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TRANSCRIPT OF PROCEEDINGS

PRODUCTIVITY COMMISSION

DRAFT REPORT ON NURSING HOME SUBSIDIES

MR M. WOODS, Presiding Commissioner

TRANSCRIPT OF PROCEEDINGS

AT PERTH ON FRIDAY, 20 NOVEMBER 1998, AT 12 NOON

Continued from 19/11/98

MR WOODS: Perhaps at this stage if I can ask for your names and the positions that you hold for the record, please?

MR RIDGE: Ken Ridge from Aged Care Western Australia.

MR WOODS: Thank you.

MR TAYLOR: Jeff Taylor from Aegis Health Group and a member of NANH.

MR WOODS: Thank you..

MR PHILIP: Bill Philip from Valencia Nursing Home, a small privately-run nursing home, member of the National Association.

MR WOODS: Thank you very much.

MS MARTIN: Alma Martin from Agmaroy Nursing Home, and member of NANH.

MR WOODS: Thank you.

MR PRIOR: Graeme Prior, ANHECA, Western Australia.

MR WOODS: Greetings.

MR DORRICOTT: Denis Dorricott, a member of the Aegis Group and president of the National Association of this state.

MR WOODS: Thank you.

MR WILMOTT: Paul Wilmott, CEO, Anglican Homes, past affiliations with Aged Care Australia.

MR WOODS: Thank you.

MR COLLINS: Geoff Collins representing Aged Care Western Australia.

MR WOODS: Thank you very much. Is it proposed therefore that the evidence that you will be presenting in this session is evidence relating to both Aged Care Western Australia and NANH WA?

MR RIDGE: Yes.

MR WOODS: And that we will be separately receiving evidence from Western Health Care and ANHECA.

MR PRIOR: That's right.

MR WOODS: Welcome to the inquiry into nursing home subsidies. As most of you will be aware, the commission released an issues paper in August setting out the terms of reference and some initial issues. We received over 60 submissions based on that issues paper, and I may say we're now up to over 90 submissions overall. So we're very pleased with the contribution and response that we have received. I and my team visited interested parties in all states and the two major territories
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I'd like at the outset to express my thanks and those of the team for the courtesy that was extended to us in our travels and deliberations, and including the very warm hospitality we received in Western Australia, and for the thoughtful contributions that have followed by way of the submissions. These hearings represent the next stage and will be followed by final submissions which are due on 27 November, together with comments on background material that we have also circulated. I would like these hearings to be conducted in a reasonably informal manner, but remind you that a full transcript of the hearings will be taken and will be made available to all interested parties. So on that basis, thank you and welcome. Do you have an opening statement you wish to make?

MR RIDGE: I think, Mike, each group has prepared some sort of preamble. Are you happy that that's the way we might do it; individually each peak body making a comment?

MR WOODS: Yes, I'm quite happy with that approach. If you make your opening statements, and then as we deal through the issues, each of you who wish to contribute to that issue are quite welcome to come forward and present your evidence.

MR RIDGE: Mike, I'll lead off, Ken Ridge. I guess that we - I think speaking on behalf of everybody in this room - see this opportunity as being paramount in persuading, arguing passionately our position in Western Australia. We had the opportunity of speaking to you about that when you were over, but I guess words can't express significantly enough I guess the need to be heard about where we feel the industry or this sector is at the moment, and more particularly where is it going to go and where will it be in the years out in front of us?

We think that the government has brought in reforms, and some of those of course have been positive, but as the reason for this inquiry I guess is to also examine where we feel the government perhaps has put us in a very difficult position in terms of our immediate viability, our ongoing viability, and how it is that we are going to address the issues that we have to address in certification, accreditation. We've seen the demise of capital subsidy funding. We've seen the loss of variable fees and so on.

I know that we need to address the issue at hand, but I think it's important before we even go into some of those just to have the opportunity of saying to you once again that we think that this inquiry needs to certainly address the terms of reference, but as you indicated to us, take on board those things that aren't necessarily

part of the terms of reference, but do have an impact on this sector and where we go in the future.

I think on behalf of Aged Care Western Australia it is proper for me to say in general we're very happy to give our support to Aged Care Australia's response to your position paper. We think that it covers many of the issues that we support, and what we attempt to do this morning is just perhaps quickly in our preamble highlight those issues that we think from a Western Australian point of view need to be drawn to your attention. I think with regard to your preliminary proposals 1 and 2 where we address the subsidy issue, permit me to say to you once again that we think in Western Australia there's never been a level playing field.

From 1 July 1996, we did not receive the extra 10 per cent that many of the other states did receive in their CAM funding. So it meant that from that point, we were already behind in our funding for higher level care, as we now refer to it, from that point. That has never been picked up. I guess that has been further compounded as we have seen in this state. There's significant shortage of registered nurses, and of course that impact has got even greater as we have seen - the public sector just recently agreed to further increases to their registered nurses. We will be some 19 per cent behind the public sector in terms of what we have the ability to pay our RNs.

