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TRANSCRIPT OF PROCEEDINGS

PRODUCTIVITY COMMISSION

DRAFT REPORT ON NURSING HOME SUBSIDIES

MR M. WOODS, Presiding Commissioner

TRANSCRIPT OF PROCEEDINGS

AT HOBART ON FRIDAY, 13 NOVEMBER 1998, AT 10.20 AM

MR WOODS: Welcome all to the Hobart hearings for the Productivity Commission inquiry into nursing home subsidies. My name is Mike Woods and I'm the presiding commissioner for this inquiry. As most of you will be aware, the commission released an issues paper in August setting out the terms of reference for this inquiry and some initial issues. Subsequently we have received over 60 submissions and I and my team have visited interested parties in every state and the two major territories.

I would like to express my thanks and those of the staff for the courtesy extended to us during our travels and deliberations and for the thoughtful contributions that so many of you have made in the course of this inquiry already. These public hearings represent the next stage of the inquiry and will be followed by final submissions due on 27 November. We are also circulating chapters of the final report dealing with background material which we have asked for comment on.

I would like these hearings to be conducted in a reasonably informal manner but remind you that a full transcript of proceedings will be taken and will be available to all interested parties. On that basis I'd like to welcome as our first witnesses to the hearings Mr Mark Stemm, Mr Andrew Vanderschoor, Mr Martin Wallace and Mr Mark Watson. Welcome. Could you please for the record state your name and the position that you hold.

MR STEMM: Mark Stemm, president of Aged Care Tasmania.

MR VANDERSCHOOR: Andrew Vanderschoor, manager of Aged Care Tasmania.

MR WALLACE: Martin Wallace. For the record actually I have to say that I've been engaged through KPMG to assist Aged Care Tasmania. I'm not representing the Tasmanian government at these hearings and so any comments I make shouldn't be attributed to the government.

MR WATSON: Mark Watson, workplace relations adviser, Tasmanian Chamber of Commerce and Industry.

MR WOODS: Thank you, gentlemen, and welcome to the hearings. Would you like to make an opening statement?

MR STEMM: Yes, thanks, Mike. Welcome to Tasmania on this typically nice Tasmanian day. Just to show that we are regionalised, it's a nice sunny day on the north-west coast where I come from, so welcome to Hobart. I was a little bit worried when you decided to hold the hearings on Friday, 13 November, but hopefully that's a good omen, Mike, not a bad one. What I would like to do is I'll make some opening comments in regard to your draft report and some very short replies. I will then ask Martin to follow up on more particular issues in regard to cost and then I'm sure you will have a number of questions which you would like to ask us and we also have a number of questions we'd like to ask you in regard to your report. So if I may proceed in that manner.

MR WOODS: Thank you very much.

MR STEMM: Thank you. Before we address specific questions, it is evident from the commissioner's report that you have found marked differences in cost to each state, and I refer to 2.2 on page 10 of your report. This difference varies from 4 to 25 per cent depending upon which study was used in the report. Secondly, there is not enough current funding in order to pay the correct level of subsidies in states that are currently underfunded, mainly Queensland. That care is not necessarily directly related to cost but on the other hand, whatever is paid for care has a direct relationship to the level of care provided. Fourthly, that over the past few years wage trends have been converging and last year that a proposed coalescence would not deliver - I repeat not deliver - the correct level of funding or guarantee an adequate level of care.

The commission then goes on to make the following solutions: that there is not a compelling case for differences in funding. We at Aged Care Tasmania find that this actually runs contrary to your first findings that there are differences in funding. Secondly, to make up for those states underfunded, the indexation money should be directed to those states underfunded. This actually contradicts your findings in point 2 where you are saying effectively there's not enough money in the whole system. Also it is sort of quasi the original proposal being put into place. However, Aged Care Tasmania has gone on the record as saying that the amount identified in ACA's position paper of $128,000,000, which has been underfunded from indexation over the last 4 or 5 years, should be used to increase funding in those states currently being underfunded, ie Queensland and South Australia.

The third point you make in your report is to move away from - the acute sector for nursing is benchmark for nursing wages. Once again we find this runs contrary to the actual market for nursing staff and wonder as to where we could get our actual staff from if it wasn't for an acute sector. The fourth point is that you suggested perhaps a right size facility is 60 beds, which I must say runs contrary to the data on average bed size throughout Australia. So you are shooting for a size which is much above what is currently the average. Fourthly, the use of the benchmarking model, which will promote best practice while not lowering the cost of care delivered, ACT or Aged Care Tasmania supports this and will make suggestions in its final submission as to how this should be arrived at.

The commission is a bit vague on what is meant by small, rural and remote and we look forward to discussing this with you and expanding this as to what is meant by that definition because we believe the current Commonwealth government definitions are insufficient. Finally, I think the commission finally comes to the recognition of the real situation in the current subsidies and refers to the overall funding issue to the Aged Care Review Committee, which quite obviously has said there is not enough money in the pool to right some of the wrongs that have come over the years. Overall the commission has identified problems correctly but then go on and offer some solutions which we feel are actually contradictory to your findings.

In summary, there seems to be one underlying proposal in the commission's paper and that is talking about taking money perhaps away from the urban and city dwellers and passing it to the rural and remote. We do not see this as being a solution either. What we think is required is, firstly to introduce a cost-based model on a state-based system to ensure adequate funding; secondly, the correct indexation is used; and thirdly, the funding pool is increased to allow for this. ACT will deal with other issues in its final submissions. Thank you.

MR WOODS: Thank you very much.

MR WATSON: Thank you for the opportunity to make some comments. Actually I will keep mine very brief. It's just to reinforce some of the key elements of the Aged Care Tasmania submission on the cost differences. The first point to make is that, relative to the other states on average, Tasmania is a high-cost location in which to provide any human services, particularly in this case nursing home services, and that's a fact that's not well recognised throughout Australia. As the analysis in the submission shows, for virtually every input that's used in providing these services, Tasmanian input prices are higher than in the other states on average and probably the only input that I can think of in Tasmania where that wouldn't be the case is land itself.

The analysis that KPMG did for the submission looked at whatever relative price information was available and, while the information is a little bit patchy in some places, the conclusion is really very clear-cut in terms of Tasmania being a high-cost location. These input price differentials really are outside the control of the individual nursing homes and they arise from, I suppose, intrinsic characteristics of Tasmania, particularly its island status and its small population size and therefore small market size, and I think it's worth pointing out that even if all 470,000 people in Tasmania are actually located in Hobart itself, the cost of providing nursing home services in Tasmania would still be higher than any other state on average. So there are elements of costs which really simply relate to Tasmania as a location, leaving aside other costs which relate to the fact that Tasmania has a very dispersed population relative to other states.

So most input prices are higher in Tasmania, if not all input prices. Secondly, there are technical barriers to achieving the same level of efficiency in Tasmania because of the very scattered settlement pattern of the population and this leads to cost differences, which I think the commission eloquently describes in this report; the cost differences that are associated with homes in rural and remote areas. I suppose the main point that I want to raise is I am certainly encouraged by the extent to which the commission has recognised and acknowledged the arguments that Tasmania has put forward that under the proposal of a uniform basic subsidy and a special need supplementation for homes in rural and remote areas, I just wonder how that system would effectively compensate Tasmania homes in general for the fact that they're located in Tasmania and therefore there are high costs associated with providing services for intrinsic reasons. Thank you.

MR WOODS: Yes, have you any other - - -

MR STEMM: Thank you. It's all in your hands now.

MR WOODS: Very good, thank you. I appreciate you bringing your opening comments to the point. A couple of points of clarification: you have drawn an assumption from our submission which you not only stated this morning but state in writing that we have a view on quantum of funds and you draw for that on our preliminary proposal - the second one. In fact, when looking at that it states a principle which says:

> In combination with resident charges government funding should be sufficient to support the level of care required to meet the accreditation and certification requirements.

That seems to be an important underpinning principle, but I see nothing in that that suggests a reflection by the commission on the question of quantum and in fact that's not in our terms of reference nor is it a matter that we've particularly investigated other than we have received many comments on the question of quantum in the submissions that have been put to us, which we note and which are now on the public record. Would you like to expand further on your perception of our view on quantum or of the quantum question more generally to clarify your point?

MR STEMM: I think it's almost explicit in the fact that one of your opening proposals is that the current coalescence as set out should not proceed and we take that as being on the basis that this is merely redistributing the pool in a different manner and a manner which brings everybody to one common level but doesn't recognise the cost differences in each state. I think the quantum of money then arises from that saying, "Well, if you can't redistribute it simply on an average, and the cost of providing care in each of the states varies to some extent but nowhere near the amount that the subsidy varies, then how do you rejig or how do you rebalance the money to ensure that none of the states are in fact worse off in regard to the level of care that they are to provide?"

MR WOODS: The question of quantum is one for government and the government has initiated its 2-year review and very clearly they will be taking into account the evidence, not only presented at these hearings but in their own processes. So we recognise that there is a means by which that issue is to be addressed in terms of the commission, and our requirement was to look at an appropriate funding methodology and in that sense we took the terms of reference as not being a choice between one - ie that existing or another ie that proposed - but looking at what is an appropriate funding methodology and we've undertaken that particular exercise and, as you see, we have preliminary proposals that address that specifically. To the extent that there may be no increase in quantum - which is a matter for government - then a natural consequence of that would then be a redistribution within the existing - that goes as an axiomatic statement.

MR WALLACE: Can I just make a point there?

MR WOODS: Yes.

MR WALLACE: Two points, I suppose. I will come probably to the more pertinent one in a sec but, firstly, I think from Tasmania's point of view a very important point that I probably should have made in my opening remarks is that while we understand there are obviously problems with the relativities between states, based on the costs studies that have been done, clearly the current subsidy arrangements seem to be anomalous and Queensland is an obvious case in point. The work that we did actually, I think, suggested that Tasmania, relative to the other states on average, is probably not anomalous; that is, that we're not necessarily advantaged but we do recognise that there are obviously a lot of anomalies in the current arrangements.

The second point I wanted to make - which is really a point of clarification or seeking clarification - was that in your report you mention that one possible funding option is to adjust the indexation arrangements to progressively change jurisdiction towards the average basic uniform subsidy over time, and I didn't quite understand in the report exactly what that meant. I thought it related to this issue of assuming a fixed quantum - there's no increase in the quantum. Is that the case?

MR WOODS: We were painting a scenario that said if there was no change in overall quantum other than indexation of that quantum in accordance with agreed processes to date that that amount over and above same nominal that is available through that process be distributed on a bottom-up basis to correct the greater of the anomalies and bring those states so affected up more quickly on that basis, and that other states during that time receive same nominal over that period. But to the extent that the government then wishes to address the broader question of quantum then that is out of the jurisdiction of this particular inquiry.

MR STEMM: I guess the other point we make in regard to quantum is that you have identified in your report that quite obviously the use of (indistinct) as indexation has been highly inadequate over the last few years, but had we had the correct level of indexation I don't think we would be discussing the point of quantum now because the $128 million would effectively have been put into the pool and you would probably find that the redistribution on that basis may well have been possible but the problem coming from behind and not having that money there to begin with makes the situation more difficult.

MR WOODS: I will come back to that point of indexation in a minute but if I can just pick up another point that you made in your opening statement. You drew an inference that there was a discrepancy or an anomaly in our report because we recognised that there are differences in input cost mix between jurisdictions and yet in our preliminary proposals we are recommending moving to a national basic subsidy rate. I don't see the two as being inconsistent in the sense that ultimately it is a question of judgment as to whether the difference between jurisdictions is significant,

and that is the essence of that point of judgment: that it is inconceivable that you would have exactly the same input cost mix in every jurisdiction, just as it is inconceivable that there will be the same input cost within any one metropolitan area, let alone between a metropolitan and a rural area in the one state.

I mean, they will vary as a matter of course, depending on the particular location and the size of the facility; the peculiarities of the local labour market, even if there are common awards in jurisdictions - I mean, there is a whole range of factors that will, of necessity, cause all facilities to have variations in particular cost mixes. Where the judgment comes is, is that of itself sufficiently significant to warrant applying different levels of subsidy to address those cost mixes with the ultimate extreme obviously being moving to a straight reimbursement of each facility's actual costs? Then you have a number of design features of the subsidy that not only in terms of administrative costs but in terms of incentives and reporting and cost-adjustment behaviours that wouldn't recommend that, I would have thought.

If I may just finish and then invite your comment: the other factor to take into account is what is happening over time and - as we understand it but are happy to receive further information - there is a progressive trend to a common rate and that that particularly has been applying in the last 5 or 6 years. The question then is, does the subsidy process support that trend and encourage it or does it stand against it and try in some way to inhibit the development of a national labour market, for instance, which is of obvious significance for this particular industry, or do you lock in a particular situation at any one point in time recognising the flux of the labour market, for instance, as to which jurisdiction has most recently received what increases? One can go back in history and many arguments have been put to us as to what happened in 86-7, for instance, as to who was in and out and - could you explore some of those from your perspective?

MR STEMM: I will take your first point in regard to move to a national rate. We would see that as, how would you then accommodate some of the significant difference in costs, particularly here in Tasmania at that national rate level, and I think that begs the question we would ask you in relation to remote and rural and how you would see that situation, because we would always argue that the whole of Tasmania was remote, simply by its location.

MR WOODS: I think you have in your submission.

MR STEMM: That's right. I think the second point is in regard to convergence of wages: I mean, there is an argument which wages have converged but, as we are price takers in the market of health, particularly in regard to nurses and carers and that market is very much driven by state governments - which I mean I think there is something inherent in the system which won't necessarily allow a convergence of wages, nursing wages, across the country. I mean, our state government has just given an overall 10 per cent increase to our nurses and I know Victoria is trying the same; Western Australia is also in that boat, too, and there is no doubt there will be other pressures from other states, but until such time as there is a convergence of

wages and there is some national scheme, which means I guess the states would be no longer involved in setting the wages of nurses, which I think would not be something which would occur very shortly, then I think we are stuck with a system that we simply have to live on a state-by-state basis and recognise there will be differences in costs in regard to costs of care.

MR WOODS: Recognising the role of state governments in negotiating the acute sector and its consequence therefore for your industry, it doesn't preclude that over the course of any 2 or 3 years that the various negotiations of state governments in that sector around the jurisdictions may not even out over time. I mean, what you are picking up is a particular dynamic. The question is, is there also an underlying structural base for differentiation between the jurisdictions or is it just that you are going through a process of your government having agreed a 2-year wage agreement now but, in 12 months' time, if that cycle is repeated in another jurisdiction, will the arguments be from them rather than from you? If you average it out over the cycle, whether it be a cycle of governments or a cycle of bargaining or whatever, does it still hold true?

MR STEMM: Perhaps Mark might like to comment on that because Mark has the history of that.

MR WOODS: That would be excellent.

MR WATSON: Possibly so, commissioner, but if I can just divert for a second: when the national rates of pay were determined by the federal Industrial Relations Commission in 1990 for all nurses covered by federal awards around the country, they made a particular statement and it was fairly significant for Tasmania - and it is not unlike this particular inquiry - that if they were to set a national rate of pay they would also have to rationalise salary-related conditions, and that included penalty rates, qualification allowances, etcetera. So whilst you might have had a national rate of pay at a certain level, if salary-related conditions of employment were at a much higher level in a particular state, then you would have to have a levelling off of those conditions, as well, so if the state with the highest conditions got the same pay rate then they're obviously in front and it does eliminate any national rate of pay because you just maintain the differences in salary-related conditions.

One of the things that came out of that case was that all salary-related conditions had to be levelled off, along with the national rates of pay, so I think we can draw the distinction here that if you are looking at a national subsidy you have also got to look at the wages costs as well and make sure you are comparing like with like, otherwise you do have the differences - you know, the eventual difference will be that the states who are paying higher wages and higher conditions are obviously going to be worse off. The federal commission recognised that and actually made it a requirement that that issue of salary-related conditions would have to be levelled off before national rates of pay could be implemented.

MR WOODS: Clearly we are interested in the recommendations from the commission having relevance over the next 5 and 10 years; not just addressing a particular issue confronting the industry at the moment. What is your view - if I can pursue your analysis a little further - as to the dynamics and trends occurring in the labour market and affecting rates of pay and conditions?

MR STEMM: I think that certainly perhaps since we have put the submission in, all the private hospitals in Tasmania have now done enterprise agreements with their nursing staff over 3-year periods and those increases are probably, on average, 10 per cent over the 3 years. As Mark said, the public sector has just reached agreement with the unions for public sector nurses for a 10.4 per cent increase over 3 years. I think that the pressure is certainly going to come on from the nursing unions now, with Aged Care Tasmania sitting outside, not having had any increase since 1 July 97 - the nursing staff - and in fact yesterday we actually received formal advice from the Australian Nursing Federation that they want to pursue further wage increases for nursing staff along the lines of, in their words, "the outcomes in the private hospitals and the public sector", so you can see the trend emerging.

