not-for-profit homes.
- *Location*: The location of a nursing home affects costs in at least three ways. First, prices of goods and services used by nursing homes vary between cities and between the city and the country. Certain costs (eg land) can even differ markedly within a city or region. Second, individual States and Territories have different industrial awards, requiring different staff ratios and staff mix, as well as different workers compensation, payroll tax and other requirements. Third, in some locations there can be a difference in the fundamental nature of care required, as exemplified in many rural and remote areas.

Cost comparisons could draw out the effects of all these different influences on the regional costs of delivering care. However, as discussed in section 4.2 and section 5.2 below, not all these factors are equally relevant to determining a funding methodology.

Importantly, the quality of care is not always directly related to cost levels. The provision of a wider range of lifestyle activities or better personal dignity does not necessarily cost more. Nor do higher costs automatically indicate better care — they could just reflect higher wages or less efficient rostering. Thus, in comparing observed costs, it is difficult to separate out the influence of quality.

Further, the current regulatory regime has the effect of disguising underlying cost drivers between homes providing different quality care or facing different input prices. As nursing homes cannot respond to increases in the prices they need to pay for inputs (such as staff, goods and services) by increasing their revenue — this is controlled by the Government — they can only respond by improving efficiency, reducing their services or by reducing their surplus (if any). The actual costs of different nursing homes can accord closely with existing subsidy levels, even though those subsidies may not accurately reflect underlying cost factors, particularly after a period in which increases in input prices run ahead of subsidy

increases. A possible indication of this 'circularity' between costs and subsidy levels is given by the correlation between qualified nursing hours provided to residents in individual States and Territories, and jurisdictional subsidy rates (table 5.1).

Table 5.1 **Qualified nursing hours compared to subsidy[a]**
Average hours per resident per week

State	*RCS 3 subsidy per day*	*Average hours*
ACT (2 facilities)	$78	10.0
SA (5)	$76	11.2
WA (10)	$78	11.9
NSW (14)	$81	12.2
Victoria (7)	$84	14.1
Tasmania (3)	$86	14.1

a Details for QLD and NT were not provided in source.

Source: Sub. 26, appendix 2, p. 2; sub. 33, p. 12.

Aged Care Tasmania contended that this limited example only provides indirect evidence of circularity of costs and subsidy levels as it does not allow for other factors influencing nursing input, such as the size of a nursing home. However, as Aged Care Queensland stated:

> a challenge is to avoid the temptation to simplify the exercise by examining the costs at any number of individual nursing homes. In a system with such rigid controls over financial inputs, costs only reflect income. (Sub. 33, p. 6)

This highlights the need for a more detailed and standardised method of cost comparisons.

5.2 Developing a basis for comparing costs

A starting point for useful cost comparison — one recognised by several participants — would be to accept that there is a relationship between input mix and care outputs, in terms of both the 'quantity' and 'quality' of care provided. Next, a series of standardised input mixes would be defined to reflect the different levels of care output required by residents with different RCS classifications. Comparisons would then consist of costing those standardised input mixes, common to all regions, at the unit costs faced by operators in individual regions (ie at the prices they have to pay).

An important issue is whether different input mixes should also be specified to account for other factors which influence costs such as ownership status and size.

As noted in chapter 4, however, the subsidy regime should not support ongoing inefficiency or remove incentives for productivity gain and cost control. This principle immediately rules out differentiating subsidies on the basis of ownership, except for possibly compensating for differences in liability for government charges on inputs such as payroll tax on labour (see section 7.5). It would also rule out compensating for small home size, except in rural and remote areas where limited demand makes scale economies unachievable. For this reason, the Commission considers it preferable to address the higher costs incurred by smaller rural and remote nursing homes separately from consideration of the basic funding methodology (see sections 7.2 and 7.6). Thus, the remainder of this chapter proceeds on the basis that standard input mixes need only differentiate on the basis of care needs.

These standardised input mixes should reflect all relevant inputs necessary for providing care, including wages, superannuation, purchases of supplies and equipment, energy costs, contracted services, as well as depreciation on buildings and equipment, and a return on investment. (In this latter regard, providing a return on equity capital invested in a nursing home is no less a cost than making interest payments on borrowed capital.) In principle, relevant input taxes and government charges such as workers compensation should also be included.

5.3 Cost comparisons

Many participants provided cost information for nursing homes. Some participants made attempts to ‘standardise’ inputs for a specific resident profile. However, in most cases, the information related to the cost of particular nursing homes, or comparisons of the observed costs incurred by different homes. Detailed comparisons were also presented of some of the underlying factors affecting jurisdictional costs, such as different wage rates, and differences in workers compensation payments.

This information is very useful in shedding light on the cost structures of particular homes, factors influencing actual costs in particular jurisdictions, and on cost trends. However, for the reasons given above, it is of less value in determining whether the basic subsidy regime should be uniform or regionally differentiated.

This section describes the cost data provided by participants, concentrating on cost information that attempts to net out variations in input mix arising from factors other than care needs. The information standardises the level of inputs for nursing homes for a given resident profile. This is a slightly different approach to the methodology outlined above which standardises inputs for each level of care.

Despite this practical difference, the essential principle of standardisation remains and the information illustrates the extent of cost variations across jurisdictions.

As most of the information provided relates to labour costs, and associated on-costs, the next section seeks to put the importance of labour in nursing home costs into context. The following section then goes on to provide the cost comparisons.

Importance of labour costs

Past subsidy and indexation mechanisms have commonly used an average wage to non-wage cost ratio of 75:25. Information from participants suggests that this ratio is conservative in respect of the current labour share (see table 5.2). However, not all of the comparisons allow for items of cost such as depreciation and interest paid on borrowed funds. As ANHECA noted, the inclusion of these items would reduce the ratio of labour to non-labour costs.

The precise ratio will vary across homes and will depend in part on the extent of contracting out of services such as food and laundry. Nevertheless, the comparisons indicate that wage costs are overwhelmingly the most important cost item. Consequently, a variation in non-labour costs between jurisdictions of 10 per cent would have approximately only one-third the impact on total costs as a 10 per cent variation in labour costs.

Comparisons of labour costs

Differences in standardised labour costs — which abstract from variations in staff mix — essentially arise from differences in wage rates and labour on-costs.

Several participants provided comparisons of wage rates. Aged Care Tasmania provided a comparison of award rates for the most senior staff in each employee category (table 5.3). The variation in hourly rates (over the six States) is approximately 7 per cent for enrolled nurses, 18 per cent for registered nurses and 19 per cent for care assistants. However, the comparisons are sensitive to the stage of wage negotiations in individual jurisdictions. Thus, relativities and the magnitude of observed differences are likely to fluctuate over time.

Similarly, labour on-costs such as leave entitlements and workers compensation premiums also vary between States and Territories. For example, according to Aged Care Tasmania (see sub. 40, attachment):

- workers compensation premiums differ from about 4 per cent of wage costs in Queensland and Victoria to 7 per cent of wage costs in Tasmania;

- long service leave entitlements range from 26 weeks after 15 years in Victoria to 8 weeks after 10 years service in New South Wales; and
- sick leave entitlements for employees in Tasmania and Victoria (4 weeks annually) are double the national standard (2 weeks annually).

Higher labour costs in one area can be offset by lower costs in another. For example, Aged Care Tasmania's data indicates that although long service leave entitlements are more generous in Victoria, workers compensation premiums in Victoria are the second lowest after Queensland.

Table 5.2 **Selected participants' comments on the ratio of wage costs to other costs**

Participant	*Comment*
Maroba Nursing Home (sub. 6, p. 2)	For the year ended June 1998, nursing and personal care costs accounted for 62 per cent, other staff costs 18 per cent, workers compensation 4 per cent, and non staff costs 17 per cent.
Sundale Garden Village (sub. 16, p. 23)	Wage costs comprised 82.85 per cent of income in 1997-98.
ANHECA (sub. 24, p. 10)	The commonly espoused 75:25 ratio of wage to non-wage costs is reasonable provided that the ratio does not include the return on investment (ROI). A more appropriate ratio of wages to non wages, excluding ROI, is 80:20. The inclusion of the ROI would distort this figure to approximately 70:30.
NANHPH (sub. 25, p. 22)	Wages together with wage on-costs account for approximately 75 per cent of the total costs of operation of a facility.
Our Lady of Consolation Home (sub. 27, p. 4)	The ratio of salaries to other costs in 1997-98 was 86.9 per cent.
Baptist Community Service (sub. 29, p. 3)	Wages and wage-related costs typically represent no less than 81 per cent of total expenditure.
Aged Care Queensland (sub. 33, p. 11)	A survey of 26 members' nursing homes showed total staffing costs represent 84.39 per cent of total expenditure.
Aged Care Tasmania (sub. 40, p. 35)	Depending on the size of home, labour costs (including on-costs) can vary from 70 to 80 per cent, with very little scope for substitution of labour and equipment.
May Shaw Nursing Centre (sub. 41, p. 3)	The commonly espoused 75/25 ratio of wage to non-wage costs does not hold true with the May Shaw Nursing Centre experience. Ratios for the three years from 1995-96 were 78/22, 78.6/21.4 and 84.5/15.5. It should be noted that in 1995-96 and 1996-97 administration wages were costed to administration rather than salaries.
Umina Park (sub. 44, p. 5)	Analysis of data provided shows that salaries plus on-costs comprised 88 per cent of nursing home expenses.
The Uniting Church Division of Aged Care & Domiciliary Services - Queensland Synod (sub. 62, attachment A)	Based on expenditure numbers for 1996-97 and using a sample of 26 Uniting Church nursing homes in Queensland, labour costs accounted for around 82 per cent of total cost. Because of wage increases since 1996-97 and some increase in the resident dependency, the ratio for 1997-98 would have been at least 85 per cent.

Source: Submissions.

Table 5.3 **Hourly award rates of pay**

$ per hour

Category	*NSW*	*Vic*	*Qld*	*SA*	*WA*	*Tas*
Enrolled nurse	14.18	13.55	14.24	13.79	13.27	14.04
Registered nurse	20.75	17.56	18.97	18.71	17.96	18.98
Extended care assistant	11.42	11.65	10.54	np	11.72	12.52
Service employee	12.00	11.65	10.91	11.50	11.22	11.07
Cook (qualified)	12.24	13.00	12.21	13.34	13.44	13.83
Trades	12.96	13.32	11.79	np	13.44	14.43
Clerical	15.09	14.75	15.25	15.48	14.23	15.57

np: not provided

Source: Sub. 40, attachment, pp. 2, 4, 5.

Although wage rates and direct on-costs differ between jurisdictions, there is little evidence of significant variation within jurisdictions. For example, according to ANHECA:

> In most cases the wages and conditions for a particular State are peculiar to that State, however, in Queensland and Western Australia there are varying award rates and conditions in the majority of the State compared to the far North of the State. The variations within States are not significant ... (Sub. 24, p. 13)

However, while wage rates may not differ much from city homes, facilities in rural and remote areas do face additional labour costs. For example, Frontier Services, which operates a number of such homes in the Northern Territory and Western Australia, considered that:

> The current funding structure does not recognise the cost implications of meeting cultural needs nor the higher costs associated with training, recruitment and retention of staff. (Sub. 8, p. 1)

These costs, and their implications for funding arrangements, are discussed in chapter 7.

Aged Care Australia

Aged Care Australia commissioned La Trobe University to undertake a relative labour cost study using various notional baskets of staff mix based on rosters provided by homes. In general, this approach accords well with the Commission's preferred basis for comparison. Aged Care Australia said:

> The notional baskets of staff mix are not prescriptive but act as a proxy for determining whether there are cost differences in delivering the same standard of care (as measured by staff mix). The study therefore examines relative staff costs without the impact of differences in staff mix. (Sub. 26, p. 9)

Initially, 12 baskets of staff mix were chosen based on two rosters from each mainland State (except Queensland), one from the ACT and three from Tasmania:

- eight are in capital or provincial cities, three in rural areas and one in a remote area;
- they are almost equally divided between stand alone and co-located facilities;
- two have fewer than 40 beds, two have over 100 beds and the remainder have between 40 and 60 beds; and
- four cater mainly for people with dementia, five for those with high level needs, one for lower level and two cater for a combination of care levels.

One basket was subsequently dropped from the study as the number of staff hours per resident was well outside the range of the other baskets. The remaining 11 baskets were costed across each jurisdiction using four different models, which progressively added shift loadings, workers compensation, and other wage related costs to the base model.

The Aged Services Association of NSW and the ACT criticised the methodology of the La Trobe study:

> the theoretical basis used to compare wage rates does not reflect the legislative requirements and practical experience of the industry in NSW ... [where] the predominant age of the labour force in nursing homes is 41–50 years ... (Sub. 35, p. 3)

However, the La Trobe study is valuable for the very reason that it nets out different 'legislative requirements'. Similarly, if the labour force is more experienced in New South Wales than elsewhere, the same number of staff may be able to deliver a higher quality of care. Thus, in costing a uniform quality benchmark, it is desirable to net out this type of effect also. For this reason, the La Trobe study costed two additional models with higher salary classifications for staff: 'the classifications used were those suggested by state associations as reflecting typical classifications in their States' (sub. 26, appendix 3, p. 8).

A summary of results averaged across the baskets is presented in table 5.4.

While noting a number of caveats to the study (in particular, relating to the 'other on-costs model'), Aged Care Australia went on to draw out a number of broad conclusions (sub. 26, appendix 3, p. 14):

- the standardised labour costs vary within a 'narrow' range, 4 to 5 percentage points for the lower salary method, and about 6 for the higher salary method;

- in the lower salary method models (leaving aside the 'other on-costs' model as suggested by Aged Care Australia), Western Australia is always the lowest cost State with Queensland and South Australia towards the higher cost end;
- in the two higher salary models, Victoria, New South Wales and Western Australia are at the lower end, Queensland is in the middle, and South Australia and Tasmania are at the higher end — thus the models are sensitive to the assumed salary structure;
- there is a reasonable level of consistency between States in the baskets of staff mix which are expensive and those which are less costly; and
- the relative differences are far less than those existing in the present structure of subsidies.

Table 5.4 **Comparison of standardised labour costs**
Averaged across baskets. Base = lowest State

Model	*NSW*	*Vic*	*Qld*	*SA*	*WA*	*Tas*	*Average*
Base model	102.71	103.08	104.74	103.29	100.00	102.54	102.73
Add shift loadings	102.76	103.51	104.92	103.54	100.00	102.87	102.93
Add workers compensation	103.17	102.33	104.02	105.27	100.00	104.19	102.98
Add other on-costs	102.05	104.45	102.05	105.43	100.00	105.70	103.28
Base model with higher salaries	100.00	100.24	102.60	103.26	100.14	103.50	101.62
Workers compensation model with higher salaries	100.89	100.00	102.34	105.76	100.70	105.88	102.59

Source: Sub. 26, appendix 3, p. 9 (as revised).

TriCare

TriCare costed common staff rosters for 60 bed and 148 bed homes, across different jurisdictions including the Northern Territory and the ACT. TriCare noted in its submission that:

> the roster was developed on a notional resident mix and the same roster as a base was applied for every State. In adding to the base roster, specific state requirements such as staff resident ratios and staff supervisory requirements prescribed in specific state awards were applied. (Sub. 34, annexure A, p.1)

Using a base roster to estimate cost accords well with the Commission's preferred approach to standardised cost comparisons. However, the concept of a standard input mix reflecting a standard quality across all jurisdictions would be lost if the base rosters are adjusted to allow for specific state staffing requirements. Further consultation with TriCare revealed that adjustments had been made for higher staff supervisory requirements for registered nurses in Tasmania. However, TriCare did

not make any adjustments to Victorian rosters for the higher staff resident ratios as required by Victorian awards, as it found little evidence of compliance in the private and charitable sectors.

Thus, the Commission has recalculated the costs for Tasmania to reflect a standard input mix. The results are shown in table 5.5.

Table 5.5 **TriCare's labour cost comparisons**
Base = lowest State

	NSW	*Vic*	*Qld*	*SA*	*WA*	*Tas*[a]	*NT*	*ACT*
60 beds								
Nursing & personal care	110.14	103.25	107.44	100.00	101.82	111.41	107.99	102.51
All staff	106.97	103.41	106.95	100.00	102.20	110.46	108.06	102.76
148 beds								
Nursing & personal care	109.27	100.00	108.04	101.06	102.25	110.28	109.63	100.92
All staff	106.75	100.00	107.24	100.42	102.12	109.02	109.07	100.56

a TriCare's estimates were adjusted to conform with a consistent standard labour input mix across all States. Initial cost estimates for Tasmania allowed for one quarter of registered nurses to be employed at level 2.

Source: Derived from sub. 34, annexure B.

These results indicate up to 11 per cent variation in costs — a greater cost variation than the averages shown by Aged Care Australia. In addition, when the TriCare results are compared with Aged Care Australia's (the higher salary models are the most comparable), the state rankings differ. In particular, New South Wales ranks much higher and South Australia much lower. Finally, TriCare's cost estimate show the ACT at the lower end of the cost scale, and the Northern Territory at the higher end.

The Commission sought further input from TriCare and Aged Care Australia to help reconcile the different results. The two organisations put forward a number of reasons to explain the divergences. For example, Aged Care Australia noted that, unlike the TriCare study, the La Trobe study does not include uniform, cleaning and on-call allowances or the cost of leave provisions (sub. 57, p. 2). Similarly, TriCare said that it did not include the costs of workers compensation premiums which are included in the La Trobe study (sub. 59, p.2). This may partly explain the low cost ranking for South Australia in the TriCare study — the inclusion of workers compensation costs significantly increases the cost ranking of South Australia in the La Trobe study (see table 5.4). (Further details of differences in workers compensation premiums are given in box 5.1.) Furthermore, the Aged Care Australia study assumed standard penalty rates across all categories of staff across all States, whereas TriCare used actual penalty rates in accordance with the relevant state awards (sub. 59, p. 2).

Although these observations highlight the difficulty of undertaking such cost comparisons, they do not invalidate the methodology nor mean that a standardised input mix (or mixes) could not be transparently negotiated and agreed by all relevant stakeholders.

Box 5.1 **Workers compensation**

Workers compensation is a state/territory responsibility. The actual premium paid by a particular nursing home is generally a percentage of wages paid plus (less) a loading (bonus) for past claims experience. Information provided by participants about base premiums by nursing homes by jurisdiction is reported in Table 5.6.

Table 5.6 **Summary of workers compensation base rates payable in each State and Territory**

Percentage of wages paid

State	*NANHPH*	*Aged Care Tasmania*	*ANHECA*
NSW	5.57	5.57	5.57
Vic	3.95	3.95	3.95
QLD	3.91	3.91	3.39
WA	5.65	5.15	5.15
SA	6.90	6.90	6.90
Tas	5 to 6[a]	7.00	6.50

a Privately negotiated, approximate only.

Source: Subs 25, 40, 24.

NANHPH

NANHPH presented funding models based on rosters worked by individual homes, in different size ranges. These models help to paint a picture of the differing cost structures across the sector. For example, they highlight the relatively greater use of registered nurses in Victoria, at least for homes of less than 60 beds.

However, the models are of less value in looking at the degree of variation in standardised costs, as they build in cost differences arising from state variations in input usage. Further NANHPH commented that its data ‘obviously has some major deficiencies’ (sub. 25, p. 17).

Aged Care Tasmania

Aged Care Tasmania started with a ‘standard care model’ for a 45 bed nursing home, including both labour and non-labour costs. The model was costed for

Tasmania and cost comparisons were made for Tasmania relative to the average across all other States and Territories. Then it was adjusted in two ways to 'quantify Tasmania's overall relative cost disability' (sub. 40, p. 16): an adjustment of input prices, and an adjustment for 'service delivery scale disability'. Allowing for input price variation is in line with the Commission's preferred basis for comparison, but the adjustment for scale builds in variations in input mix. (As noted, the Commission considers it preferable to make any funding allowance for smallness and remoteness separately from the basic subsidy regime.)

In regard to input costs, Aged Care Tasmania calculated the Tasmanian disability (ie the percentage by which costs are higher compared to the average) as 5.7 per cent for labour, 11.5 per cent for labour on-costs, 7.1 per cent for non-labour costs, equating to a total disability of 6.5 per cent. The scale disability was estimated as an additional 7.7 per cent.

ANHECA

ANHECA presented detailed costings of subsidy rates which it considered should apply for each of the high care RCS classifications in each jurisdiction. Although ANHECA's costings also include non-labour costs, this section concentrates on the labour component and associated on-costs, presented in its submission.

The basis for the costings are average 'state based hourly wage rates' for different categories of employee: RNs, non-RNs, therapists and domestic (including clerical). These averages were calculated from 'actual nursing home rosters in each State, as at 1 July 1998' (sub. 24, attachment 2, p. 1). The averages were multiplied up to give total wage costs, using standard staff weightings and standard hours of care, for each RCS category.

In ANHECA's costings, the differences between jurisdictions in total wage costs can be fully explained by the differences in state based hourly wage rates. The rates used in the calculations are summarised in table 5.7. When these figures are compared with those in table 5.3, some significant differences are apparent. For example, for RNs, Aged Care Tasmania has Victoria with the lowest rate, NSW with the highest, and a variation of 18 per cent. In contrast, ANHECA has Western Australia as the lowest, Victoria as the highest, and a variation of 21 per cent.

Some of the differences can be explained by the different basis for the two tables. ANHECA's average hourly rates include 'basic rates (weighted to include the various penalty rates) plus the additional costs involved with annual leave, sick leave, other leave, public holidays and the cost of replacing staff on leave' (sub. D84 p. 3). Aged Care Tasmania's data covers just the basic award rates.

Table 5.7 **ANHECA's average hourly wage rates**

$ per hour

State	*NSW*	*Vic*	*QLD*	*SA*	*WA*	*Tas*	*ACT*	*NT*
RN	25.97	26.99	24.57	25.49	22.31	25.18	23.12	22.75
Non-RN	14.50	13.70	15.03	14.95	14.20	15.75	14.20	11.26
Therapist	15.76	12.53	11.96	13.71	11.88	14.15	12.12	11.54
Domestic & clerical	13.94	12.85	12.84	13.53	13.29	14.51	12.64	13.71

Source: Sub. 24, attachment 2.