Some of us have tried enterprise bargaining and that has been a very difficult process. The unions seem very reluctant to support that. Some of us have been able to make some headway, and yet I guess just bringing the latest issue with GST and FBT, that was one opportunity that we may have had at our disposal to try and if you like recognise the value of our registered nurses. Just staying with the funding issue I guess in the subsidy, we think that that is a critical issue. There are other aspects that I'm sure my colleagues, particularly in the private for-profit sector, have done their homework extremely well in terms of indexation and the cost of infrastructure. So I won't deal with that because I think they will deal with that more adequately.

But I recall in August this year there were headlines in our papers indicating that this was the highest cost of living for food in Perth. So that along with the issues of the RNs in terms of not being able to match payment there, the fact that in this state we have to rely so very, very heavily on agency staff, and in any comparisons that people may want to do in taking into account where we sit with our costs in Western Australia, it is not a true reflection because the cost of agency staff isn't going to be shown when you're comparing awards and those sort of costs that we're taking into account when some of those exercises were done by particularly Aged Care Australia.

So we do want to highlight that, although we support Aged Care Australia's submission on your proposals 1 and 2 in terms of the subsidy, we think the impact here in Western Australia of the continuing licensing department or the private sector licensing unit here at the Health Department are also putting tremendous pressure on our sector here once again as to our costs. We understand that in other states that may not be an issue, but certainly in Western Australia, the continuing over

exhilaration if I could put it that way of the private sector licensing unit department of the Health Department of Western Australia is putting extra demands on us. That's something that again isn't reflected when you're trying to do comparisons across a nation. Am I doing the right thing here, Mike?

MR WOODS: Yes.

MR RIDGE: I just want to address some of those proposals. Is that okay? Shall I continue?

MR WOODS: If you could, but could I be advised if in the audience we have somebody from the WA Health Department who will be giving evidence this morning?

MR WILMOTT: Mike, Paul Wilmott. The Commissioner of Health I spoke to the day before yesterday, he was having put before him yesterday a proposal to in essence pull the Health Department essentially out of this process to have a risk strategy put in place. He's well aware of the duplication and stupidity of what's going on here and the quite zealous build-up of inspectorial approach by Health Departments. So I think there might be some light at the end of that tunnel for the local level.

MR WOODS: Okay. I have a submission from the Health Department which you have no doubt also been aware of and may have read, but clearly in terms of this hearing today I won't have the opportunity to discuss some of those with them, but I am certainly happy to receive your evidence in relation to that issue. Please proceed.

MR RIDGE: I'll just finish off if you like just responding to the points that I think I made in my brief synopsis to you or your department in terms of what we would be saying as Aged Care Western Australia. I think the proposal 3 in your preliminary proposals, I guess one of the questions we're interested to know what you mean by benchmarking or benchmark level of care. We wonder what the cost of that will be and how that will be funded in terms of - I guess they're clear questions for us. How does it sit in relation to accreditation and certification?

I guess the other thing that we're concerned about too is what efficient sized facility - how do we agree on that? I know that 60 beds has been used there as a figure, but most of the size of nursing homes around Australia I'm told is far less than 60 beds, and so I guess we're concerned that that would have an impact in terms of trying to work out what would be an efficient sized cost or a cost related to an efficient sized facility when if you've got a smaller number of beds, it would be pretty hard or almost impossible to provide the same standard of quality of care because you don't have the position of having 60 beds and what goes with I guess a more viable approach with 60 beds.

I think the other thing, too, that we just want to make a comment about there, Mike, is the government - the way in which it hands out bed numbers and its insistence up until now in terms of using the local government area statistical

information. We think getting back to your point that it might be more opportune for the government to realise that people are prepared to travel some distance when there's a quality product being offered, and so it could be time for the government to think about combining some local areas in order to get more beds into one facility.

I think the other issue that we're concerned about in Western Australia is the fact that over the last 5 or 6 years, we've worked very, very hard to offer senior Western Australians a quality product in terms of a home-like environment. So what happens is if you keep trying to what might be deemed to be funding based on efficient size, do you use home-like? Wouldn't it be better to address the issue that the government says that they want to do with their rhetoric and offer the funding that goes with a quality of care that they're asking us to provide?

I think the other thing in proposal 3 is about the rates for RNs, and certainly we would feel very strongly as I have already indicated that we value the role of our RNs. Certainly they provide care for our residents who have many complex needs. They have we believe significant responsibilities with the requirements placed on them for documentation. We think that we need to be able to reflect that in our ability to pay our RNs, and certainly in Western Australia. If I can make the point again, we think that that is a very difficult task for us given our current recurrent subsidies, and we very strongly argue that although it's not as highlighted as well as it should be, it is in the ACA submission. We think that Western Australia together with Queensland and South Australia should find immediate relief to that, and even if we can be so bold to agree with ACA and say even to backdate it back to 1 July of this year, it certainly needs to be looked at.

I think in terms of proposal 6, we accept what you say there. I think we just want to make the issue that certainly in our sector as I've already said, there is a huge reliance particularly in Western Australia on agency staff, and so we would like to see that there be cost reimbursement, and we don't have a problem with that, as long as everybody is entitled to be reimbursed for their costs. It's normal, it's just been pointed out to me. Certainly it's not uncommon; it's certainly normal that we have to rely very heavily on agency staff.