The comments that are coming back to us through the union are that their members are saying to them, "Well, look, okay, we understand the problems in terms of funding but we're not going to stay in these positions whilst the wages remain the same, whilst our counterparts in the acute sector and the public sector are able to get increases in rates of pay." That is a fairly broad statement but you can see that the pressure is building, and if a sector is unable to do anything about that, then I guess the outcome is going to be that they will lose their best people and that's going to be a consequence of that.

MR WOODS: I understand that in terms of the flow of expected action over the next 2 to 3 years in Tasmania specifically. I would be interested in an observation from you though or somebody who is in this field and is aware to some extent of trends and events happening in a broader context, as to do you have a view though whether in other jurisdictions you would expect, based on past trends and your knowledge of this field, to have similar dynamics and that over any 2 to 3-year period there will be a general movement across the industry? You know, if there are increases provided now in Tasmania and you were commenting on Western Australia and Victoria as other possible jurisdictions, would you expect that then though to multiply out through the others and that over time on average there is a movement in a more national form?

MR WATSON: I think that's probably a reasonable assumption, that wage trends will approximately reflect what's happening in other states in terms of percentage increases. For example, traditionally the state Industrial Relations Commission in Tasmania has picked up the national wage case determinations of the federal commission in terms of safety net adjustments, and with some minor amendments has effectively ratified those decisions and put them into the Tasmanian jurisdiction in terms of wage flows. In terms of bargaining increases, traditionally since enterprise

bargaining became an issue, the outcomes in Tasmania have been similar to other states as well.

MR WOODS: That applies not only to the registered nursing component of the sector but broadly across the various labour markets that the industry draws on?

MR WATSON: Not so much employees in other classifications, like domestic food services, clerical, etcetera. The enterprise bargaining for those types of people has not necessarily got to the extent that it has for nurses at this point, and in fact part of the reason that we didn't continue with our negotiations earlier this year was this exact issue, that the sector was faced with uncertainty in relation to funding and therefore couldn't commit to any wage increase for the other group of staff.

MR WOODS: And that the labour force in total accounts for at least three-quarters, if not 80 per cent of total costs in the industry.

MR WALLACE: Can I just make a comment on this, Mr Woods. My understanding of what Mark was saying - and I could be wrong - was that basically the state Industrial Commission here seems to be taking into account the percentage increases that have been awarded in other states. If that is the main driver, then that suggests that convergence is a long way off because you start off at a higher base and the percentage increases are the same. I think this issue of convergence is a very difficult one. I mean Pyrrhically what you've found is there does appear to be some convergence in labour costs, and there is this issue about whether it's a cycle of governments or you know, what it is that's causing this.

The Commonwealth Grants Commission itself believes that the differences are intrinsic and they relate to cost of living. In Tasmania, while we're not the highest cost of living, that's clearly New South Wales, the Grants Commission's calculations do show us as having an above average cost of living, which suggests that if you look in the medium to long term you would expect that the wage rates in Tasmania will continue to remain above the national average. So my view is that that is still a pertinent factor for the commission to take into account.

MR WOODS: Yes, the judgments relate to the quantum of difference, to what extent that is significant, and also the trend, so we need to adjudge on both of those.

MR WALLACE: Yes, I agree entirely with that. If there isn't a significant difference then the issue is why develop a complicated system. I suppose my comment there would be Tasmania's wage costs are higher but every other input - and while they might only be 25 per cent of total cost, they are significantly higher and overall that makes Tasmania's cost structures significantly higher than the other states.

MR WOODS: Other than land, I think you identified one where particularly - - -

MR WALLACE: Yes, which is not a recurrent input of course.

MR WOODS: Not a recurrent input, that's true.

MR WALLACE: Building costs are higher, you see, so if for example Tasmanian homes were forced to amalgamate, physical amalgamation in urban areas -for example, where you may have a number of small homes - what you'll find is that because of declining population this will be a very substantial capital cost. You will have a facility that is no longer being used; it has no alternative use in the market, in the economy, so effectively the whole value of that has to be written off, and a separate facility has to be expanded to take in the residents of that other home, and building costs in Tasmania are significantly higher. So the cost of adjustment in Tasmania will be significantly higher than the other states, and I think that's also a pertinent consideration.

MR WOODS: Yes, Mr Vanderschoor.

MR VANDERSCHOOR: If I can just add a comment, Mr Commissioner, just to illustrate further that the accreditation regime that we're about to embark on we believe is going to see rationalisation of a number of service providers, and it's very pertinent that such economies of scale as may be available probably relate to having the largest number of units, the largest number of persons that you can accommodate on a site so that you get them expanding, enlarging - and some of that is referred to in your position paper. So that would mean rebuilding costs, etcetera, and we are already seeing this commencing - intentions for rationalisation. I've not had the opportunity to check it out in some of the other states but we can start to see it emerging here, and we believe it could be quite a prominent feature in the accreditation period.

MR WOODS: Yes, and I would like to pick that up - perhaps if I can deal with that next. But just finishing off our previous conversation, workers compensation premiums, how do they relate in Tasmania compared to other jurisdictions?

MR STEMM: Ours are higher and they're higher for two reasons. One is we have a much smaller premium base. In other words the market must extract its administration costs and other things out of a much smaller group, and the other thing is it's effectively not a state system, such as in other states where there's WorkCover, which means that we are much more exposed to the commercial realities of insurance companies in the marketplace, and on a much smaller scale means that if one or two homes have a very bad experience then the rest of the members also pay for that, because the average rate for nursing homes increases. So in the larger areas where one or two may have a nasty experience, there is a much larger group to spread that cost over but I'm afraid in Tasmania it's a much smaller group.

MR WATSON: Commissioner, we do have some figures in relation to workers compensation premiums, a percentage of wage costs, and they are as follows. In Tasmania it's 7 per cent, Victoria is 3.95 per cent, New South Wales is 5.57 per cent, Western Australia is 5.15 per cent, South Australia is 6.9 per cent, and Queensland is 3.91 per cent. So Tasmania is clearly at the top of the tree in terms of workers comp.

MR WOODS: I just thought it was useful to have that point clarified.

MR WATSON: Mr Commissioner, I just ask you a question in regard to national trends. You opened this original part about moving the national trends and you then made the comment that this be a 5-year or 10-year or whatever. If we move towards a national subsidy rate over what time period and under what terms and conditions would you see us moving to that?

MR WOODS: Well, that would depend clearly on the extent to which the government made any other decisions on quantum but if it didn't address those, then in fact we have some work in hand that would project out the period, and my recollection is that we're talking 5 years - of that order - over which the bottom states, if they were to be receiving the indexation on a bringing them up basis, would cause a significant degree of convergence.

MR STEMM: Can I ask you, in that case would that leave a situation where no current state would be worse off?

MR WOODS: The states that were being supplemented in that way would have same nominal, so in real terms clearly there would be a reduction in funding. I mean, that's just a straight mathematical process.

MR STEMM: I raise the point because that would refer to your supplementary papers you proceeded the other day - where the department gave you a calculation of coalescence which showed that by the year 2004 and 5 at page 11 of that funding regulatory arrangements that for a category 1 the rate in year 2004 and 5 is $110.36 per day. Tasmania is currently receiving $110 a day for its rate 1, which I mean if you were to use the indexation over a 5-year period to bring the lower states up, then quite obviously in nominal terms we receive something but our real wages or our real subsidy would go down. That would lead to two things: one would be a reduction in the quality of care staff and a quantity of about three to four hundred staff, and the second thing would, as a consequence of that, be lower care for our residents. So we just need to point out that the consequences of any scheme which doesn't at least keep us intact with indexation costs over that 5-year period means that it will have an effect upon the level of staff employed and therefore care delivered to residents.

MR WOODS: Do you have any views on the table that we provided on page 17 of our position paper which puts side by side, looking at the RCS3 subsidy - and you could use any of the RCS1 to 4s, but ranks jurisdictions on the basis of that subsidy and then looks at the average hours of qualified nursing in the states. Does that cause you to draw any conclusions?

MR WALLACE: I don't think this is surprising at all. Basically what it appears to be a function of is the size of facility to some extent, and Tasmania has a lot of small facilities and so does Victoria. As a facility gets smaller in size, I suppose the economics of resource application - whether it be nursing hours for example - will

change, and Tasmania is equal with Victoria as having the highest rate. What we've argued is that Tasmania has a lot of small homes for intrinsic reasons because we have a very scattered population. Why Victoria has a lot of small homes and high average qualified nursing hours I don't know, but I can certainly see why Tasmania sits where it does.

MR WOODS: Would you expect that if we analysed that on the basis of size of nursing homes, that that would be the sole explainer of that table?

MR WALLACE: Well, I think it's the main thing that explains it but I wouldn't say it's the only thing that explains it. Mark might have a comment.

MR STEMM: I think there's an underlying - there in regard to size of nursing homes but the data doesn't include Queensland. That's one of the problems we have.

MR WOODS: No, only because we drew it from a submission that didn't include Queensland data, not for any other reason.

MR STEMM: That's right, and I think that would have been extremely useful, since they are at the bottom end and Tasmania is at the top. I wish to talk about the La Trobe study with you but I would caution the use of those figures and so on.

MR WOODS: Do you want to make your comments on La Trobe at this point?

MR STEMM: Yes, actually my home was one that had to complete the data for the La Trobe study and we're not happy with the study and not happy with it probably for three main reasons. Whilst we think the study itself was well-intended and is, I think, a good methodology, as you say in your report, to arriving at some answers, there are some flaws, and the main thing is that the data used for wages was simply incorrect. We have conferred with our people in ASA and other associations where the actual wages used did not reflect those of actual wages paid in the various nursing homes and so on, and if you compare our rates of pay that we included in here not too many of them actually relate to the study itself.

The second thing was that the sample was far too small and I would suggest to you that it's not statistically relevant. I mean out of, was it 31 or 41 nursing homes, several thousand is statistically not significant. The third point is that actually having been involved in the study itself the methodology was incorrect. The data was collected without validation of its correctness and there was no way of verifying the data. There was no control group used; there was no standard to see whether everybody actually filled out the forms in exactly the same manner. I passed my comments on to Aged Care Australia when they did the study and said, "Look, you be very careful that what comes out of this may not be representative of the industry."

So I just caution you in that regard, that a properly conducted study may well find a different answer, although I think that the methodology in the study was okay in regards to comparisons of rates and so on. Just the methodologies, like in any

research, what you put in is what you get out, and I think in this case we had a situation of - excuse the example - garbage in, garbage out.

MR WALLACE: Just on that point, just for clarification, these numbers on table 3(1) after each state, is that the number of facilities that were - so there's only three in Tasmania?

MR VANDERSCHOOR: I think, Mr Commissioner, that was our overall concern about the table on page 17, that it's a very small sample relative to the whole regiment, and although other points that Mark has mentioned are relevant in relation to the quality of the La Trobe study the intention of using it I think was very valid in the Aged Care Australia submission but the sampling is just inadequate, we think.

MR STEMM: I refer to the point that I made before, commissioner, that there was no Queensland data supplied at all.

MR WOODS: Mr Wallace, to then go back to a comment you were making in relation to small size of facilities, and Mr Vanderschoor made some comments early on as well in relation to some degree of rationalisation emerging in the industry, could you elaborate on what you see as the trend occurring in Tasmania? I notice in your submissions that you made reference to a 60-bed facility as almost being at the small side of efficient, which I would be interested in getting your comments on.

MR WALLACE: Yes, I can clarify that.

MR WOODS: Please comment.

MR WALLACE: The 60-bed facility, I certainly didn't mean to imply that it was in the words that you used there. I think the comment related to the fact that if you look at the diseconomies of the cost curve reflecting economies of scale the curve starts the level off at 60 but if you go further, 70, 80, 90 and 100-bed homes still achieve some economies of scale. So the 60 wasn't actually intended to be - I mean obviously the costs of running homes of 10, 20 and 30 are much greater than the costs of running a 60-bed home. The comment was intended to simply point out that 60 seems to be where you're getting to the stage where you've got it towards optimum efficiency but it's not optimum efficiency because the cost curve continues to go down after 60. So that was purely the context in which that was made.

MR WOODS: The question is to the rate of reduction of that cost curve, I think you were saying, flattening.

MR WALLACE: After 60 it's very small, yes.

MR WOODS: I notice interestingly in your submission, your first submission itself, you drew on needing population centres of at least 20,000 to provide a minimum catchment but then one turns to page 13 and you find that that is to be able to establish and operate an 80-bed home.

MR WALLACE: That's right.

MR WOODS: Is that sort of picking up something a bit further along the cost curve than we need to?

MR WALLACE: No.

MR WOODS: And if you were looking at a 60-bed home or something near that would the population centres be a bit less than 20,000 perhaps?

MR WALLACE: Perhaps they would be but it doesn't make a great deal of difference to the analysis of the way it was done, but I used 80 because that's where the cost curve does actually level out. It doesn't level out at 60, so that's why 80 was used, but I don't think it influences the analysis because the analysis is a continuum. So it's just a point of reference that the 20,000 is the catchment you need for an 80-bed home effectively.

MR WOODS: It just allowed you to conclude that about 50 per cent of Tasmania's live-in centres are less than 20,000?

MR WALLACE: That's right.

MR WOODS: Presumably it's a different percentage if you chose a smaller bed size?

MR WALLACE: Again what we're trying to do is represent the Tasmanian situation, of how different it is from the population pattern in the other states.

MR WOODS: I did get that from the submission. If we could then go back to the trends as you see them occurring.

MR WALLACE: Sorry, you asked a question before this one. I can't quite remember what it was. It was elaborating on the rationalisations.

MR WOODS: Yes, what is happening in the industry. To what extent will there be progressive rationalisation and the evolution of larger facilities and whether they're co-located or whether it's co-management but of several sites. I mean there are a number of opportunities that don't just require pulling down what's there and rebuilding something bigger.

MR WALLACE: This might be something I can pass on to Andrew or Mark.

MR WOODS: Yes.

MR WALLACE: I would just make one comment though. I personally have done a lot of work on administrative level amalgamations in other studies versus physical

amalgamations. The administrative level amalgamations do not generate much return in terms of efficiencies. Physical amalgamations have the potential to generate significant returns over a long period of time. The comment I made previously that you wanted me to elaborate on was essentially that what is happening in Tasmania - and just driving around Hobart you'll see it - is that where facilities, whatever they are, are closed down there isn't an alternative use

So we are talking about physical level amalgamations. There is no alternative use. They don't have a value in the market, they just empty. They're empty schools; they're empty whatever they are, nursing homes. Then there is a very significant cost, capital cost, associated with - and we've got high occupancy rates in the industry so you've effectively got to move all those 20 beds to another physical location, and that is a significant capital cost in augmenting that other location. So I suppose my point is that it takes quite a long time before the recurrent cost savings, before total cost, actually reduce because of the high capital cost in any adjustment. Now, I think it probably is best to pass on to Andrew about what's actually happening in the industry.

MR VANDERSCHOOR: I just wanted to illustrate, Mr Commissioner, the occurrences in the last few years which may give us a setting, some context. In the last 7 years there have been, to my knowledge, seven nursing homes closed in the state and the respective bed numbers were eight, 23, 10, 25, 23, eight - I think that's the sixth number - 51, and a number which I can't recall. So out of the eight six were very small in number, which gives some context, and they were primarily closed on economic grounds and the one of 51 beds was closed on quality of service grounds effectively. So that's an interesting scene for context. There are about 70 to 80 facilities in the state and the very smallest ones, as you can see, are dropping out. There's another one of six and another one of 17.

MR WOODS: Thank you for the extensive information we have on all of that in your submissions.

MR VANDERSCHOOR: So in fact as I'm talking it's rising to eight or nine and it's all the small ones excepting one in terms of quality. None of those beds have been lost. They have all been taken up by other providers but there remain in the state, and we've provided statistics, a large number of small number providers and of the eight or nine that I've just mentioned four of those were in Hobart environs of 23, 10, 25 and eight beds and six and 17 beds. So you can see a number of the smaller ones are dropping out, and that was prior to this particular set of reforms. So it's interesting that in a relative free-funding situation this amount of movement has occurred in a regiment of 70 to 80 facilities. So once we get into a more structured regiment, if you like, and we move into an accreditation of services we're likely to see more of this occurring - one might assume that more of this will be occurring.

As Mark has been illustrating economies would probably only offer for those facilities which take on beds becoming available in this way by having large numbers of units of activity on single sites, and that's of course partly due to the very high

labour intensiveness of the industry. So that's the setting of the past 7 years in a relatively freely-funded industry.