Another important reason for these differences is that ANHECA's average rates include the effects of differences in staff structures across jurisdictions. Thus, it noted that its costings take into account 'state variations from the norm eg the Victorian 10/15 rule, and the NSW requirement for a Deputy Director of Nursing in a nursing home with 40 or more beds' (sub. 24, p. 29). Also, ANHECA's costs include differences across jurisdictions in the average experience of staff. In this regard, the relatively low average rates for the Northern Territory may be explained by high staff turnover which results in a higher proportion of staff being at the lower levels of the wage structure. As noted, differences in the experience of staff will affect quality, meaning that their effects on costs should be excluded from standardised cost comparisons.

These differences in wage structure carry through into ANHECA's comparisons of labour costs, see table 5.8. The reported cost variation — of the order of 25 per cent between the highest and lowest — is therefore much more than in Aged Care Australia's and TriCare's standardised comparisons.

Table 5.8 **ANHECA's labour cost comparisons**

For NPC and domestics: $ per day

State	*RCS 1*	*RCS 2*	*RCS 3*	*RCS 4*
NSW	97.46	84.80	75.30	49.98
Vic	98.21	85.36	75.71	50.00
Qld	91.26	79.34	70.40	46.55
SA	94.77	82.41	73.15	48.44
WA	91.21	79.41	70.55	46.95
Tas	100.78	87.72	77.92	51.79
ACT	89.95	78.23	69.45	46.02
NT	80.22	70.05	62.42	42.08

Source: Sub. 24, attachment 2.

Further, the jurisdictional rankings also differ. For example, in comparison with the 'workers compensation model with higher salaries' from Aged Care Australia and TriCare's 60 bed all staff model, ANHECA's RCS 1 model shows Victoria to be a

much higher cost jurisdiction, and Queensland and the Northern Territory in particular to be much lower cost.

The jurisdictional variation of about 25 per cent in ANHECA's cost-driven subsidy rates is of the same order as the variation in existing subsidies of about 22 per cent. Further, leaving aside the two territories and Western Australia, the ranking of jurisdictions exactly matches that of the existing RCS 1 subsidies. This could indicate that the non-standardised input mix used by ANHECA captures much of the influence of present subsidies on costs. Essentially, ANHECA's model is based on cost reimbursement. For this reason, the Commission has not drawn further on ANHECA's data in the comparison of subsidies and standardised costs given below.

ANHECA - SA

ANHECA - SA costed a staffing roster for a 50 bed nursing home across New South Wales, Victoria, South Australia and Western Australia. Costs included direct labour, plus annual leave, sick leave and public holidays. The comparisons appear to net out the impacts of state-specific award conditions and regulations that would affect actual staffing levels in each of those jurisdictions.

On the basis of its calculations, ANHECA - SA concluded that 'the total cost of identical rosters in each State under the present funding system [is] not significantly different' (sub. 21, p. 3). Its data show aggregate cost differences of only about 4 per cent (see table 5.9).

Table 5.9 **ANHECA - SA's labour cost comparisons**
Based on a 50 bed roster

Category		*Proportion of South Australian cost*
Direct labour costs		
South Australia		100
Victoria	no enrolled nurses	99.34
	50% enrolled nurses	101.22
Western Australia		99.48
New South Wales		101.82
Direct labour costs (including annual leave, sick leave and public holidays)[a]		
South Australia		100
Victoria		na
Western Australia		na
New South Wales		104.12

na: not available.

[a] Excludes long service leave. ANHECA commented that adding in long service leave would narrow the gap considerably, as long service leave in South Australia is more generous than in New South Wales.

Source: Sub. 21, appendix 1.

Comparisons of non-labour costs

While comparisons of most non-labour costs should, ideally, also be made on the basis of a standardised input mix, no such data was available. However, given that non-labour costs represent a smaller proportion of total costs, lack of standardisation is a much lesser problem in comparisons than it would be for labour costs.

ANHECA presented summarised information on recurrent non-labour costs, drawn from the 1995-96 cost survey by Bentleys Chartered Accountants. Generally, the reported variations between jurisdictions in non-labour costs were quite small, especially when related to total nursing home costs.

ANHECA (Tasmania) provided information on the comparative retail prices, in capital cities, for food, cleaning and hygiene, and petrol costs. The rankings are different across each category (see table 5.10). For example, Adelaide has the lowest cost of cleaning and hygiene, and food, while Perth and Hobart are at the high end of the scale. The cost of petrol is the lowest in Brisbane and highest in Hobart. For these items, the overall cost variation around the average is approximately 6 per cent. However, these figures only represent variations between capital cities.

Table 5.10 **Comparison of some non-labour costs across capital cities**
Base: lowest city = 100

Category	*Sydney*	*Melbourne*	*Brisbane*	*Adelaide*	*Perth*	*Hobart*	*Average*
Food	108	104	105	100	110	110	106
Cleaning & hygiene	104	104	110	100	105	115	106
Petrol -leaded	114	110	100	114	116	120	112
Petrol -unleaded	115	111	100	114	117	125	116
Total	106	104	107	100	107	112	106

Source: Derived from Sub. D63, p. 10.

In contrast, there appear to be more significant variations in non-labour costs between city and country areas. Frontier Services gave a number of examples of higher costs for homes in more remote areas including: additional freight, higher cost of food, STD rates for phone calls, shorter life of fittings and fixtures and higher maintenance of building and grounds due to climate (sub. 8, p. 4).

In regard to capital inputs, NANHPH noted that:

> land and building costs in New South Wales are significantly greater than in all other States. The greatest contrast is between New South Wales and Tasmania. (Sub. 55, p. 7)

Aged Care Australia noted that both the CPI capital city housing cost index and the Housing Industry Association's Multi-Unit Building Cost index point to considerable variations in building costs. It also observed that land costs vary markedly across regions, but argued that these are likely to be relatively homogenous within a local community. Aged Care Australia concluded that:

> this is a relevant consideration where there is a component of user-pays funding towards the capital cost of residential care accommodation. (Sub. 26, p. 13)

The Commission also observes that lower land costs will often offset to some extent other cost premiums incurred by homes in rural and more remote areas. It is relevant to note, however, that land is sometimes provided free, or at subsidised rates, to nursing home providers.

5.4 Wage trends and productivity

Each of the standardised cost comparisons presented in the previous section reflects differences in wage rates at particular points in time. Over time, these differentials could change, as wages in one jurisdiction move relative to those in other jurisdictions. As NANHPH stated: 'wage movements will continue to move out of kilter with each other' (sub. 25, p. 28). However, as reflected in the terms of reference, it is relevant to ask whether the differences are likely to narrow (or widen) over time.

There is conflicting evidence on whether the differences in wages within the aged care sector have been narrowing in recent years. Information provided by the department shows that, in April 1993, wages in the highest wage State were on average 29 per cent higher than those in the lowest wage State. In April 1998, wages in the highest wage State averaged only about 9 per cent more than those in the lowest wage State. This comparison indicates that the differential in hourly wage rates has fallen by close to 70 per cent over the last five years.

Some participants differed with this assessment. For example, the Australian Nursing Federation (SA Branch) commented that there is a very significant range in outcomes in the aged care sector, with a growing gap (transcript, p. 64). The NSW Nurses' Association provided evidence of a growing gap in nursing home wage rates for New South Wales, Queensland, Western Australia, and Victoria, over the period from 1994 to 1998 (table 5.11). Based on nursing award wages in 1994, the

weekly wage dispersion between the highest and lowest wage States was approximately 4 and 8 per cent for first year nurses and eighth year nurses, respectively. By 1998, this dispersion had increased to 19 and 24 per cent, respectively.

Table 5.11 **Weekly wage rates for registered nurses in nursing homes**
Base = lowest State in 1994

State	*1994*	*1995*	*1996*	*1997*	*1998*
First year or grade 1 RN					
NSW	104	105	107	117	119
Vic	101	103	103	105	107
QLD	100	102	111	113	116
WA	100	100	100	100	100
Eighth year or grade 2 RN					
NSW	108	108	110	121	124
Vic[a]	100	100	100	101	103
QLD	101	101	110	111	113
WA	101	100	100	100	100

[a] Grade 2, year 6 nurse.

Source: Derived from sub. D107, attachment 1.

Aged Care Australia supplied ABS information which it claimed showed mixed results in relation to the notion of increasing convergence of wages rate (sub. D94, p. 1). However, the information covers both hospitals and nursing homes, and relates to average weekly earnings, not wage rates.

It was argued by many participants that there is a strong relationship between nurse wages in the nursing home sector and those in the acute sector. This raises two further issues: the size of any gaps in wages between the sectors, and the differences between jurisdictions in wages within the acute sector.

In regard to the first issue, participants indicated that in some States, nurse wages in the aged care sector lag significantly behind those in the public hospital sector. The Australian Nursing Federation (Federal Office, sub. 48, p. 11) said that there are significant wage disparities in Victoria, Western Australia, the Australian Capital Territory and the Northern Territory. A joint submission from the NSW College of Nursing and the NSW Nurses' Association (sub. 46, p. 4) made similar observations and added Queensland to the list. The Australian Nursing Federation (Victorian Branch) indicated that Victorian private nursing home wages lag the public sector by around 10–15 per cent (sub. D105, table 1). Information provided by the department shows similar differences (table 5.12).

The Australian Nursing Federation has tabled a log of claims aimed at closing the gaps between wages for nursing home and acute care nurses. Whether this would lead to a closer alignment of nurses wages in the aged care sector across different jurisdictions (and consequently less variation in standardised costs) would then depend on the range of variation between jurisdictions in acute care nurses wages.

Table 5.12 **Award wages for first year registered nurses by sector, by State**
$ per hour

State	*Public hospital*	*Non-government nursing homes*	*Percentage difference*
NSW	14.78	14.49	2.0
Vic	14.52	13.26	9.6
Qld	14.34	14.00	2.4
WA	14.16	13.31	6.4
SA	13.30	13.93	-4.5
Tas	14.20	13.30	6.7
ACT	15.22	13.30	14.4
NT	12.80	13.30	-3.8

Source: Department of Health and Family Services.

In regard to this second issue concerning wage differentials within the acute sector, the evidence is mixed. The ANF (SA Branch) indicated that in the early 1990s there were nationally consistent wage rates both for registered nurses and enrolled nurses (except for New South Wales). It stated that all States and Territories have achieved ‘similar order increases’ in the public (acute) sector since then as a consequence of enterprise bargaining agreements (sub. D102, pp. 7–8). Information from Aged Care Australia, however, suggests that the gap may have widened over the three year period from 1994 to 1996.

The impact of enterprise bargaining

In looking at future trends in wage costs, a relevant factor is the likely extent of productivity-based wage increases. If a wage increase in a particular jurisdiction is matched by a productivity increase, then the disparity in wage rates between jurisdictions resulting from that wage increase is not relevant in considering whether to differentiate subsidies in terms of total output costs.

At present, the scope of over-award payments in the non-government sector appears limited. The Victorian Employers’ Chamber of Commerce and Industry, for instance, reported the results of a survey of more than 150 Victorian residential aged care facilities which indicates that less that one per cent of nurses receive such payments.

Further, many participants considered that the scope for significant productivity improvements in the residential aged care sector was minimal. For example, Aged Care Australia (sub. 26, p. 11) indicated that ‘the opportunities for productivity gains by nursing homes through enterprise bargaining or through the substitution of labour inputs with equipment are extremely limited’. This is due to:

> the nature of the industry, quality care standards, the high level of productivity and staff flexibility that already exists, and insufficient funding or productivity gains to offset further changes in working conditions. (Sub. 26, p. 11)

Some participants indicated that previous SAM funding, which had applied for about 10 years, had driven improved productivity in the non-labour areas. They went on to argue that the scope for further productivity gain is therefore minimal.

These views were not universal, with some participants pointing to enterprise based negotiations that will lead to potentially significant improvements in productivity. Box 5.2 summarises TriCare’s experience with enterprise bargaining, where cost offsets and productivity improvements helped to fund an increase in wages.

Box 5.2 **TriCare’s recent enterprise agreement**

- Conditions of employment throughout TriCare have been standardised:
  - Permanent nursing staff who work regular shifts without rotation lose a week’s annual leave. The reduction to four weeks attains consistency with other categories of staff.
  - Sick leave entitlements have been reduced from 10 to 8 days per annum for all staff.
  - Penalty rates for Sundays have been reduced from 175 per cent to 150 per cent.
  - Night shift penalties now apply only to actual hours worked rather than starting time.
  - Seniority based progression has been abolished in favour of competency based progression.
- Demarcations which prohibit the efficient delivery of care and service to residents have been abolished. Staff must now perform any task within their range of competency.
- The team based structure inherent in TriCare’s best practice program has been enshrined as the core unit of workplace activity and review.
- The new wage increase amounts to 3.6 per cent over two years. A CPI adjustment will follow after a year.

Source: TriCare 1998, pp. 14–15.

Some participants expressed doubt over whether these types of tradeoff reflect true productivity gains. For example, the Australian Nursing Federation (SA Branch) noted that:

> Wage increases appear to be totally or substantially funded through cutting of other conditions of employment. This is at odds with the objective of sustainable improvement to real efficiency or productivity and is instead a short term negative cost cutting approach ... (Sub. D102, p. 5).

Nevertheless, TriCare's agreement demonstrates that it is possible to undertake enterprise bargaining within the nursing home sector. Enterprise bargaining can lead to less rigid employment conditions and flexibility in improving quality care.

5.5 Relationship between standardised costs and current subsidies

Relating standardised labour costs to existing subsidy levels gives an indication of the inequity in the current funding arrangements. Some caution is needed in such comparisons because most residents pay a flat dollar charge, irrespective of location, therefore existing subsidies relate to less than 100 per cent of the cost of providing care. This means that a given variation in total costs requires a somewhat larger variation in subsidy rates to fully compensate. Even so, it is clear that standardised costs and existing subsidies are very much out of line.

Using Aged Care Australia's standardised costings, a comparison between standardised costs and subsidies is made in table 5.13. Two results stand out:

- the range of variation in subsidies (22 per cent) is much greater than the range of variation in standardised labour costs (6 per cent); and
- the state ordering is very different. All States, except for Queensland and South Australia, rank higher (or equal) in terms of subsidy order than they do in terms of costs. In contrast, providers in Queensland and South Australia receive the lowest subsidies although they appear to have the highest (or near highest) standardised costs.

Using TriCare's data, Queensland's ranking on the subsidy scale would again be much lower than its position on the standardised cost scale. TriCare's data would also place the Northern Territory and possibly New South Wales in the 'disadvantaged' category. The cost ranking of South Australia in TriCare's comparison lines up more closely to its subsidy ranking than in the Aged Care Australia comparison.

Table 5.13 **Comparison of standardised costs with subsidy**
Using ACA's data, and RCS 1 subsidy rates

State	*Index*	*State*	*Index*	*State*	*Index*
Model including workers compensation		Workers compensation model with higher salaries		RCS1 subsidies	
WA	100.00	Vic	100.00	Qld	100
Vic	102.33	WA	100.70	SA	108
NSW	103.17	NSW	100.89	WA, ACT	111
Qld	104.02	Qld	102.34	NSW	116
Tas	104.19	SA	105.76	NT	118
SA	105.27	Tas	105.88	Vic	121
				Tas	122

Source: Derived from above tables, and subsidy rates.

5.6 Conclusion

There are considerable uncertainties and caveats in the cost data available to the Commission.

Nonetheless, the Commission considers that regional variations in the standardised cost of delivering nursing home care are significantly smaller than the current jurisdictional differences in subsidy rates.

Moreover, the correlation between the state and territory ordering of the current subsidy scale and the ordering of standardised cost is poor. In particular, all standardised cost comparisons show Queensland to be particularly disadvantaged. Even if a regionally differentiated subsidy regime is to be retained, the current scales would need to be restructured to more closely reflect underlying costs.

6 Should coalescence proceed?

The choice between nationally uniform and regionally differentiated basic subsidies rests primarily on the significance of regional differences in the prices of inputs for the production of a benchmark standard of care. The narrower the regional dispersion in input prices, the stronger the case for nationally uniform rates, with supplementary funding for services in high cost regions.

Additional arguments advanced in favour of nationally uniform subsidies include that they would:

- obviate the need to set and process regional subsidy rates;
- discourage significant movements in the input costs of any one jurisdiction; and
- enable integration of the subsidy regime for high care residents with the uniform regime applying to low care residents.

The potential savings from not having to set and process regional subsidy rates are likely to be relatively small. For example, a nationally uniform subsidy regime would not obviate the need to assess the industry's cost base on a regional basis from time to time to ensure that government funding in combination with resident charges was sufficient to support the benchmark standard of care. Also, it would not remove the need for an indexation arrangement that provided for some link between funding levels and temporal movements in the industry's costs.

6.1 The merits of a uniform basic subsidy

The cost data in the previous chapter are not conclusive. The estimates of differences in standardised costs vary considerably, the rankings of some States and Territories vary, and the estimates are sensitive to the underlying assumptions.

Given these uncertainties, the Commission considered the option of applying a percentage-based regime which would see the Government meeting a fixed percentage of the cost incurred by a home in providing care services. Residents would then meet the percentage balance of the cost.

A percentage-based regime would automatically differentiate subsidies across providers and regions on the basis of even very small differences in the total cost of

providing care. Thus, at least in its pure form, it would remove the need for the detailed cost calculations necessary under either a regionally differentiated or uniform dollar subsidy regime.

But the Commission concluded that this alternative approach would be impractical, and unacceptable — a view shared by most participants who commented on the approach. For example, it would be likely to reduce the pressure on providers to deliver services cost effectively. It would also mean that, for the same standard of care, low income residents in a high cost location would pay higher fees than low income residents in a cheaper location.

Despite the uncertainties, the available data suggest that the choice between nationally uniform and regionally differentiated subsidies is finely balanced. On the one hand, cost variations do not appear all that large. On the other hand, however, several participants noted that a continuing unfunded cost penalty of even a few percentage points can be significant for home viability.

In broad terms, the current cost situation can be summarised in the following way.

- The standardised cost comparisons show jurisdictional variations in labour costs of up to 11 per cent. However, the broadest set of comparisons (from Aged Care Australia) suggests a much smaller variation of 4 to 6 per cent, or 2 to 3 per cent either side of the national average.
- While there may be some regional differences in wage costs within jurisdictions, there was no evidence provided to suggest that these are generally significant in total cost terms. (However, as discussed later, providers running small homes in rural and remote areas have higher recruitment, retention and training costs, and are required to undertake a range of additional functions, the costs of which are not reflected in these types of comparisons.)
- Non-wage recurrent costs vary across regions, but are a relatively small part of the overall cost of providing care.
- Land and building costs vary significantly across Australia. However, the Commission notes that the need to reflect differences in these costs in the basic subsidy depends on the nature of the resident charging regime. As Aged Care Australia (sub. 26, p. 14) and others pointed out, if accommodation bonds were reinstituted for high care residents, then the need to allow for these sources of cost difference would be reduced. As an example, a home located in a high land or building cost area would have greater capacity to raise revenue through accommodation bonds for residents who had lived in the area, than a home located in a cheaper area.

However, in assessing the merits of uniform basic subsidies, it is also necessary to consider likely future trends in cost variation. This is particularly important in relation to labour costs — the major cost driver in the nursing home sector.

Assessing trends in labour costs is complicated by the fact that comparisons at any point in time are sensitive to the stage of wage negotiations in particular jurisdictions. Accordingly, there will be fluctuations in the spread of labour costs as well as differences in jurisdictional rankings over time.

As discussed in chapter 5, there is conflicting evidence on whether or not the longer term trend has been for a narrowing of jurisdictional differences in wage costs for nursing staff. The key issue, though, is whether jurisdictional differences in wages are likely to narrow (or widen) in future. A number of factors are relevant, including:

- the extent of productivity-based enterprise bargaining;
- the influence of the subsidy regime for residential aged care; and
- the relationship between nurses wages in the residential aged care sector and in the acute (public hospital) sector, and the relativities between jurisdictions in acute sector wages.

While greater uptake of enterprise bargaining could lead to some increase in wage rate differentials, such increases would be offset (at least in part) by productivity improvements. Without such offsets, there would be little incentive for employers to deviate from awards. Against this background, the underlying differential in overall labour costs (adjusted for productivity change) is more likely to narrow further in the future than to increase.

The current variations in wage rates presumably partly reflect the current differences in jurisdictional subsidy rates. In other words, the current subsidy regime may underpin some of the observed difference in wage rates, as noted by the ANF (SA Branch) for example. On that premise, a move to nationally uniform basic subsidies could tend, over time, to bring about a reduction in wage differentials.

Many participants argued that wage increases for nurses in the acute (public hospital) sector create strong pressures for similar increases in residential aged care. Thus, under an indexation regime more closely related to actual price movements, an important influence on the differential between jurisdictional wages for residential aged care nurses could be the differential between wages in the acute sector. Although May 1998 data supplied by the DHFS indicate the range of wages in the acute sector is greater than in non-government nursing homes, the important issue is how acute sector wages will compare in future. However, as noted in

chapter 5, here the evidence is mixed also about whether jurisdictional differences are narrowing.

Evidence presented during the inquiry suggested that the financial performance of providers varies within each particular jurisdiction. The less 'efficient' providers will be under greater financial pressure than the more efficient, irrespective of whether there are jurisdictionally based subsidies or not.

Further, with jurisdictionally based subsidies all providers in those jurisdictions which have below average standardised costs would receive lower subsidies than under uniform subsidies, while all those in jurisdictions with above average costs would receive more. Thus, jurisdictional subsidies would not advantage all providers facing financial difficulty — some would be better off, and some less well off, than under nationally uniform subsidies.

In summary, the current variation in standardised costs between jurisdictions is relatively small, and the current case for continuing to differentiate basic subsidies is not compelling. However, future cost trends are uncertain, and thus cost differentials between jurisdictions would need to be monitored.

On the basis of the information available to it, the Commission's view is that an approach based on nationally uniform basic subsidies should be adopted. However, there are two important provisos:

- there must be adequate additional 'special needs' funding to ensure equitable access to services in some particular circumstances, for example in rural and remote regions where costs are significantly higher than average; and
- the extent of dispersion in costs across Australia must be monitored. If the dispersion in standardised costs across or within jurisdictions were to increase significantly, then the nationally uniform approach should be reassessed.