Workers compensation, Mike, I guess is an issue. It's not an easy one. We believe that the submission from ACA is heading along the right track, but we do want to emphasise the fact that we think that again there should be some scope for cost reimbursement. We understand there may be some capping, there should be some incentive I think the old funding arrangement we have with CAM and SAM by the government recognise that if you had done the right thing in terms of making sure that you had policies and procedures in place for your workers comp, then you were in water.

We think that given what we have gone through again in this state where we have had a 40 per cent hike in our premiums, many of us have had 50 per cent loading on top of that, there is an adequacy in recurrent subsidies to cope with that sort of huge impact on our financial viability. We agreed with the transfer of the government

beds to the non-government sector. We support that proposal and emphasise that. It's perhaps not so strongly put in ACA's submission. Rural and remote, we again heartily support that, but we would want to make the point very strongly that that would have to be new funding, new moneys. We don't see just a recarving up of the existing funding.

Certainly with proposal 13 we would certainly want to see Western Australia included in any change there, and I know my colleagues will put up very strong arguments there for that to be the case. So they were the issues that I think I referred to in my fax to Ian. So I guess that takes me out from my preamble at this point, Mike. So thank you for the opportunity of presenting that. We do appreciate that, and we'll look forward to hearing what others have to say.

MR WOODS: Thank you very much. I do have that list in front of me and I have been through it and have various questions that I would like to raise of you in relation to that list, but if we can go through the various introductory comments first, and then I would sort of - if you bear with me - try and span across the range of submissions that I have and the issues you raise and try and pull them together in some form of coherence. So please proceed.

MR TAYLOR: I'll go next. Jeff Taylor from the Aegis Health Care Group and a member of NANH. Our overall view of your preliminary proposals was that we agreed with most of what you had there. We thought that what you have come up with is very good. We thought that what you've come up with is very good. Just as a comment on some of those proposals, again on the third proposal, we would wonder what an efficient sized facility was going to be and how it was going to be arrived at. On the question of the acute sector and aged care sector being different, we certainly disagree with that for the reasons and exactly the points that Ken has raised.

In proposal 4, we're very much against the productivity discount. We found over 25 years or so in the nursing home industry that the government always finds a way of not paying us as much as they should anyway. So to give them the opportunity of discounting the fees could end up in chaos in our opinion. With respect to payroll tax, I was asked at the time that the funding was being put together and made the suggestion with OCRE that superannuation and workers compensation rates were known for every state, and that to simplify the system that they could be put into the RCS figure, and I assume that they have been.

Payroll tax was dealt with differently because of the private sector paying payroll tax. As a radical move, something that we would suggest that would simplify it further would be the amount paid to each state for payroll tax or in each state is known. Perhaps the Commonwealth government could look at paying those amounts to the state governments and make all homes exempt from payroll tax, including low-care facilities. That would simplify the problem overall in our opinion. Regarding your extra items you wanted special comment on, you spoke about the impact of input taxes.

One that would be significant is fringe benefits tax. I don't know what can be done with that, but where there is the differentiation between the acute sector and the aged care sector, if fringe benefits tax was exempted again for everybody in the area, then it would give us that 30 per cent salary packaging availability for staffing which might help to bring us up closer to the acute sector. With the income testing, just one point on the extra services area, we have an extra service home and find it very difficult with people paying an extra service fee and also being income tested, and one of the things that we would like brought in is that the extra service fee that they pay be deducted or counted as an expense against their income before the means testing was brought to account, or else the claw back to the government be eliminated because the people are paying twice out of their pension. It's not just the 25 per cent they're losing; they're also losing the extra service fee and the government is getting part of that fee as well.

Finally on the merits and scope to combine the resident daily fee and the accommodation charge, we don't agree with that point at all because the accommodation charge was brought in to replace the accommodation bond which in itself we don't agree with, but if they were combined, then there would be no showing people that they are actually paying an accommodation charge which goes towards their accommodation. They would just see it as part of one fee, and we think that it should be kept separate so that people are aware that that is going towards their accommodation. That's our points on the issue, thank you.

MR WOODS: Thank you. I appreciate that, and I do have before me submissions from some of your members, and I'll be raising those together with the points that you have made in your introductory comment at the conclusion of this round.

MR PHILIP: My name is Bill Philip. I'm the owner of the Valencia Nursing Home and a member of the national association. Valencia is a small independent nursing home not connected to any sort of group, and the point that I want to make in the preliminary discussion, Mr Commissioner, is the urgency of our situation; that we are being absolutely decimated by the infrastructure costs, by payroll tax, by workers compensation and by the RN funding to the point where it's dubious whether or not we'll survive long enough for the government to make some sort of move that will fix the situation.

We've been in business since 1976. We've been associated with the industry for some years before that, and right through the time that we've been in the business, we've put up with the government's peculiar ideas of funding and, as my colleagues said, their capacity not to pay us as much as they should. The situation has never, ever been anywhere near as critical as it is now. We are probably around about $12,000 a month below what we need to operate, and that $12,000 can be attributed directly to payroll tax, to the workers compensation, and to the infrastructure costs that vary.

So I agree with all the things that the two previous speakers have said with regard to your proposals. What I want to bring home to you very, very seriously is the urgency of the situation. It's critical, it's desperate, it needs fixing now.