MR STEMM: However, Mr Commissioner, you'll notice that most of those occurred in Hobart. In other regional centres throughout Tasmania there are currently impediments in amalgamation mainly because of the extra returns that are available in the industry. I'm aware of one nursing home in a regional area of 24 beds which has been up for sale for 6 years and unable to sell its beds to any of the local providers simply because the amount they're asking for the beds they're simply not capable of paying that amount of money and actually providing a service. What I would suggest to you that the Commonwealth has done in regard to nursing home subsidies - I'm sure I'll bring a smile to your face - is that they have produced a low-cost delivery of care, that they have effectively left very little margins for nursing home operators to work on which means that they probably have achieved a funding which is as close to a cost base as possible.

MR WOODS: It causes me neither to smile nor scowl. I just note the information. At this point in time are there other issues you wish to raise in relation to Aged Care Tasmania or is it an opportune time to look at the alternative methodology that was proposed in the submission from Mount St Vincent Manor Home?

MR STEMM: If it's okay with you, commissioner, there's a couple of other points we would like to make, if that's possible?

MR WOODS: Yes.

MR STEMM: One of the issues which we saw in your report was a movement towards a viability supplement or payment.

MR WOODS: Yes, special needs.

MR STEMM: Special needs, and this just goes back to my last comment in regards to the viability of homes. You put in there that perhaps this supplement would be looking at rural remote - whatever.

MR WOODS: Indeed.

MR STEMM: What would you see as being a definition for rural remote?

MR WOODS: Clearly the commission in the period that it has available to it is not going to pretend to provide the definitive answer. That's a matter for industry and government to resolve the detail, which is appropriate. The basis for that preliminary proposal is recognising that in a move to a national uniform basic subsidy there are centres and locations who have - and again it's a question of judgment - a significant cost pressure beyond which it is not reasonable for them to come to a national uniform basic subsidy. Some of that relates to the sort of structural issues that you've referred to in your submissions, whether it be transport costs, whether it be the costs

of the flexibility inherent in the local labour markets and the degree to which you need to bring staff in from other centres to provides support and the like, and it can relate to costs of servicing equipment, etcetera.

Some of it however in some of the rural and remote areas relates to the level of care in a whole-of-life context that is required to be provided; that in those centre facilities have no discretion as to who they take. They are the resource for the community and therefore those who are in need are serviced by those facilities, and that's appropriate, but it does mean that they can't align their resident mix with their labour force in the same way that, in a large metropolitan area for instance, some facilities may wish to do. It does mean that the level of support by family in many instances is a lot less.

If there is no family present or if the family that there is is in a community that is some 5 or 7 hundred kilometres away and can therefore visit only infrequently or in fact you do reverse care of respite care of sending the residents back to their community for short periods of time, it relates to simply things such as there being no external person to the home who can buy the little amenities of life or look after the finances or arrange visits that they place inordinate burdens on the staff at the facilities. The facilities that we've visited where that has occurred, they cope magnificently, but the stresses and strains are enormous. That needs to be recognised.

The viability supplement - there was considerable consideration by industry and government in the development of it. The question is has it been allowed to go far enough? In the view of the commission the answer is, no, it hasn't and that there is a significant need in those areas to address that particular type of issue. So it goes significantly beyond the structural transport cost of goods and services to looking at the costs incurred by those centres in providing a whole-of-life experience for those people with very little additional support in very trying circumstances and they can be anything from climatic to cultural.

MR STEMM: Can I then ask you perhaps as to whether you see that viability supplement as being part of the quantum question or not?

MR WOODS: Given that the terms of reference of this inquiry don't address quantum, I feel compelled to put forward recommendations in relation to the need for additional support for special needs as part of this inquiry and we will be putting that to government for them to address.

MR WALLACE: Mr Woods, just for clarification on something you said - actually I was very encouraged, as I said in the opening remarks, about the acknowledgment by the commission of the issues around this particular question - would you also see the viability supplement as looking at issues of optimisation of resource use where, effectively to ensure the quality of access and the quality of care, there's an intrinsic need to have smaller nursing homes in rural areas and therefore they can't achieve the same benchmark levels of efficiency in say big homes?

MR WOODS: Undoubtedly that's one of the consequences that in small population areas, although geographically they may be very large - well, not so large -but they won't sustain a 60-bed facility quite evidently and that there are economies or diseconomies or scale in providing a very necessary facility for that community.

MR WALLACE: One particular aspect we raised in our submission was that one of the problems that occurs in Tasmania, and presumably in other areas, in regional rural areas, is that there is really little scope for getting cost reductions through use of services which are contracted in. That's simply because in many population centres in Tasmania there isn't a private market or it's a very thin private market. There might be one supplier. Say for example you can't contract any of the cook-chill sort of arrangements and whatever - and I don't think anywhere in Tasmania - so presumably again this sort of viability supplement would consider those sorts of characteristics or rural and regional areas or remote areas.

MR WOODS: They would be one element of the mix but I would have thought that they were getting to the smaller end of the spectrum but it doesn't deny their existence.

MR STEMM: Just a couple of more questions, if I may, commissioner.

MR WOODS: Indeed.

MR STEMM: You make a point in your study that the use of best practice inputs would be appropriate. I guess my question is how would you go about balancing the use of the best practice input so that it makes sure we don't end up with lowest cost is equal to best practice and we maintain quality and care? Page 42.

MR WOODS: Yes, I'm looking more at your comments on that. In fact, I considered that you had quoted the report and that comment out of context, which I was rather surprised at that being the case. Yes, "The use of best practice inputs would be appropriate" is the quote you make. Then you respond to it but in fact it caused me to reread pages 42 and 43 with some interest. As I had thought when I read them, you seem to have stopped the sentence halfway through. If I can read the rest of the transcript:

> If the sole objective was to improve the efficiency of service delivery -

which strikes me as an important qualification to the first half of the sentence - the position paper then goes on to talk about:

> Basing subsidies on average costs would reduce pressure on less efficient operators to include their performance and would provide windfall gains -

which is true. Then we go on in the paper to say:

> However, too much short-term emphasis on efficiency could put some residents at risk -

and then continues the debate and on page 43 says:

> On balance the commission sees subsidies based on the average cost for providing the benchmark level of carers and appropriate compromise between encouraging efficient delivery and safeguarding the welfare of residents.

That strikes me as a reasonable and balanced approach to the particular issue and I wasn't quite sure as to why half of a sentence would be quoted, given the views that we come to.

MR STEMM: I apologise I took it out of context but I guess the point I was making was how you arrive at that average cost and, what method you arrive at your benchmarking level, in fact will determine whether best practice is equal to large costs. You make suggestions about benchmarking and the appropriate level of care but I mean the actual methodology we go about in arriving at that is we see as being probably one of the most important parts or the next part that comes out of the commission's report.

MR WOODS: Absolutely, and that would be acknowledged by all, including the commission. When you look at our preliminary proposal 3 it talks about basic subsidy rate linked to the cost of providing the benchmark level of care, and we look forward to submissions and comment from relevant parties on whether the accreditation and certification process is sufficiently robust to base that particular component on an efficient-sized facility, and we've explored cost curves and talked about various sized facilities using an average input mix. That average input mix relates directly to the comment on page 43 where we're not talking about the use of best practice. We're talking about achieving an appropriate balance between best practice and what occurs throughout the industry in general so that it doesn't cause undue disruption.

If you take the average, which is what we are putting forward in our preliminary proposal, for a profile of input mix, then what that does is reward those who achieve better than that and they retain that surplus and either convert that into additional care or surplus for distribution or whatever it is that the individual providers wish to use it for. If you don't achieve the average, then you have cost pressures that you need to address and to look at your management performance and see what you can do to achieve that. So that's why we've pursued the concept of the average rather than assuming that all industry can move immediately to best practice. We think that would be an untenable situation which would cause disruption.

MR STEMM: I am pleased with the answer.

MR WOODS: I thought it was evident in pages 42 and 43.

MR STEMM: I just want to move on to the next point which is in fact that's where the industry has just come from. Industry since 1987 has been working on a cost basis for CAM and SAM, and CAM in fact did reward those who were able to contain their costs and they had an X percentage above their cost for that paid whereas if you spent more than what your CAM money allowed you, then there were cost pressures for you to bring that back down again.

MR WOODS: We acknowledge the past design features of CAM, SAM and OCRE. What this subsidy arrangement would achieve is a degree of managerial autonomy in the particular resource mix that can be brought to bear by individual proprietors, and I think that's an important feature to allow that degree of flexibility. It provides an incentive to perform at least as well as if not better than the average. Also importantly it creates a distinction between a direct reimbursement for actual costs which doesn't have an incentive mechanism in it but allows instead for the government to derive a price for an output, the output being an RCS level of care of one to four, but the price that the government is willing to pay proprietors is transparently related to the costs that the industry is incurring. So that by not moving to a direct reimbursement, we think there are significant improvements in the design features of the subsidy arrangement and that, by moving to an output price with transparency by having regard to the input costs, that enhances accountability throughout.

MR STEMM: Okay, I guess my final question on that might be would that be done across jurisdictions or within jurisdictions?

MR WOODS: We're proposing by moving progressively to a national uniform basic subsidy that the sampling would recognise the costs in all jurisdictions. At the moment if you are in Tasmania, it doesn't matter where you are located, whether it be Hobart or in some small community town, if you are not eligible for the viability supplement you get the one RCS subsidy level. This would recognise similarly that across jurisdictions you would have ultimately that one level, except for the special needs pool which we think deserves expansion and reconsideration.

MR STEMM: I guess it sort of raises a point that we make here in Tasmania that if you were to take an average across all jurisdictions as opposed to within jurisdictions, it may well disadvantage us to a significant degree.

MR WOODS: We recognise that being the thrust of your submission, yes. Are there other matters that you - - -

MR STEMM: No, I think that has concluded on a fairly relevant point.

MR WOODS: Did you wish to then pursue - - -

MR STEMM: Yes, just very briefly, Mount St Vincents and - - -

MR WOODS: Manor Homes.

MR STEMM: The Manor Homes put forward a submission to effectively dispense with the RCS to create a funding pool which would be on the basis of a benchmarking model. We suggest this for two reasons. One is that the review process which has occurred in October last year has changed the focus of our nursing homes from care to a focus on funding and working the numbers, so that there has been great effort in the last 12 months for our providers to make sure that they get the right level of RCS funding for particular residents. I think that has been at a detriment to their actual level of care because there's a great emphasis on administration and paperwork to work the system, so to speak, as opposed to actually providing the level of care that is required. This is not to say that the level of care is diminished but it certainly means - and you ask any of the providers this - the providers are simply working harder now than what they were before because they must squeeze the same amount of juice out of lemons than as they did before. The suggestion by Mount St Vincent on the matter was to say, "Well, we understand the funding constraints, we understand that government must fund care at an appropriate rate but why go to the micro level and why not do it on a macro level, which can be validated during a new accreditation process, and take away the focus in regards to continually working the system as opposed to knowing what your funding will be over the next 3, 4 or 5 years, and actually providing the best level of care and actually cut the costs in administration rather than increasing them as the current system does?"

MR WOODS: I must say I found the submission very interesting. I say that in a positive sense. But if I could pursue just a couple of points - and I thank those who have done the thinking behind this. One area of a little concern is that a benefit put forward is reduced administrative paperwork, and that is to be applauded wherever it can effectively be achieved. However, you then talk about the need for some form of verification that there hasn't been a significant change in the profile of residents over that period; getting an average subsidy but then avoiding the costs of certain residents in that process. I am a little concerned in that wouldn't that of itself still keep the need for the paperwork, it's just that you don't have to put it in as often?

MR STEMM: No, because there's a basic understanding as to how the paperwork system currently works. In nursing, particularly the high-care area, the nurses are required to keep nursing notes and then they are required to use care plans for each of their residents. They then transcribe these care plans into another document which is then used for the RCS. I mean it's not just duplication, it's about triplication and quadruplication. The point is that the care plans are required as a matter of managing the residents' needs, and I think that they should be used as a basis for verification in regards to care needs of residents as opposed to some statistical method which has been worked out on an average and doesn't really apply to anybody because of the fact that they work within ranges.

So the argument there would be that it would cut down the level of paperwork that the nursing staff were required to do but they would have still have to have the very basis to be able to verify the level of care that they're giving different residents. Currently the validation officers review not only the work-sheets that go into the RCS

but also review nursing notes and also review the care plans. So that work is already being done by the Commonwealth currently.

MR WOODS: Yes, it has certain design features that are positive but I'm a little concerned that they're not quite as large as on first inspection they may appear. The second, which was again an attractive proposition, is then the separation of what constitutes the costs of providing care needs for residents and the costs of operating a facility - and other jurisdictions have given a significant thought to that as well - again is a proposition that has some attraction to it. But again, at the practical level, my concern is how do you divorce the provision of food, which is a hotel service, from feeding a resident, which is a personal care service? In practical terms, are the hotel and care functions so interlinked at the interface that something that has an attraction in principle may not work well in practice?

MR STEMM: Up to a point, and when I refer to the operating of a home I talk more of the business and management side than necessarily the sort of micro kitchen or domestic duties. The people who live in our homes - it is actually their home and those people who work in kitchen on domestic duties actually form relationships and friendships with the residents and so on. I would see that as being part of caring because they invariably deliver the food to them, talk to them and so on, not necessarily feeding them, as opposed to actually running a business, making sure that budgets are produced, making sure that the operation is run within budget and so on.

MR WOODS: So your differentiation is a little different from some other material that we've had put to us which tries a slightly different separation.

MR STEMM: Yes.

MR WOODS: Thank you for that clarification. Is this a paper that is intended to be developed further in the industry generally? Clearly some of these issues will be outside of the time-frame of our particular inquiry.

MR STEMM: I have had extensive talks with you and Lindsay Smith about the concept and he's of the thought that eventually one day our funding will eventually arrive at a macro level rather than at a micro level, but to get to that we need to go through the process to make sure that we are funding at the correct level, now micro, so when we move to a macro at least there's some benchmark for us to work from. Yes, we would hope to develop that. It's up to my colleagues in Aged Care Tasmania and Aged Care Australia as to whether we deliver. But I think if we're going to move to a model of care then we have to reduce the amount of non-care time that is allocated.

MR WOODS: Perhaps if I can comment at this point that my report will discharge the terms of reference that the treasurer has given to me, and that relates to an appropriate funding methodology, but in the course of this inquiry we have been fortunate in being provided with a range of thoughts and issues that extend beyond our narrow terms of reference, and I include this submission in that category, and I

look forward to being able to provide a little air space in our report at the back in that it opens up some perspective that I consider warrants further investigation. So not only in that particular case but for all of those others who have broadened the perspective and shared it with us, thank you, and we will respect that and deliver appropriately. Thank you very much for your time. I propose a short adjournment and then we will recommence with our second set of witnesses. Thank you.

MR WOODS: Thank you, ladies and gentlemen. If I could resume the Productivity Commission inquiry public hearing as it relates to nursing home subsidies and welcome Mr Michael Keats and Mr Bruce Craike: if you would like to give your names and positions for the record, please, gentlemen.

MR KEATS: Thank you, commissioner. Michael Keats, chief executive officer of the National Association of Nursing Homes an Private Hospitals.

MR CRAIKE: Bruce Craike, a national board member of the national association and also a chief executive officer of Nursing Home Consulting and Management.

MR WOODS: Thank you very much. Would you like to make an opening statement?

MR KEATS: Thank you, commissioner. First of all, the document which we forwarded you on 11 November - there are two small corrections, if I could take you to those, if you wouldn't mind? On page 2, item 3, that sentence should have read, "Our interpretation of this commentary is therefore based on what we understand the concepts to be" and, on page 5, paragraph 3, the end of line 1, it should make a reference to the "ABS".

MR WOODS: Yes, fine.

MR KEATS: Apart from those minor issues - - -

MR WOODS: Yes.

MR KEATS: Just sort of highlighting the major points from our commentary, I would like to talk a little about workers compensation and payroll tax and, in terms of the key issues, the association would argue that both of these items should be reimbursed in full. We don't believe there is any case to deny the reality that these costs are incurred and we believe that the basic subsidy should recognise that these payments should be reimbursed. On funding we argue strongly that funding must be sufficient for all providers to meet the costs of certification and accreditation and provide the services necessary to deliver care to concessional residents and we also make the point, I think, in the submission that we don't believe that the productivity index when it is formulated for nursing homes, or for aged care facilities, should be a discount. It should rather be, if anything, a plus and should provide more resources to enable providers to do a better job and therefore deliver better service.

MR WOODS: We will be addressing that.