A nationally uniform basic subsidy itself could bring about some realignment of jurisdictional costs — so time is needed for this to occur. Thus, reassessment of the case for separate jurisdictional subsidies should not be done every year, but could be done in conjunction with the periodic reviews of the industry's cost base (see chapter 7).

6.2 Should the announced coalescence arrangements proceed?

While giving qualified support for nationally uniform basic subsidies, the Commission does not endorse the current coalescence proposal. It sees this as being deficient in several important respects.

First, the national subsidy rates that would emerge from the current proposal are simply an (indexed) average of the current state based subsidies, not linked transparently to the cost of providing a benchmark standard of care.

Second, the indexing arrangements that would continue to apply under the coalesced regime are deficient in that they are not directly related to movements in industry-specific costs. The COPO index used to increase subsidies since 1996 is premised on the view that virtually all wage increases are productivity based. Hence, it only makes provision for safety net increases in wages (and for economy-wide movements in non-wage costs).

While there is clearly some scope for productivity-related wage deals in the nursing home sector, as noted above, wage costs are fundamentally influenced by pay outcomes for nurses in the acute care sector. Wage increases in that sector inevitably create pressure for increases in the nursing home sector, irrespective of whether productivity offsets are available. The fact that a number (but by no means all) in the nursing profession consider the aged care sector to be ‘less attractive’ than the acute sector, only adds to the pressure to closely match wage increases so as to attract and retain staff. In these circumstances, if equitable access to quality care is to be maintained over time, indexing must clearly reflect movements in nursing home costs.

Moreover, funding methodology should build in periodic reviews of changes in the nature of residential aged care and the expectations of residents. Examples include the need to make provision for the purchase of improved incontinence aids, and for the lower number of beds per room that will be required as accreditation and certification progresses.

Finally, the Commission considers that current special needs funding arrangements are inadequate. Payments under the viability supplement ($6 million a year), together with capital support for remote area services ($10 million a year) account for only around one-half of one per cent of total Commonwealth support for residential aged care. Apart from the intrinsic cost disadvantages that come from smallness and remoteness, some of these services must undertake a wider range of

functions than services in the major population centres. The current subsidy regime makes little or no allowance for the costs of these extra functions.

A move to nationally uniform basic subsidies which does not address these types of deficiencies would lead to inappropriate and inequitable outcomes. The next chapter spells out changes that should be made to the broader subsidy framework as a precursor to implementing uniform basic subsidies.

Recommendation 1: The Commonwealth Government should adopt nationally uniform basic subsidies (that is, a separate nationally uniform basic subsidy for each RCS category) for high care residents, as part of a package of changes to address deficiencies in the current subsidy arrangements.

7 An alternative uniform regime

7.1 Introduction

When measured against the assessment criteria spelt out in chapter 4, the Commission has concluded that the current coalescence proposal should not proceed. While a move to a nationally uniform basic subsidy regime is supported given the current fairly limited dispersion in the standardised costs of providing care, there are broader shortcomings in the current subsidy arrangements. The need to consider the coalescence issue in this wider context was an important message in many submissions.

This chapter spells out a subsidy framework which would address these deficiencies while moving to a nationally uniform basic subsidy regime. This approach is consistent with the terms of reference which ask the Commission to report on whether the proposed coalescence of basic subsidy rates should be replaced by an alternative funding structure.

At the outset, the Commission wishes to emphasise some important aspects of its subsidy proposal.

- The arrangements could apply to all those in residential aged care, rather than just high care residents, and irrespective of whether they lived in a hostel or a nursing home. The subsidy design principles outlined earlier in the paper are no less relevant to low care residents than to high care residents.
- To complement the basic subsidy regime, there would be an augmented role for special needs funding which would replace the current viability supplement. Such funding would provide additional support to services facing special cost circumstances, particularly in rural and remote areas.
- The basic subsidy regime would not make provision for the higher unit costs of small facilities as such. Where higher funding for small services is warranted, it would come through special needs funding. Also, the basic subsidy would not differentiate between homes on the basis of ownership.
- While the proposal is premised on there being nationally uniform basic subsidy rates (based on the currently available information on the dispersion in costs), all other recommendations would apply equally to a regionally differentiated regime, if a subsequent assessment of the cost base (see below) were to reveal

wider dispersion in standardised costs and a case for retaining or reinstating regional subsidies.

In developing its subsidy proposal, the Commission has not specified detailed subsidy rates, detailed eligibility criteria for access to special needs funding and the like. There are a number of reasons for this.

The Commission is seeking to focus attention on the key principles underlying its proposal. Moreover, the specific subsidy rates would depend crucially on the Government's preferred outcomes by way of the benchmark standard of care. Many participants claimed that the current level of funding is inadequate, especially in the context of the quality of care that the Commonwealth is pursuing through accreditation and certification. Other evidence suggests that current funding can provide an adequate return to providers, with some being willing to pay substantial amounts for bed licences. Reconciliation of this tension through the current Residential Aged Care Review would be necessary before subsidy rates under the Commission's regime could be struck.

Some of the changes canvassed by the Commission are beyond the direct purview of this inquiry. Further assessment of the merits of these proposed changes as part of the Residential Aged Care Review may also be appropriate.

Finally, there will be costs in implementing the Commission's preferred funding methodology. Thus, there is merit in awaiting the Government's decisions on the Commission's recommendations before the detailed implementation work is commenced.

7.2 The benchmark standard of care

A deficiency in the current coalescence proposal is that the national subsidy rates which would emerge are not linked transparently to the cost of providing a benchmark standard of care. In effect, the quality of care could become a residual balancing item, irrespective of the accreditation, certification and other regulations aimed at promoting quality care. Quality care is central to the well-being of nursing home residents, and the standard of care supported should be a conscious and transparent decision.

Accordingly, the starting point for the Commission's proposed regime is explicit specification of desired outcomes by the Commonwealth in terms of the standard of care benchmark it wishes to support. In its position paper, the Commission observed that this has effectively been achieved by the Government through the new

accreditation and certification requirements (see box 7.1) in combination with the objectives set out in the *Aged Care Act 1997*.

Box 7.1 **Certification and accreditation**

Certification

Under the *Aged Care Act 1997*, certified residential aged care services which meet specified building and care standards may ask residents to make accommodation payments and/or receive concessional resident supplements. However, certification is not mandatory. In the medium term, the focus of certification requirements will be on improving fire safety. In the longer term, improving privacy and space for residents will be the major goal.

Accreditation

To continue to receive Commonwealth funding after January 2001, services must be accredited. To obtain accreditation, services must meet the legislative requirements of the *Aged Care Act 1997* and be providing high quality care within a framework of continuous improvement. More specifically, a service must meet the Accreditation Standards which incorporate the Residential Care Standards, the building and care standards required for certification, and a Management Systems, Staffing and Organisational Development Standard. These incorporate an ethos of continuous improvement.

The Aged Care Standards and Accreditation Agency will manage the accreditation system and carry out regular supervision of services. Up until 2001, it will be up to each service to decide when to apply for accreditation. Accreditation will be for a period of up to three years, depending on the overall assessment of a service's performance against the standards. Services will then need to re-apply for accreditation.

A service does not have to be certified to meet accreditation requirements, but it does need to meet the relevant building standards.

Source: DHFS (1997a), DHFS Service Provider Newsletter No. 2.

Most participants supported the principle of explicitly stating the standard of care required, but some expressed qualifications about the use of accreditation as the benchmark. For example, Resthaven noted that accreditation outcomes will be reported as 'commendable' or 'satisfactory' for three year accreditation, 'unsatisfactory' for one year accreditation, and 'critical' with no accreditation. It commented that accreditation and certification may involve 'outcomes more divergent' than the Commission's position paper assumed (sub. D72, p. 2). Aged Care Australia considered that a 'satisfactory outcome' for each of the four accreditation standards would be the minimum requirement along with a 'satisfactory' certification pass-mark (sub. D77, p. 5).

The Aged Services Association of NSW & ACT presented information about a national project to develop a 'first generation' set of financial, organisational and quality 'benchmarks'. It commented that:

> Because of the complex relationships between minimum standards of care, quality care ('best practice') and financial viability, there is currently no unanimity as to what are the best indicators. (Sub. D67, p. 2)

The Commission accepts that some rule such as that suggested by Aged Care Australia would be needed if accreditation is to serve as the specification of the benchmark standard of care. With this qualification, it is clear that accreditation could serve to specify the care standards required by the Government — in any case, a more satisfactory specification does not appear to be currently available.

Recommendation 2: The Government should specify its intended outcomes in terms of a standard of care benchmark. The purchase price of care outputs from providers by way of subsidy funding, in combination with funding from residents, should be adequate to meet the cost of providing that benchmark standard of care.

The underlying cost base

In basing funding on a standard of care benchmark, it is necessary to decide on which costs would be included, and which excluded, from the standardised model.

In the Commission's view, the Commonwealth should not support costs associated with the provision of a higher standard of care than that required under its quality benchmark. For example, the Commission would not propose indefinite support for the higher nurse ratios required in Victoria under the relevant award. As ANHECA - SA (sub. 21, p. 5) noted, if a particular State wishes to impose higher quality requirements on its providers, then it should meet the resulting costs.

In the position paper, the Commission proposed that basic (uniform) subsidy rates should be linked to the cost of providing the benchmark level of care in an *efficient* sized facility using an *average* input mix. It was proposed that the average cost base should include the costs of workers compensation premiums, and that the industry cost base should reflect nursing wage rates and conditions applicable in the aged care sector rather than in the acute care sector.

While some participants supported these proposals, many participants had significant concerns, or requested the Commission to provide greater details about how they would operate in practice. These issues are dealt with immediately below, with the exception of workers compensation which is addressed later in the chapter.

Size of home

As foreshadowed in chapter 4, there is a tradeoff to be made in determining the broad size of home which the *basic* subsidy regime is based on.

- Setting a low home size would add to overall subsidy costs because of the proportionately higher costs incurred by small homes. It would provide higher than necessary subsidies to the larger, relatively lower cost, homes. Further, it would impede the rationalisation necessary in the sector. Although the number of facilities with less than 25 beds fell by more than 40 per cent between 1992 and 1997, the median size remains at around 40 beds and the mean at around 50.
- Setting a higher home size, say at the 60 bed level which a number of participants suggested now constitutes minimum efficient scale, would reduce overall subsidy costs. Although it would reduce the level of over subsidisation to larger homes, it could adversely affect smaller homes which currently provide a good level of care and which were established when smaller homes were more favourably looked on by the Government. For instance, the Australian Nursing Federation (Federal Office) commented that in the 1980s large facilities had been broken up into 30-bed homes to conform with government policy (transcript, p. 198). Aged Care Australia also referred to existing homes established under government policies which ‘favoured small home-like environments’ (sub. D77, p. 8). The Ainslie House Association said that it had been ‘forced’ to reduce bed numbers by 11 to receive Commonwealth capital funding for its new home (sub. D98, p. 1). According to Geriaction, any strategy which actively encouraged the demise of smaller homes would ‘contradict the philosophy of care espoused by government which is to allow “ageing in place”’ (sub. D99, p. 3).

Irrespective of the range of home sizes chosen to set the cost base, the Commission is not proposing that smaller centres be necessarily closed, rather that all homes be efficiently run. In addition, in rural and more remote areas, where there is limited scope for rationalisation to achieve economies of scale, ongoing additional support for small facilities may well be warranted on equity grounds. The need to target this component of support dictates that it is best handled through the special needs funding pool.

On balance, the Commission considers that subsidy levels should be set initially on the basis of the input structures that embrace the average sized homes together with ones of greater size — a range of homes from, say, 40 to 60 beds — rather than focus on the higher level of 60 beds proposed in the position paper. Over time, the mean number of beds would increase as smaller homes are amalgamated or closed, and there are fewer remaining very large homes to be broken up.

Level of costs

A related question is whether, for the representative facility sizes used in the standardisation exercise, the cost base should reflect the input structures of the 'average' provider or those of the most efficient provider. In other words, should standardised cost calculations reflect typical staffing profiles and average usage of non-labour inputs, or industry best practice? Participants indicated that there is considerable variation in efficiency in the sector.

The use of best practice input structures would be appropriate if the sole objective was to improve the efficiency of service delivery. Such an approach would increase the pressure on less efficient operators to improve their performance and minimise windfall gains for more efficient operators able to supply services at below the benchmark cost.

However, too much short term emphasis on efficiency could cause significant dislocation and put some residents at risk. In the first instance, inefficient providers might try to offset their higher costs by running down the quality of care provided. On the assumption that the accreditation and certification requirements set a floor on such behaviour, the capacity of some to stay in operation would be under threat. While more efficient operators could move in to take their place, extensive rationalisation over a short period would entail disruption for a large number of residents at a time when they are frail and their families and other carers are also in need of support.

Here, again, there is no 'correct' answer. On balance, the Commission sees subsidies based on the 'average' cost of providing the benchmark level of care in a range of 'efficient' (that is well-run) homes as an appropriate compromise between pursuing best practice delivery and safeguarding the welfare of residents. Calculation of such an average should exclude, of course, smaller higher cost homes in rural and regional areas.

With subsidies based on average costs, providers using a more expensive mix of inputs would still face pressure to improve their efficiency or exit the industry. Over time, this would put downward pressure on the 'average' benchmark cost. Indeed, it is important that the indexation arrangements ensure that these effects occur (see below).

Nurse wages

Another cost base issue raised by many participants was how nursing labour should be priced in determining the base. Their concern was to ensure that the aged care

sector is not disadvantaged in competing for nursing staff. Participants indicated that there were growing difficulties in particular jurisdictions in attracting nursing staff into the sector, because their wages and conditions were significantly below those in the acute sector. ANHECA, for example, stated that:

> Without wages parity for nursing staff between the acute and aged care sectors nursing homes will find it increasingly difficult and eventually impossible to attract and maintain good nursing staff. This will result in a decrease in standards or a further erosion of staffing levels with over award payments being compensated by a decrease in staffing levels. (Sub. D84, p. 5)

Hence many participants, including for example the Australian Nursing Federation (SA Branch), recommended adoption of 'a base subsidy rate for nursing and personal care immediately based on parity with nurses wages in the acute public sector' (sub. 11, p. 16).

The link between wages for nurses in the acute care and aged care sectors is not in dispute (see chapters 5 and 6), nor does the Commission have a view on whether wages in the aged care sector should be below or equal to those in the acute care sector. The Commission does acknowledge that the level of subsidy paid to nursing homes has an important influence on the wages they can pay. In turn, under the Commission's proposals for a revised indexation system which would more closely reflect the sector's costs than the current system (see below), changes in wages paid in the sector would be factored into the subsidy. The issues are: should subsidy changes lead or lag wage outcomes; and should the extent to which indexation reflects wage increases be limited?

The Commission considers that it would be unreasonable to ask taxpayers to fund a one-off increase in subsidies in the expectation that the increase would automatically flow through into increased wages for nurses leading directly to improved quality of care. There would be too much uncertainty: the wage increases could be delayed, funding could be diverted by providers into other areas of recurrent expenditure or into capital works, or even into higher profits. There would be little incentive to challenge wage claims, or to strive for productivity gain. Further, it could discourage enterprise bargains tailored to the specific requirements of the aged care sector.

The Commission considers that adjustments in subsidies should lag rather than lead wage outcomes. In addition, under a nationally uniform subsidy regime, those adjustments would reflect the national average change in wages, rather than the change in any particular jurisdiction. This would provide greater incentives to providers to control cost increases than would jurisdictionally based subsidies, as

only a proportion of an above average cost increase would index through into the national average subsidy.

Nevertheless, under the Commission's proposed indexation, the incentives for providers to challenge wage claims would be reduced because the costs could be passed through to the Commonwealth, albeit with some lag. Thus, without some form of control, nurses wages in the aged care sector could ultimately exceed those in the acute sector. For this reason, the Commission considers that when the Commonwealth determines its purchase price for outputs, the basic subsidy rates should reflect nursing wages and conditions in the aged care sector only to the extent that these do not exceed those applying in the acute care sector.

Deriving the cost base

In the position paper, the Commission commented that the cost base could be set on the basis of a survey, or alternatively by a joint industry and government panel of experts. The work would aim to define a standardised bundle of inputs, reflecting the agreed home size and cost basis, which could deliver the standard of care required to meet accreditation.

As Aged Care Australia commented, however, 'it is imperative that these inputs do not become prescriptive' (sub. D77, p. 7). The Commission agrees. The bundle would be used merely to derive the cost base, and individual homes would be free to use whatever input mix they considered necessary to meet the benchmark standard of care. The Commission does not support the call of some participants to reintroduce some elements of the previous acquittal system (see below).

A central point about this method for deriving a cost base is that it has been proven before. For example:

- cost data together with expert advice were used to develop CAM (differing between care levels);
- the RCS itself implicitly matches subsidy relativities and categories of care need; and
- the development of casemix in the hospital system relies on cost data and relativities.

The exercise could be based on the allowable input structures of a representative sample of efficient homes of relevant size, which already meet accreditation standards (if that were chosen as the quality benchmark) and whose resident mix approximates the average mix Australia-wide. A standardised input structure could be developed which reflects the average input structure of those homes. This would

then be costed on the basis of the average of the prices faced by homes in different regions. At this stage, a final decision could be made on whether the extent of cost variation justified regionally differentiated subsidies or not. Total funding would be set at a level which was adequate to meet the benchmark level of care. RCS subsidy relativities could continue to be used to apportion the subsidy between residents with different care needs.

The Commission notes that, even with revised indexation arrangements (see below), there would still be a need to periodically review the industry's cost base. Changes in the care environment would be relevant in such a review, such as if the Commonwealth were to mandate a higher level of care, or if innovations — such as improved incontinence aids — changed the cost of providing an 'acceptable' standard of care. The Commission considers that cost assessments should be undertaken every five years, transparently and independently of Government, in the context of a broad industry review.

Recommendation 3: As a basis for setting the output purchase price, the Government should arrange for a five yearly assessment of the jurisdictional and national average input costs of providing the benchmark level of care using a standardised input mix averaged across a range of efficient facilities (with, say, 40 to 60 beds). These assessments should be set in a broad context taking into account any changes in the residential aged care benchmark and in care expectations, and re-examining the case for nationally uniform basic subsidies. The reviews should be conducted transparently and independently of Government.

Recommendation 4: Basic subsidy rates should reflect nursing wage rates and conditions applicable in the aged care sector, but only to the extent that these do not exceed the rates and conditions applying in the acute care sector.

Funding adequacy

A dominant theme in many submissions from providers was that an accreditation/certification standard would be higher than the standard of care currently delivered by many in the sector. They considered that, with current levels of government funding, and without significant increases in resident charges, they would find it difficult to meet the standard of care required to achieve accreditation and certification. Indeed, many claimed to be experiencing viability problems at the current quality level.

Some of their concerns related to the impact of the new requirements on recurrent costs. For example, Aged Services Association of NSW & ACT (sub. 35, p. 31)

suggested that, by 2008, facilities will potentially have to be twice the physical size as at present to meet certification requirements in relation to residents per room, and that this will have a significant impact on operating costs. Lucan Care (sub. 1, p. 2) said that utility, maintenance and cleaning costs increase by nearly 30 per cent in single bed wards, with the cost of personal care increasing by around 15 per cent. There were also concerns about the additional licensing and administrative costs of achieving and maintaining accreditation status.

However, the greatest concern related to the capital costs of meeting the new standards and of building new nursing homes, particularly given the limited availability of accommodation bonds.

The Tasmanian Department of Health and Human Services noted that small rural facilities in that State are in need of 'significant' upgrading (between about $1.5 million and $2 million per site) to meet certification (sub. D100, p. 2). Many participants contended that the Government's decision not to implement accommodation bonds for nursing home residents will leave the sector starved of investment capital. Most suggested that income from accommodation charges and the concessional resident supplement will be nowhere near sufficient to meet the investment gap. In this regard, Sundale Garden Village commented:

> The measures in place to deliver capital for infrastructure will not deliver sufficient funds for many years hence. If the Government is so convinced that their figures are correct, then they should be prepared to fund the capital investment and take the income from the accommodation charges in repayment. (Sub. 16, p. 17)

A number of participants provided 'ball-park' estimates of the funding gap. For example, Baptist Care - WA estimated that, across Australia, an extra $1 billion would be required to bring the existing stock up to standard (sub. 5, p. 10).

Estimating the extent of any capital funding shortfall goes well beyond the scope of this inquiry. Nonetheless, the Commission observes that some investment in facilities that will comply with the new standards is occurring under the current subsidy regime. Moreover, there is evidence of significant interest from potential investors in the sector. DHFS argued:

> recent planning rounds indicate record levels of interest from prospective providers in entering the sector or expanding the size of their existing services. The market value of places — a good indicator of confidence — has also increased since the reforms. (Sub. 52, p. 22)

In contrast, Aged Care Queensland suggested that prices for bed licences had fallen substantially over the last two years, and that such prices are not necessarily an indicator of the health of the residential aged care sector: 'it may well be an indicator of the speculators who are coming in or their lack of experience in prices'

(transcript p. 102). Nevertheless, the substantial prices paid for bed licences do not sit comfortably with the view that there is a funding crisis in the sector. Similarly, the Commission notes that many homes, private-for-profit and non-profit alike, are producing operating surpluses under current subsidy levels, even in the lowest subsidy State of Queensland.

The nexus between care standards and funding is not clear cut, especially in the shorter term. Although accreditation is based on continuous improvement, this will not necessarily add significantly to costs of providing residential aged care, if improvements can be made by using current resources more effectively and efficiently. In addition, not all the extra costs associated with accreditation will necessarily be incurred in the near future: for example, some of the new building requirements do not come into effect until 2008.

The terms of reference for the Residential Aged Care Review direct it, amongst other things, to examine the adequacy of subsidy rates. That review is therefore the appropriate forum for resolving whether the current quantum of Commonwealth support for residential aged care is compatible with the standard of care required to meet the accreditation and certification requirements (see recommendation 17).