MR WOODS: Thank you, Mr Philip, and I do have the benefit of a very frank and honest submission from you outlining your situation in some detail which I found helpful, and if you don't mind a little later on if I can just pursue some of the detail in that to gain an appreciation of the situation.

MR PHILIP: Be pleased to.

MS MARTIN: I'm Alma Martin from Agmaroy Nursing Home. I'm part owner, and I'm also a nurse. I'd just like to endorse the other speakers' statement and impress the urgency in relation to - particularly in relation to the care staff. The RN situation in Western Australia is desperate to the point that there are not even agency staff available to work. Demand on nursing staff is going to increase dramatically with the expectations that will become accredited.

My questions in relation to those issues there were how would an average mix be arrived at because it seems to indicate that we're working towards casemix as opposed to the RCS for our funding needs. In some areas that would be much easier, as long as the funding as higher for the categories - taking away the eight categories. I'd like to know how the average cost base is going to be arrived at, and what incentives there will be in that cost base to allow us to retain and train our skilled staff, but also our non-skilled staff, because once we have a lack of skilled staff, we're going to have to be able to retain trade people to an adequate level to do appropriate care, let alone quality care.

The other issues that raise are - proposal number 5, you're not proposing any change to the supplements at all, and currently those supplements don't cover adequately areas such as oxygen therapy, dietary supplements that are prescribed, and dressings. Apparently a resident could prescribe a dressing that costs $275 a month, and there is no provision in the supplements to cover these extra costs. If the resident can't bear them, they have to be particularly worn by us. Basically I was wondering if the new basic subsidy rate will take into account these differences in the supplements or will that be funding from the - basically there needs to be in addition a special needs charge applied there because they're additional costs to us that we have to bear, along with payroll taxes and everything else that just aren't covered, for the residents, the pensioners that don't have any extra income.

We come from a low income area and we have a high ratio of concessional residents. So I would just like to impress, too, the urgency that WA has relief immediately along with South Australia.

MR WOODS: Thank you, and I do also have the benefit of the document that you submitted to us. I have it in front of me and would like to pursue some of the issues that you raised.

MR WILMOTT: Mike, can we go on with a couple of other points, please? Paul Wilmott from Anglican Homes, Perth.

MR WOODS: Yes, Paul.

MR WILMOTT: I met with you and have not made a personal submission, but have been very much supportive of ACA and ACWA's work in this area. One area that really troubles me amongst the three is the notion by the department that concessional residents' supplements together with accommodation charges are the panacea of the capital problems' solutions in the industry. They are clearly not. We cannot afford to set aside the revenue from concessional residents' supplements to provide for future capital replacement. It is a major fatal flaw in the funding regime for the future of nursing homes; a major one I emphasise to you.

The other point I would like to make is that in terms of registered nurses, you've been told this several times already; we have a major crisis here in WA of immense proportions. Ken has drawn your attention to it, and all other speakers have also said that we have a particular crisis problem here. One of the things not touched on I think by either ACA or other people that I have heard is the extent to which our valued RNs in the nursing industry now have to increasingly spend more and more time on documentation to the detriment of good care. This is a major issue which numbers, calculations, dollars, analysis are not bringing to the fore at the moment.

We have more documentation requirement in residential aged care now in Australia than there is even in acute care, intensive care in hospitals. I know they are short staying as opposed to long-stay, but there is simply no reason why we should have to work harder and harder at producing more and more slick and comprehensive documentation to justify subsidy claims. It's simply not good enough. The other issue which hasn't been touched on is the impact that prescribed services are now having incrementally on low band facilities and hostels. The government has an agent in place - RCS strategy - to coalesce over time hostels and nursing homes as you know, Mike, but the increasing numbers of high band people now ageing in place at hostels is having a very clear impact on the cost of running those facilities that we do not anticipate, and I'm sure the government has not anticipated.

The new level of prescribed services attaching itself to high band care in low band facilities is an emerging major problem. It probably doesn't - I don't know whether it fits into the purview of your inquiry, but there is an emerging major attendant problem in residential aged care. Thank you.

MR WOODS: Thank you very much. Are there further opening comments?

MR COLLINS: Yes, Mike, I'd like to make a general comment about the implications of the Commonwealth government's tax reforms, particularly alerting you to the potential catastrophic implications of the withdrawal of any existing benefits under FBT currently enjoyed by the industry. You may have found in your

submission evidence across Australia of significant no-cost support infrastructures put in by particularly the charitable sector that enjoys benefits under FBT in financing salary packaging for not only senior staff, but this permeates right through to ANF staff and other staff.

If the government were allowed to proceed with the present shall we say claw-back of these conditions, you will see a further exacerbation of the inability of organisations that we represent to fund services to the aged. In your meeting with us here in Western Australia, I referred to the fact that a withdrawal of a dollar of existing benefit would have an escalating or multiplier effect throughout the industry, and I would therefore carefully ask you to examine the potential implications of the government's tax reform proposals on subsidy levels, etcetera.

MR WOODS: Thank you.