MR KEATS: I'm sure. On the indexation question we believe that indexation is perhaps fundamental to the whole of the inquiry into nursing home subsidies. It is one thing to have a basic daily fee rate but it is another to make sure that that fee rate actually moves in line with the real costs which are incurred in wage movements,

continuous improvement as required by the Aged Care Standards Agency and also to provide a realistic return on investment.

Finally in respect to opening comments I would like to make a comment regarding the rebalancing proposal. We are also cognisant on the terms of reference that you have, which is no more quantum money to play with, but we believe that the rebalancing proposal as it currently stands is unacceptable and we would point out the very existence of rural and remote homes was a social policy initiative of former governments and, if the current government wishes to sustain those facilities and we certainly support the sustaining of those facilities, then it shouldn't be done at the cost of diminishing the financial viability of other facilities in urban areas. We are happy to address any other points after my colleague has made some statements.

MR WOODS: Thank you.

MR CRAIKE: A couple of issues that were elaborated on before with regards to workers compensation: obviously, the past funding system up until October addressed with a degree of transparency with regard to the problems of nursing homes and the current system now provides basically a significant penalty - mainly because nearly all the states, as alluded to previously, are now moving to an experience-based system and invariably a no-fault system in terms of employee claims.

I think the figures also quoted in terms of rates are somewhat anomalous with regard to the fact that it is very difficult to get in fact from each state the actual experience-based rates for the nursing home industry because of problems of how employers are grouped and certainly there is work under way through the Department of Health and Aged Care to try and identify more closely the actual claims experience rates, but certainly, as quoted there, the figure of Victoria 3.95 per cent as being low; in fact it is probably significantly higher than that because it is not necessarily a function of the work environment or the unnecessarily unacceptable work practices but merely a function of a no-fault system where the typical age of employees in the industry, and being predominantly female and, historically, degenerative diseases, unfortunately, compounds an employer at the wrong particular time of their working career.

In terms of another issue just in relation to the economic size or efficiency, certainly there has been a significant move to aggregation in a number of states. From an industry perspective I guess we see that the Commonwealth should be facilitating a process where that is not only based on simply high care but access to also a range of services for all providers in terms of hostel care and also community aged care packages under the funding regime because one has to look at the basic issue that a facility really has a fixed sale price; it really has very few mechanisms to improve its income, as such, and in fact invariably its costs of sales have a number of variables that can be influenced from outside of the control of the facility and therefore it is fairly important that that issue be addressed in terms of providing an appropriate resource base for a facility to operate. That's it for the moment.

MR WOODS: Thank you, gentlemen. We might as well pick up workers compensation, front-up, given that it seems to be generating some interest. If you look a the three types of costs that fall into that category - payroll tax, superannuation and workers compensation - superannuation is now on its national basis and hasn't generated any debate; payroll tax is non-discretionary other than to the extent of debating the payroll component of outsourced activity but, other than that particular issue, it is an area that the commission has proposed - there are different rates and jurisdictions; it is easily isolatable; it is a matter of legislation as to what is the rate that applies, is calculable and can be reimbursed as such. It is that question of it being non-discretionary that I think separates it to some extent from workers compensation.

The premium that is paid relates to a number of factors and having run a significant organisation myself in previous times I am very conscious of this, together with the submissions that have been put forward to the commission on this occasion, but it relates in large part to the design of the scheme in the relevant jurisdiction and how that scheme is then administered and what industry groups this industry is grouped with and how the claims experiences are pulled across facilities and what period premiums are adjusted to recoup claims experiences, etcetera, but it does, in part, undeniably relate to the performance of the facility itself in terms of the occ health and safety in relation to the workforce.

Some events will occur despite best practice but best practice can prevent some events from occurring, and it is that aspect, together with then a question of judgment on the significance of that issue in the totality of funding costs that at this stage hasn't persuaded me to identify it separately; in part, because of the signal that it may inadvertently send - and this isn't reflecting on management of any particular facility, but it would add to that view that whatever the cost it will be picked up. How do you address the question of incentive motivation, other than the underlying one of wanting your workforce to operate in the best practice in occ health and safety generally, but have you addressed that if you also just directly reimburse workers comp?

MR KEATS: If I could have first bite?

MR WOODS: Yes.

MR KEATS: The question of incentive, I suppose, could be measured to the degree with which the employer invests in occupational health and safety as an issue in terms of proportion of the payroll or a proportion of the premium paid in workers compensation. I mean, I have a case of a member who operates five rather large facilities and they invest the equivalent amount into occupational health and safety that they pay in workers compensation premiums, which I think is very laudable. They have recently unfortunately had a case which has added a million dollars per annum to their workers compensation premium for a period of 3 years and that has really put the organisation in an invidious financial position and I would regard this particular member as being a very responsible employer doing everything possible to make sure that occupational health and safety featured very strongly as part of their philosophy. I don't know that I have an answer but it would seem unfair that they are

going to pay a penalty for 3 years which is going to adversely affect their financial performance.

MR WOODS: I can understand the circumstances for that particular provider but are there not cases on the other side, as well, where less attention is given to occ health and safety and just straight reimbursement may not add to their incentive levels to improve their performance?

MR KEATS: Yes, well, perhaps the compromise is a safety net of some kind and of course being multi-jurisdictional, as you have already identified, that is probably not as easy to achieve as just saying the words.

MR CRAIKE: I think that certainly the safety net concept was explored through the Gregory deal and was part of the funding process - whether it was totally transparent and recognised all the factors involved in workers compensation claims is another matter, but certainly it was probably the best approach in terms of providing an incentive to employers with regards to OH and S and, at the same time, simply not providing no incentives or giving no incentive and sit back and take a best - not best practice, but adopt simply a no-go position with regards to occupational health and safety and have a poor claim record, so I think, yes, a safety net approach is in part giving the appropriate level incentive, as long as again the mechanism is transparent. I think all the states are also moving essentially to experience-based systems simply because, historically, there is no way known they can avoid the problems of cost blow-out so whether, long term, that means that there is a national system of workers compensation - - -

MR WOODS: By evolution rather than by revolution.

MR CRAIKE: Yes.

MR WOODS: There are certainly trends but that is a matter for the sovereign states, as they say.

MR CRAIKE: I think the Victorian example highlights it, although there was a significant reduction in overall costs and the controlling of the blow-outs that very quickly reversed itself with regard to the legal costs impinging on the system; it has gone quickly back into a deficit again.

MR WOODS: Your submission doesn't explore what a safety net might look like. You argue for the reimbursement proposal but if you were to give some thought, would it be largely along the lines of that material already dealt with in Gregory or - - -

MR KEATS: It would be largely along those lines but I think it would be more accessible than it is at the present time.

MR WOODS: Perhaps another one that we can deal with fairly early on is the question of a productivity discount factor which you raised and I indicated some desire to debate. I have read your submission and reread that particular set of paragraphs where you argue for a productivity increment incentive, and say:

> What incentives would such an arrangement have for providers if they were going to get less assistance by being more efficient?

I guess the fundamental design feature is: who should share in productivity? There is the question of what are the incentives to generate productivity and then who should share in that which occurs, and it seems to me there are probably three broad groups who would lay claim to some of that. One would be to the facility providers as the management component, one would be to the staff who are putting the productivity into practice, and one would be to the taxpayer who is funding a large part, the majority part, of the cost of the care.

It strikes me that if you were looking at features that distributed some of the productivity across those three sectors in various ways, none of them lead to the taxpayer actually paying an increment for the productivity being achieved. Do you have any further elaboration on that point?

MR KEATS: I'd perhaps like to go back a step before we come to that point, and talk about the capacity of the industry for productivity. If we look at the acute care sector as our example, I'd suggest that the opportunity for the acute care sector, particularly that which is run by state governments - the opportunity for technology substitution for labour is much greater than it is in aged care. Given the funding regime that the aged care industry is bound by, the opportunities for major capital investment in technology are also limited, so the opportunities for productivity gains I think are minimal. At the same time, we've already had the presentation earlier today that talked about the fact that we are a follower when it comes to the wages component, and I think we've got those two factors working against us in terms of achieving productivity.

Now, I don't know the architecture of the proposed index probably any more than you do, but I'm concerned that we may end up with some hypotheticals which don't really reflect what's going on in the industry. I'd love to see us be in a situation where we could substitute some of our labour with technology. I'd like to see some of the experimental work that's being done with RCS and documentation being done directly into electronic means being downloaded and sent straight to Canberra and funding following immediately. There are opportunities there for removing a lot of paperwork and a lot of duplication. I can see then there's an argument for productivity, but until the industry can afford that sort of investment then I think we have a problem, and that, I suppose, then leads us on to talking about such things as optimum size and efficiency of units and all the rest of it.

MR WOODS: Which I would like to explore in a minute.

MR KEATS: Yes. But I think they're very closely related. I don't have a problem with talking about sharing the benefits three ways from productivity increases. I just don't think, the way I read the proposal - that it's all coming from the provider and it's not being shared with the staff and the taxpayer. I would think if we're going to have a three-way equity split, we ought to have it.

MR WOODS: I'm not recommending what the proportions would be. I just note that there are three interested parties in benefiting from the productivity, but I don't recall having written anything that would preclude the productivity benefits from not - being distributed amongst the parties.

MR CRAIKE: There's a couple of points there. Obviously the introduction of SAM funding in 1987 gave a fairly significant catalyst to productivity gains if they were available, so on an historical basis that's in part already happened.

MR WOODS: We have had a number of submissions put to us that the SAM funding structure did take out a lot of the productivity component, or forced it to occur.

MR CRAIKE: And when one looks at - as was touched on earlier by Aged Care Tasmania and your questions with regard to wage rates - most of the issues - and the example highlighted in the commission's report with regard to Tricare tends to highlight that they're not necessarily productivity based, the enterprise agreements, but in fact merely are conditions, which is likely to happen more so over a period of time with regard to differentials in states. In fact it appears to be the only area of negotiation per se with regard to any enterprise agreements with the various labour sectors.

MR WOODS: And Tricare will have an opportunity to respond to that on Monday in Brisbane, but it's certainly a matter that we should explore further and I welcome your views on that question. Again it's a matter of judgment, but there do seem to be differences in operational and ultimately financial performance between facilities, some of which presumably relates to the management of anything from the devising of rosters, to the training of staff, to the reduction of staff turnover. There are a whole range of areas where some managers, in what appear to be reasonably similar facilities to others, achieve a greater level of care and a better financial performance. Presumably some of that relates to productivity in that facility. So I, having observed those differences, have to question whether there is no further scope for productivity across the industry generally. My view at this stage is that some operators have demonstrated that there is scope for improvement.

MR KEATS: Given that very statement, is it appropriate and correct that, having achieved productivity increases, then it should be applied to funding in a negative way?

MR WOODS: In what sense?

MR KEATS: Well, if you've achieved a better outcome both in terms of care and also your financial result as a result of your productivity, surely that should be a gain which is passed on to the people responsible for its performance.

MR WOODS: Under a uniform national basic subsidy, those who are in that position would generate a surplus which can be either distributed or reinvested, and so in fact are the beneficiaries of that process. This design of a subsidy in fact rewards them, whereas a straight reimbursement of costs would track them down that productivity curve and keep taking away from them as they followed it down. So I see this meeting your point exactly - that those who are achieving productivity greater than the average are receiving the benefits.

MR CRAIKE: I guess that in part comes back to what was being discussed earlier this morning, which is the overall quantum of funding and therefore where the benchmarking or averaging term comes into play, as to how low that is particularly set.

MR WOODS: Let's differentiate. In our proposal we use "benchmark" in the sense of the quality of care and talk about the average input mix, so we attribute the phrasing "benchmark" to accreditation and certification, and then for the cost side we debated quite long and hard within the team and looked at the submissions and were ultimately of the view, as I was talking to the previous witnesses on, that an average met the right balance, whereas if you strike the subsidy at best practice then by definition all but the best practice will be significantly disadvantaged, which will then have other ramifications back through the industry as well. So I think we've addressed that by taking the average cost.

It would also be our hope and expectation that over time that average would decline. If you revisit the average costs over time, those who were incurring costs above the average would need to improve their performance to get their financial house in order, and there is still incentive for those who are doing better than average to keep pursuing that course because they keep generating the surpluses. So one would hope that over time that average would therefore decline, and we think there are enough incentives in that structure of subsidy to achieve that outcome.

MR KEATS: Commissioner, does that apply across places of different size - I mean if you look at a place with 20 places as opposed to a place of 80 places?

MR WOODS: Two points on that. One is that it then gets re-translated back at your RCS levels by your actual number of residents, so that determines your ultimate absolute funding that you receive in the year. But the other question fundamentally is why is it a place of 20 residents. If it's in a rural and remote area that warrants a small facility to meet a community demand that can't be otherwise met, that speaks for itself. If it's the choice of a provider in a metropolitan area who considers, weighing up all things, that they can operate a 20-bed facility efficiently then it's entirely their choice. If the economies of the subsidy show that's very difficult then, by doing this,

you would expect further rationalisation in the industry in those circumstances. But all that's doing is having the subsidy support a trend, not create a trend.

MR KEATS: So for those smaller facilities in urban areas we can expect structural adjustment to occur fairly rapidly once this new funding regime becomes operational?

MR WOODS: Structural adjustment has been occurring fairly rapidly.

MR KEATS: Yes, I realise that, but it's going to accelerate.

MR WOODS: I don't think we're adding to it, but what we're doing is having a subsidy that recognises that's an ongoing process and supports it. But it hasn't created it. That's been occurring for some time now. The figures are quite significant, particularly in some jurisdictions. We've heard about Tasmania today and there was also reference to Victoria.

If I can then pick up a point in your submission where you talk about partial deregulation of the industry encouraged by allowing providers who achieve accreditation to charge a single-ward supplement up to $12 a day. From my recollection of your submission it was two-part, $6 a day for those who have a single ward but shared facility and $12 for single-ward owned facility.

A couple of questions that I'd like to explore there. One is, does this constitute in itself a broadening of the concept of extra service, and why $6 and $12? But can we discuss the extra service side of it first?

MR KEATS: Yes, I'm aware, as I'm sure the commission is, that the take-up of extra service places has not been in line with the government expectations. I think it's running at about 3 per cent and I think the target was about 12.

MR WOODS: Our latest understanding is 1½ nationally.

MR KEATS: One and a half. That's even worse. I guess I was looking at the opportunity there for providers who had met their targets and in fact exceeded their targets for concessional residents to have the opportunity to access additional resources to expand what they offer and I take your point, it probably is a variation on the extra services concept but opening it up a little more without the constraints that the extra service places currently have.

MR WOODS: What reaction would you expect that would have amongst the various stakeholders to such a proposal?

MR KEATS: I think providing the concessional resident ratios were exceeded, or at least met, and that there was no unmet demand for those places it, in my mind, would represent opening up the market to greater choice and for consumers to be able to elect the quality of care that they wanted given their capacity to pay.

MR WOODS: Do you have any comment on that as an operator?

MR CRAIKE: Yes, certainly in the extra service field there is a bit of a paradox with regard to a demand for essentially what can be concessional residents to occupy extra service facilities as long as the fee is affordable. So it's in fact, if you like, a dichotomy that's occurring where those extra service facilities are moving towards certification, which may well under the criteria mean only single or two-bed room accommodation - be in fact forcing out access to people who are willing to physically pay to a certain degree but not exceeds the limit that a single or two-bed room configuration is going to place on them in terms of charges. So it's quite common to see virtually what would be defined as a concessional resident on a pension-only income, where their family is paying a small amount, up to about $10 a day extra, that they can afford, but obviously can't afford to move into a single or two-bed room.

MR WOODS: The frailty of residents is increasing, the length of stay is decreasing. How does that sit with providing extra service? Is the fact that the take-up rate is so low nationally a reflection of what are seen to be the fundamental needs of people as they enter and reside in nursing homes?

MR KEATS: I think it's probably more a reflection of the lack of diversity in what's presently available. We've already got a number of facilities in several states which have less than full occupancy and I think it's because the diversity of ward size and amenity and so on is just not there.

MR CRAIKE: I think it's stepping away from the frailty of the residents. In fact their relatives make the admission decision and in some respects one could use the old terminology of Bob Ansett, a la the "quality price illusion", is part of a determinant with regards to placement and certainly that comes down to also the location of the facility. Not everyone can simply be an extra service operation because there is a limited market for it in terms of demand and willing to pay a certain price.

MR WOODS: This would be changing the nature of extra service from extra personal care and type of food and things into a structural issue. I mean I understand extra service requiring a separate wing and things now anyway, but presumably you would be proposing that you wouldn't need separate wings, etcetera. It's just that wherever there is a single ward in the facility and provided that you had met your concessional numbers that that could then be offered to somebody who was willing to pay this extra charge. Is that your proposal?