7.3 Relating subsidies to the care needs of individual residents

Under the present regime, the Resident Classification Scale (RCS) is the instrument for relating subsidies to the care needs of individual residents and thus to the circumstances of individual aged care facilities. The system, which has been in operation since October 1997, replaced separate classification instruments for the nursing home and hostel sectors.

A significant number of participants raised concerns about the detailed operation of the RCS. Some of these related to the administration of the system, some to the adequacy of the subsidy rates specified for the various classification scales, and some to the subsidy relativities between the scales.

On the other hand, there was support from Aged Care Australia and others for persisting with the new RCS.

Like the quantum of funding issue, possible changes to the RCS approach go beyond the scope of this inquiry. In any event, as the new scales have only been in operation for little more than a year, it would be premature to contemplate significant changes at this stage. This is particularly the case as the Centre for

International Economics has recently undertaken a review of the scales and made a number of 'fine tuning' recommendations to the Government (DHFS 1998b).

A few participants suggested variations to the present system of funding based on the care needs of individual residents. These are described in chapter 8.

Another concern is that under the present arrangements, a person can only be admitted to residential aged care after an ACAT assessment team classifies the person as needing high care or low care. Several participants commented on the adverse effects on nursing home providers where people admitted on the basis of an ACAT high care assessment are subsequently reappraised as low care under the RCS (ie to classifications 5 to 8). Similar losses of income can occur when a pre-October 1997 resident, considered high care under the previous classification system, is reclassified as low care under the RCS. According to ANHECA:

> Not only does the provider lose subsidy, which in some cases and in some small way can be overcome by roster variations, he/she also loses the payroll tax supplements for those residents [as payroll tax supplement is only provided in respect of high care residents]. (Sub. D84, p. 12)

Some participants considered that part of the difficulty arises from the fact that the ACAT team often sees the person in an acute phase, but that the person subsequently responds positively to the regular medication and regular care provided in the nursing home.

The Commission suggests that the situation be kept under review.

7.4 Indexation of basic subsidy rates

As spelt out in the previous chapter, the current COPO indexation regime is not based on movements in industry-specific costs. With other sources of income for providers largely tied, inadequate increases in subsidies after allowing for possible efficiency improvements will, in one way or another, compromise the delivery of quality care. As Aged Care Australia put it:

> nursing homes will be forced either to reduce the standard of care provided by employing lower qualified staff or they will progressively become non-viable. (Sub. 26, p. 15)

Aged Care Australia went on to claim that under-compensation for cost increases under the indexation formula has cost the industry $128 million in the past three years. (The Commission notes, however, that many actual costs are linked closely to available funding which, in turn, is linked closely to the existing indexation methodology.)

In its position paper, the Commission proposed that:

- a revised indexation arrangement should apply. It would not extend to full cost reimbursement, but would explicitly link increases in subsidy rates to movements in industry-specific costs;
- a discount would be made to reflect productivity improvement (if any);
- once developed by the ABS, sector specific productivity indexes should be utilised; and
- pending availability of those indexes, current COPO indexing arrangements should continue.

Participants supported the proposal to relate indexation more closely to industry costs. However, although some participants, such as Aged Care Australia and Sundale Garden Village, gave in-principle support to the notion of a productivity discount, others expressed strong opposition. ANHECA, for example, considered that 'the word "discount" is incorrectly used. This is a levy on industry and simply a discount for Government' (sub. D84, p. 6). Others considered the real need was for additional funding, rather than the removal of funding through productivity discounting. For instance, in noting that accreditation required continuous improvement by providers, the Queensland Government commented that:

> to have a productivity discount at a time when there's general acknowledgment that the level of funding nationally is insufficient is a ... problem. (Transcript, p. 76)

However, it is important to recognise the draw-backs of linking changes in subsidies too closely to movements in the cost of individual items.

- Relating subsidy increases solely to changes in the unit prices of inputs will make no allowance for improvements in productivity. Thus, if wage rate increases are partially paid for through higher labour productivity, increases in the wage rate component of the subsidy will overstate the increase in overall labour costs. In this regard, the Department of Finance commented that an underlying principle of wage cost indexation is that taxpayers should not fund productivity-based wage increases (sub. 50, p. 2).
- Full compensation for increases in industry costs will greatly reduce incentives for providers to improve efficiency. For example, there would be little incentive to challenge wage claims, or to seek improved productivity in return for higher wage rates. The absence of such incentives has been a problem with previous indexing arrangements.

Three additional points are relevant. First, as noted in chapter 5, many participants considered that the scope for productivity gain was minimal in the nursing home

sector. *If this were in fact the case, then any productivity discount should be minimal.* Not all participants shared that view, however. As also noted in chapter 5, there have been examples of enterprise bargaining encompassing productivity tradeoffs. Further, the trend towards larger nursing homes where unit costs are lower, and the scope for making economies through the association of nursing homes with hostels, provides further evidence of productivity gains.

Second, several participants argued that full discounting of productivity gains would remove incentives for providers to increase efficiency. For instance, NANHPH (sub. D 70, p. 4) commented that: ‘what incentives would [there be] for providers if they were going to get less assistance by being more efficient’? However, as the discount would relate to the *average* level of productivity gain, incentives would certainly remain for providers to do better than average.

Third, in response to the claims for additional funding, the Commission notes that this issue needs to be addressed in relation to the consideration of overall quantum, not as part of the indexation arrangements. In this regard, the Commission considers the question of the $128 million claimed to have been lost over the past three years through inadequate indexation as a quantum issue also.

Since the position paper was published, the ABS has advised the Commission that it will not be developing a sector specific productivity index:

> The ABS has no plans to undertake productivity analysis, even on an in-house basis, for components of the health service industry, for example, the nursing home component, as suitable input measures are not available at a component level. (Sub. D91, p. 2)

There are several possible alternatives to indexation of the subsidy, however. One approach would be to derive a suitably weighted average measure of wage movements through annual surveys of the wage rates in each jurisdiction (a move back, in this regard, towards the previous CAM arrangements). The productivity discount could be derived from empirical evidence of actual productivity gain. Non-wage costs could be indexed by the TMUI (Treasury Measure of Underlying Inflation), as at present.

Another approach to the labour component would be to adopt a readily available index as a proxy for wage movements in the residential aged care sector. For example, Aged Care Australia preferred the use of the Wage Cost Index for Health and Community Services (sub. D77, p. 11). The Australian Nursing Federation (SA Branch) preferred an index based on AWOTE earnings in the health sector (sub. D102, p. 13). It would be necessary to determine how closely these indexes are likely to reflect actual labour cost movements in the residential aged care sector.

Further, in this case, the productivity discount might have to be more ‘arbitrary’ as direct empirical evidence would not be available.

The Commission has not endeavoured to come to a final conclusion on the most appropriate indexation methodology, as it is not in a position to assess all the benefits and costs of the various alternatives within the limits of this current inquiry. However, in contrast to its approach in the position paper, the Commission considers that revised indexation arrangements for the subsidy should be introduced as soon as possible. The Commission suggests that the Government immediately establish a committee of relevant experts, including sector representation, to decide on a suitable indexation arrangement in line with the principles established in this report.

As noted above, the Commission considers that there is a need to periodically reassess the industry’s cost base, in the context of a broader review which considers any changes in the residential aged care benchmark and in care expectations. Some participants were concerned that such a process of review could lead to ‘double discounting’ of productivity gains. This is not the case, however. Applying a productivity discount to the yearly indexation of the subsidy would compensate, as it were, for the fact that the input base is not revised every year. The reassessment of the industry’s cost base would re-establish the standardised input mix anew against the then current benchmark standard of care.

The Commission sees the proposal to align indexation more closely with actual changes in the sector’s costs as being compatible with the Government’s policy on the indexing of budget outlays for programs of this type. In this regard, the Department of Health and Family Services commented that the policy allows for non-standard indexation where this:

> is necessarily and explicitly linked to Government’s policy objectives and alternative indexes comply with certain principles of indexation, most notably that they exclude productivity based wage increases.
>
> Residential care meets the first of these because it is tied to providing a set standard of care for residents of different levels of dependency. (Sub. 52, p. 27)

The proposed approach would also enhance the transparency of the indexation system for all involved in the industry.

Recommendation 5: Basic subsidy rates should be adjusted annually according to indices which clearly reflect the changes in the average cost of the standardised input mix, less a discount to reflect changes in productivity. Revised indexation arrangements should be introduced as soon as possible.

7.5 Supplements and deductions

Under the Commission's proposed regime, there would be a continuing role for supplementary payments. Such payments are a way of supporting care needs not closely linked to a resident's classification under the RCS. For instance, not all high care residents require oxygen treatment. Supplementary payments are also a way of addressing special cost circumstances which would be difficult to incorporate within the basic subsidy regime.

There are currently several supplements available:

- pensioner supplement (which replaced the former Residential Care Allowance);
- concessional and assisted resident supplements;
- transitional supplement;
- hardship supplement;
- respite supplement;
- oxygen supplement;
- enteral feeding supplement;
- payroll tax supplement; and
- viability supplement.

In the position paper, the Commission proposed that the pensioner, oxygen, enteral feeding, respite, and hardship supplements should be retained in their current form in the new subsidy regime. This proposal was generally supported by participants.

However, there were some queries about the appropriate levels of funding. For example, the Victorian Healthcare Association considered that the respite supplement should be set higher than at the current RCS 3 level. There was also concern about the adequacy of funding to cover all additional areas of particular need. The Agmaroy Nursing Home stated that:

> Currently if a resident requires a prescribed dressing which costs $275 per month, or dietary supplements which do not fall under the category of enteral feeding, oxygen that is not delivered other than by a concentrator and continence aids there is no provision in any of the supplements to cover these extra costs when they are incurred by an individual who is unable to bear the additional cost. (Sub. D89, p. 2)

In view of these comments, the Commission has modified its preliminary proposal.

Recommendation 6: The pensioner, oxygen, enteral feeding, respite and hardship supplements should be retained in their current form at this stage. The rates should be suitably indexed. The appropriateness and adequacy of these

existing supplements, and the justification for any additional supplements, should be re-examined in each five yearly assessment of costs.

In the Commission's view, there are arguments for modifications to the concessional and payroll tax supplements, as well as a need to replace the viability supplement with a new and augmented special needs funding pool — see next section. There is also the question of how best to reimburse workers compensation premiums and superannuation charges.

The concessional, assisted resident and transitional supplements

The concessional and assisted resident supplements are paid in respect of 'new' residents assessed as unable to afford all, or part of, the accommodation charge. ('New' residents are those entering a certified facility after 1 October 1997, or after the date on which a facility was certified, whichever is the later.) The transitional supplement is paid in respect of residents who cannot be assessed for eligibility for the concessional and assisted resident supplements. Essentially, these supplements substitute for the accommodation charge which is intended to be used for capital purposes.

The concessional supplement is two-tiered, with the higher rate of $12 (indexed) a day for eligible residents applying where 40 per cent or more of new residents qualify as concessional residents. Where the percentage is lower than 40 per cent, the rate is $7 (indexed) a day. The assisted resident supplement is a flat $3.50 (indexed) a day. Transitional supplement rates of $2 per resident per day apply to certified nursing homes, and $1.50 to non-certified homes. (There are also separate arrangements prescribing minimum, regionally-based, ratios of concessional residents — see section 7.9.)

In the position paper, the Commission invited comment on whether the current two-tier concessional resident supplement is appropriate, and on the implications of any changes in the structure of the supplement for the assisted resident and transitional supplements.

In response, participants raised a number of issues. Some relate mainly to quantum: the desirability of separately identifying payments for capital purposes; the withdrawal of $66 million from the existing funding pool to fund these supplements; and concerns (widespread) about the adequacy of the daily rates to fund the sector's capital needs.

In regard to the tiering of the concessional supplement, there is a major discontinuity in the level of support at the 40 per cent tier. For example, a certified

100 bed home with 39 new concessional residents would receive a supplement of around $100 000 a year. Were the home to have 40 new concessional residents, the payment would rise to around $175 000 a year. The Commission notes that according to the recent RCS review (DHFS 1998b, p. 19), the average proportion of concessional residents is about 38 per cent. If this figure is still valid, then the discontinuity can have real impact, rather than being just theoretical.

Participants generally considered that such a major discontinuity was not justified, and called for either a sliding scale to be implemented, or for a common rate of supplement to apply. Aged Care Australia considered that the original rationale for the tiering — to provide greater support to those facilities unable to achieve levels of capital funding through accommodation bonds or charges — had been weakened when the provision to allow accommodation bonds had been replaced by the maximum $12 per day accommodation charge (sub. D77, p. 20). The Victorian Healthcare Association considered that the two-tier system may encourage some homes to 'discriminate' against residents able to afford the accommodation charge (sub. D85, p. 4). In supporting a single rate of payment, the Queensland Government commented that as the payment was meant for capital purposes, its rate should not depend on a home's proportion of concessional residents (transcript p. 79).

In the Commission's view, the funding inequity created by the present two-tier concessional supplement should not be allowed to continue. It effectively discriminates against non-concessional residents by providing significantly greater funding at the margin than the accommodation charge of about $12 per day (ie $4380 per annum) — in the above example, the marginal funding for an extra concessional resident is about $75 000 per annum.

This inequity could be eliminated by setting a sliding scale of payment increasing up to $12, or by setting a uniform rate of $12 per resident. Although the uniform rate approach would have some quantum implications, it would remove one more layer of regulation and administration. Further, a sliding scale approach is not necessary to encourage homes to cater for concessional residents as an alternative mechanism to do so already exists.

The Commission notes that concessional resident ratios (see section 7.9) apply (on a regional basis) to encourage homes to care for concessional residents. Homes are required to comply with these minimum ratios and, according to the Residential Care Manual (DHFS 1997a, p. 6-10), 'financial sanctions will apply to those facilities which do not meet the required ratio'. The Commission notes that these required ratios are generally less than the 40 per cent breakpoint under the concessional supplement. However, these requirements could be tightened if it were

considered that the incentives for providers to accept concessional residents were unduly affected by the removal of the step in the rate of concessional supplement through a uniform rate. In the Commission's view, this more direct approach to ensuring the needs of concessional residents are met would be preferable to the regulatory impost of a sliding scale subsidy.

Recommendation 7: The concessional supplement should be set at a single uniform daily rate.

Input tax supplementation

The Commission's proposals would generally not recognise variations in ownership structures, except to the extent that they should take account of the ownership impacts on the price of inputs. Thus, the Commission supports the concept of a supplement for private providers to offset differential taxes levied on their inputs. Without such supplementation, the capacity of private homes to provide the same quality of care as charitable and government homes could be compromised. This rationale does not extend to supplementation for income tax, which is a tax affecting the distribution of profit, not a tax affecting the cost of inputs.

At present, such tax supplementation is limited to payroll tax liability. In principle, it could extend to other input taxes levied on private providers such as fringe benefits tax, sales tax and land taxes. In the position paper, the Commission commented that, in practice, however, it is not clear whether these other taxes are sufficiently significant to justify the additional administrative costs of establishing a system of supplementation or exemption.

In response, TriCare indicated that its nursing home division incurs about $500 000 annually in sales tax and FBT for purchases related to resident care and accommodation — equivalent to slightly more than $1 per resident per day (sub. D78, p. 4). If this is typical of private providers, then the Commission would not consider the cost sufficiently significant to warrant the administrative burden of supplementation or exemption.

However, the Commission considers that this issue could be considered further in conjunction with formulating the arrangements for the nursing home sector in relation to the proposed GST.

Payroll tax issues

Most participants' comments on tax supplementation were about specific aspects of the payroll tax supplement. A number argued that there are major inequities in the

current structure of the supplement — both across States and Territories and between small and large homes (see box 7.2). A few canvassed major changes to the arrangements. For example, ANHECA (sub. 24, p 11) raised the possibility of paying the supplement in the form of a grant to the States who would then exempt nursing homes from payroll tax. Another alternative would be to institute a cost reimbursement system.

The Commission concurs with participants that there are significant inequities in the current payroll tax regime. Moreover, a number of these would remain at the end of the proposed coalescence process. For example, despite the fact that the rate of payroll tax in NSW is higher than in Tasmania and the tax-free threshold the same (see table 7.1), NSW homes of 60 beds or less would continue to receive a much smaller supplement than their Tasmanian counterparts.

More generally, there is the question of whether inequities are an inevitable outcome of linking payroll tax supplementation to the number of beds in a facility. The existence of tax-free thresholds means that the average payroll tax liability per resident increases with the number of beds in a facility. However, it is likely to be very difficult to reflect this changing liability — which actually depends on the wages bill rather than the number of residents — in a simple tiered structure tied to the number of beds.

In proposing an appropriate funding methodology for this item, the Commission notes that it is non-discretionary, with rates set at arms length by State and Territory Governments, and it has particular effect on one group of providers. An exemption system (with corresponding grants made to State and Territory Governments) or a cost reimbursement system might be warranted in this one particular area. The Commission, however, notes that State/Territory Governments have already rejected an exemption system. This leaves a cost reimbursement system as a possible alternative.

To avoid increased payroll tax imposts on nursing homes, such reimbursement would be limited to the generally applicable rate of payroll tax in a particular jurisdiction.

There was strong support from participants for such a cost reimbursement system for payroll tax. For example, ANHECA commented that this is ‘the only equitable method of funding payroll tax’ (sub. D84, p. 14).

Box 7.2 **Payroll tax arrangements**

Payroll tax is a state tax, paid by firms on their wages bill (typically including a range of labour on-costs such as bonuses and fringe benefits). The structure and level of the tax vary somewhat across the States and Territories (see table 7.1).

Table 7.1 **Payroll tax arrangements as at 1 January 1998**

State	*Scheme*	*Threshold $000*	*Maximum rate %*
NSW	Single rate	600	6.85
Vic	Single rate	515	6.25
Qld	Single rate with phase out	850	5.00
WA	Marginal rates with phase out	675	5.56
SA	Single rate	456	6.00
Tas	Single rate	600	6.35
ACT	Single rate	800	6.85
NT	Average rates with phase out	520	7.00

The nursing home payroll tax supplement is payable to providers who care for RCS 1 to 4 residents and who are liable for payroll tax. The structure of the supplement varies across jurisdictions — in some cases it increases with the numbers of beds in a facility, in others it is a flat rate (see table 7.2).

Table 7.2 **Payroll tax supplement**
dollars per high care resident per day from 1 July 1998

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
61+ places or grouped	4.61	3.83	3.31	4.58	3.11	4.85	4.79	5.29
31-60 places	3.15	3.24	1.27	0.99	2.33	4.85	4.79	5.29
1-30 places	1.41	2.08	1.03	0.55	1.19	4.85	4.79	5.29

A number of participants said that, in jurisdictions where the tiered structure applies, homes in the 31-60 bed category can be significantly disadvantaged. Western Health Care Group gave an example for Western Australia:

> a 60 bed nursing home [in Western Australia] is about $80 000 per annum worse off than a facility of 61 beds. The 60 bedder makes a deficit of $18 000 and the 61 beds enjoy a surplus from this one item of funding of $61 000! (Sub. 2, attachment B, p. 2)

It also argued that the flat rate structure for homes in Tasmania, ACT and the Northern Territory allows them to make a considerable profit out of the payroll tax supplement.

Coalescence

Under the proposed nationally uniform subsidy regime, the payroll tax supplement is to be coalesced. The process for each tier will be the same as for the basic subsidy rate. However, Tasmania, the ACT and the Northern Territory will retain a single rate structure at the level of the coalesced rate for the top tier.

Some participants drew the Commission's attention to an administrative arrangement that allows charitable facilities that are exempt from payroll tax to access the payroll tax supplement. In essence, by incurring a few dollars of payroll tax liability through the use of contract nursing labour, a charitable facility can apparently access the full supplement. For a 61 bed facility in say New South Wales, the supplement would be worth around $100 000 a year. In the position paper, the Commission suggested that the Commonwealth should take immediate action to end this anomaly.

In response, many participants agreed that the anomaly should be removed, but considered that there should be provision to reimburse payroll tax actually paid by charitable and not-for-profit homes. They argued that tax could be payable when, for instance, a home used the services of agency nurses. The Commission agrees with participants that its recommendation should encompass payroll tax paid by the charitable and not-for-profit sector, as well as the for-profit sector. The Commission draws the line at contract nursing and personal care staff, however, and does not propose extending reimbursement to cover the payroll tax components on contracted food, laundry, maintenance or other services.

Recommendation 8: The current payroll tax supplement should be replaced by a system of cost reimbursement for payroll tax paid by providers for their employees and for contract nursing and personal care staff.

Workers compensation

In each State and Territory, nursing homes are obliged to pay workers compensation insurance. The premiums generally consist of a base rate plus an adjustment for claims experience. As noted in chapter 3, base rates vary from nearly 4 per cent of wages in Queensland and Victoria to 7 per cent in Tasmania.

Under the current subsidy regime, funding for workers compensation premiums is incorporated in basic subsidy rates. This was in response to concerns that the previous cost reimbursement system had removed incentives for homes to reduce their premium costs or employ sound occupational health and safety practices. As the Department of Health and Family Services commented:

> this arrangement provided no control over discretionary expenditure such as workers compensation insurance. Providers had no reason to negotiate with insurance companies or indeed improve occupational health and safety arrangements. (Sub. 52, p. 15)

There are, however, transitional provisions that provide top-up funding for those homes facing the highest workers compensation costs in each State or Territory. These are to be phased out by 2001.

In its position paper, the Commission argued that Commonwealth contributions towards workers compensation costs should continue to be provided through the basic subsidy regime. This attracted some support from participants, for example from Aged Care Queensland which considered that 'individual state levies, surpluses or penalties should [not] be supported in the aged care funding system' as the 'body imposing the costs should be responsible for their impacts' (sub. D69, pp. 14–15). However, this position was rejected by most participants which commented on the issue. They generally requested that a system of cost reimbursement apply, possibly with limits to provide some incentive to providers to endeavour to improve occupational health and safety.