MR COLLINS: One final comment I would like to make about capital funding. I would like to amplify Paul's comments about the way that subsidies and capital funding are linked in terms of providing quality of care for the aged. We believe that the settings by the government under its aged care reforms are wrong, and these settings if allowed to continue will have dire consequences for the provision of quality aged care into the future. We're already seeing - for example my own organisation's illustrations where not only has the government withdrawn from capital funding - and I underscore the word "withdraw" - we have got a situation in our organisation where the government has agreed that we have a requirement for 108 high care beds in our locality with something like 3900 persons over the age of 70.

The Commonwealth government under its present regimes has never approved a high care bed in that locality. There is not one approvement in the history of this nation for places, and it certainly hasn't provided any capital funding to provide for those infrastructures. What the Commonwealth did, it provided under its initial reform package for accommodation bonds for high care facilities. It currently withdrew its capital funding to provide for those places, and they have never been replaced. Therefore when you link the capital funding requirements to not only provide for new places but for refurbished existing places and then note that the Commonwealth has completely withdrawn that capital subsidy, it has a major impact, not only in present day service delivery, but potential disaster for the future provision of those services.

MR WOODS: Thank you very much. Are there others who wish to make an opening comment?

MR PRIOR: Yes, there is, commissioner. My name is Graeme Prior. I'm the president of ANHECA in Western Australia, and I'm also the joint proprietor of 400 high care beds, and you may recall when we met in my office at Forest Apartments, we discussed a number of micro issues, and your reform agenda.

MR WOODS: I do indeed.

MR PRIOR: I have five things to raise with - sorry?

MR WOODS: I do indeed recall that, yes.

MR PRIOR: Okay. I have five things to raise with you. You noted in your opening comment that ANHECA (WA) made the submission to your investigation in the very near future. The five things I want to raise with you today though are the process and direction of the Commonwealth micro reform and its effect on the industry; the lack of recurrent funding in certain issues, the capital cycle and how it has been raised already, and I'd like to address a few of those issues again - taxation generally, and whether your commission would look at recommending any kind of benchmarking to the Commonwealth on the efficiency of delivery of services in the future. So if I address those five things?

MR WOODS: Thank you. Please.

MR PRIOR: The micro reform process that the federal government has launched on the industry was in some circumstances required, and it's certainly recognised as a way of the future, but I think the issue of the rate and pace of that reform is having a major effect on the industry's current capacity to deliver - in other words contracts for the Commonwealth. The 2 years we have left to accreditation, you've heard this morning that that is having a significant inability to either find staff or keep staff or pay for the simple costs of delivering care right at the moment.

You may wish to consider whether the reform process should be re-evaluated or re-examined to see whether your rate of reform is in line with the capacity of the industry to meet that reform process. That's an issue I raised with you at my office, and I think there's ample evidence today and all throughout the industry that the requirements of the Commonwealth on this purchasing model can't be delivered under a reform process. The micro reform process has delivered its tack at two levels: on the capital cycle in reducing capital, and also on the level of quality improvement required from services to the Commonwealth. On the latter issue of delivery of services to the Commonwealth, it is fully recognised that if you (indistinct) Commonwealth of Australia or of any state government, you'd have to have quality services, and that's fully recognised. It's just that the rate of change in the industry has had a major fallout.

The fallout effectively is in staff leaving the industry in droves. It is almost impossible in some places in Perth to find staff. It is also impossible sometimes to find agency staff. Our existing group of professional employees, registered nurses, enrolled nurses and registered nursing wish to leave the industry because they don't see a future for themselves. The government needs to examine very carefully whether the 2 years to accreditation is too tight a time-frame on the industry's labour force.

Point 2, the lack of recurrent funding. You've heard this morning on the recurrent funding issue as it affects pricing and supply of labour into the industry. We

in the west at the moment or over a very short term, commissioner, face a 20 per cent differential in the pricing of labour in the industry compared to the acute public sector. These people come from the same labour force we can't compete. We can't compete because the level of funding into the west from the federal government simply isn't sufficient to meet the cost of labour.

If you are a qualified registered nurse, you get two choices or three choices. One choice is to work in the public sector or work in our sector. If you are driven by money of course - you have no choice but to pay the mortgage and pay your own running costs to yourself -you will choose the higher earning capacity, and that's to leave our industry. With the reform process taking place, the reform process is forcing the creation of groups or joint operators of a number of facilities. This already exists in the charitable sector and has for some time, but there is no allocation of funding or any kind of consideration of allocation of resource to attract, retain and pay executive staff to run the executive risk programs in this industry. You wish to reform it, you wish to aggregate a number of beds, but there's no capacity to pay for the people to run those aggregate beds.

The last issue is workers compensation. The reform process has also deregulated the market of the workers compensation, and we in the west have faced in some cases 110 per cent increase in premiums with no increase of funding. Once again that affects your capital cycle, it affects your capacity for long-term funding. Point 3, commissioner, is the capital cycle. The capital cycle is severely under-catered for. This issue you and I discussed in my office. I showed you a model that we wished to run in the west on the long-term viability of the capital cycle. This was put to a joint industry meeting over here and I certainly hope the wisdom prevails to have the cycle fully evaluated and fully examined.