MR KEATS: We would see that also as prerequisites, being certification and accreditation, for 3 years.

MR WOODS: Absolutely, yes.

MR CRAIKE: I think there's also a blurring of the boundaries just simply in the process of accreditation and certification with the standard of facilities that's occurring, so a lot of the original applicants that were providing extra service places in

some respects are seeing the marketplace catch up to them in terms of standards of facilities, which means that a lot of them are electing to move away from that particular field because the cost structures to differentiate again are becoming somewhat prohibitive for certain operators.

MR WOODS: Would that carry with it the other attributes of extra service in terms of accommodation, bonds and the like, or is this a substitute for that? Could you go through your thinking for the $6 and $12 and what lies behind that?

MR KEATS: We would see it as being a combination exercise so that there would be the flexibility to charge accommodation bonds as well but at the discretion of the provider.

MR WOODS: So in that sense they would be classified as an extra service place?

MR KEATS: Yes, they would.

MR WOODS: Although that wasn't explicit in this submission.

MR KEATS: No.

MR WOODS: Why $6 and $12? What's the underlying financials that generate those figures?

MR KEATS: I have to confess they're figures that were provided by one of our providers suggesting that would be the sort of additional rate per day which would make it an attractive proposition.

MR WOODS: In terms of recouping the capital cost of having single wards constructed or the operating cost of the extra cleaning and supervision and other costs incurred in having single wards, or what?

MR CRAIKE: A combination of both..

MR KEATS: It's a combination.

MR WOODS: If there was additional information I would be entirely interested in seeing what underlies those cost estimates. Thank you. Quantum has been raised as a comment by yourselves in your introductory comments. Your submission of - we've got it down as 10 November, 10 or 11 November, talks about:

> The anomaly is that despite the inappropriateness or inadequacy of the funding package that currently prevails the industry is still enjoying a significant growth in capital investment for new facilities and bed licenses are transferring at a premium for providers who wish to aggregate licenses in order to build efficient facilities.

How do you explain that anomaly?

MR CRAIKE: I think in part it has been highlighted historically as while significant prices were being paid previously - even prior to the introduction of the new funding system - where simply the cost of adding on a few extra bed licenses to a building program has meant a more efficient operational base and therefore people have paid a fairly high premium, in the current environment it reflects that there is a time-line in terms of meeting accreditation by the year 2001 and obviously operators can't necessarily sit round and wait for approval in principle or planning processes to take place with regards to potentially getting additional beds. So they go into the marketplace, and obviously there is a limited number of approved places available to be purchased and hence one has seen a fairly rapid escalation in the asking price, and that's unfortunately corresponded with a fairly high paying price as well.

MR WOODS: Some figures that I recall in one of the submissions suggested that for a $90,000 bed that 10,000 of that was land, 25,000 of that would be the licence and, say, 55,000 would be the constructions costs. Is that a reasonable sort of profile?

MR CRAIKE: Not unrealistic at all.

MR WOODS: In which case then the licence is a very significant component of the total cost of putting up a bed. That doesn't strike a chord with an industry in a quantum crisis, in terms of subsidies, if the marketplace is prepared to pay those sorts of figures.

MR KEATS: I think there's also a positional aspect in respect to licence prices. The licences relate to particular geographic areas which are prescribed and if you want to rebuild or build a new facility in one of those areas then you need to acquire licences in that area, and I think that also is a factor in determining what prices licences change hands at.

MR WOODS: I understand that concept of a locational premium, however, where you've got large operators who are content to construct in a whole range of locations and are still doing so, then maybe that premium is less important in that context, as distinct from a single facility operator who for other reasons has a particular desire to be in that one location, but we are now seeing in the industry several operators who spread across a multitude of locations and therefore that may discount that particular component a little. You talk about, with the deregulation of extra service question, how a monitoring system would work in practice. It's something that the commission itself has given some thought to. Do you have any views on what would be an appropriate way of monitoring what's happening in the extra service field to ensure that those who are in need are getting the places first?

MR KEATS: I suppose the complaints mechanisms that the department have got in place and are evolving under Mr Valentine would probably provide mechanisms which

could then be verified by on-site visits or questioning people who feel affected, but I don't know that there is any other mechanism.

MR WOODS: I mean short of some form of returns being required and to what extent then you're adding significantly to administrative cost yet again - - -

MR KEATS: I think that's something we want to get away from. We don't want any more paperwork in the industry.

MR WOODS: I'm just also a little worried that the complaints mechanism has a bias in it, that there are many who don't feel that they can take part in that process easily and prefer not to, and whether that therefore discriminates against those who don't feel that that's an accessible and reasonable process.

MR KEATS: I would make a comment there that I think the residents who are coming forward today, and their families, are far more articulate and far more ready to criticise than they have been in the past and I think the fact that the department is looking at mediation as well as a complaints mechanism is indicative that, okay, this problem is not going away, and it also I think is very healthy, in that it provides this opportunity without any sort of punitive action being followed up.

MR WOODS: I understand your point. I still remain concerned though that there would be a sector who felt unwilling to use the complaints mechanism and they may be disadvantaged.

MR CRAIKE: I think we saw that the issue of monitoring equity of access and concessional resident ratios would be in part an appropriate mechanism but experience to date with the Commonwealth funding system and tracking of concessional resident ratios left us with a lot to be desired, so to speak.

MR WOODS: I know your point. Efficient sized facilities: from your perspective as operators - and there are no doubt many who operate facilities that aren't at 60 or so beds - what's the view of your organisation, that if we're to try and devise a subsidy that recognises a level of efficiency without pursuing it to its nth degree but picking a reasonable sized facility, and excluding the question of rural and remote, do you have a particular view on whether - choosing a 60-bed facility or not?

MR CRAIKE: I think there is, in general, a consensus - an access to economies of scale as the facility goes up in size, and that does taper off, and certainly I think most people look at 60 beds as sort of being a benchmark in that regard. Obviously there's a bit of a paradox there with regards to the service provision and a home-like environment. Consumer expectations are changing quite significantly, so there's a bit of dilemma in terms of service delivery. One obviously has to be innovative, etcetera, as a facility goes up in size. I guess there's also a view that the word "rural" - and one has to be careful in terms of how that is specifically applied because the viability funding was based on obviously ABS statistics, which of course crunches out 30-bed facilities in what were deemed to be provincial cities, and therein lies again a dilemma

where a facility that is providing a small size home-life environment that is meeting consumer expectations is in part discriminated against and potentially doesn't have any ability to co-locate or even sell off its beds, as the example that was given this morning.

They are under pressure obviously because they have a smaller pool of referral which does affect their occupancy. It also does affect their dependency levels because obviously a smaller pools means that they can't necessarily pick and choose with regards to a trade-off on occupancy. So ultimately in some respects that provider is operating in an environment which is far more restrictive in terms of their potential return.

MR WOODS: Through choice.

MR CRAIKE: Through choice in part, yes.

MR KEATS: I think there's also some opportunities here for some quite creative thinking. I mean operating a nursing home with 30 beds can still be economic if you've got another 30 or 40 community aged care packages because the critical mass of the total group of people you're dealing with is such that all your costs can be spread over a great number of clients, and I think we need to look laterally and think creatively about how we solve some of these problems.

MR WOODS: So this is looking at integrating a broader range of care?

MR KEATS: Yes, a much broader range of care, and I think there should be encouragement given in future subsidy structures which doesn't really discriminate between residential places and non-residential places. I think a lot of places at the present time, that are probably struggling with economies of scale or whatever they want to call it, would find that their problems could be solved if they were to think outside the square.

MR WOODS: So they may be a resource base for carers but who then provide care back out in the community or - - -

MR KEATS: You can think about meals, you can think about laundry, you can think about specialist services - podiatrists and all sorts of other people who are centrally based in the nursing home or the aged care facility but who have a much larger client group.

MR WOODS: There is some experimentation with that in terms of multipurpose.

MR KEATS: Yes.

MR WOODS: What's your assessment of those initiatives? Is that something that will expand over time?

MR KEATS: My only knowledge of multipurpose facilities is in rural and remote areas.

MR WOODS: Yes.

MR KEATS: I believe they have special needs and special funding. I think there's no reason why similar experiments couldn't be conducted in urban areas.

MR WOODS: Yes. Is that something that you would be interested in expanding on in the time available?

MR KEATS: Yes, certainly. The other concept that's probably worthy of mention is that I've got at least one member who is experimenting with the integration of straight hotel services in conjunction with nursing home and care services so that relatives can actually stay with the family for a period of time. This facility is coming on stream in Queensland in about 3 months' time and I think that will provide some very interesting data about how the community views the facility and how the community actually uses the facility. Rather than seeing it as something remote it's seen as something that's part of the community.

MR WOODS: So that the relations aren't living nearby. They come from some distance away.

MR KEATS: Yes.

MR WOODS: That the facility offers them a hotel function.

MR KEATS: Yes.

MR WOODS: Which relates in part to a conversation we had earlier this morning.

MR CRAIKE: There was a comment this morning with regard to physical aggregation as in aggregation facilities as to the individual benefits of the two approaches. Certainly we would see that aggregation by facilities rather than just physical aggregation still provides benefits obviously on a nursing resource administration base. There are still advantages and I guess it gets back in part to the response to the question you made over prices being paid with a diverse location of facilities. At the end of the day there is still the advantage of aggregation of total numbers irrespective of where they're located to give economies of scale.

MR WOODS: Multi-sight facility.

MR CRAIKE: Yes.

MR WOODS: Gentlemen, are there other matters that you want to canvass?

MR KEATS: The only area I'd like to make further comment is on the rebalancing issue. That brings up this dreadful word "quantum". I think the development of the special viability supplement some time ago was an important initiative which recognised the specific problems of those facilities and I think that in rejigging the funding, that we've currently got to give more money for those rural and remote facilities is not the right approach. You've already made mention of the fact that there is the other review taking place and I would like to think that perhaps the timing of implementation of this inquiry coincides with the recommendations that are available from that other inquiry so that the total quantum of money that's available for the industry is reflective of its total needs.

MR WOODS: If there was a redistribution within the pool, would that cause bed licence values to fall perhaps?

MR KEATS: It might cause some facilities to fail or to go if people were to leave the industry.

MR WOODS: So they would be selling their bed licences cheaper than what they may currently wish to?

MR KEATS: Yes.

MR CRAIKE: Historically, despite what's been imposed, prices have tended to go up irrespective.

MR WOODS: We certainly have seen graphs to that effect, which always puts a salutary light on the quantum question. In which case then, thank you, gentlemen, for the evidence and I'll have a brief adjournment.

MR CRAIKE: Thank you.

MR WOODS: I would like to recommence the hearings and welcome as witnesses Mr Khan and Mrs Wendy Nicholson. Thank you very much. If you would like to state your names and positions for the record, please.

MS NICHOLSON: I am Gwen Nicholson, director of nursing.

MR KHAN: Brian Kahn, Ainslie House Association.

MR WOODS: Thank you very much. Would you like to make an opening statement?

MS NICHOLSON: We have a 40-bed nursing home as well as a 22-bed hostel; they are located on the same site, joined by a walkway in a town which is 50 kilometres from the nearest city, small city.

MR KHAN: That being Launceston.

MS NICHOLSON: Launceston, yes. We find the cost of food higher; prices in Tasmania, especially in country areas, food is higher. We have problems getting qualified, experienced staff. We also have specialised equipment in the nursing home like a cook - not a cook-chiller; compotherm oven, and if we have problems we have to get experienced people in from Launceston, which is $45 travelling expense; podiatrists we have to get from Launceston and they charge also for some travelling cost on top of what our normal charge is. We have had to reduce our bed numbers by 11. We built a new nursing home 2½ years ago and to get the Commonwealth - we did get capital funding for it - we had to actually reduce our bed numbers by 11 - from 51 we reduced to 40, so that made us less viable than we had.

We've had a problem with our RCS. We have had a drop - two residents drop from four to six under the new RCS, which was a total of $24,265.20, but those residents still expected the same level of care and service; therefore we thought it - you know, there wasn't any equality in the new act as these residents - the amount of money we were receiving was less but the residents still were demanding the same quality of care. We live in quite a depressed area as far as houses go and I know this is only - and I know this is only on high care or resident classification 1 to 4 but, with our hostel residents, we can only take bond of what the house is worth and the houses are worth about 40,000 in the area, so that limits the amount of money that we can actually get from bonds.

Because we are a rural area we take what residents that are available, despite what categories they are. In the city we would be able to look and then maybe choose higher categories but, as we are, in there - and we are there to provide a service to the community - or to the people of the community; therefore we take what residents are waiting, so at the moment our funds are fully expended, so we don't feel any cut in our funding - as the years go on would make us even less viable than we are now. We've had problems with residents coming into the high care being seen by ACAT

and being admitted to high care and when we have actually got them into the high care they have been low-care residents.

Instead of say like if they were a 4 where you get $22,502, but they have turned out to be category 6s, which is only about 10,000, therefore we have had a loss of 12,000 in the high care area and once a resident is in a room and settled it really - you know, the residents' rights - you really can't move them to the low care area because they are settled; it would unsettle the resident. We have actually - try and rectify the problems we have had in our drop of funding - had the Commonwealth nursing officer down to look at our documentation. We find documentation is taking a lot longer; we employ one nurse at least a day a month to help with documentation.

The other problem we have is when residents are admitted to nursing home and hostel, they are actually - the RCS has done all their classified, but with quality of care, over time, the residents actually improve. We have one lady who came to us as a 3 on the old scheme and then dropped to a 4 and then a 5 and she has just been reclassified and she is now a 6, so when she came to us there was a real problem but, a lot of our residents - once they're in they get good food, they get good care - that you know their classification does drop and they still expect - I feel there is a duplication - when residents drop in the nursing home and they're a low category then when they get iller and have to be reclassified you have to get the aged care assessment team in to reclassify them and I find that this is a problem; it is a duplication because they basically go on what we have said with our notes, so it is just being duplicated.

We also have a problem with certification. We have a fairly new nursing home and with state regulations we traded off fire hoses because we have an inbuilt sprinkler system right through; we have fire retardation in the walls and ceiling; we have got hard-wired in smoke detectors, but when certification was done we rated poorly - we did pass but we rated poorly because the state regulations differ very much from what the federal regulations were or what was requested by the federal government for that. We also are governed by state regulations - I think it was in your paper that you said only in Victoria, but we are registered as a private medical establishment and we have to have two registered nurses on during the day as part of our certificate.

MR WOODS: Yes, I see that in your submission.

MS NICHOLSON: Yes. I think that is all from me at this time, so if you would like to - - -

MR WOODS: Do you want to make any introductory comments or - there are some matters that I would like to pick up with you later, but - - -

MR KHAN: Would you like to pick them up with Gwen now and then I will - - -

MR WOODS: Yes, if I could. Can you give me a little further understanding of your move from 51 bed licences to 40 when you were constructing your new facility? What was the underlying - - -

MS NICHOLSON: I think Mr Khan can answer that.

MR KHAN: The underlying factor was that the nursing home was built in the early sixties and it didn't meet the new Commonwealth requirements in standard of care, wanting en suites and all this type of thing, and we have architectural advice that if we turned around and tried to alter the old nursing home it was not going to be cost-effective, so we had this land there on a far better site and we were able to build it adjacent to our 20-bed hostel, which we have only recently - which was mentioned here a while ago. The old building was not saleable, so the old building has been demolished because there's nobody that would want that type of thing, but part of the Commonwealth requirement was that if we turned around - before we received funding for the new facility we had to sacrifice 11 licences but those licences remained and were taken up by the Northern Region Health Board and stayed within the region.

MR WOODS: And that was a requirement of the department - that you give up those - - -

MR KHAN: That was a requirement of the department. Also it was a requirement of the department at the time - and some of you may recall here in this room - that previously you could have draftsmen draw your plans for your buildings, and then the Commonwealth changed the ground rules in the late eighties early nineties and said that you had to have architects to turn around and build your complexes, and approved by the Commonwealth and this is one of the things that we find it amazing - that we have an architect; plans go to the Commonwealth and 3 or 4 years later say that the standards - they don't meet the Commonwealth standards, so there is some problem somewhere along the line there and I believe that is being addressed now.

MR WOODS: If you had had the option would you have preferred to have built a larger facility or would your population not have been able to sustain it?

MR KHAN: No. We would have preferred to have retained the 11 licences because there is a need there. Because of the inversion problems in the Tamar Valley, particularly in Launceston; the city of Launceston has problems with pollution, smoke pollution from the chimneys and that around the city and an inversion layer comes over the city and quite a lot of people in Launceston suffer with lung complaints and heart disease - above the national average - and you also have the situation that we are at a very beautiful spot, looking straight out across Bass Strait and it does add itself - which people in their twilight years would like to rather spend their time there, looking out at the seas, and ships coming into the river, rather than turning around, looking into four walls and a fog-related city.