ANHECA recommended a 'constrained cost reimbursement arrangement' which would set caps that introduce a maximum loss and a maximum gain that a facility can occur. It described the arrangement as follows:

> The state average is calculated from certified returns provided by the provider. The upper cap is set at a level that would protect the 5 per cent of providers paying the highest levels of workers compensation premiums in each State. Once that cap is set the lower cap is set at the corresponding level. (Sub. D84, p. 9)

In contrast, the Aged Services Association of NSW & ACT proposed that workers compensation be reimbursed on a jurisdictional basis to the state average level, with 'further funding provided for an amount over an unfunded component' (sub. D67, p. 6). The Association suggested that 'a reasonable percentage could be 20 per cent' of the 'base tariff premium' (sub. D67, p. 6). It commented that the state average could be calculated annually, by requiring providers to submit their final premium notice received from their insurer to the department.

A number of reasons in support of cost reimbursement were advanced. The first related to a supposed need for consistency with the cost reimbursement proposal for payroll tax. However, in the Commission's view this is not an issue of substance because, unlike payroll tax, workers compensation does not differentiate between the charitable/not-for-profit sector and the for-profit sector, and because it is important to include an incentive in the discretionary element of the premium.

The second reason concerned jurisdictional differences in base rates. In this regard, NANHPH said:

> The diversity of rates and the range and complexity of formulae used for calculating workers compensation varies markedly from State to State ... The workers

compensation premium is not a cost input that readily lends itself to any form of universal coalescence. (Sub. 25, p. 27)

However, the Commission observes that the standardised cost calculations provided by Aged Care Australia and others include an allowance for the costs of workers compensation premiums. Hence, jurisdictional variations in those premiums are one of the factors contributing, in a net sense, to the relatively small differences in total standardised costs. This would suggest that at least the costs arising from the average premium payments (base tariff plus experience adjustments) could be incorporated into basic subsidy rates without creating significant distortions.

Of course, the average workers compensation rate factored into the basic subsidies would need to be accurately based, included in the five yearly reviews and monitored for any significant changes that went beyond the indexation formula. Some participants, such as the Aged Services Association of NSW & ACT, contended that the translation of subsidies from OCRE into the rates applying from October 1997 had failed to pick up 'sharp increases' in workers compensation costs since 1994-95, resulting in underfunding of about $2.60 per resident per day (sub. D67, pp. 3–4). Further, many participants noted that significant variations in premiums can occur from year to year.

A third reason concerns additional premiums which may be levied on particular providers, for a period of up to three years, in response to a workers compensation claim from an employee. It was not only claimed that these costs could be significant, but that in many cases the original cause of the claim could be largely beyond the control of the provider. For instance, Catholic Care of the Aged considered that 'nursing homes can have their financial viability threatened by excess workers compensation costs caused by factors beyond their control' (sub. D75, p 3). NANHPH cited the case of a 'very responsible' member 'doing everything possible to make sure that occupational health and safety featured very strongly' who had recently had a case which has 'added a million dollars per annum to their workers compensation premium for a period of three years' (transcript, p. 27). Valencia Nursing Home indicated that it went from a 20 per cent discount to a 20 per cent loading, and that its claims experience was 'by no means unacceptable' (transcript p. 341).

These views were not universal however. TriCare commented that 'workers compensation costs can be largely influenced by individual proprietors depending upon workplace policies and procedures' (sub. D78, p. 6). Although it supported a cost reimbursement arrangement, the ANF (SA Branch) considered that 'increases in costs attributable to poor performance in claims management or injury prevention should not be recoverable' (sub. D102, p. 17).

In summing up, the Commission considers that the costs arising from the average workers compensation premium payments should continue to be incorporated in the basic subsidy, with periodic review and with indexation. On the basis of the evidence, the Commission considers that there is merit in providing additional top-up funding to particular providers where they incur significant extra costs. However, this additional funding should not cover 100 per cent of the additional costs as this would remove all financial incentive for providers to improve occupational health and safety. The Commission also considers that such incentives would be enhanced if providers were able to retain premium savings in years without claims. For this reason, it prefers a mechanism such as that proposed by the Aged Services Association to that proposed by ANHECA. However, it would initially set the discount 'hurdle' at a higher rate, 30 per cent, and apply it to average premiums, to provide a greater incentive than the 20 per cent of base tariff suggested by the Aged Services Association. The discount could be adjusted up or down in the light of experience if it were found to be inappropriate.

Recommendation 9: The assessment of costs should include a component to reflect the average workers compensation premiums (base tariff plus experience adjustments) incurred by residential aged care providers. This component should be adjusted between the five yearly assessments if indexation of basic subsidy rates fails to cover significant changes in average workers compensation costs.

In addition, supplementary funding should be made available for individual providers which incur higher workers compensation costs than the amount allowed for in the average cost base, on the condition that those providers bear an excess equal to 30 per cent of that amount.

Superannuation

Several participants raised the issue of reimbursement for superannuation charges. The July 1998 adjustment in basic subsidies allowed for a flat amount of $0.52 per resident per day increase to cover the costs arising from the 1 percentage point increase in the Superannuation Guarantee Charge.

However, ANHECA, for example, argued against this approach:

> Superannuation is directly related to staff input time and therefore the Government's inclusion of a standard amount across all categories ignores the increased staffing requirement for increased dependency ... ANHECA considers that superannuation should be funded on a cost reimbursed basis ... (Sub. D84, p. 2)

Similarly, as well as querying the methodology for calculating the flat amount, the Western Health Care Group stated that:

> We find it inconsistent and incorrect that the increase has been added on a flat amount to all funding levels which of course loads excessive funding into low care to the detriment of high care funding. (Sub. D116, p. 2)

The Group estimated that the increase for low care residents should have been in the order of $0.22 per day, and for high care residents about $0.68 per day.

The differences between differential rates and a rate which is uniform across RCS classifications are small in absolute terms. However, given that separate basic subsidies would continue to be set for residents in different RCS classifications under the Commission's methodology, the extra administrative burden in calculating reimbursement rates appropriate for each classification would be insignificant. Further, the Superannuation Guarantee Charge is non-discretionary, applies nationally and affects all providers equally. The Commission considers that changes in the superannuation charge should be included in the assessment of costs in proportion to the staff time spend in caring for the residents in each category.

Recommendation 10: Superannuation charges should be included in the assessment of costs, at rates appropriate for each RCS classification.

Deductions

There are currently several deductions applying to basic subsidies. Apart from deductions to reflect revenue from income tested resident fees and charges for extra service (see section 7.9), there are also deductions for homes where residents pass on workers compensation payments (for which the Commission proposes no change) and for government homes.

A few participants raised concerns about the deduction arrangements for government homes. Their primary concern was that lower rates of basic subsidy continue to apply when government-owned facilities are transferred to the private sector. The Queensland Government also noted that the flat rate deduction has a greater proportional impact on government homes in Queensland because of the lower basic subsidy rates applying in that State (sub. 10, p. 2).

These arrangements reflect a previous agreement that the Commonwealth should not pay for capital funding, maintenance costs and a return on investment in state government homes.

However, as noted above, the Commission sees no reason why the basic subsidy regime should differentiate on the basis of ownership. Thus, in the position paper it proposed that government-run homes and those transferred to the non-government

sector should receive the same level of basic subsidy as their private and charitable counterparts.

While this was generally agreed by most participants to be valid in principle, they raised some issues of practical application. For instance, Aged Care Australia considered that, in view of the estimated cost of $33.2 million per annum for this proposal, the particular financial arrangements which had been entered into must be taken into account:

> to establish to what extent the financial agreements regarding the transfer of beds from State Governments to the private sector have included inducements (such as capital grants) and/or have taken into account the adjusted subsidy reduction. (Sub. D77, p. 13)

In other words, participants expressed concern about possible over-funding, or windfall gains.

The Commission notes that such gains and losses can occur whenever funding arrangements change. Coalescence, for example, will deliver a gain to Queensland at the expense of currently more highly funded States such as Victoria, and Tasmania.

However, it is relevant to examine what arrangements currently exist between State Governments and the private operators of previous government homes. In Victoria and Tasmania, at least, there are arrangements for the State Governments to provide supplementary funding to such private operators. Removing the subsidy deduction in such instances would transfer funds to state government consolidated revenue, rather than to nursing home providers. Thus, given constraints on the total quantum of funding available for residential aged care, there could be merit in phasing out the subsidy deduction over, say, five years.

Recommendation 11: The current subsidy reduction for government-run homes and those transferred to the non-government sector should be phased out over a five year period.

7.6 A separate special needs funding pool

In revamping the subsidy arrangements, the Commission sees the enhancement of special needs funding — that is, funding to cater for special high cost circumstances not addressed through the basic subsidy or standard supplements — as of the highest priority. For example, people in high cost rural and remote locations are most likely to face reduced access to care or care that is provided in more difficult

circumstances than applies in other parts of Australia. A move to a uniform basic subsidy regime makes the adequacy of special needs funding doubly important.

The present viability supplement goes some way towards meeting the need for additional funding for services operating in very high cost regions. However, it is deficient in at least two respects.

First, funding for the supplement is inadequate to compensate for the additional costs incurred by services in special circumstances, such as smaller homes operating in rural and remote areas. These additional costs do not only reflect remoteness and smallness — they also arise from the wider range of functions that homes in these areas perform (see box 7.3). As a result of their higher costs, many of these services have to rely on assistance from State and Territory Governments, local councils and their communities to remain viable. The higher costs may also explain why, as noted in chapter 3, rural and remote areas remain underserviced in terms of the planning ratios for places.

By way of perspective, services in remote and rural areas (outside the major rural centres) account for around 18 per cent of total nursing home beds. On the assumption that these services get a similar share of total Commonwealth funding, they receive some $400 million a year. Payments under the viability supplement of $6 million a year to homes in these areas therefore allow for an average cost premium of just 1.5 per cent over and above services in the major population centres. It is therefore not particularly surprising that, although the private-for-profit sector provides nearly 50 per cent of nursing home beds Australia-wide, outside metropolitan and major rural centres the share is less than 25 per cent.

Aged Care Tasmania synthesised the problem as follows:

> A strengthened viability supplement provides the opportunity for a two-tier system of nursing home subsidies ... However, the existing viability supplement would need to be redesigned and funding levels increased in order to provide adequate assistance for delivery scale and dispersion related costs ... (Sub. 40, p. 31)

Similarly, NANPH stated:

> One of the issues which the industry has been arguing with the Commonwealth and State Authorities over many years is the inability of ‘authority’ to listen to reality and understand that remote areas, climatically adversely affected areas, particularly communities such as the Aboriginals and Torres Strait Islanders do require market specific funding assistance rather than a meek acceptance of an Australia wide funding formula on the basis that one size fits all. (Sub. 55, p. 18)

Box 7.3 **Nursing home services in rural and remote areas**

A significant number of submissions addressed the challenges and additional costs of providing nursing home services in rural and remote areas. In the summary that follows it is difficult to capture the totality of those challenges. Nevertheless, it serves to highlight that nursing homes in rural and remote areas have a much wider role to play in the lives of their residents than most homes in the major urban centres.

The care environment

Perhaps the major difference between rural and remote services and those in the main population centres is the additional functions that service providers are expected to perform. Maranoa Retirement Village put it this way:

> Our experience has shown that facilities in rural areas have a great expectation of providing services, usually above and beyond what is required by them to provide, placed on them by the local community.
>
> Many of our clients have no family contact whatsoever and not only does our facility have to actually arrange for the person to move to our facility but staff are also required to provide ongoing support in all areas of the person's life usually provided by family eg: organising finances, purchasing of goods, paying of bills, transport etc. Some of our residents arrive at our facility with only the clothes on their back and it is up to staff to organise extra clothing, toiletries etc. (Sub. 20, p. 4)

Frontier Services made similar observations, as well as pointing to the cultural issues surrounding service provision:

> Culturally appropriate care is an issue we constantly struggle with and have never been able to completely address. The social implications as well as environmental factors that need to be considered when providing care to older Aboriginals from a variety of language groups and skin colours need to be factored into funding levels. The inability to financially compensate language and cultural interpreters, the need to consider gender issues for care providers and the difficulty in recruiting appropriate members of the Aboriginal community all impact on the quality of care in our services. (Sub. 8, p. 5)

Further, the lack of access to allied health professionals such as physiotherapists and occupational therapists places additional demands on nursing home staff.

Some specific cost pressures

While not exhaustive, the following illustrates the type of cost pressures, additional to those stemming from smallness and the requirement to provide 'whole of life' support for residents, that homes in rural and remote areas must confront:

- lesser capacity to manage the resident mix because of a smaller population pool to draw on and a sense of 'duty' found in smaller communities;
- more variable occupancy rates, particularly for respite care beds;
- lower staff productivity in tropical regions due to climate;

(continued on next page)

Box 7.3 **(continued)**

- added costs of bringing in and accommodating agency staff to cover leave and other absences;
- more expensive food and basic services such as power, water, telephone, fuel;
- higher transport costs for capital equipment;
- lack of access to skilled tradespeople to maintain equipment and facilities, and higher costs for service calls;
- reduced life of equipment and fittings due to the harsh climatic environment;
- the cost of sending staff away to training courses; and
- the cost of transporting residents back to communities for ceremonies, family contact visits and the like.

The second problem with the current viability supplement is that the eligibility criteria give a heavy weighting to remoteness from major population centres. Thus, it is difficult for services in larger rural centres to attract the supplement, even if they are providing the wider services to residents described in box 7.3. For example, phasing out of the 24 hour top-up funding arrangement (see below), and its replacement by the viability supplement, will apparently end additional support for some services in Darwin which, as noted by the Northern Territory Government (sub. D101, p. 1), serves large numbers of residents from more remote communities.

Against this background, in its position paper the Commission proposed that there should be new special needs funding arrangements that build on the current viability supplement. Specifically, the arrangements would have the objectives of providing additional support (that is additional to the relevant basic subsidies and supplements and deductions):

- to small, high cost homes in regions where demand for care is insufficient to support facilities of an efficient size; and/or
- to homes required to deliver services additional to the standard care services allowed for in the basic subsidy regime.

The Commission indicated that given the very diverse range of circumstances confronting services in rural and remote areas, it intended to propose that the Commonwealth develop and cost new special needs funding arrangements in consultation with providers, resident groups and State and Territory Governments.

In response to the position paper, participants generally supported the concept of a strengthened special needs pool. Aged Care Australia, for instance, considered that increased funding for services in rural and remote areas was 'a matter of funding equity and that it must be accorded a very high priority' (sub. D77, p. 14). However,

Aged Care Australia, together with many other participants, did not support a rebalancing of the existing funding pool to provide that funding, stating that new funding needs to be allocated.

Costing an enhanced special needs funding pool goes well beyond the purview of this inquiry. Suffice it to say that without a significant rebalancing of total funding between the basic subsidy and special needs, underlying equity objectives are unlikely to be met. The Commission considers that this issue is of such high priority that it must be achieved through additional funding.

A number of other issues were raised. Some participants considered that special needs funding should be made available to all small nursing homes. For instance, Aged Care Victoria considered that there should be additional funding support for smaller nursing homes, irrespective of location (sub. D79, p. 5). However, the Commission reiterates that the subsidy regime should not lessen the incentives for rationalisation. In its view, special needs funding should not be available, for instance, to prop-up small-scale services in urban areas or major rural centres.

The Tasmanian Department of Health and Human Services considered that addressing the 'critical funding issues' for small rural and remote facilities is 'so important and specific' that there is a need to separate metropolitan and non-metropolitan into two separate funding structures (sub. D100, p. 3). It considered that the minimum basic subsidy needs to be structured similar to that of the Multipurpose Service Program. However, because of the diverse range of circumstances facing homes in rural and remote areas the Commission considers that the question of additional special needs funding needs to be assessed on a case-by-case basis in accordance with appropriate criteria (see below). Providing additional funding to all rural and remote homes without examination of particular circumstances could not be justified.

The Ethnic Communities Council of Queensland considered that special needs funding should not only acknowledge the situation of rural and remote services but also the 'higher costs associated with the provision of some culturally inclusive services' (sub. D113, p. 7). Examples given were the engagement of interpreters, the extra costs of preparing traditional meals, and the need to employ bilingual or multilingual staff.

In the position paper, the Commission commented that developing criteria for the distribution of the special needs pool is a major task. Indeed, there will be some special needs for which it will be difficult to specify criteria in advance of the event. That said, the criteria must be sufficiently rigorous and transparent in application to limit support to genuine cases.

As a guide, however, the Commission considers that special needs funding (which would replace existing viability arrangements, and provide extra funding) could be considered in three circumstances:

- to provide additional funding to homes in rural and remote areas in each jurisdiction to take account of factors such as distance and climate. Standard definitions of rural and remote could be utilised for this purpose (see DPIE 1994, for example);
- to provide additional funding for small homes in locations where demand in the local catchment area is only likely to be sufficient to support homes of less than average size. This could imply a population cutoff of about 10–15 000 people and, of course, 'local catchment area' would require suitable definition; and
- to provide additional funding to homes, including those in metropolitan areas, which provide services to residents beyond those normally provided and not captured by the RCS formula or existing supplements. This could include those homes providing 'whole-of-life' support to indigenous and other special needs groups. Additional support for homes in urban centres needing to employ interpreters, or that service residents from more remote areas may be other cases in point.

The Commission considers that the Commonwealth should also consider some form of supplementation to the special needs homes for one-off capital costs of achieving accreditation and certification but that this should only be available when services in a region as a whole would not otherwise be viable.

Finally, in advocating enhanced support for small homes in rural and remote area services, the Commission acknowledges that this will not address any wider problems with community health facilities and social services in many of these areas. It may be that related programs such as Community Aged Care Packages and Multipurpose Services will give impetus to the development of these facilities and services. In the meantime, increased funding for residential services will go some way to ameliorating the pressure on nursing home residents, providers and employees.

Recommendation 12: Additional funding support for higher cost homes in special circumstances, such as smaller higher cost nursing homes in rural and remote areas, should come from a special needs funding pool. The Government should add to current outlays to meet this purpose, separate from, and additional to, the funding of the basic subsidy. The new special needs arrangements should be developed and costed in consultation with providers, resident groups and State and Territory Governments.

Top-up support for Victorian nursing homes

The Commission gave consideration as to whether the special needs pool should cater for the cost impacts of the nurse to resident ratio requirements applying in Victoria. These requirements, which have existed in the relevant nursing awards since 1936, specify that providers must employ one Division 1 or 2 nurse for each 10 residents or part thereof during day and evening shifts, and one Division 1 or 2 nurse for each 15 residents during the night shift. Aged Care Victoria commented that as a result of these requirements:

> *all* nursing homes in Victoria suffer a significant cost penalty, when compared with the regulations in the other States and Territories which do not stipulate a nurse/resident ratio. (Sub. 23, p. 12)

The Victorian Government considered that 'unavoidable additional costs' such as these should be recognised in the standardised input bundle' (sub. D92, p. 2).

Some participants said that the Victorian CAM component in the previous subsidy regime made an allowance for these higher costs. Any such allowance would have transferred across into the current state based subsidy regime. In addition, some smaller Victorian homes (along with small homes in other States) received top-up funding to cover the costs of providing 24 hour registered nurse coverage. This supplement has now been replaced by the viability supplement. However, transitional funding arrangements apply to homes that received support under the previous arrangements.

The Commission accepts that the staff to resident ratio requirements are a unique impost on providers in Victoria, although it notes suggestions that compliance with the requirements is far from universal. The Australian Nursing Federation (Victorian Branch) (sub. 54, attachment 5) supplied the results of a survey of its members which indicated that nearly two-thirds of homes are in breach of the ratios.

However, putting the compliance issue to one side, in the Commission's view, Australian taxpayers should not be expected to indefinitely underwrite staffing arrangements that prima facie deliver a higher quality of care in Victoria than in other parts of Australia, and which are not necessary to meet the accreditation requirements. Compensatory funding will simply reduce the pressure to address the underlying issue.

Thus, the Commission considers that the issue is not whether special support should end, but how quickly it should end. Transitional top-up funding for smaller Victorian homes is to continue until October 2001. Further, while the Commission's proposed basic subsidy regime would remove any generalised compensation for

Victorian providers, the new regime could not be implemented immediately (see section 7.11). The Commission considers that these periods of grace are sufficient.

7.7 Acquittal of subsidy

Under the previous subsidy regime, providers had to return underspent CAM and OCRE funding below a 1 per cent tolerance level. The primary rationale for these formal acquittal requirements was to prevent providers improving their profitability by reducing the quality of care supplied.

The Aged Care Structural Reform Package has removed the requirement for providers to acquit subsidies against expenditures. As under the previous regime, policing of the various regulatory requirements governing the provision of nursing home services will provide one avenue of quality assurance. In addition, the accreditation and certification systems will provide a financial incentive for nursing home operators to deliver an acceptable level of care. That is, non-accredited providers will not attract Commonwealth subsidies, while those not meeting certification requirements will be unable to collect accommodation charges.

An end to the acquittal system has provided an administrative cost saving for nursing homes and for the Commonwealth which no longer needs to validate financial returns. It has also removed a potential disincentive for providers to deliver services cost effectively. Under previous arrangements, providers had a financial incentive to seek productivity gains that would reduce their CAM costs to the jurisdictional CAM rate, but not significantly below it. This was because any additional cost savings had to be returned to the Government. Further, because only CAM expenditure had to be acquitted, there were a range of cost demarcation issues (see Gregory 1993), as well as incentives for creative accounting to transfer costs to the CAM category.