Mr Wilmott, running a very large and very credible aged care group in Perth, has already told you that there is insufficient funding to replace long-term facilities. Mr Wilmott's industry doesn't face the leakages and the capital cycle we face in the form of taxation and the cost of capital, and I think that your capital cycle needs to look at, if you wish to examine this from the point of view of viability, the leakages from the cycle.

Taxation is point 4. The only issue I wish to raise here is that the write-off or the actual depreciation and write-off under the Tax Act for buildings should be borne in mind with the economic useful life of the buildings. We have a similar industry in Australia called the retirement villages industry. They have effectively a 20-year write-off allowed where ours is 40 years. The (indistinct) Institute recognised that the real life of facilities is no more than 25 years, and that is far less than a 40-year write-off. So if you want to go back and examine your capital cycle, I certainly echo the sentiments of Mr Wilmott and other people that the allowance of 4 and a half thousand dollars per annum either with or without leakage is insufficient to replace a capital cycle.

Point 5 is that you may wish to take on board, and I'd like you to consider this very carefully - if we are to build a future for aged care in this country at a residential level, we need to look at the allocation of all the capital resources out of the Commonwealth, and at the moment you have two industries. You have the private sector which basically pays tax, and you have the public sector or the charitable sector which doesn't pay tax and is virtually exempt from tax. My point is that as far as I'm concerned, the relationship a taxpayer has with the Commonwealth is a very private one and should remain that way. However, if we are to have an efficient allocation of resources to fund long-term vituperative aged care, we need to look at the capacity for the industry to compete and therefore benchmark cost of delivery of services.

This is one major issue. What this industry does not currently have is any benchmarking. If your report is to look at some wider issues as you mentioned to me you may want to consider, this certainly is one of them because it does attack the heart of the issue of long-term viability, efficiency of delivery of services. The Commonwealth in the last 12 months has increased funding for aged care. All the funding has gone at delivering lower cost options for aged care, ie low care residential aged care services or community aged care packaging. We need to look at the wider picture for costs of delivery of services, and I'd like you to perhaps consider that as a recommendation to the Commonwealth of Australia. Thank you.

MR WOODS: Thank you very much. Any further contributions?

MR DORRICOTT: My name is Dorricott and I am president of the state branch of the National Association and national director. Really I'm supporting some of the others, but with regard to salary, there is a general assumption that there is a major difference between nurses who may be working in one sector - the acute sector - and nurses who are working in the aged care sector, and I strongly challenge that in that if we are to have people who specialise in the running of care for geriatric people - and this has now become a speciality - they have a very significant amount of training in this special area, and this should be acknowledged.

It seems quite improper to even suggest this is not the case. The thing that concerns me is that with the taking out of the people from hospitals and putting them in to many nursing homes early in their care situation, the levels of care that are required - I mean, providing dialysis and things of this kind is happening in nursing homes, and to suggest that the people giving that care in one place is vastly different to the people giving that level of care in another place I think is quite improper. So I want to emphasise that if we are to build up and be required to do the things we are often doing now which often, as well as giving care in the sort of palliative service, then the people giving this care should be given the dignity of a proper vocational status. I'm quite sure it wasn't the intention of anybody to suggest otherwise, but I think it's something we should be very careful to emphasise to you.

People have mentioned documentation, and I think the major or one of the concerns that has been expressed often is that documentation - to meet all the challenges - is often done by the most senior people in the place or some of the most

senior people in the place, but it seems to me that there has to be some balance reached with regard to how this is performed, and balance reached with regard to the assessment of documentation by various players within the industry, and a more balanced attitude adopted about what is the requirement for people who are therefore going to be there a long time are in a place where care is an important issue. But if documentation becomes more important than giving care, then we have a concern; the industry has a concern.

There's a general complaint from the staff about the merry-go-round of change. Over recent years we have had so much change that I think it has contributed to a serious position with regard to staff morale. It's difficult enough to have people working in an environment where there are no miraculous recoveries, there are no wonderful things. There is the fact of watching people die and being with them all the time. If we on top of that overload these people with a massive amount of change all the time, some of which is seen to be change for change's sake, it's making our job much more difficult.

It seems important that whatever happens - I mean, we're going to have to have change, but it's important that at some stage you create a fairly stable atmosphere for people to be working in and all the people who wish to use it, and this is also the families of the people who are placed in our care. There is a significant need in my opinion for a sense of stability and we should all be working towards this. I also want to reiterate the comment - and without appearing gauche - about when FBT is built up. It's important to remember it applies to others. The privileges of certain taxation concessions apply to one sector of the community, but we're constantly being told about people having choice.

If people have choice, then how they're serviced afterwards shouldn't depend upon privilege to one group as against the other, and the best way I can explain this is I went to buy a bus and I paid upwards of $20,000 more than the people who are providing the same service down the road. We'd both be carrying aged people. We're both doing the same thing. It's seems quite improper that one group should get a privilege that the other doesn't. In the case of caring for the very young apparently they make things tax free, there are many, many items - incontinence pads we pay more than other people. It's got to be used by the same people. It seems that that has always appeared quite improper. The arguments that you hear really relate to the fact that if you're providing care for the special sector of the community and it's a health care need, then all the players should be receiving the same sort of treatment and work under the same conditions and at least have a level playing field. Thank you.