MR WOODS: I recall with interest reading your description of that in your submission and it sounded very attractive.

MS NICHOLSON: Except when the wind blows.

MR WOODS: Well, there is always a down side.

MR KHAN: An interesting fact that you made and we have found - one of the former community health ministers, Senator Don Grimes, said that with people living by the sea their life span is a lot longer and we have found that. We have had people up to over 20-odd years that have remained in our nursing home.

MS NICHOLSON: Yes.

MR WOODS: You were saying 50 kilometres?

MS NICHOLSON: Kilometres, yes.

MR WOODS: I mean, in some senses that isn't a significant distance, particularly if you are attracting people from Launceston to your nursing home, then clearly they see it as a somewhat lengthy but an extension of their total hinterland and that it is conceivable for them to go and live in your nursing home, but having lived previously in Launceston.

MR KHAN: Commissioner, there is a bit of an impediment in Tasmania. Tasmanians are not conditioned to public transport like as in other states where the - Tasmanians use more motor vehicles than any other state; they are not conditioned to public transport.

MR WOODS: Right, but I am just then interested in the actual additional costs that a distance of 50 kilometres from a quite significant metropolitan centre does incur for you, and you referred to call-out charges for service people and the like, but are there any other evidences of that cost? I mean, is your general cost of supplies significantly greater because of 50 kilometres.

MS NICHOLSON: No. I think it is a general - you know, we have most of our food, our bulk food, delivered actually from Launceston.

MR WOODS: Perhaps if you could explore that cook-chill - that in fact you do use the cook-chill or not - - -

MR KHAN: No.

MS NICHOLSON: No, we don't.

MR WOODS: - - - or it is available.

MR KHAN: We don't use the cook-chill at our facility but the cook-chill is available from the Launceston General Hospital. They do cook-chill and they supply

the Maranatha Homes at Legana, the Park Group Homes at Legana, (indistinct) Hospital and the Cosgrove Park facility in Launceston.

MS NICHOLSON: As well as our own facility.

MR WOODS: What sort of radius is that from their facility? I mean, what is the length of - - -

MR KHAN: They would be about 10 K's. The furthest one would be 10 K's and the other ones would be within the city area.

MR WOODS: Have you explored that option yourself or the fact that you have set up a new facility and presumably it has got a new kitchen and all of that in it anyway.

MS NICHOLSON: Yes.

MR KHAN: No, we haven't explored it. Previously we bought our meals, originally, from the George Town Hospital, which was run by the Launceston General Hospital and then as they scaled down, as the cuts took place in health in Tasmania, we had to put in our own facility and we are in the position at the present moment of having discussions with the state government following on what has happened in the last federal budget where the federal government announced that there would be 30 multipurpose services granted across Australia and we are looking at going into a multipurpose service operation with the state government.

MR WOODS: Picking up that particular point could you assist the commission with understanding at the practical level of the multipurpose services? I understand you have some experience in implementing them, so - - -

MR KHAN: Yes, I had the experience with the multipurpose - - -

MR WOODS: - - - - so that would assist us.

MR KHAN: Thank you, commissioner. The multipurpose centre on Flinders Island, which is a very remote area, and a multipurpose service at Beaconsfield. Now, the multipurpose service was an initiative of the previous minister, Carmen Lawrence and it has been pursued by the present government. With a multipurpose service you have the ability to take your levels, nursing home and hostel, and your medical beds - what is required at the time - and it does enhance the facility, particularly as mentioned by the previous speakers that were here just before us - it gives a facility which meets the community needs and community aspirations and where you can have your podiatry and all those other allied facilities in with it.

In our particular case we are going a little bit different with it because we believe that the allied health situation, such as podiatry and some of those things, drug and alcohol, would be better based in the community of George Town. We're about 10 minutes - - -

MS NICHOLSON: 5 minutes in the car.

MR KHAN: 5 minutes in the car from the city of George Town and that would be better as a social interaction. The Tasmanian government, or health service in Tasmania, put in a very similar - not a multipurpose service at Westbury, but they put in all these allied health facilities in Westbury when they closed their hospital and then from the Westbury initiative came the services on Flinders Island and at Beaconsfield. That is a very, very good concept and it's a partnership between Commonwealth and state and it makes the best use of resources, and those are rural areas that have the possibility in remote areas - this could be part of the solving of their problem - of going into a multipurpose service.

MR WOODS: Thank you. That is very helpful to have that experience relayed to us. You referred to the difficulties in a very practical sense of when the ACAT team classifies somebody as high care and then when you do your RCS in fact they're several pegs down the scale. Can you elaborate for us on why you see that occurring and what steps are there in place to resolve those fundamental problems?

MS NICHOLSON: I think why it's occurring is that the ACAT are actually assessing the resident in the hospital when a crisis has taken place and by the time a bed becomes available the resident has actually started to improve, and by the time they've been with us for a month they have actually improved. One of the steps we're taking to avoid is that before we admit the residents myself or the clinical nurse go and actually assess the resident in the hospital or in their home, so that we have an idea of what their RCS will be and then if we feel - - -

MR WOODS: So in a sense it's a prospective assessment to say that once they've been here for a week or two and have got a regime and health care and food and things then what will they look like, as distinct from what state are they in today?

MS NICHOLSON: Yes, but it's doubling up our work if we've got to go out and reassess them.

MR WOODS: Yes.

MS NICHOLSON: But it is working and ACAT are actually cooperating with us.

MR WOODS: I was then going to ask what has been the reaction of ACAT to that and is that something that they will then progressively take into account in doing their own assessments? I mean are they limited by the fact that they've got their questionnaire and looking at the resident now, or the patient now, as they are, tick, tick, tick, here's an answer, as distinct from you saying, "What are they going to look like in a couple of weeks' time?"

MS NICHOLSON: Yes, they are limited by their assessment and we had a meeting about one particular resident and when we sat down and they said, "Well, this is how

they were when we assessed them and this is our assessment criteria," then we looked at the RCS scale and it was completely different. I know the ACAT teams have had some education with the new RCS but I think more education is probably needed, but we have one person at the moment. We have an ACAT team member for the area for probably 6 months and we have a good relationship with them at this particular time.

MR WOODS: Do you understand that is happening more broadly, not just in your own area?

MS NICHOLSON: Yes, I've been to meetings in Launceston with the DONs of all the nursing homes and it's very much a problem happening right across the board, not just with one assessor but with several.

MR WOODS: You then also talked about the care regime and in fact how, with proper personal care and nursing, etcetera, these residents can improve. Where's the incentive for you to work to that end?

MS NICHOLSON: There's not. There is no reward at all in a resident being well looked after - no, that's the wrong word - in getting to being better. There is no incentive at all.

MR WOODS: How would you see that could be overcome?

MS NICHOLSON: By probably a basic subsidy, as the gentleman spoke about; just the one subsidy for residents right across the board, it didn't matter - despite their classification.

MR WOODS: Although that still is a design feature required that you look at the average profile over time to make sure that there's no significant reduction in that, ie, by excluding those who have higher care hour needs and the like. So I think it still needs a little further exploration but I understand your point.

MS NICHOLSON: But we have a duty of care to residents.

MR WOODS: Yes, absolutely.

MS NICHOLSON: So it's the duty of care that we do the best we can for them, and it's excellent at times.

MR WOODS: Entirely plausible and what every resident would hope, and we've certainly witnessed that ourselves in other jurisdictions, at homes where coming in from a remote area and then having a period of time in a facility there's considerable improvement in their wellbeing but with a consequent loss of subsidy.

MR KHAN: The one that was mentioned previously here this morning, we have applied for CACPs packages on a number of occasions and each time we haven't been able to get them, but CACPs packages would help in a lot of the areas with making

their places viable and to treat it as a total package, and the CACPs packages are a very, very essential part in which you can keep the people in their homes and not requiring the intensive care that is mentioned by Mrs Nicholson. The federal government has made more of these available but I think it needs to be explored more and consideration should be given to allowing CACPs packages so as to make nursing homes viable.

MR WOODS: In that question of viability I notice you operate both a high care centre of 40 beds and the 22-bed low care centre. Is that in part to improve the efficiency of the total operation. For instance, are you the DON across both?

MS NICHOLSON: Yes, I am.

MR WOODS: That obviously in itself has certain efficiencies.

MS NICHOLSON: Yes.

MR WOODS: But what was the driving force? Is it more the question of providing a multi-tiered facility for the community or financial viability or recognition ageing in place. For instance, when your hostel residents age up into an RCS1 to 4 do they move to the nursing home or is there ageing in place in the 22-bed facility?

MS NICHOLSON: In the 22-bed facility we don't have the coverage of staff there as we have in the nursing home, so we're not ageing in place; we're actually moving them to the high care facility.

MR WOODS: But they are nearby each other, so they're not changing significantly?

MS NICHOLSON: They are nearby. No, they're not completely changing and I am a familiar face, the CNC is a familiar face. Most of the staff work - - -

MR WOODS: So there is some continuity of personnel and care across.

MS NICHOLSON: Yes, some of the staff work between both facilities.

MR WOODS: And presumably they get some of their friends who have already preceded them that are up there and all of those - - -

MS NICHOLSON: Yes, and we combine for concerts and things and they come down and visit their friends who have moved or they go back up, yes.

MR WOODS: You find that is a very useful way of providing a range of care, by having the two facilities co-located in that form?

MS NICHOLSON: Yes.

MR WOODS: Is that again something from your experience that is occurring elsewhere in Tasmania that will assist this question of viability for small areas?

MS NICHOLSON: Yes, I think so. Yes, I think some people are sort of starting to do ageing in place and other people are actually - you know, like as we're doing. I know of one place that actually has two different numbers and therefore their certification was different and therefore they're not having ageing in place.

MR WOODS: I notice that the population of your hinterland is only about 7000, so how many residents on average would come from outside of that population? How many would be Launceston or other based?

MS NICHOLSON: When I went about 15 years ago it had very few local people but George Town is a funny town. There was only a population of about 300 to the early 1950s and then Comalco started. Now the people are actually staying in the area. They used to come, work and then move out, but they're actually staying in the area and probably 70 per cent now are from the area.

MR WOODS: That's still quite a significant number who are coming from outside of your current population and that may in fact apply in other parts of Tasmania where people move from metropolitan areas to a rural environment for hostel or nursing home stay, which puts a slight counter to the question of what's viable and what's not. You've obviously created a viable enterprise for your facility?

MS NICHOLSON: We had until this year and with the new RCS our funding has actually gone down 5 per cent.

MR WOODS: 5 per cent is a critical figure for you?

MS NICHOLSON: Very much so, yes.

MR KHAN: Yes, very much so. That's how we would have preferred if we could have kept our 11 licenses and built a larger facility.

MS NICHOLSON: With the new facility it's all en suites, single rooms and en suites, and the same with the hostel, so therefore we've had to basically keep the cleaning staff exactly the same and they work twice as hard because of the extra cleaning that needs to be done.

MR WOODS: So it's all single rooms and single en suite, dedicated en suite?

MS NICHOLSON: Yes.

MR KHAN: We were very interested to hear it this morning, because we've already looked at it, that if we could provide increased services but not have to have a complete wing tied up - and it was for a person in their own room and they were prepared to pay it - I believe that is an initiative that we should be able to take. We

were very much in favour of the accommodation bonds and we believe that was a retrograde step that happened there and unfortunately they didn't have the fortitude to stand up with it, and I think if we could do that then that would help our viability, because people who own another organisation I'm tied up with, we're finding that - who have a full - partially with en suites - they are finding people have got more selective now.

People are getting very selective coming in and if you haven't got the facility, well, they possibly don't want to come to it. They will go to the facility that does have it, and I think if people do have the potential to pay then they should be allowed to pay because, as we're aware, we've got a responsibility to the taxpayer, and if we can pursue our own viability then we're not a liability on the taxpayers.

MR WOODS: From looking at your resident profile would you expect many of them would have that capacity to contribute?

MS NICHOLSON: I think probably a couple of them would, yes. Probably two or three in the hostel and the same in the nursing home.

MR WOODS: Your occupancy rates are close on full?

MS NICHOLSON: Yes, full.

MR WOODS: Very good. One final question. You mentioned earlier on about discrepancies between Commonwealth and state jurisdictional requirements in planning and buildings, etcetera. Is that something that was peculiar to your own particular facility, or is this a more general issue across Tasmania?

MS NICHOLSON: Yes, it's a general issue, because I know of two other DONs who have actually spoken to me and they are both rebuilding and they had said, "Oh, well, the state Farr commission said we could do this," and I said, "But the man will come from the Commonwealth and say, 'You have not done it,'" and I said, "There are no grey areas. It's all in black and white. There is a tick for hose reels and a number attached to it. If you haven't got them you miss out on that weight."

MR WOODS: Even if you've got the sprinkler on them?

MS NICHOLSON: Yes, even if you've got the sprinklers. The other thing is the wages. We have had wage increases this year which haven't been funded by the Commonwealth and, as I mentioned, if there is an increase in the registered nurses I believe that HACSU the local union won't be far behind as well. They said they would just wait at the moment while things settle down but I would say they would be close behind the ANF in demanding wage rises.

MR WOODS: Thank you for that. Are there any other matters that you would like to explore?

MR KHAN: The only conclusion that our board of directors believe that we should be - because I come out of private enterprise - looking more into enterprise agreements. We seem to be followers rather than initiators in aged care and because this one sector gets a salary increase, well, we think that if we can look at the awards, across the country if necessary, and even if the Commonwealth has to do something like it did with the maritime unions in the revamping of the industry, because we find that some of the people with the conditions are, you know, not on a par with what private enterprise have to put up with, and it's something that you can - whilst we appreciate the funding cuts and why they had to take place - then if we can make the incentives for the staff and improve the conditions under the enterprise bargaining it may be better for the whole industry.

MR WOODS: Thank you. I understand that point. Thank you very much for making your time available.

MR KHAN: Thank you.

MR WOODS: I trust it's not raining, looking out over your river banks, in which case we will adjourn there.

MS NICHOLSON: Thank you for listening.

MR WOODS: You have provided two excellent submissions. I appreciate that, thank you.

MR KHAN: Commissioner, if you're ever in that area, at Low Head, you're quite welcome to visit our facility.

MS NICHOLSON: Feel free to visit.

MR WOODS: Our pleasure to visit. Thank you very much. I will adjourn for a lunch break and resume at a mutual convenience with our next witnesses of the South Australian ANF.

(Luncheon adjournment)

MR WOODS: I would like to resume the hearing into our inquiry into nursing home subsidies. Welcome, Ms Jill Ashby and Mr Rob Bonner. If you'd like to state your names and positions for the record, please.

MS ASHBY: My name is Jill Ashby. I'm a member of the ANF and I'm also a director of nursing of a 146-bed nursing home.

MR BONNER: Rob Bonner. I'm a senior industrial officer at the ANF in South Australia.

MR WOODS: Very good, welcome. Would you like to make an opening statement?

MR BONNER: Thank you. The first thing we would like to talk about is what productivity and efficiency mean for the aged care sector and we think that's not an issue that's at all clear from either the submissions or the report at this stage, which seems to concentrate on cost outcomes. I guess we believe a number of performance indicators should be taken into account and we'd simply refer the commission at this stage to the report that was conducted for the Australian health ministers' conference in 1996 which actually sets out a multiplicity of performance indicators for acute hospitals and we recognise that they're not directly applicable but they are based on four key areas of what they describe as efficiency or productivity, being quality, appropriateness, accessibility and cost. Those four areas we believe are relevant.

MR WOODS: Could you just run through those: appropriateness - - -

MR BONNER: Quality, appropriateness, accessibility and cost. There is a range of sub-indicators that they've developed underneath those four headings. We believe that those four headings are broadly relevant to an examination of the issues in aged care. It's important to note that improvements to quality, access and appropriateness do not necessarily deliver cost savings or reductions and in fact they can actually deliver real cost increases to providers but they're nevertheless tangible to the consumer for the providers and to the employees who generate them. The capacity to share those quality or those efficiency improvers is therefore not necessarily equal and not necessarily available through the distribution of saved resources.

The second point we wanted to make in relation to productivity and efficiency in aged care is that it is important not to look at residential aged care in isolation from the full gamut of health and aged care services. Only about 75 per cent of nurses who actually work in aged care, for example, actually work in nursing homes according to a study that was released last week by the Australia Institute of Health and Welfare. Over 10 per cent - I think it's a little over 11 per cent in fact - work in acute public hospitals with others working in community-based services and so on. There have been some significant structural changes in the delivery of those services over the last 5 or 6 or 10 years with things like the introduction of case mix funding to the acute public hospitals which have had implications for the admission of residents from aged

care services and to aged care services because of things like shorter length of stay in acute hospitals.