Nevertheless, a few participants sought a return to some form of system which would ensure that funding made available for personal and nursing care was actually used by providers for that purpose. For example, the ACHCA recommended that providers should provide an audited statement that the subsidies and grants have been spent in accordance with the purposes intended (sub. D110, p. 14). The Queensland Nurses' Union stated:

> The shift to an accreditation system based on quality assurance will not ensure adequate standards unless it is accompanied by complementary controls in the expenditure of funds. (Sub. 45, para 5.4.1)

Similarly, the New South Wales Nurses' Association stated that it had consistently sought some form of acquittal for the care component of funding:

> The complexity of and dissatisfaction with previous acquittal arrangements is acknowledged. It is our view however that accreditation itself and the capacity of the Accreditation Agency to monitor compliance with the accreditation process is not tested and will not be sufficient to ensure a satisfactory standard of care for each resident in each aged care facility. (Sub. D107, p. 5)

However, several participants expressed opposition to a reinstatement of formal accreditation requirements because of the possible administrative costs and inefficiencies involved. Aged Care Queensland commented that:

> The acquittal of subsidies will only serve to increase the inefficiencies in the system as money will, from time to time, be spent simply to avoid its repayment. (Sub. D69, p. 16)

The value of acquittal as an assurance of quality is suspect. Further, participants noted that the accreditation requirements are intended to provide an effective discipline on providers to deliver quality personal care. Aged Care Australia argued:

> Continuous improvement is expected to drive the accreditation system and to deliver quality improvements over time. This will benefit all residents, especially as the residential care funding system must guarantee universal access to quality services consistent with accreditation to all residents, irrespective of their financial position. (Sub. 26, p. 21)

The Victorian Healthcare Association (sub. 22, p. 8) also saw value in supplementing accreditation and certification requirements with published 'league tables' to help prospective residents make informed choices about the quality of service available in particular homes.

At this early stage, it is not possible to judge how effective the accreditation and certification requirements will be in addressing the sorts of problem at the heart of the acquittal debate. For instance, it remains to be seen whether in smaller centres with a single nursing home facility, there will be a tendency to 'lower the height of the bar' for accreditation and certification so as to remove the possibility of major disruption for residents.

At the commencement of mandatory accreditation in 2001, average standards will not necessarily be significantly higher than at present. However, there is an expectation that over time the continuous improvement inherent in accreditation will lead to higher standards of residential aged care. Further, the Commission considers that the new approach to quality assurance must be given reasonable time to prove itself.

Recommendation 13: There should be no requirement for providers to acquit subsidy payments.

7.8 Providing subsidy to providers or residents

Under current arrangements, the Commonwealth pays subsidies to providers rather than to residents.

In contrast, in areas such as child care, some subsidies are paid to the recipient. In the past, nursing home subsidies have also been paid to residents.

One rationale for payment to recipients is that it makes them more conscious of the total cost of the service they are receiving and therefore more selective in their purchasing decisions. There is also the view that, by 'empowering' recipients, direct payment encourages providers to be more responsive to their needs. This view was supported by the Victorian Government:

> where individuals have a funding entitlement ... [p]roviders will ... be required to compete in a market where common standards are developed. Program growth or industry restructuring provides the capacity to deliver a more open market with greater choice for consumers. Where the consumer chooses to spend the funding entitlement in a residential care service, the funding entitlement should flow directly to the provider of the consumer's choice. (Sub. D92, p. 8)

More detail of the Victorian model is described in chapter 8.

Although paying subsidy to recipients has merit in terms of purchasing care across a range of service delivery models, in terms of the residential aged care sector itself, the significance of such benefits is less clear. In general, subsidies paid to providers but which follow the recipients will give the same broad outcomes as direct payments to recipients. Thus, the key to making providers responsive to the needs of consumers who are purchasing residential aged care is portability of the subsidy, not to whom it is paid.

More specifically, in the nursing home sector, the Aged Care Assessment Teams (ACATs) are positioned between the person seeking care and the provider. That is, an ACAT determines that an individual requires nursing home care, with the Commonwealth funding the home 'chosen' by the individual.

Further, there are a number of other factors which limit the scope for residents (or potential residents) to exercise consumer sovereignty. Many suffer from reduced mental capacity and, once in a facility, it can be difficult for them to switch to another facility, even if they are unhappy with the service. In addition, providers

have some discretion in choosing whether to take a person approved for entry to a nursing home. The limits on overall and regional bed numbers supports high occupancy rates and limit competition between facilities (see section 7.9). Hence, the empowerment argument is weaker within the residential aged care sector.

Channelling money to homes via the resident would also involve additional administrative costs. Further, ANHECA (sub. 24, p. 25) argued that providers' propensity for bad debts would increase and that there would be a need for changes to legislation and resident rights principles.

Given these costs and the doubtful nature of the benefits of paying subsidies to residents (unless there is some unbundling of the accommodation, care and clinical components with greater ability to exercise choice), the Commission sees no case for changing current payment arrangements.

Recommendation 14: Residential aged care subsidies should continue to be paid to providers rather than to residents.

7.9 Extra service arrangements and other subsidy related issues

Extra service arrangements

The core equity objective of the Commission's subsidy proposal is to ensure that residential aged care would be available to all Australians needing such care, in a suitable location and of acceptable quality, with access not constrained by ability to pay.

This leaves open the question of whether people willing to pay for additional services should be free to do so, or whether the funding regime should aim to provide the one set standard of care to everyone.

There are currently provisions allowing for a significant number of extra service places which offer an appreciably higher standard of accommodation, food and the like. However, there are a range of restrictions on these places, including a deduction from the basic subsidy for residents receiving extra services — the subsidy is currently reduced by 25 cents for each dollar of extra service income. Residents entering extra service places may be asked to provide an accommodation bond.

In the position paper, the Commission noted a range of views from participants on the merits of freeing up these arrangements. It concluded that it is counterproductive to try to prevent those wishing to pay for extra service from doing so and, accordingly, set out the following preliminary proposal for comment:

- the controls on what constitutes an extra service, where in a facility extra service places are provided, and the price charged for such services should be abolished;
- the current reduction in the basic subsidy for residents receiving extra service should be abolished — this defacto income tested charge should be incorporated in a budget neutral way into an income test applying to the basic subsidy; and
- the Commonwealth Government should give consideration to replacing the current quota on extra service places with a monitoring system aimed at identifying any cases where extra service provision is reducing access to basic care. It should also look at the scope to simplify the concessional resident ratios.

Some participants expressed outright opposition to this proposal on philosophical grounds. The Australian Nursing Federation (SA Branch) stated that it:

> continue[s] to oppose the principle of resident fees for either capital works or additional services. Such systems have the capacity to either discriminate against the well off or alternatively to create a 2 tier system of care one for those who can afford to make payments with another 'welfare' based system for those who cannot. (Sub. D102, p. 19)

Similarly, but recognising some exceptions in relation to 'hotel' services, the ACHCA considered that:

> a fundamental principle of access to aged care should be that the same standard and quality of care is provided to all regardless of capacity to pay. The expansion of the user-pays principle should only apply to the additional hotel services and accommodation style and should not apply to short-stay nursing home residents. (Transcript, p. 158)

Many participants expressed in-principle support to the freeing up of extra service arrangements, although some concerns and caveats were expressed. These participants included Aged Care Australia, NANHPH and ANHECA. Aged Care Australia considered that the reduction on controls would enable:

> residents and their families ... exercise more choice regarding the standard of accommodation provided ; and
>
> the overall standard of accommodation provided in nursing homes [to be] improved thereby benefiting all residents over time. (Sub. D77, p. 15)

It considered that 'there are other more appropriate strategies than constraining consumer choice for safeguarding universal access to quality care by all residents'. It listed these strategies as: determining an appropriate benchmark level of care for

all residents; ensuring that this is adequately funded; removing inappropriate regulation of extra services places, including freeing up access for concessional residents; and monitoring to ensure that access to the standard benchmark level of care is not reduced (sub. D77, p. 15).

Similarly, Aged Care Queensland stated that:

> The Department [of Health and Family Services] should not be active in regulation of the standard of accommodation being provided or the 'hotel' services being provided therein.
>
> This is an issue of choice. Residents should be able to choose the type and standard of accommodation being sought. They should be able to pay more for single rooms, larger rooms, balconies ... They should be able to pay less for shared rooms, shared facilities, set menus rather than choices ....
>
> ... the use of excessive regulation to control an industry such as nursing homes leads to monotony, sameness and minimum standards of quality rather than experimentation, innovation and increasing quality through competition. (Sub. 33, p. 17)

PJ Pusey, the operator of an 81 bed facility in Perth (including 51 beds funded entirely by residents), commented on the degree of choice available to residents:

> there is very little freedom of choice. It is largely a matter of take it or leave it for the consumer. Unfortunately for them, they have to take it. (Sub. D97, p. 2)

Whilst acknowledging that there is some sensitivity regarding the issue of extra services, the Commission confirms its view that it is counterproductive to try to prevent those who wish to pay for extra services from accessing them. With a funding regime aimed at supporting equitable access to a guaranteed minimum quality of care, freedom to purchase extra services has a role to play in encouraging the development of a diverse and responsive industry. Rather than seek to artificially constrain the development of extra service, the objective should be to manage its development so that it does not compromise access by those seeking standard care (that is, to those seeking the benchmark standard of care which is available to all residents irrespective of their financial means).

The Commission notes that the planning controls, the issue of bed licences and ACAT assessments will continue to determine the overall numbers of nursing home residents. In these circumstances, the need for controls on the distribution of those places between extra service and standard service will depend, in the first instance, on the adequacy of Commonwealth support for standard care.

If subsidies (in conjunction with resident charges) give an adequate financial return on the provision of the benchmark standard of care, then the need for any specific safeguards would be debatable. Of course, this relies on competition between

providers eliminating any excessive returns on extra service places. The bed licensing system (see box 7.4), and the other constraints on competition in the sector noted above, may prevent this occurring, thereby requiring a mechanism to ensure that the provision of extra service places does not reduce access to standard care.

Box 7.4 **Planning ratios and the bed licensing system**

The planning ratio and bed licensing systems reduce competition in the nursing home sector. Together, these mechanisms underpin very high occupancy rates and thereby lessen the need for homes to compete for residents. This restriction on competition is reflected in the value of bed licences, which trade for as much as $30 000 in some parts of Australia.

However, these controls have other, potentially beneficial, effects.

By limiting the total number of places eligible for subsidy, the planning ratios (and the ACAT assessment process) are the primary means of capping Commonwealth expenditure on residential aged care. (Of course, if demand exceeds the available number of places, then there will be an element of cost shifting to other parts of the aged care and hospital systems and a degree of inadequate assistance.)

Similarly, while it would be possible to implement the planning controls without a bed licensing system, this could have adverse consequences for residents. In essence, the bed licensing system limits competition between providers in the delivery of the available number of subsidised places. In so doing, it increases expected occupancy rates to close to 100 per cent. Removing the licensing system would increase the risks of operating a nursing home and consequently the incidence of disruption to residents from failed undertakings. As the Australian Catholic Health Care Association argued:

> Such a move could lead to lower occupancy rates in many facilities thus raising costs, potentially reducing the quality of care and finally closure for marginal operators.
>
> The dislocation and disruption for residents their families and staff would be enormous ... (Sub. 7, p. 18)

This is not to argue that such considerations necessarily justify retention of these arrangements. Rather, it is to recognise that the case for retention involves broader considerations than just their impact on competition between providers.

At present, the primary safeguard is a quota on the number of extra service places equal to 12 per cent of total nursing home beds. This percentage applies at the regional level as well as in aggregate. While the constraint is apparently biting in particular regions such as the Gold Coast, Australia-wide the total number of extra service places is well below the limit.

The concessional resident ratio requirements provide a secondary safeguard (although they are not in place only for this reason). These require homes to care for a specified proportion of concessional residents who would not, in the normal

course of events, be able to pay for extra services. These ratios are specified on a regional basis with the differentiation across regions sometimes being only a fraction of a percentage point. In most parts of Australia, the actual number of concessional residents greatly exceeds these ratios.

Looking to the future, the Commission sees merit in a less prescriptive safeguard mechanism as part of a general reduction in the controls on extra service places. In its view, any growth in demand for extra service places is unlikely to create widespread problems for those seeking access to standard care. Hence, the quota system is an unnecessary addition to an already complex regime.

A preferable approach would be to:

- first clearly define items to be included in the benchmark standard of care — that is, specify what care and hotel-type services are required to be made available to all residents irrespective of their financial means; then
- leave it to nursing home proprietors to determine the number of extra service places they wish to provide, applying to the Department of Health and Aged Care in the expectation of virtually automatic approval, with the department monitoring those places and the waiting lists for standard care.

The definition of items to be included in the benchmark standard of care could adopt, or build on, the specified care and services already required as set out in chapter 12 of the Residential Care Manual. Some participants considered that extra services should relate only to hotel-type services. However, the Commission does not consider that this should necessarily be the case — that is, there should be scope for extra services to also encompass personal care services where they are genuinely additional to the standard level of care.

Several participants requested that the provision of a single room should be treated as an extra service. For example, in its initial submission, NANHPH recommended that ‘partial deregulation of the industry be encouraged by allowing providers who achieve accreditation to charge a single ward supplement up to $12 per day’ (sub. 25, p. 3). The Commission notes that, while this suggestion has merit, many providers are already offering single rooms and have no intention of imposing an extra service charge.

The Commission notes that the department currently monitors places and waiting lists when assessing applications to provide extra service places. In the unlikely event of evidence that those seeking standard care were being squeezed out by provision of extra service places, it would be open to the department to resume regulation. As an adjunct to this change, there would also seem scope to reduce the excessive precision in the concessional resident ratios.

The Commission also considers that the nature and price of extra services should be a matter for providers to determine in response to the 'market place' demand from residents and their families. This in turn calls into question not only the current regulations covering what constitutes an extra service, but also where in a facility extra services can be provided, and the price charged for those services.

Finally, the current reduction in the basic subsidy effectively means that providers must charge $1.25 for a service costing $1 to deliver. As such, the subsidy reduction is a defacto income tested charge, levied on those capable of paying for extra services. Importantly, it is additional to the generally applicable reduction in basic subsidies for those on higher incomes. In effect, two residents of identical means pay differing amounts for standard service, merely because one has chosen extra services and one has not.

In the Commission's view, the reduction should be abolished. If the Government wished to recoup this amount in a budget neutral manner, a possible approach would be to end the subsidy reduction for those residents receiving extra service and compensate by increasing the stringency of the general income tested charging arrangements.

Recommendation 15: There should be greater opportunity for the provision of extra services to residents who wish to meet the relevant costs. In this regard:

- ***an extra service should be any facility or service that exceeds standard care as defined under the benchmark level of care required to be provided to all residents irrespective of financial means;***
- ***the controls on where in a facility extra services are provided, and the price charged for such services, should be abolished;***
- ***the current reduction in the basic subsidy for residents receiving extra service should be abolished; and***
- ***the current strict quota on extra service places should be replaced with a lighter-handed approach and a monitoring system aimed at identifying any cases where extra service provision is reducing access to standard care. The Government should also look at the scope to simplify the regional matrix of concessional resident ratios.***

Separation of accommodation charges and resident daily fees

In its position paper, the Commission sought views on whether it is appropriate to continue to separate asset tested accommodation charges and income tested daily fees. In other words, is it necessary or desirable to separate charges for capital from

contributions towards recurrent costs? The Commission commented that the current separation of the charges could make the subsidy regime more complex for both providers and residents.

Several participants considered that there was value in providing an earmarked income stream for capital works, particularly as the Commonwealth has reduced its funding support in this area. Aged Care Australia also pointed to the role of a separate asset tested capital charge in catering for regional fluctuations in the cost of care resulting from differences in land and building costs (see chapter 6).

Some participants considered that present administrative difficulties in making payments to providers would only be compounded if these two charges were combined.

The Commission considers that accommodation charges and the resident daily fees should continue to be separated.

7.10 Administration and transparency

Development of the alternative nationally uniform basic subsidy regime has drawn on the assessment criteria set out in chapter 4, making a number of explicit and implicit tradeoffs between criteria such as equity, efficiency, flexibility, and administrative simplicity. Some participants, however, drew the Commission's attention to various specific concerns about administration and transparency. Boxes 7.5 and 7.6 outline these concerns.

The Commission's inquiry does not extend to examining the detail of these. It is possible that on closer examination some of them might be readily resolved, or not be well founded. For example, Euan Lindsay-Smith, co-author of the recent review of the RCS, contended that the RCS appraisal undertaken by care providers relies completely on documentation already existing at the time of the appraisal (sub. D90, p. 1).

Nevertheless, there is ground for legitimate concern about the costs imposed on providers by administrative inefficiencies. Similarly, the lack of past transparency gives real cause for concern. Changes which can significantly affect the viability of residential aged care providers should not be made without adequate supporting data being made publicly and transparently available.

Recommendation 16: The Government should work closely with providers and other stakeholders to resolve quickly all outstanding concerns in relation to program administration and transparency of information.

Box 7.5 **Concerns with administration**

Aged Care Australia

There have been serious and protracted problems with the payment system for residential care subsidies since 1 October 1997 which have created an enormous workload for service providers ...

In addition, frequent reviews of pension entitlement mean there are frequent adjustments to the income tested user contributions and the resulting residential care subsidy payable, creating confusion for residents and ongoing work for service providers. (Sub. D77, p. 22)

Resthaven

The first priority is for the payments system to be accurate ... errors associated with the payment system ... [still] stem back as far as the October commencement period. In addition to this the whole sector has been funded at the $12 a day concessional rate irrespective of their entitlement. This will be recovered when the Department has managed to fix the software problems. Will this cause a cash flow problem for some providers? Is such a recovery reasonable? (Sub. D72, p. 8)

Anita Villa

The problems currently experienced are widespread largely due to the fact [that] compounding errors are committed by the [department], consistently hampering facilities. While a range of supplements may be added to the basic care subsidy, these compounding errors have a resounding effect on sustaining & maintaining even a basic level of service. (Sub. D115, p. 1)

ANHECA

If the current arrangements for income testing remain, nursing homes and hostels for that matter, will be required to utilise extra clerical hours to sort out the mess and the billing problems involved with ensuring that residents pay the correct amount of resident contribution ... This is not income for the provider but goes directly to the Government. (Sub. 24, p. 51)

Queensland Health

In the interests of consistency and transparency, it is recommended that responsibility for assessment of a resident's assets base (concessional resident status) be transferred from the provider to Centrelink or the Department of Veterans Affairs. The current system is considered too onerous for the provider and open to abuse. (Sub. 87, p. 7)

(continued on next page)

Box 7.5 **(continued)**

Baptist Care - WA

Through its aged care reforms the Government promised less red tape and regulatory controls. In fact the opposite has occurred. Beyond any doubt, the documentation and checking process required as a result of the many changes, additional reporting and recording has placed significant demands on the financial and staff resources of nursing home and hostel providers. (Sub. 5, p. 4)

Uniting Community Services Australia

One nursing home has identified an extra nine hours of staff time is required to execute the new administrative arrangements for each new resident. This specific example reflects a common trend throughout the majority of our nursing homes. (Sub. 47, p. 2)

Queensland Nurses' Union

The introduction of the RCS ... has only increased the burden of documentation in nursing homes ... the significant time spent by nurses on this activity is over and above that done by nurses to meet professional and legal requirements. This activity remains unaccounted for in the RCS instrument and therefore is unfunded despite the significant time it takes. (Sub. 45, section 5.2.5)

7.11 Implementation issues

Some aspects of the proposals will require more detailed consideration by the Government prior to actual implementation.

In the position paper, the Commission outlined two broad approaches to implementation:

- phased introduction involving transitional subsidy rates; or
- implementation in full, following a period of grace to give residents and providers time to make the necessary adjustments.

It sought views from participants on an appropriate timeframe for implementing the full proposal, whether new arrangements should be phased-in or simply introduced after a grace period, and the inter-relationships with the Residential Aged Care Review.

Box 7.6 **Concerns with transparency**

Aged Care Organisations Association (SA & NT)

The difficulty with a differential rate identified in the previous RCI or CAM system and now the RCS, has been the 1) lack of rigorous and transparent data, 2) lack of review. Thus, in South Australia, we believe there is little, if any, objective criteria that explains existing differentials between the States. This lack of transparency has caused emotive rather than objective arguments and a lack of appreciation of the key issues. (Sub. 31, p. 8)

Aged Services Association of NSW & ACT

... the Department has been contacted and requested to provide details of the state average OCRE costs for 1996-97, excluding payroll tax ... we can see no reason why this information cannot be officially provided. We suspect the Department is not keen to provide this information because it will show average OCRE costs [to be much higher than allowed for in the basic subsidies]. (Sub. D67, p. 4)

Resthaven

... brings into question the accuracy of the base data used to formulate the RCI differentials in 1987 when this system was introduced. The secrecy surrounding this information has never allowed for this data to be checked by providers, the bureaucracy often arguing in the past some restrictions by Treasury preventing the transparency of information. The impact has been the institutionalisation of an inequitable funding scheme. (Sub. D72, p. 4)

Australian Nursing Federation (Federal Office)

The ANF believes that the Productivity Commission should be more prescriptive in relation to what it means by desirable transparency and accountability arrangements. The Productivity Commission should specify the Department's reporting obligations and even individual performance indicators that the Department should release publicly on a regular basis. (Sub. D 74, p. 4)

Australian Nursing Federation (SA Branch)

Surveying the industry or benchmarking have the same limitations, which led to the CAM system's obsolescence soon after implementation. Because the process was not transparent, able to be dis-aggregated and related to particular inputs and was not subject to change or review, the relative positions of States was fixed. (Sub. D102, p. 11)

Aged Care Australia

ACA supports [the principle that residential care funding must be sufficient to provide a standard level of quality care to all residents] as the primary policy design principle for residential care funding. This will require the development of new concepts and methodologies as well as clearly transparent funding arrangements which are appropriately managed to ensure this policy objective is maintained over time. (Sub. D77, p. 1)

In response, there was fairly general support for the view that implementation arrangements need to be conditional on the outcome of the Residential Aged Care Review, in particular regarding funding adequacy. The ACHCA commented that:

> Substantial changes to the funding arrangements should be subject to any recommendations emanating from the residential aged care review. On this basis 1 July 2000 would be the earliest date of implementation other than for correction of basic subsidy rates and indexation. (Sub. D81, p. 7)

Aged Care Australia also supported 1 July 2000 as a commencement date for the full proposal. It considered that detailed work on funding adequacy, defining the standard benchmark level of care, and its subsequent pricing, should commence immediately and be finalised within 12 months. Detailed 'implementation arrangements are best resolved once the review of funding adequacy and the development of the new funding methodology have been completed' (sub. D77, p. 24). NANHPH, together with others, considered that phase-in arrangements needed detailed discussions with the industry as a whole including 'a careful analysis of the long term impact to minimise disruption of services and resident care delivery' (sub. D70, p. 12).