MR WOODS: Thank you very much. I appreciate your comments. Are there any further opening comments to be made?

MR DORRICOTT: No, not for me, thank you.

MR RIDGE: We don't think so, Mike. Everybody's shaking their head.

MR WOODS: Thank you very much. In terms of proceeding from this point, I'd like to first clarify a couple of points that were raised as concerns in your opening comments and in the submissions I have in front of me, and then proceed to discuss some issues such as benchmarking and workers compensation, payroll tax and the like. I leave it up to you at your end as to how then you respond and perhaps if it requires a greater number of you sitting closer to the front table or whatever, then please feel free to deal with it as best you wish.

If I can first comment on this question of parity of nursing wage rates between the aged care sector and the acute care sector, we do have the information in relation to Western Australia and Victoria and the other states and territories. So we do fully understand the differentials that you are experiencing and the trend that is occurring. When reading the position paper, I am a little surprised, but nonetheless note that you have interpreted the phrasing of the preliminary proposal as in some way suggesting that there be a differential between the wage rates whereas in fact the proposal says that the industry cost base should reflect nursing wage rates and conditions applicable in the aged care sector rather than in the acute care sector, but it doesn't form a judgment on whether those wage rates should be different; that that's a matter that in the commission's view should be dealt with in the marketplace, and the subsidy proposal which talks about identifying the average cost of a standardised bundle of inputs would reflect what was the outcome of costing those various inputs.

To put it more precisely in terms of your own jurisdiction, if under this proposal over time there was negotiation between the aged care sector and the relevant employee groups that resulted in an increase in wages and labour costs, that would be reflected in the annual assessment that would be subject to indexation, and there would be a form of recompense. Now, that has two additional features to it. One is obviously indexation will always lag that which occurs on the ground and in terms of your own financial situation, but nonetheless does have the ability to reflect over a period of time the cost pressures that you're incurring.

Secondly, depending on whether it's a national uniform standard subsidy or whether it's jurisdictionally based, if it's nationally based and any one jurisdiction is lagging behind in this area, then the subsidy would be set at a level that would allow that sector to negotiate an outcome and catch up to the national level, but it also acts as a constraining influence on any one jurisdiction moving significantly ahead in the marketplace and coming to a wage rate agreement, recognising that the subsidy would only in part reflect the additional costs that they were then bearing.

Separately if it was a jurisdictional-based subsidy, then there would be greater immediacy and relationship between the wage rates in that jurisdiction and the indexation and therefore the assessment of the input costs, and presumably the government in setting the output price that it was willing to pay would wish to ensure that there was some ceiling on that process so that the wage rates reflected in the price it was willing to pay were not significantly above for instance those applying in the acute care sector.

Just to reiterate the point that the proposal seeks to reflect what is actually occurring in the aged care sector but not to form a judgment on whether that as such in dollar terms be different from the acute care sector. I welcome any reaction you may have to that clarification.

MR DORRICOTT: Dorricott again. I was aware of the section that was written. I think the concern is that our experience was that at a time when there were adjustments made by the department, it set a time line, and if you were before the time line you got the adjustment; if you were after the time line you didn't get the adjustment, although it didn't necessarily reflect the actions of the arbitration commission in making payments.

I was really talking from or my concern is from experience rather than from making a value judgment. It's purely and simply trying to emphasise to you that we are now required to perform functions which are quite different to those we performed 10 years ago or even 5 years ago, and if we are to - I mean, it's a growing concern. If we are to properly perform these functions, then we must have people who are properly qualified and rewarded for what they do. I'm not suggesting that your findings or your comments were in any way detrimental to that. I'm just wanting to reiterate the importance of this in our industry.

MR WOODS: Thank you. I appreciate - - -

MR DORRICOTT: We regard it very importantly.

MR WOODS: I appreciate those comments.

MR COLLINS: Mike, can I be a bit - - -

MR WOODS: Yes, please.

MR COLLINS: Mike, Geoff Collins. Perhaps I can be a bit more blunt because your time is very valuable. I think that if the way that your commission is heading doesn't result in an adjustment to ANF wages in this state and in the other states, then it would have to be seen by the industry as a complete failure; not necessarily on your own commission findings, but on the government. It's that serious. There must be a positive outcome to this problem.

MR WOODS: Thank you. I do note and understand the degree of differential and the impact it is having on your industry, and as I see it the proposals that we are putting forward would assist you in that respect. Are there any other comments on that question of parity before we move on to other issues?

MR PHILIP: It's Bill Philip here. I think there's a general point. The government seems to have a view that where they have a uniform subsidy or a uniform funding arrangement across Australia, they seem to have the belief that there are swings and roundabouts existing in each state whereby you will be able to survive whatever

average it may perpetrate. In fact there are a hell of a lot of swings and very few roundabouts for most of us, so that while they may under fund something - wages in this case perhaps - there isn't somewhere where you're being generously treated, so there's a trade-off.

MR WOODS: Can I pursue with you at that point then the question of a national as distinct from a jurisdictional-based subsidy? The data that we have had put to us by Aged Care Australia and other data that other organisations have put to us, albeit with various perspectives, suggest that the differences in the costs experienced by the different jurisdictions are not as great as the differences in the subsidy levels paid to jurisdictions, and further that there is some evidence of trending closer together between jurisdictions over time.