There has therefore been an increase in the level of technology and acuity of residents in aged care as a result of those sorts of features as well as the general growth in frailty as a consequence of the limit and the number of aged care facilities for the frail aged. So it's important in any examination of efficiency we think not to concentrate on the pure efficiency or productivity gains that are made in individual providers to look at the overall savings or gains to government but to look at the gains and savings a government is making through reduced funding of public hospital beds through the more efficient use of nursing home and hostel facilities, and the reduced cost of being able to provide care through things like domiciliary nursing services or community aged care packages rather than continue with the growth in the number of beds in nursing homes, all of which may be cost savings to the government and therefore to the taxpayer.

So in terms of there being a need for further productivity dividends, we think there's a strong argument that in fact government and the taxpayer are already getting more than their fair share through the broader restructuring of the system and the savings that are made through that process rather than through the need for a further productivity discount. In relation to some labour force issues, we think that it's important to place on the record our concern about the comment that was made in the position paper regarding the nature and work environment of nurses working in aged care being somehow different to nurses working in the acute care environment, and that's the position that we strongly disagree. It has also not been supported by other examinations of the facts and, for example, the five-member full bench that reviewed nursing salaries and wages across the country through 1989-1990 looked at the relative work value, which included those sorts of factors, of nurses in aged care, nurses in acute public hospitals, nurses working in private hospitals and nurses working in the community, and awarded the same pay and conditions outcomes after examination of all of those factors.

We recognise that there are differences in the client base but the essential skills as the essential role of the nurses is unchanged by that, and indeed there's a strong argument by many nurses working in aged care that they are doing so with less other supports around them than is the case of nurses in acute hospitals, so that in fact there may be an argument for a reverse discrimination, if you like, in this case - and Jill might want to touch on that in a moment. It's important also in looking at those issues of the changes in the labour force and skill mix that have occurred over the last 10 years or more and certainly there has been evidence of continuing decline in the overall numbers of nursing positions in aged care, particularly at a time when patient numbers or resident numbers have gone up, and that report that I referred to earlier from the Australia Institute of Health and Welfare - - -

MR WOODS: Yes, we have that.

MR BONNER: - - - contains interesting information about declines which are in the order of 29 per cent in the public sector with only a 15 or 17 per cent reduction in beds and a growth of 5 per cent in the private sector nursing home beds with no growth in staffing. So there are significant staffing savings that have been made in the industry. At the same time there have been real shifts in skill mix as a result of the funding base. For example, the nursing home that Jill manages has moved from an all RN-EN mix to a third, a third, a third because of the financial limitations that are placed on it. So they are the sorts of things that are going on in the industry that we think are important to look at.

The two remaining things we wanted to talk about this afternoon are the proposal to develop the standardised input - the bundle - and whether or not there should be some greater accountability for the use of funds. Before I do that, I should say that ANF in South Australia actually welcomes the move or the prospect of a move to there being some greater relationship between delivering funding or care outcomes and a relationship with the funding base. We think that should be developed and made more explicit, so we welcome that broad shift that's referred to.

We also believe there's a need to move to greater elements of national consistency and outcome because clearly, whether you are looking at dollars or whether you are looking at nursing hours per resident, there is currently no equity across the national scheme the way things stand. Thirdly, we are keen to move away from the prospect of coalescence for two key reasons: we didn't think that the time-frame was at all appropriate because most of the real changes in funding were going to occur later in the 7-year time-frame and, given that most of our residents are actually not surviving their first year of stay in nursing homes, we could in fact see about five or six generations of nursing home residents die before there was any equity in the funding base or the resources necessary if we rely purely on the coalescence tool. For that, we welcome the prospect of something different.

There's also the concern we have that coalescence really delivered a prospect of some sort of broad averaging of outcomes rather than moving to a real examination of the real cost inputs that are required and that was something that we always had a concern about. So perhaps if I stop at that point and, Jill, if you want to make any comments.

MS ASHBY: We're experiencing more difficulty attracting expert staff or potentially expert staff into being aged care nurses. The ones in aged care who are very experienced are now seen as a very viable option for the acute care settings now, which is rather sad, so there has been a shift and some of the staff will go there. One of the issues in aged care I believe is that there has been a burgeoning of careworkers and they have received various training and skills development in the aged care setting. Most of the development of registered nurses and enrolled nurses has occurred elsewhere and aged care hasn't really offered a clear developmental model to erase the standards quickly and so on. So young registered nurses are going to the acute settings for their graduate nurse program and they are funded quite often through DEET to the tune of about $11,000 a year I think and not many come to

aged care. So there's no real career path and the value of aged care has diminished by several processes but that's one of them.

Particularly the registered nurses work a lot of overtime that's unpaid and I think they call it voluntary labour, so the statistics in the report are a little off because you haven't counted all the overtime done by the care staff in terms of volunteer work. I believe the clients should - and I think we mentioned this - know the skill mix of the staff and their capabilities. I think that's an honest thing to do for them.

MR WOODS: You make that point in your submission.

MS ASHBY: Yes, I think Rob mentioned that. I believe the role of the registered nurse drives the care, sets the standards and also organises the documentation to achieve the funding. It's a very heavy load for registered nurses when there's really not enough of them and I believe they are overburdened in that respect. The solution of course is more qualified expert registered nurses. There's an increasing complexity of care required, which means that the registered nurses in particular will be held accountable, and so they should, regarding their duty of care and they will be held accountable before their professional bodies as well.

The people who come to us now have multiple medical problems. They have enterostomies, they have IV therapy. They have a whole range of issues that must be grappled with, and they often have no family, or they have guardianship issues. They have a whole range of social issues. They have families in dispute, and the sorting-out place is often the nursing home, and it's the key registered nurses who sort all that out and keep our society harmonious. Essentially I see that they do that frequently at least once every day.

The 60 per cent of the residents that are in the home - I'm director of nursing - have dementia or some sort of cognitive impairment. That requires an extra skill of communication and assessment ability where the people that they're trying to care for cannot communicate to them about their issues and their ills, and that requires a high expert level, to get that right.

I believe that the RCS does reward rehabilitation and care of those people to some degree, and I think that's to be applauded, and I feel that that rehabilitation focus, it that's carried out, actually stops residents from becoming frail and very debilitated and they are able to lead a more normal life or a better life until they die. I think that is a big shift in the focus of care and that's helped, that shift, and I think that's an excellent thing that's occurred. Whether it's funded at the right level is another issue.

I think there's another major issue which I will just touch on, because I think Rob has a few things to say about that, and that is the occupational health and safety issue in terms of the care. Certainly at the place I work we have developed and driven good occupational health and safety work practices, and the issue that's coming up more and more is physical aggression from some of the clients who are older and have

dementia, and it's particular types of dementia. I think once you sort out your manual handling, what is left is those things, so you have to grapple with those as well. So I believe that aged care nurses and carers really have to contend with quite a lot on a daily basis.

Being a director of nursing for a 146-bed nursing home, we have the economies of scale, so that if somebody is dying and they need one-on-one care because they have dementia or they're restless and there's no family, then we have that economy of scale. I don't believe that smaller places do, and my colleagues in smaller places say it's very difficult to provide that for 48 hours or 24 hours or even for 6 hours. So I think there are some issues regarding that.

There's palliative care in the RCS tool, and people who move from just, I suppose, whatever normal care is, from routine care to palliative care, do so fairly quickly in nursing homes and you may be giving full-on palliative care for 48 hours for which you don't put in a claim at a higher level, so one wonders about the benefit of having the palliative care in the RCS. It just isn't rewarded in any shape or form in that sense, given the character of palliative care.

The other thing I need to mention: at the place I work we have four beds, two beds and one bed, so we have a lot of mixed accommodation, and we have a 99.3 on average occupancy rate. So they come to us now, they assess whether the standard of care is where they want to be, and there are other reasons they come, so sometimes the type of accommodation isn't the only reason they come. But one of the issues is that when we've done a survey of falls, most of the falls happen in the evening in their rooms, where there are less staff on in the evening. It's what occurs, I suggest, across the board. So with the advent of changing the buildings and going for single and share rooms, there really will be in the future - I'm looking at 5 or 10 years here - there will be in the future the need to assess the requirement for technology and staff to keep people safe, given that they will still be very very frail by the time they get to nursing homes.

I think the two-category shift is excellent and I think that happens. I think, as we get more used to the tool, that will happen more and more - when people get sicker and frailer, that then you can get a bit of extra funding. I have some concerns about macro funding. I don't think it would reflect the changes quick enough in a person's change in status. I also think it takes away from some of the control or some say by the caregivers about the funding. I think it takes it further away - even further. It's hard enough to get the funding from some of the managers into care, and that would separate that out even further I think. I agree totally with the ANF position that the money for care should go to care. I think that's all I have on my list at the moment, thank you.

MR WOODS: Do you want to add to it at this point or shall we launch into some issues?

MR BONNER: Yes, that's fine.

MR WOODS: Thank you. You've given us quite an agenda to work through. Perhaps if I start with your last comment because it was the theme of your submission, I recall, when I was reading it - of in effect moving away from a consolidated subsidy quantum back into disaggregating according to care and then other services. You didn't suggest going down back to three but at least into sort of two categories of funding.

You also were proposing in your submission that the subsidy should be in effect a reimbursement of actual cost basis. My concern with that is twofold. First, by disaggregating, do you reduce flexibility in operating a nursing home, to which you might answer, "Yes, and that's a good thing," but are there some downsides in that, in that you can't always predict specific situations and if you have no ability to move funds from one area to another then you can in fact constrain the care that you're giving? Second, does it lead to any behaviours on the part of managers once you go back into disaggregation to try and put claims in where they can get the best reimbursement as distinct from the best care? What are the incentives, once you go back to an actual reimbursement, to improve efficiency and to deliver the best outcomes in the circumstance?

MR BONNER: If I can deal with the last point first almost.

MR WOODS: We all have been, so why not.

MR BONNER: Whether or not there's manipulation of a claims process - I mean, to some extent that's what we've got now. There is no doubt that the growth industry in assessment at the moment is, "How do we maximise scores on the RCS so as to give us the best possible result in terms of the funding profile that we get for residents?" and so the documentation and the planning of care is only partially driven by the actual needs and outcomes for residents and is substantially driven by the dollar value that comes out of that whole process. So I think it would not be right to suggest that there's not manipulation of that process under the present arrangements.

I think that what we have seen since the re-amalgamation of the CAM-SAM-OCRE system, certainly in some survey work we have just completed in Adelaide that we'll attach to our final submission, is something like a 30 per cent growth in the non-nursing duties that are being expected to be performed by registered enrolled nurses, not a growth in the care activities that are being required of people who were previously in housekeeping and other roles. So what tends to happen is that there is a greater drawing away from care or direct care from those staff who are primarily there to provide care rather than - - -

MR WOODS: What sorts of other duties?

MR BONNER: Doing laundry, washing dishes, those sorts of things that are really basic housekeeping functions rather than providing direct care.

MR WOODS: Why would they be employing staff on RN salaries to do that rather than having personal care staff?

MR BONNER: Well, they're using care staff generally and that might mean some of the personal care assistants as well as the nursing staff in the service.

MS ASHBY: It's called multiskilling in some people's terminology.

MR BONNER: That's right. There has been a great effort to talk about multiskilling, but generally when people are talking about that they are talking about people picking up non-nursing work or low-grade activity rather than multiskilling in a genuine way to improve skill of the individuals. So we don't see that the quarantining if you like of funding is necessarily a bad thing at all and we think that it's going some way to in fact reinforce why government is providing the funds in the first place, and that is to achieve certain care outcomes for residents, quality-of-life outcomes, rather than necessarily put that at risk from the viability or the profitability of the particular providers.

MR WOODS: Would you go so far in that to explore options that others have put in submissions to us of separating out the care and the hotel accommodation type functions? In which case at the practical level though, my concern remains of how do you differentiate some elements of that?

MR BONNER: One of the options that's open is to develop a model based on the standardised inputs that you've described, but to break that down into constituent elements that are transparent so that there's not necessarily a binding force, if you like, between, "That's the money and that's how you've got to spend it," but that's how the bundle has been developed.

MR WOODS: But without the accountability that then follows, does that fall down?

MR BONNER: The accountability I guess, what we would argue, is that the provider should have to disclose how they use the money, maybe in the form of an annual report to their residents and to their staff, but that there be some sort of accountability mechanism or report about how they're actually using the money as opposed to what it's provided for, and then if someone is creaming too much off of that or they're spending more in a particular way than was intended, they will have to be able to answer the questions about why that's occurring in their particular facility, and it certainly strengthens the arm of people who are directors of nursing.

If they know that their organisation is getting 60 per cent or whatever it is of the standardised input bundle is supposed to go for care, then at least they can have an argument based on that kind of transparent arrangement, which they don't have presently, and that's causing some real difficulties on the ground. A system that works that way is case mix, where there are various weights of the standardised cost reimbursement for a case mix that are ascribed to medical inputs or nursing inputs or

whatever else. Now, no-one sits there at the end of the day and quarantines off that particular amount, but at least there's a notional disbursement there.

The other advantage of that kind of model in our view is if those basic building blocks of the bundle change over time, then you're actually able to adjust that, based on some knowledge base, whereas the difficulty with the current scheme, of course, that came out of a CAM-SAM origin is that once the original amounts were set, there was no way of actually disamalgamating them again and then adjusting them for changes in the circumstances. So for example in our South Australian case, the nursing wages and conditions changed tremendously in the period post the 1986-87 survey work, and it was never possible to go back and adjust the figures to take account of that.

MR WOODS: The relevant component.

MR BONNER: Yes, that's right. I guess in our view that's an option that's a way forward rather than necessarily being too tied up with whether or not we go into a national subsidy scheme or whether or not we go to a state-based subsidy scheme. Our view is it's the outcomes that we ought to be trying to achieve that are consistent, and as long as we are making sure that there's an equitable or equal capacity to provide the same inputs to deliver those care outcomes, then in fact you can adjust it based on state or national variables and cost.

MR WOODS: A lot of your position is premised on the importance of the nursing staff providing the personal care, which I understand that point. Is another perspective to look at outcomes in terms of accreditation processes and to say, "Provided those outcomes are met, the input mix to achieve those can be a bit discretionary at the edges"?

MR BONNER: I think the little bit of research that's around would strongly be at odds with that. Certainly a lot of the work that has been done in the United States demonstrates very clear outcomes in both aged care and acute care, based on the inputs affecting directly the quality of the outputs. So I think this idea that has really been around the aged care sector for the best part of 10 years now, that somehow by prescribing outcomes we can forget about regulating or worrying too much about the inputs has not really worked very well.

MR WOODS: It's not ignoring them. What it's saying is that the provider must ensure that the inputs are correct to be able to achieve the outputs as required. That doesn't say, "Use whatever inputs you like." That puts the onus back on the provider.

MR BONNER: It assumes the funding base is available to the provider to do that. Some providers would argue - the Southern Cross group in Adelaide is a case in point, where 10 years ago they had all qualified staff, and they started to employ personal care assistants, nurse assistants - call them what you will - not out of a belief that that was somehow better or as good as in terms of achieving quality outcomes, but the funding base would no longer allow them to make that decision. So people's

decisions are not based purely on whether or not the outcomes are appropriate for their residents, but the funding base is driving them. It's on that basis that we are saying that there's been a separate of inputs from output requirements over the last decade.

MR WOODS: You refer to the specific instance in your own nursing home of where you went from straight RN-EN base to a much broader mix. What have been, in your view, the quality impacts of that process?

MS ASHBY: I went to that organisation 3½ years ago when they had failed standards, so there would be multiple factors. The reasons for that would be multiple, and it would have been the management of the change; that would have been a component. It would have been not sorting out the roles and the responsibilities of people sufficiently. There would have been a large management component in that - education development component for all levels of staff. There was antagonism between the groups, which has now settled down. But there would have been multiple reasons. So I think that the outcomes were fairly profound in that sense.

MR WOODS: In a positive sense.

MS ASHBY: In the quality sense for the residents, yes.

MR WOODS: So it is manageable. Is that a story to get from that?

MS ASHBY: Yes. Well, now it's about a third, a third and a third of the different - I think in terms of accreditation the major component is the continuous improvement with the appropriate structures in place, and I think that's what you have to show. I think that's mostly driven by the registered nurses. Those accreditation processes are mostly driven by the registered nurses, essentially, because they end up being the facilitators, coordinators of the other services as well; as well as the health care needs of the resident and the social activity programs and all of those things, and the medical services. They're the ones that call medical practitioners in, and so in the end they are the coordinators in any case. It depends whether the nurses expand their areas sufficiently enough to encompass those other activities, and then direct it appropriately.