The thrust of the Commission's proposal is that basic subsidy rates, together with funding from residents, should be set at a level that is adequate to meet the cost of providing the benchmark standard of care. As the terms of reference for the Residential Aged Care Review direct it to establish the adequacy of subsidy rates, it would be appropriate for the Review to oversight the initial development and costing of the standardised input mix.

Recommendation 17: The Residential Aged Care Review should undertake the first assessment of average costs as part of its examination of the adequacy of subsidies for residential aged care (as required by its terms of reference). This should be carried out in accordance with the subsidy methodology set out by the Commission in its recommendations and in the body of this report.

In the position paper, the Commission noted that providers in Queensland are particularly disadvantaged by the current arrangements. It commented that, in view of the delay that would be involved in introducing the new arrangements — particularly given the required input from the Residential Aged Care Review on the quantum issue —it considered that some short term relief for Queensland providers is warranted. It also commented that, while the situation is less clear cut, some of the cost data suggest that interim relief for South Australian providers may also be warranted.

The Commission noted the suggestion from Aged Care Queensland that, if additional government money is not available, funds earmarked for indexing subsidy rates across-the-board should be redirected to a progressive increase in the lowest jurisdictional subsidy rates (sub. 33, p. 19). It proposed that, subject to any recommendation from the Residential Aged Care Review for an increase in total Commonwealth funding for residential aged care, funds earmarked for indexing current subsidies should be redirected to increasing basic rates for the currently low subsidy States (see appendix D).

In looking at interim changes, the Commission also noted the compelling case for an immediate boost to funding for smaller rural and remote area services also arises. However, given the complexity of the issues involved, it proposed that the Commonwealth develop new special needs funding arrangements in consultation with the various stakeholders. Rather than pre-empt this process with an immediate funding boost, the Commission simply stressed the importance of developing the new arrangements quickly.

Many participants recognised the current inequity in funding between jurisdictions, and also supported additional special needs funding. However, they generally considered that the necessary funding should be *additional* rather than being redirected from the existing quantum. For example, Aged Care Australia agreed that 'urgent action' is needed to address inadequate funding in Queensland and South Australia, and of residents in rural and remote areas. However, it did not support redirecting funding from indexation for these purposes as 'such action would compromise the quality of care and viability of services' (sub. D77, p. 16).

Providers from Tasmania and Victoria, in particular, pointed to possibly dire consequences for care from reductions in subsidy. Aged Care Tasmania considered that 'redistribution alone, by coalescence or other methods reducing the current subsidy levels to Tasmania, will mean loss of jobs and thereby loss of standards of care. Full coalescence would cause the loss of more than 300 jobs in Tasmania' (sub. D65, p. 5). The Tasmanian Government (sub. 53, p. 14) said that coalescence in conjunction with changes in viability funding, likely wage increases and the impact of accreditation and certification requirements 'has the potential to result in the closure of facilities and hence reduced access'. The Victorian Healthcare Association argued that if coalescence proceeds, up to one third of Victorian nursing home beds would be forced to close (sub. 22, p. 10). The Victorian Synod of the Uniting Church presented data for 10 nursing homes which 'have had to make significant reductions in costs already, especially with the first reduction in funding because of coalescence. We believe that any further reduction can only impact on the quality of residential care' (sub D80, p. 1). Similarly other providers, such as the Ashfield Baptist Homes (sub. D106), considered that some homes are on the verge

of collapse under existing funding, let alone less. Many participants requested restoration of the $128 million per annum claimed to have been lost through the change to COPO indexation in 1996.

The Commission does not necessarily agree with the severity of these assessments. The Commission notes that providers in Queensland, for example, have coped with relatively low subsidies for years. Further, there continue to be willing investors in residential aged care at current subsidy levels in the lower as well as in the higher subsidy jurisdictions. Recommendations about the level of funding provided to residential aged care are beyond the Commission's terms of reference. However, as noted above, the Commission considers that enhancing special needs funding is of such high priority that additional funding should be provided.

Chapter 5 establishes significant inequity in the ordering of individual States and Territories on a standardised cost basis compared with their ranking on current subsidy scales. The Commission considers that this inequity should be removed as soon as possible, even if base funding quantum were not to increase, while giving some protection to the higher subsidy jurisdictions.

The original coalescence proposal is deficient as it postpones meaningful change until about the fourth year of the seven year process. Thus, existing inequities would continue largely unchanged for at least three more years. The proposal from Aged Care Queensland has the advantage of implementing the required adjustment from the first year, while preserving subsidies in nominal terms in every jurisdiction. These adjustment paths are illustrated in appendix D.

Recommendation 18: Subject to any recommendation from the Residential Aged Care Review in relation to the adequacy of funding provided by the Government for residential aged care, funds earmarked for indexing current subsidies should be redirected to progressively increase the basic rates for the low subsidy States until a coalescence (or, if nationally uniform basic subsidies are not adopted, until a revised set of jurisdictional subsidies) is achieved.

In this report, the Commission has sought to focus attention on broad concepts and to make recommendations on an appropriate funding methodology that would better meet the Government's objectives in supporting residential aged care. A consolidated list of the Commission's recommendations is given at the end of the Summary, together with a table which summarises the Commission's subsidy proposals using the current regime as a reference point.

In broad terms, the Commission considers that its proposals would:

- support a uniform quality of care across Australia at a specified benchmark level;

- establish greater transparency in the link to the cost of providing care to meet those standards;
- address current funding anomalies across jurisdictions;
- improve the resources available to homes catering for special needs, for example those in rural and remote regions;
- provide incentives for improvements in the efficiency of residential aged care service provision; and
- encourage the development of services which are more responsive to the needs of residents.

8 Some longer term options

The terms of reference, and therefore this report also, focus on examining and reporting on an appropriate funding methodology for high level residential care.

In their submissions and at the public hearings, however, some participants raised issues which, although extending beyond consideration of subsidy arrangements, might contribute to improved longer term outcomes for the aged and for the community generally. This chapter presents a brief overview of some of those ideas. The intention is not to come to any firm conclusions or judgments, but to acknowledge the contribution of some of those who are debating these important 'bigger picture' issues.

By way of a broader context, it is of interest to observe that not all countries deal with aged health care in the same way as Australia. There are a range of differences in funding mechanisms, the balance between institutional and home care, and in institutional structures. A brief review of the international scene in set out in appendix C.

8.1 Income and asset tested resident charges

Resident charges account for most of the costs of care not met by the Commonwealth subsidy. (Donations, contributions from State and Territory Governments and cross subsidies from other aged care services are among the other minor sources of revenue available to homes.)

While resident charging arrangements would fall outside a narrow interpretation of the terms of reference, in any broader sense it is impossible to isolate them from the government subsidy regime. For example:

- the level of resident charges has a critical bearing on what quality of service the available Commonwealth funding will support; and
- the more that those who are able to contribute to the cost of their care do so, the more any given government contribution can be channelled to those most in need of support.

In the position paper, the Commission sought comment on issues relating to resident charges, in particular comment on whether, in moving to a new subsidy regime, another round of changes to income and asset tested resident charges should be contemplated.

A few participants considered that resident charges should be reduced or eliminated. As noted in chapter 7, the ACHCA considered that parallels could be drawn between those entering the acute sector under Medicare, and high care nursing home residents. It proposed that the accommodation charge and income tested fee should be removed for ‘short stay’ residents — that is, those staying for less than about one year (sub. D81, p. 5 and transcript p. 163).

ANHECA considered that the income tested arrangements should be abolished in favour of recoupment via the taxation system:

> administration on both the provider and the Government would decrease if income testing was abolished and in return the rebatable amount for nursing home and personal care fees was excluded from the medical rebate. This would also decrease the burden on residents and take away one of the barriers to access for the resident and family. (Sub. D84, p. 14)

Some participants were mainly concerned to ensure that the financial burden on residents did not increase, at least at present. The Queensland Government (sub. 10, p. 1), for instance, argued that any new funding model ‘... must not increase the proportion of care costs for which residents are responsible’. According to the Victorian Healthcare Association, another round of changes to resident charges at this stage would be ‘unacceptable to the community and impose unwarranted administrative burdens on staff’ (sub. D85, p. 5). However, while commenting that it is unlikely there would be political support for further changes at this stage, Aged Care Australia considered there was a need to promote ‘informed public debate’ on the role of income testing and user contributions and other approaches to financing in the context of developing a National Strategy for an Ageing Australia (sub. D77, p. 22).

Several participants pointed to the scope for raising additional revenue from residents without compromising basic equity objectives.

In some cases, these proposals related to the provision of extra services. As noted in chapter 7, Aged Care Australia and NANHPH, for example, suggested that homes be allowed to charge a single room supplement.

There was also support for seeking greater capital contributions from nursing home residents more generally. In this regard, NANHPH (sub. 25, p. 5) expressed its disappointment about the Government’s decision not to implement an

accommodation bond system for nursing homes, arguing that bonds are 'inherently sound'. Similarly, others such as ANHECA, claimed that the accommodation charge is deficient in that it is limited to a maximum rate of $12 a resident a day. It considered that the charge should be increased to $16 per day 'commensurate with the return from the average accommodation bond, with interest calculated at 6 per cent' (sub. D84, p. 14). Alternatively, it suggested that the Government should extend taxation concessions to providers.

Increased levels of residents charges could be facilitated if they were to receive extra services in return, some participants considered. Aged Care Queensland noted that 'there is an expectation by residents and their families that the payment of additional charges should permit access to a higher level of service' (sub. D69, p. 21). Similarly, the Residential Care Rights Advocacy Service pointed to the 'need to link any proposals for increased resident charges to the actual delivery of improved care quality' (sub. D93, p. 5).

TriCare's experience suggests that even pensioners and their families are willing to pay higher charges for extra service. Greater access to occupational superannuation and larger numbers of self-financed retirees may increase the ability of residents to contribute more towards the costs of care in future.

Some consider that, after a lifetime of paying taxes, access to subsidised nursing home services is a right. Others draw parallels with the Medicare system which provides free or heavily subsidised medical and public hospital treatment irrespective of a person's means. However, access to many social support payments and programs is limited to those of lesser means. For example, the aged pension is means tested as is access to public housing programs.

Importantly, targeting support for residential aged care to people and areas most in need is consistent with both general equity principles and the *Aged Care Act 1997.*

The Commission has identified at least four areas where resident charging arrangements might be seen as deficient against equity criteria.

- Income tested daily fees only apply to residents entering facilities after March 1998. Hence, those in residential care prior to this date, no matter how wealthy, pay only the standard fee applying to concessional residents.
- There is a ceiling on the maximum income tested daily fee. Thus, once a resident's income exceeds $57 500 a year, he/she faces no further increase in the fee.

- Providers can collect accommodation bonds from low care residents and from high care residents receiving extra services, but not from high care residents receiving basic care (who entered as high care residents).
- The asset tested accommodation charge of up to $12 a day for high care residents receiving basic care does not apply to those in nursing homes as at October 1997 (unless they have subsequently changed facilities).

Of course, considerations other than equity are relevant. As noted by Gregory (1993), it is important that efforts to promote equity in charging do not discourage residents from earning investment income. Also, there is the question of whether the returns from an extension of income and asset tested charges would justify the administrative costs of collecting them.

Residents on low income, many with low levels of assets, will almost certainly continue to account for the large majority of new entrants to facilities. The capacity of this group of residents to pay more for their care is generally very limited. For this reason, the Government expects that, over the next few years, revenue from income tested charges will comprise only a very small proportion of the total income available to homes.

Nevertheless, the inequities in present charging arrangements identified above should not be allowed to persist indefinitely.

8.2 Alternative funding models

At present, funding is based on the care needs of each individual resident under the RCS scale, paid per bed day. Some participants suggested there would be merit in basing funding at a more ‘macro’ level.

The Manor Homes and Mt St Vincent Nursing Home Inc (sub. 4) proposed that funding could be calculated on a Care Based Model (CBM) appropriate to the facility. Facilities would be funded for either High Care or Low Care depending on their resident mix. Under this model a High Care CBM, for instance, would be one with a resident mix close to the state average for high care facilities. The CBMs would be costed on a state-by-state basis, and an average per bed day cost determined for each CBM. Facilities would then be funded on the basis of their utilised bed days per annum.

Under this proposal, facilities would be reviewed every three years with regard to their mix of residents, as part of the accreditation process. Where there was a

change, the facility would be reclassified as a different CBM and funded accordingly.

TriCare commented on the difficulty in managing staff which arose from variations in funding from changes in resident composition:

> In such an environment, it is harder to attract and retain highly trained, motivated staff and to introduce workplace change aimed at *continuous quality improvement*. (Sub. D78, p. 2, emphasis in the original)

It commented that a system could be considered which would allocate funding to facilities annually, based on a projected resident mix. Where the resident mix diverges more than an established tolerance from the projected mix, adjustments to funding would be possible. In order to minimise administrative costs the funds so allocated should not require acquittal. TriCare said such a system would encourage more permanent staffing arrangements, minimising the need to utilise casual staff.

Aged Care Organisations' Association (SA & NT) (ACOA), together with other participants, noted that in different jurisdictions different proportions of residents fell into each RCS category. It commented that it was unlikely that such a 'skewing' was expected:

> We had assumed that with a 'normal population curve' distribution the percentage of the RCS population in each State appearing in each level of the RCS [would] be in close proximity. (Sub. 31, p. 8)

The ACOA was concerned at the compounding effect of the higher RCS subsidy levels in Victoria and New South Wales, coupled with the higher proportions of residents in those States falling into RCS classifications 1 and 2.

ACOA suggested that an option would be to consider 'block funding States', based on equal subsidy rates (per RCS classification) across Australia, with equal proportions of residents in each jurisdiction within each RCS classification, allocated according to the proportion of the population above the age of 80 (rather than 70). Each jurisdiction would then be responsible for resolving 'cost issues' within that jurisdiction.

Lucan Care (Subs 1 and D83) considered that current funding arrangements generate conflict between the providers of care and the department. Further, it considered they do not provide an incentive to improve the environment in which care is provided, or to increase care quality.

It suggested that funding could be based on the average mix of residents in the home, reviewed on a 12-monthly basis. Funding rates would be related to whether care is provided in single rooms, two to four bed rooms, or five to ten bed rooms.

Funding would be based on average regional costs, with cost increases due to award increases or state government requirements promptly taken into account. Lucan commented that as care providers currently had to assess residents with regard to the means tested fee payable, there was tension created between residents and care staff, and between residents paying different fees for the same care. Lucan Care suggested that these difficulties could be overcome if a new government agency was created to assess the financial status of residents and fees were collected by the Australian Taxation Office.

In response to the request for comment in the position paper, participants generally supported continuation of existing arrangements. NANHPH, for instance, considered that the alternative of moving away from a per resident per bed day basis of funding 'has the potential to be more inequitable' given factors such as the increasing rate of resident turnover, and wide swings in dependency (sub. D70, p. 7). Aged Care Australia also commented on equity, further stating that an alternative may involve additional administration, be less transparent, and not interface well with income testing (sub. D77, p. 17). While the ACHCA considered that 'in the longer term there may be more efficient alternatives' these would:

> need to be developed in conjunction with how the residential aged care sector is to be better linked to the acute and community care sectors in order to achieve a seamless continuity of care for people with growing dependency and complex care needs. (Sub. D81, p. 3)

In the Commission's view, a move away from the current basis of subsidy does raise some equity issues. Nevertheless, the existing funding mechanism (and that recommended by the Commission in chapter 7) is complex, bringing with it significant problems in terms of efficiency incentives, administration and transparency. Alternative mechanisms, such as those described above, deserve further consideration to see whether they give a better balance between relevant funding assessment criteria.

8.3 Facilitating access, choice and quality care

A number of participants considered that the residential aged care sector should be better linked and integrated with the acute and community care sectors. As the ACHCA commented (see above) this could help to achieve 'a seamless continuity of care'. Further, although encouragement has been given in recent years to non-residential aged care where this is more appropriate, there is still concern that the choices faced by older people are too rigid. The following section describes the broad details of a model proposed by the Victorian Department of Human Services which could help address these issues. It also sets out Aged Care Australia's

comments with regard to the options available to older people. It subsequently describes a ‘self care’ residential model proposed by Catholic Care of the Aged.

In a submission on behalf of the Victorian Government, the Victorian Department of Human Services (subs 60, D117) said it was concerned that the Commonwealth reforms of the aged care arrangements have been unable to remove funding rigidities and program boundaries to provide access, choice and quality care for older Victorians. The department emphasised that older people should be able to exercise choice in the kind of care they receive and in what kind of setting that care is to be provided.

The department proposed an aged care system whereby funding is provided on the basis of eligibility and care needs according to a classification scale perhaps similar to the current Resident Classification Scale. The care classification would link the individual to a care package with a maximum dollar value, and access to defined services. Individuals would then be able to purchase care in accordance with their preference for either home-based care, care in a residential care setting, or in another form of accommodation. The department suggested that the subsidy levels should be determined on a state-by-state basis to reflect cost differences. Income testing arrangements could be used to determine the amount to be contributed by an individual at each dependency level.

If an individual chose a residential care setting, the subsidy could be paid direct to the service provider selected. The department suggested a separate payment stream would be required for capital upgrades and building quality maintenance, either contributed by an individual (eg by means of an accommodation bond or charge) or provided by the Commonwealth, or a mixture.

If an individual chose to remain at home, the funding could be used to purchase the appropriate package of services through a ‘brokerage service’. The department said that given the preference of people to remain at home, there would be likely to be a shift in service provision from residential care to community care. This would necessitate a increase in the availability of respite care, making respite care an integral component of the department’s proposal.

The department saw the advantages of its proposed system as being a significant improvement in consumer choice, as well as providing an integrated system of service, more responsive to consumer needs. Furthermore, it saw its proposal as neutral in terms of funding requirements, as increased expenditure in community care and respite care services would be offset by reduced expenditure on residential care. It recognised some disadvantages, for instance, less ‘certainty’ for residential care providers in terms of a supply of residents, and increased pressure on carers.

Some of these themes also emerge from Aged Care Australia's submissions (especially sub. 26, p. 21). It considered that a primary objective of funding policy in aged care must be to enhance the care and accommodation options available to older people to ensure that wherever possible they receive the care they need in the place they would most prefer to receive it.

Aged Care Australia commented that this does not necessarily require common funding approaches or integrated management. However, it considered it would be desirable to facilitate greater flexibility and transparency in regard to funding arrangements so that the choices and options become more apparent to both consumers and providers. It considered that the application of common principles (such as funding linked to assessed care needs and accreditation; access to quality care services based on need not capacity to pay) and greater clarity regarding components of funding (such as the component for care as distinct from board and lodging) may facilitate greater synergy between residential and community care services and improved flexibility and choice.

Catholic Care described the concept it called 'self care plus' (sub. D75, p. 4). This is an expansion of the self care/independent living accommodation model. Under the arrangement, self care accommodation units would be located, designed, managed and supported in a manner which aims, as far as possible, to maintain aged persons in their self care accommodation for life. Services such as community care packages, nursing home packages, HACC services etc, could be provided when required. The units would be designed prior to construction to expedite the provision of community type care and support while not destroying their appeal as a self care option. Catholic Care commented that such an approach has the advantage of removing the need to find capital funds and also would be appealing to the aged, who would be less likely to have to relocate to hostels or nursing homes.

Chapter 2 notes that health care for older people is provided in a number of ways. These range from non-institutional care provided by relatives or friends, through community programs such as HACC and the community aged care packages, to institutional care in hostels, nursing homes and acute hospitals. The Commission has heard evidence about multipurpose services, and has visited one such service in a rural location.

There is some evidence of 'discontinuity' in the boundaries between the various forms of care. Possible indicators of this include: early discharge from acute hospitals into nursing homes (see submissions from Sundale Garden Village (D104, p. 6) and the New South Wales College of Nursing (D109, pp. 3–4)); lack of monetary incentive for nursing home providers to achieve greater rehabilitation of

residents; and inadequate and disjointed funding for services provided in a community setting.

Possible solutions to these problems not only include service models which can pool a range of funds and provide flexible services according to the needs of the aged, but also mechanisms which give consumers greater ‘sovereignty’ in choosing the most appropriate range of services for their own particular needs. The Commission considers that the models proposed by a number of participants are worthy of further study, with a view to improving the longer term outcomes for the aged and the community generally.

A Terms of reference

I, Peter Costello, Treasurer, under Parts 2 and 3 of the Productivity Commission Act 1998, refer the current and alternative funding methodologies for nursing home subsidy rates for inquiry and report within six months of receipt of this reference. The Commission is to hold hearings for the purposes of the inquiry.

Background

Nursing home subsidy rates currently differ across States and Territories, with a large component based on historical variations in wage rates for nursing and personal care staff.

The Aged Care Structural Reform Package, announced in the August 1996 Budget, included a process of 'coalescence', under which the different nursing home subsidy rates in States and Territories would gradually move to national rates over a period of seven years, commencing from 1 July 1998.

The Government has decided to delay the implementation of the coalescence process, pending a review by the Productivity Commission into differential subsidy rates.

Scope of the inquiry

The Commission is to:

(1) report whether the proposed coalescence should proceed or whether it should be replaced by an alternative structure;

(2) examine issues including the current and alternative funding methodology and report on:

  (a) relative costs between the States and Territories of providing nursing home care, with emphasis on the relative wage costs of nursing and personal care staff;

  (b) trends in wage costs and likely future directions;

(c) the extent to which, if any, subsidies for nursing home care should vary by State and Territory; and

(d) if differential subsidies are considered appropriate, possible methodologies for maintaining appropriate relativities over time.

(3) make recommendations on the appropriate funding methodology and take account of the views of the sector.

PETER COSTELLO

[Reference received 13 July 1998]

B Participation in the inquiry

Submissions

Submissions designated 'D' were received after the Commission's position paper was finalised.