MR WOODS: I'm interested in exploring through that then the extent to which it is the quality of the nursing staff which can have just as much impact as the quantity of nursing staff; that in fact with good quality nursing staff you can still improve the quality of the outcomes in a nursing home while diversifying your staff base.

MS ASHBY: If you have the expert ability, particularly in the registered nurses and the enrolled nurses, but particularly the registered nurses, then their assessments of situations and of problems and their ability at problem-solving is rapid because they're able to define what the issues are quickly. Their knowledge of what is available to resolve it or to bring about a change is used appropriately, and it's efficient, and the problems don't get out of hand which is inefficient, and don't trickle on for a long time

and have inappropriate outcomes for both the residents and their fellow staff, and so on.

A simple example is the care of the dementia, where there may be weight loss or a urinary tract infection or any number of other things where it's quickly recognised, dealt with; it is cost-effective, and the person has a quality of life, and it is also anxiety lessening for the rest of the staff because that person is careful. So all round it's very efficient, and it also fulfills the care and professional obligations.

MR WOODS: Picking up the question of the proficiency of the nursing staff, do you find - you've got a 146-bed facility - that you're able to provide training and the flexibility of backup support and the like to enhance the quality of your staff in a larger facility compared to some of your DON colleagues in small facilities?

MS ASHBY: Yes. I tried to make a deal with the staff that they pay a bit and we pay a bit, and they pay the bit - they can get their tax off. So we have a high level of education, and we also have negotiated with education providers for a series of programs and we have offered that to other nursing homes around who are smaller, so that their staff can join in too, rather than having to coordinate it themselves. So we've done that as well. I think that's a possibility in areas, you know, to join a - - -

MR WOODS: So you could play a lead role and the others act as sort of satellite, smaller facilities, that feed into your training program and the like.

MS ASHBY: We could do that. Yes, and they could do that too. They could invite us, and we could pay them to come to a program so that they get a bit of money as well. I think that's a possibility.

MR BONNER: Which some of us use quite a bit in our state, in the acute hospital environment, where we have a number of 20-bed or less country hospitals that have access or use base hospitals, if you like, as a basis for their staff development.

MR WOODS: It raises the question, because we put forward a proposal for an efficient sized facility and what you're saying tends to reinforce the point, that the larger facilities can offer a broader range of training and other activity. How does it affect the quality of care? You mentioned the one about the flexibility of providing palliative care intensively for an extended period. In terms of the general ambience of the facility and the sense of home, does the curve start to move up the other way if the facility gets too big and we're talking institution rather than home?

MS ASHBY: This place was built in 1979, and at the time they wanted more single rooms but I think the department said, "No, you have to build it this way," then and of course that changed again, so the rules change, depending. It was built, I think, on a hospital look.

MR WOODS: They've got corridors and wards.

MS ASHBY: Yes. So everybody works very hard - multiple pictures and different designs - but it still looks like that to some degree - well, to a lot actually - and so the thought is that that would be changed; either the facility would be altered or a new building.

MR WOODS: Are there also staffing practices whereby you tend to have a group of staff, more working in one wing or section, so that they build up their rapport with the residents and that, rather than an unending - - -

MS ASHBY: What I've done is rostered the same staff in the same areas so that they actually are - the ones without family; they're their family essentially. So they all know each other very well, which can work against you in the RCS because they won't make a claim for things. They'll just say, "Oh, well, they're just like that,:" so it does work against you sometimes.

MR WOODS: Talking of the RCS, you made an interesting comment earlier where you said that the RCS does reward rehabilitation. Do you want to elaborate on that for me?

MS ASHBY: Yes, I will. What we did at our place when the RCS changed - and we all hated the change but we thought we'd get right into it - we had started this process prior to that. We sent the enrolled nurses for a week to the physio. We have a rehab service which also services outside people as well as our own residents, and there's a hostel and so they have got a large client base. We sent the enrolled nurses for a week to work with the physio so they knew how to move people and to give the basic movements and now, if physios do an assessment and they require maintenance physio, then the enrolled nurses can now take that on in their normal daily work with the residents so it's an efficiency thing. They can actually do the right movements when they're in the shower or when they're being cared for and that's worked quite well because that is a claim. It also has made the residents feel better. They have less falls and the enrolled nurses actually feel good about doing something like that. I don't think you could do that in a smaller place because sending the enrolled nurses off for a week, you can't buy and sell the time as easily, so that's one of the difficulties.

MR WOODS: You also talked about, and many other submissions have talked about, the increasing level of documentation and how it's taking away from care time, and you offered the suggestion that as a consequence you needed more nurses to be there to back up and do that work. What activity is happening in the industry that can streamline documentation, can turn it into an electronic form where you get automatic interchange between your personal care notes and create RCS profiles automatically from it so that you fill in these eight boxes and that spits out into the 23 boxes required for - - -

MS ASHBY: Yes, it's set up when the key words are put in and it automatically - - -

MR WOODS: Is that happening? I know it's only at the margin but we've got to look at all these margins and see if we can make some gain.

MS ASHBY: Yes, the case mix type funding would do that but that would require a lot of prefatory work and setting up in the beginning.

MR BONNER: It's also an issue about how common and consistent that can be done because certainly if you look at the same sort of trends in acute public hospitals, in our state it was decided not to implement automotive case note systems or care planning in places of less than 100 beds because the infrastructure investment just wasn't worthwhile in smaller places. You're better to maintain paper systems. The point that we were making was that the level of documentation that's been required in aged care, given the relatively slow, in most cases, changes and conditions, was in a whole lot of cases more than was being required of nurses working in intensive care units where they are experiencing hourly or even minute-by-minute changes in a client's condition. It just seemed to us to be relatively ludicrous that that kind of investment in paperwork was being asked of the industry.

MS ASHBY: I think with the new RCS we revised our documentation system and our assessment skills and abilities and so we have a fairly streamlined system. As time goes on we will streamline it a bit more so that if something occurs with a resident where it is an RCS claim as well as a care matter, then I think there should be a margin where you can write which number on the care it can relate to. So that when you're going through endless notes to find and do your claims, you can just quickly pick that up along the way. There are efficiency things that we could develop even just with the hand notes. I think that would transfer quite well also into other technology.

MR WOODS: Yes, that makes sense. I confess to being somewhat disappointed at your opening comments where you referred to four criteria, which I strongly endorse, of appropriateness, quality, accessibility and cost, and suggested that the commission and its paper hadn't properly addressed those, whereas my clear recollection of putting the paper together with my team is that in fact they're the very things we were conscious of and were addressing. We put forward a number of criteria by which we would judge the design features of any subsidy, and equity was first amongst all and equity expressed in terms of equity of access, equity of financial circumstance and equity in relation to quality of care, which ticks off all of the ones above cost in fact. Efficiency translated in part as cost was one of the others. On reflection do you still hold the view that the paper is narrowly focused on cost?

MR BONNER: I think we still would have a view that when the commission is describing things like the so-called productivity discount and the like, the emphasis there is - well, certainly the reading that we gave of the report was that it was focused on cost outcomes and not necessarily taking into account those other factors. Maybe when you see the kind of index that has developed for so-called efficiency or productivity improvement, that might be changed, but it's a bit hard in some cases. The point about I think the complexity of performance measurement in this area is how you give it a bottom line in moving towards something like a productivity discount based on overall performance. To what economic value do you place on

some of those things about improvement in quality or equity of access and so on versus the fairly clearly measurable cost outcomes? I guess the overall impression we got was the commission was focusing on the cost outcomes. That may be unfair but that was nevertheless the sort of reading we gave of it.

MR WOODS: I would have thought the view we came to, for instance, in relation to average costing rather than best practice was a strong demonstration of our commitment to the criteria we put forward of which equity was first.

MR BONNER: We would concede that in terms that that was clearly a measure there. We do have concerns with both of those approaches. It seems to us that the averaging approach just starts from where you are now and we assume that the average of the inputs, as they are able to achieve the outcomes and the alternative of the benchmark sampling approach, does much the same thing which is what gave rise to the various loadings under the old CAM-SAM model, and we all know how incorrect the outcomes were there - in terms of that kind of benchmarking approach. Our view is that the elements that form the basis of the standardised input bundle should each be costed so that we are measuring the inputs that are required to deliver the outcomes and then be able to adjust them, as we say, in the future. We know there's a deal of work to be done in that kind of model but it's not unachievable and it's been done in other areas and we think that's a more viable way forward.

MR WOODS: That triggers a further point and I notice the presence of some people from Queensland in the audience, but South Australia and Queensland being at the low end of the funding, has that required staff and management therefore to work harder or be more innovative to achieve the same levels of care with the lower subsidy levels than your colleagues in other jurisdictions?

MS ASHBY: Mark explained all that volunteer work that they're doing.

MR BONNER: I think too that one of the difficulties we've got is the inconsistency in the data from state to state in terms of outcomes and their measurement as well as the inputs. I think it's fair to say that the current validation program even for the RSC process, that there are often arguments amongst the validators about whether someone should end up at one point or another on the scale after they've been through the exercise. The process of accreditation is too soon to say, whether that's going to end up being any different given the sort of state-based nature of the way the organisation is structuring. We need to wait and see but I think that there is a great deal of unreliability with the data on outcomes.

MS ASHBY: I suppose that's a question to put forward: are the validators going to be validated as an audit, you see, as a matter of their quality improvement?

MR WOODS: Yes. Are there other areas that you in particular would like to explore? I've got a couple of small ones relating to particular things in your submission but are there any broader issues you want to raise first?

MR BONNER: Two things that we perhaps should have raised in our submission and didn't, and it may have seemed odd, given the nature of our organisation, that we haven't - the first being wage outcomes. You asked questions earlier about trends in wage movements and how they might impact on national funding arrangements, and I think it's fair to say that what we had was a process of trending to commonality in the late eighties, early 1990s and that was maintained through to probably 1991. Since that time there has been then an opening up of divergence again, particularly in the aged care sector as a result of whether or not states got in before the end of indexation in 1996 with the wages agreements.

So we currently have a relatively small gap in nominal terms in wage outcomes in the acute public sector and a very significant range in outcomes in the aged care sector with states like Tasmania, South Australia and New South Wales who have had relatively significant increases since 1991 that are not safety-net based and a lot of other states who've only had safety nets, so that in Victoria the gap is somewhere, I think, around 13 per cent between the acute public sector and aged care private, and in our state it's only 3 per cent presently but widening.

I think that the earlier comments were correct in that the setting of wages outcomes are largely determined by state governments, given that they are the principal employer of nursing labour. However, there does tend to be relatively common outcomes ultimately. If you look at net public sector outcomes for nurses over the last few years, they range from around 11 per cent in New South Wales to about 10.2 per cent as the minimum, so there's a relatively small gap between the age outcomes. The same can't be said for the other staff of the service though. They do tend to operate very much on state-based markets and have their own state-based conditions of employment; so clerical and admin staff, cleaning staff, catering staff and so on tend to be much more diverse in terms of the wage outcomes nationally than do nurses.

MR WOODS: Picking out the nurses, and this is sort of completing one of the areas I wanted to finalise, is it reasonable to conclude from your comments that at the nursing level at least over a 2 or 3-year cycle for the aged care sector, as distinct from its relationship to the acute sector, there is a reasonable level of national homogeneity or not?

MR BONNER: No, there isn't for the aged care sector. There is in the acute public sector. But if you look at the trends over the 5 years since 1991 - - -

MR WOODS: The divergence is increasing.

MR BONNER: - - - then the gap has opened up by about 10 per cent in aged care from a common position, or relatively common position, in 1991.

MR WOODS: And what do you foresee, looking into the future of the various dynamics, as to what may happen to that?

MR BONNER: I think that if there is not resolution of the funding base issue, and that's the issue of indexation, then that will continue to be a problem and it will continue to get very divergent outcomes, both potentially within and between states. For example, in our own state we have begun or we are currently involved directly with negotiations with a number of aged care facilities. Some of the larger ones think that there is some capacity to meet similar outcomes over the next few years. With the acute public sector, most of the smaller ones are saying that there is no potential for anything because there is no flexibility or movement. So again I think that even within states, never mind between, unless that issue of funding is resolved then we will get very different outcomes.

MR WOODS: Do you think though that a movement to a national uniform basic subsidy would support or exacerbate the movement to a national common wage outcome?

MR BONNER: I think it would probably make it much more difficult for our colleagues in Victoria to see further increases come their way if they're held back effectively for a number of years whilst the rest of us were theoretically catching up, and they are already paid in outcome terms less than we are in South Australia so there is no relationship presently between the rates of pay being paid and where you stand on the funding order. So if you actually sort the states into relatively well-off, into pay scale versus the relative position on the funding scale, we'd probably be second or third and yet we're second-last on the funding table. and I think Queensland is probably about fourth in pay scales and outright last on the funding scale.

MR WOODS: How do you explain that?

MR BONNER: I can't. I'm just saying to you that there is - - -

MR WOODS: Does that seem unusual to you?

MR BONNER: I think there are many other variables. Victoria has a much better skill mix in nursing and personal care staff than we do in South Australia.

MR WOODS: How do you define "better"? What are its features?

MR BONNER: Well, a much richer skill mix. They have a much lower proportion of personal care staff versus registered enrolled nurses. We have one of the poorest skill mixes nationally. So when employers are talking to us about wage outcomes for registered enrolled nurses, they're dealing with typically 30 to 50 per cent of their workforce, whereas in Victoria they might be talking about wage increases for 80 per cent of their workforces, therefore the wage outcomes are for a much smaller group of people and therefore have a lower impact on their overall budget. All of those things are considerations.

MR WOODS: Very good. Thank you for that.

MR BONNER: The other thing I was going to raise was an issue that was raised with a couple of the witnesses this morning relating to WorkCover, workers compensation funding.

MR WOODS: Yes.

MR BONNER: We have a view that funding for workers compensation ought to be based on a system that rewards good performance. The performance of the industry is relatively bad in terms of the level of injury that's being sustained by certainly nursing and personal care staff, and I think in South Australia we rank in the top half dozen industries or the worst half dozen industries in terms of the likelihood of injury, and when you look at the profile of injuries over the last 10 years, there really hasn't been much of a shift. We're still looking at something close to 70 per cent of injuries being manual handling based, which the industry has known about for decades, so there doesn't seem to have been any significant improvement. We would be hoping that the commission would adopt a system that rewarded good performance and lower premium costs, if you like, for some of the - - -

MR WOODS: How do you do that?

MR BONNER: Well, some of the providers do get, under some of the state schemes, additional levies or whatever. Some are granted exempt status, and maybe those sorts of costs could be rewarded and those that get penalty bonus payments, if you like, have to meet those out of their overall costs.

MR WOODS: You're starting to talk about a facility-specific subsidy when you do that.

MR BONNER: Or some sort of sliding scale based on performance. Clearly as part of that there would need to be some provision for that positive improvement program as well. If places are to do something about their manual handling record there's a need to do something about equipment, and in many facilities they're saying they don't have the budget capacity to buy that capital equipment, which is part of the problem.

MR WOODS: I guess I'm just concerned that the subsidy is a very blunt instrument to be homing in on a very specific issue such as occ health and safety practice.

MR BONNER: It's a huge problem and a huge cost for the industry. We are dealing with people who are, in 30 per cent of the cases that came out of our state, being maimed in such a way that they are not able to return to work. Now, that kind of economic loss, never mind social and human loss, is just something that ought to be addressed. That's why we're saying it's a worthwhile approach to look at.

MR WOODS: I agree with the importance of the issue. I'm questioning whether a subsidy at a jurisdictional or national level is sufficiently capable of addressing the specifics of what happens with managerial practice and occ health and safety, etcetera, in a particular facility.

MR BONNER: Yes.

MS ASHBY: I think one of the issues is that WorkCover, or whichever label they have, are state based and the funding essentially is Commonwealth, and South Australia has a bonus scheme currently but they're looking at taking that away. With that bonus scheme, if you did participate you could buy your equipment, which was very handy. You could actually put that back into keeping on improving. But if they do remove that or revise it and you've lost that, then that leaves you begging all the time again.

MR BONNER: All you're left with is a poor performance rather than rewarding the people who are trying to do something about it.

MR WOODS: All right. That in fact picked up a couple of things I had outstanding. Are there other concluding matters that you want to raise with us?

MR BONNER: No.

MR WOODS: Thank you very much. I will conclude the public hearings for Hobart and we will resume in Brisbane. Thank you for all who attended.

AT 3.07 PM THE INQUIRY WAS ADJOURNED UNTIL
MONDAY, 16 NOVEMBER 1998

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