Participant	Submission No.
Aged Care Australia	26, 57, D77, D94, D95, D96
Aged Care Organisations' Association (SA & NT) Inc.	31, D82
Aged Care Queensland Inc.	33, D69
Aged Care Tasmania Inc.	40, D65, D114
Aged Care Victoria Inc.	23, D79
Aged Care Western Australia	30, D68
Aged Services Association of NSW & ACT Inc.	35, D67
Agmaroy Nursing Home	D89
Ainslie House Association Inc.	12, D73, D98
Allied Health and Community Consulting Services	D90
Anita Villa Nursing Home	D115
Ashfield Baptist Homes Ltd	D106
Australian Bureau of Statistics	D91
Australian Catholic Health Care Association	7, D81, D110
Australian Medical Association Limited	43
Australian Nursing Federation (Federal Office)	48, D74, D108
Australian Nursing Federation (SA Branch)	11, D102
Australian Nursing Federation (Vic Branch)	54, D86, D105
Australian Nursing Homes and Extended Care Association Limited	24, D84
Australian Nursing Homes and Extended Care Association - SA Inc	21, D111
Australian Nursing Homes and Extended Care Association (Tasmania)	D63
Australian Nursing Homes and Extended Care Association - Victoria	61
Ballarat Health Services	39
Baptist Care - WA	5, D64
Baptist Community Service Queensland	29
Carramar (Stanthorpe) Home For Senior Citizens Association	14
Catholic Care of the Aged	D75
Chamber of Commerce and Industry Western Australia	49
Coorparoo Nursing Centre	56, D66
Department of Finance and Administration (Commonwealth)	50

Participant	Submission No.

Department of Health and Family Services (Commonwealth)	52
Department of Health and Human Services Tasmania	53, D100
Eldercare Inc.	15, D112
Ethnic Communities Council of Queensland	D113
Frontier Services	8
Geriaction Inc.	36, D99
Health Department of Western Australia	51, D121
Laurina Lodge Heyfield	38
Lerwin Nursing Home	37
Lucan Care	1, D83
Maranoa Retirement Village	20
Maroba Nursing Home Incorporated	6
May Shaw Nursing Centre	41
Melbourne Citymission	42
Mid North Coast Aged Care Discussion Group	9
Minister for Families, Youth and Community Care; Minister for Disability Services (Queensland)	D122
National Association of Nursing Homes and Private Hospitals Inc.	25, 55, D70, D103
Northern Territory Government	17, D101
New South Wales College of Nursing	D109
New South Wales College of Nursing and New South Wales Nurses' Association	46
New South Wales Nurses' Association	D107
NT Carers Association Inc	13
Our Lady of Consolation Home	27
Paradise Lakes Nursing Centre and Paradise Lakes Hostel	19
PJ Pusey	D97
Queensland Government	10, D87
Queensland Nurses' Union	45, D76
Residential Care Rights Advocacy Service	D93
Resthaven Inc.	32, D72
South Australian Government	58, D120
Southern Cross Homes for the Aged Incorporated	18
Sundale Garden Village	16, D104
The Manor Homes and Mt. St. Vincent Nursing Home Inc.	4
TriCare Limited	34, 59, D78
Umina Park	44
Uniting Church Division of Aged Care and Domiciliary Services (Queensland)	62
Uniting Church in Australia Synod of Victoria	D80
Uniting Community Services Australia	47, D118
Valencia Nursing Home	D88
Victorian Employers' Chamber of Commerce and Industry	D71
Victorian Government	60, D92, D117

Participant	**Submission No.**
Victorian Healthcare Association	22, D85

Warrina Innisfail	3
Wesley Uniting Mission Inc	28
Western Health Care Group	2, D116, D119

Public hearings

To receive comment on the position paper, public hearings were held in Hobart (13 November 1998), Brisbane (16 November), Melbourne (18–19 November) and Tamworth (27 November). A public hearing by video conference was held with participants in Perth on 20 November. The following participated in these hearings:

Aegis Health Group
Aged Care Australia
Aged Care Organisations' Association (SA & NT)
Aged Care Queensland
Aged Care Tasmania
Aged Care Victoria
Aged Care Western Australia
Aged Services Association of NSW & ACT
Agmaroy Nursing Home
Ainslie House Association
Anglican Homes
Anita Villa Nursing Home, Katoomba
Australian Catholic Heath Care Association
Australian Medical Association
Australian Nursing Federation (Federal Office)
Australian Nursing Federation (SA Branch)
Australian Nursing Federation (Victorian Branch)
Australian Nursing Homes and Extended Care Association
Australian Nursing Homes and Extended Care Association (Western Australia)
Australian Nursing Homes and Extended Care Association - Victoria
Catholic Care of the Aged
Columbia Quality Care Group
Council on the Ageing
Geriaction
Hilton Nursing Home, Armidale
Nambucca Valley Care
National Association of Nursing Homes and Private Hospitals
National Association of Nursing Homes and Private Hospitals (Western Australia)
Nazareth House, Tamworth
New South Wales College of Nursing
New South Wales Nurses' Association
Queensland Health

Queensland Nurses' Union
Residential Care Rights Advocacy Service
Resthaven Inc.
The Manor Homes and Mt. St. Vincent Nursing Home
TriCare Limited
Uniting Church in Australia Synod of Victoria
Valencia Nursing Home
Victorian Department of Human Services
Victorian Healthcare Association
HN McLean Retirement Village

Informal discussions and visits

New South Wales
Aged Services Association of NSW & ACT
Australian Nursing Homes and Extended Care Association
Banksia Village
Braidwood Multipurpose Service
Edgewood Park Assisted Living Apartments and Nursing Centre
Hammond Care Group
National Association of Nursing Homes and Private Hospitals
NSW Ageing and Disabilities Department
New South Wales Nurses' Association
Southern Cross Homes

Victoria
Aged Care Australia
Aged Care Division, Victorian Department of Human Services
Aged Care Management Services Pty Ltd
Australian Nursing Federation
Australian Nursing Homes and Extended Care Association
Council on the Ageing
Cyril Jewell House

Queensland
Aged Care Queensland
Assisted Living Association
Hillcrest Nursing Home
Queensland Government Officials
Queensland Nurses' Union
St Martin's Nursing Home
TriCare Limited
Underwood and Associates
Wishart Village

Western Australia

Aged Care WA
Anglican Homes
Australian Nursing Homes and Extended Care Association
National Association of Nursing Homes and Private Hospitals
Health Department of Western Australia

South Australia
Aged Care Organisations Association (SA & NT)
Alzheimer's Association
Australian Nursing Homes and Extended Care Association
South Australian Office of Ageing

Tasmania
Aged Care Tasmania
Corumbene Nursing Home
New Norfolk District Hospital
Tasmanian Department of Community Services
Tasmanian State Government
The Gardens Nursing Home

Northern Territory
Aged Care Assessment Team, Katherine
Juninga Aged Care Facility
Kalarno Facility
Katherine Hospital
Northern Territory Health Services
Red Cross Nursing Home Facility, Katherine
Rocky Ridge Nursing Home
Salvation Army Nursing Home

Australian Capital Territory
Aged Care Standards and Accreditation Agency
Australian Catholic Health Care Association
Department of Health and Family Services
Uniting Community Services Australia
Villagio Sant' Antonio Hostel

C Overseas developments

The material in this appendix is based on material from a 1996 report by the OECD on 'Caring for frail elderly people' (refer to the reference list).

Governments in various countries have adopted different ways of dealing with the growing demand for long term care and rising expectations of elderly people and their families.

Originally, long term care for the elderly was provided primarily in hospitals for those needing long term nursing care, or in public or charitable old people's homes for those disadvantaged persons who had no family support and who needed shelter and social support.

In a number of countries, long stay sections in hospitals have continued to provide most long term care for the elderly (eg Ireland and Japan) while in a number of other countries (such as Canada, France and New Zealand) hospitals continue to play a major role. However, in many other OECD countries the provision of long term care for elderly people in hospitals has been progressively reduced and replaced by other forms of institutional and community care.

Methods of financing

A number of OECD countries fund hospitals and other institutional health services from general taxation. In the Nordic countries, Local Governments are funded by a combination of central and local taxes to provide social services as citizenship rights, similar to rights to social security and health care. Long term institutional care is funded by this mechanism. Some countries, including Spain and the Nordic countries, now supply long term care for the elderly on a universal basis, with no user charge other than a proportion of the public retirement pension.

Some other countries have health insurance systems which provide considerable coverage of long term institutional care in hospitals and elsewhere. The French insurance system provides coverage for the health care component of care in long-stay sections in hospitals or in retirement homes with a 'medical section.' However, the user is responsible for the social or board or lodging component in full. The

Japanese health system has found itself funding considerable long term hospital care by default, as other forms of care have been slow to develop.

A number of insurance-based systems are developing new forms of social insurance to provide cover for institutional long term care. Germany has passed a new law to extend social insurance to long term care and to raise new contributions to fund these services.

The financing of long term care for the elderly has retained a strong private component in many other OECD countries, where a significant part of the cost is met by the user, with only the low-income elderly receiving long term care without charge, on social assistance terms. In the United Kingdom and the United States it has been estimated that about half of the cost of long term care in nursing homes is met by private payments. The United States provides cover for the nursing home costs of low-income elderly people through the Medicaid system, which is funded from both federal and local taxation. Elderly people with assets above a minimum level are required to 'spend down' their savings in meeting nursing home fees before they qualify for assistance.

Residential versus community care

Several other OECD countries with a relatively high provision of institutional care for the aged in the early 1980s have either capped the growth in places or begun to reduce their number. Denmark, France and Sweden all had a significant reduction in the proportion of elderly people in institutional care together with a strong emphasis on expanding home care services. In Denmark and Sweden this was supported with benchmarks for the reduction of beds in those types of institutions which were felt to be overprovided at the expense of more appropriate forms of service. Canada, the Netherlands and Norway have adopted a similar policy stance and have begun to see a significant downward trend in the overall level of institutional provision since the later 1980s. Most OECD countries have for some time been pursuing policies intended to maintain as many elderly people as possible in their own homes.

The Nordic countries are 'high service' countries with the extent of home care services provided to the elderly higher than in any other OECD country, except for the Netherlands. Home help services developed in many countries as a gradual adaptation to demographic changes, more in parallel with, than as a substitute for, institutions.

The OECD estimates that provision of home help is almost non-existent or at best negligible (with 1 per cent or less receiving home help) in Greece, Italy, New Zealand, Portugal and Spain. With the exception of New Zealand, these countries

also provide low levels of institutional care. Countries with very modest levels of home help (2–3 per cent) are Austria, Canada, Germany, Ireland and Japan. Many areas of the United States would also fall into this category, although the extent of coverage varies across States from 0 to 8 per cent. Countries with a significant level of provision include Belgium, France, the Netherlands and the United Kingdom. The countries with a very high level of provision of home help (over 10 per cent) are the Scandinavian countries, especially Denmark and Finland.

In the Nordic countries (Finland, Norway and Sweden) and the United Kingdom, Local Governments now have global budgets from which to fund institutional and home care, rather than multiple subsidies for specific services. This has been introduced with the aim of encouraging a more flexible approach to arranging services and greater responsiveness to various needs.

Alternatives in residential care

Some countries have been pursing alternatives to institutional care through other forms of specialised or adapted housing which can offer a similar level of support for elderly people with disabilities and high care needs. For example, Denmark halted the building of traditional nursing homes from 1988 and modified existing nursing homes into self-contained apartments. Similarly, in Sweden where there was a reduction in the proportion of the elderly living in institutions during the 1980s, over 3 per cent live in specialised service apartments.

In some countries these developments have taken the form of specialised housing with wardens and services on call, sometimes by conversion of communal old-age homes into apartment blocks and supported accommodation for people with dementia, who require small living units and some help on call, but have no physical disabilities.

‘Assisted living’ has come to be used in the United States for housing arrangements where care services are also provided. The development of assisted living blurs distinctions between home care and residential services. Some assisted living programs are made up of separate housekeeping units with full baths and kitchenettes. In such cases, they are more like small private apartments than rooms in institutional settings. Some assisted living settings provide housekeeping, laundry and meals through an internal staff and rely on outside agencies for personal care and nursing services.

For example, the State of Oregon has encouraged assisted living as a major reform and a replacement for nursing homes. Thus, while it imposes no admission and retention criteria based on disability levels of the clients, the State will pay for the

care of low-income persons in assisted living only if they are also disabled enough to qualify for subsidy in a nursing home. Any Oregon program licensed as ‘assisted living’ must meet a minimum standard that includes single occupancy unless by choice, doors with locks, full baths, kitchenettes, voice-to-voice inter-communication systems and individual temperature controls. In addition, Oregon’s licensing standards are flexible about the types and numbers of staff needed but require at least one staff member be awake at all times, that individualised care plans be brought to people in their own units and that three meals a day be served in the dining room.

D Illustrating coalescence

The purpose of this appendix is to illustrate differences between some possible coalescence paths. The paths use as starting points the basic subsidy rates as they applied during the 1997-98 financial year. However, they should be seen as notional, illustrative, examples only, as many different possible coalescence paths exist.

Achieving coalescence without a real increase in base funding

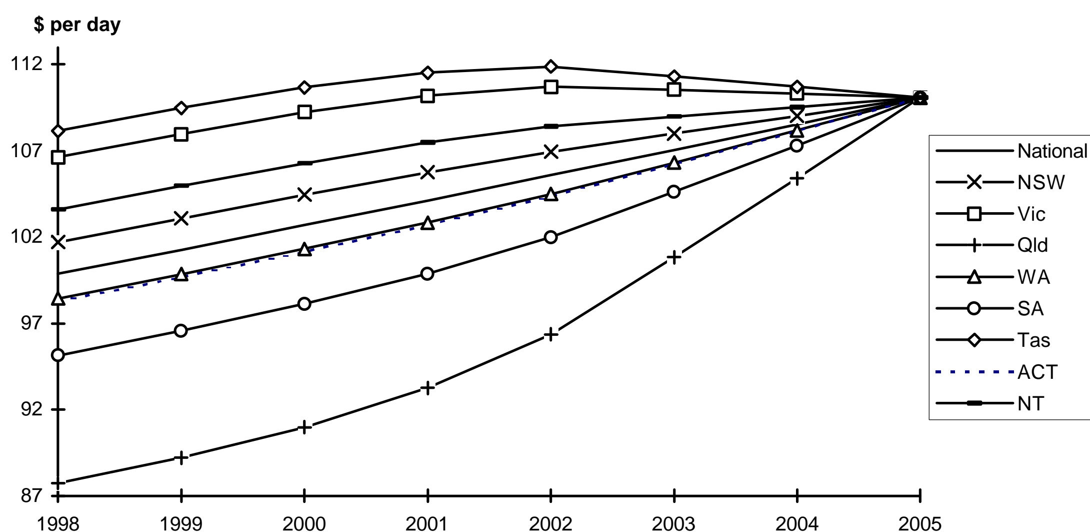
The alternatives discussed in this section involve no real increases in base funding. The only additional money available is through indexation.

Option 1: DHFS coalescence proposal

Under the DHFS coalescence model, rates would be indexed and subsequently coalesced up or down by reducing the difference between individual state rates and the national average by 2, 4, 8, 14, 24, 24 and 24 per cent in successive years (see box 3.4 in chapter 3 for a notional example of how the Queensland RCS1 rates change under the DHFS model). Rates in the low rate States would increase and rates in the high rate States would decrease. At the end of the seven year process the rates would have become uniform in all States.

States originally with rates below the national average would receive increases in both real and nominal funding. States with rates above the national average at the beginning of the process would receive reduced funding in real terms. An exercise carried out by the Commission (using an indexation factor of 1.4 per cent, and ignoring any superannuation adjustments) shows that, in some cases, funding for States currently above the national average could fall in nominal terms also. For both Victoria and Tasmania (the two highest rate States) in years 5, 6 and 7 the RCS1, 2 and 3 rates would fall in nominal terms. For Tasmania the RCS4 rate would also fall in nominal terms in years 5, 6 and 7. Figure D.1 below depicts the changes in RCS1 rates over the seven years.

Figure D.1 **DHFS coalescence of RCS1 rates[a]**
notional example[b]



[a] Year ending 30 June. [b] Using an indexation rate of 1.4 per cent for the entire period.
Data source: PC estimates.

Option 2: Use funds available through indexation to bring lowest rates up first.

There are any number of ways to use the funds available through indexation to increase subsidies in the lowest rate States. For instance, all the indexation funds could be used to bring the lowest rates up to the highest as quickly as possible, giving nothing to the States with the highest rates (Option 2a). Or some of the indexation funds could be used to bring the lowest States up leaving a proportion to increase funding for the other States (similar to the Aged Care Queensland proposal — Option 2b).

Option 2a*: Use all indexation funds to bring lowest rates up successively until all rates are the same as the highest (Tasmanian) rate.*

This would mean Tasmania would receive no additional funding for the duration of the process, and Victoria would not receive an increase until the last adjustment. Queensland rates would increase over the whole period. As in the year 0 (1997-98) Tasmanian rates are roughly equal to the average national rate achieved under the coalescence proposal in year 6, it would take 6 years (at 1.4 per cent indexation) to achieve nationally uniform rates equal to the Tasmanian rates. Indexation in year 7 would then bring all the rates up to the same uniform rates as those at the end of the coalescence proposal.

This would be the quickest way to achieve uniform rates while avoiding nominal reductions. However, Tasmania's funding would decrease in real terms until the seventh year, when it would benefit from indexation. Victoria's funding would also decrease in real terms during the initial years.

***Option 2b**: Aged Care Queensland option*

Aged Care Queensland proposed that funds available from annual indexation be allocated to bringing all States to a national rate of funding not less than the present rate of funding in Tasmania. In order to do this each year around 90 per cent of the indexation funding would be used to bring the lowest rates up and the remaining 10 per cent would be allocated on a flat rate per bed/day to the remaining States. This would maintain an upward nominal trend in all the States (but still be a reduction in real terms for the highest rate States for some years).

For instance, in the first year the proposal would move Queensland rates up to South Australian rates and then move both a small way towards Western Australian rates. It would also allocate 19 cents per bed/day across the other States. In the second year Queensland and South Australian rates would continue to rise. As they passed Western Australian and ACT rates, these would also begin to move towards New South Wales rates. The other States would receive an increase of 25 cents per bed/day. The process would continue until in year six full equalisation had been achieved and normal indexing of all rates could resume. Aged Care Queensland used an indexation rate of 1.8 per cent in its proposal. If a lower rate applied, the process would take longer. Figure D.2 depicts graphically the movement of the RCS1 rates under Option 2b.

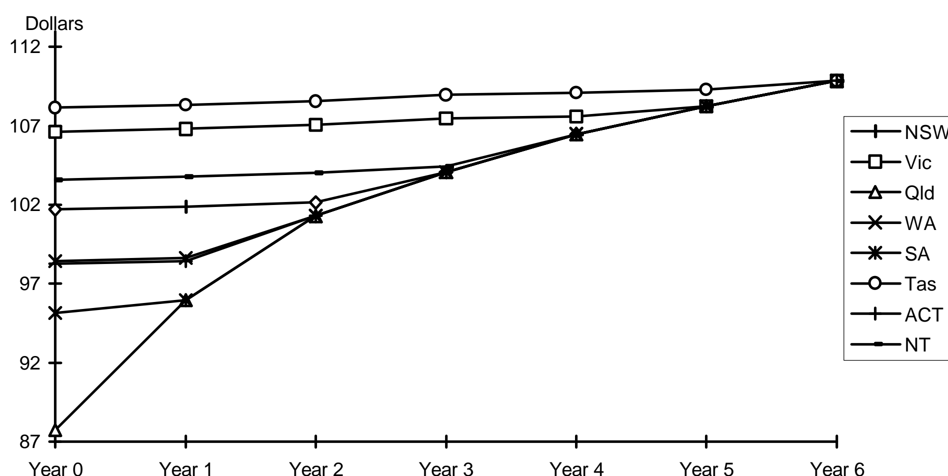
Comparison

Key points to note about the DHFS coalescence model versus Option 2b are:

- With DHFS coalescence, funding for the high rate States might at some stage of the process decrease in nominal as well as real terms, while with Option 2b all the States would receive an increase in nominal terms at all stages of the process.
- Whether funding for the high rate States would fall at any stage during the DHFS process of coalescence would depend on the indexation rate (and allowances for superannuation etc). The higher the indexation rate, the less chance of a decrease in funding.

Figure D.2 **Movement of RCS1 rates under Aged Care Queensland's proposal**

notional example[a]



[a] Queensland Aged Care used an indexation rate of 1.8 per cent.

Data source: Aged Care Queensland (Sub. 33).

- The DHFS coalescence model as proposed (with coalescence of 2, 4, 8, 14, 24, 24 and 24 per cent in successive years) would always take seven years to achieve uniform rates. (It could be slower or faster with different percentages coalesced each year.)
- The time taken to achieve uniform rates with Option 2b would depend on the rate of indexation. The lower the rate of indexation, the longer the process. This is because fewer dollars would be available to raise the lowest rates each year.
- Tasmania and Victoria, as the highest rate States, would receive (at least initially) larger increases under the DHFS coalescence model than under Option 2b.
- Queensland and South Australia, as the lowest rate States, would receive larger increases in the early years under Option 2b than under DHFS coalescence.
- The DHFS coalescence model would largely postpone the start of the adjustment process until year 4, whereas it would commence in year 1 under Aged Care Queensland's proposal.

Achieving coalescence with a real increase in base funding

A real increase in funding would enable uniform rates to be achieved more quickly. For instance, an addition to base funding of around $200 million would permit all basic subsidy rates to be brought up to the highest (Tasmania's) level in one step.

Indexation of the new base funding would allow all the rates to be maintained at that level. To bring Queensland, South Australia, Western Australia and the ACT up to New South Wales rates would require an increase to base funding of around $80 million. Again, indexation thereafter would allow those increased rates to be maintained. Similarly, bringing Queensland, South Australia, Western Australia, the ACT, New South Wales and the Northern Territory up to Victoria's rates would involve an increase in base funding of around $160 million.

A number of participants considered that the change to COPO indexation in the 1995-96 Commonwealth Budget had resulted in reduced funding to nursing homes of $128 million over three years. An addition of $128 million to the funding base, together with funds available from indexing existing funding (around $34 million for the first year under the existing arrangement) would make available sufficient funds to bring Queensland, South Australia, Western Australia, the ACT, New South Wales and the Northern Territory up to Victoria's rates in one year. Indexation of the new base would almost enable full coalescence of all rates in the subsequent year, with all jurisdictions receiving virtually full indexation in the third year.

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