Clearly there will be no complete agreement across jurisdictions on all cost items at any one point in time, but also there will be - and history has shown to date that there is no one set of rankings over time that is stable either; that some jurisdictions who, because of wage outcomes or other factors, are higher in their average costs at one point in time may not be the highest at a subsequent period. So there is some level of movement and change in that ranking process; all of which suggests that a movement toward a national rate may have some merit, particularly if the variations over time are in the order of 2 to 3 per cent around a national average which is not significantly different from the differences in financial performance between homes in the one jurisdiction. Do you have any comment?

MR COLLINS: Mike, one in principle I would suggest - Geoff Collins again - the best system has got to be that system that reflects the actual costs in any jurisdiction. So if the actual costs in New South Wales are 5 per cent today, higher than they are in Western Australia, then the system should accommodate for that variation, because over a 12-month period for example the net cash effect of that can be very, very significant. Similarly any adjustment process should in my opinion - if it was operating to its optimum level - allow for adjustments or variations that occur within a particular jurisdiction.

The Western Australian situation for example in relation to workers compensation, if the system is true about its ideal to compensate or to maintain the viability of providers, then it must have in place a system that spontaneously in my opinion adjusts to movements in the costs of providing those services, otherwise over time what you'll get is what we're experiencing now, natural run-down in the extended quality of service.

MR WOODS: I'm interested in your comments that the subsidy should reflect the actual costs. That can lead to a subsidy design based on reimbursement in which case I don't see the incentive for providers to improve their efficiency while maintaining an appropriate quality of care, and if we can take it down to the specific level of workers compensation, we've had various views put during this inquiry, some of whom have argued for specific recompense for actual premiums paid, while others have argued for a subsidy or inclusion of workers compensation in the subsidy so that those who

have sound occupational health and safety practices and record and who therefore have the benefit of lower premiums receive a reward and have an incentive to do so, whereas those who don't, incur the financial penalty and similarly have an incentive to at least get back to the average, with the one proviso that has often been expressed, that there can be occasions when there is a significant claim that is largely outside of the control of the provider, and that that can - because of a 3-year or similar claw-back period as it affects their premium can significantly affect their viability. I'd appreciate your further comment on that.

MR RIDGE: Mike, it's Ken Ridge. I guess in my own organisation's journey through the workers compensation saga this year, in talking to our broker, there was a distinct belief that the industry had done a disservice to itself in previous years and now was about to sort of hit back with some vengeance in terms of the position that they found themselves in, but the thought also has been expressed that a claims under common law had caused the issue to sort of bubble to the point that it's at now. So I guess that's one of those things that is outside a provider's control.

Certainly in Western Australia with a 40 per cent hike, we were told that that was a reflection of what was happening to the industry as a whole as the second gate, and our state government is trying desperately to close that, and there is still some debate going on about that, but that's an issue for example where you can't control that. Again our own experience was that up until the last 2 years, we were one of those organisations that had benefited under the previous structure of being rewarded because of our claim history. You only need to have sort of one bad year, and all of a sudden that previous history has been forgotten, and you're lumbered with what we're experiencing now in this state along with everybody else; this 40 per cent hike plus a 50 per cent penalty.

So those two factors I guess are just highlighting maybe the point that you had made; that there are some factors outside the control from time to time that will occur. So I don't really know what the answer is except to say philosophically I think I personally - I'm just expressing my own personal viewpoint - I think that there is scope - there needs to be scope for rewarding those that have done well, and some opportunity for those ascribing to do better to be recognised in whatever finding you can come up with, and I think the previous CAM and SAM arrangement did in fact identify that.

It certainly did in our own case. We've seen our need to improve and to do better than what we've done in the last year and a half, and we put a risk management. That's also a cost on top of the additional costs that we have incurred in terms of just having somebody being prepared to underwrite us. I'm not sure whether that's making sense, but I'm just trying to share with you what we're doing in a practical way, and yet there are issues outside that we just can't control.

MR WOODS: If I can respond in part on that, the extent to which there is a change to the fundamental cost of workers compensation such as the 40 per cent increase across the board in premiums in your case would be reflected in the annual indexation

process that is being proposed. The variation however between providers in terms of whether they receive discounts or additional penalty costs due to performance, if you incorporated workers compensation into the subsidy would be a matter borne by the individual providers, as I say with the exception of some form of safety net that recognised where a major claim threatened the viability of a home over a period of years, that some form of support would be needed.

So the subsidy structure that is proposed in this paper can adjust for and reflect the base premium increase such as you've experienced, but allows those who receive discounts to benefit from that and those who are incurring penalty payments to have to meet those costs, reflect on their causes and change their practices.

MR PHILIP: Could I take you a little bit further on workers compensation?

MR WOODS: Yes, please.

MR PHILIP: It's Bill Philip. I canvassed in my submission attachment C was a summary of the marketing that my broker did to renew my workers compensation in July, and you'll see if you look at it there are six quotes received or six people that we solicited a quote from them. Three of those declined to quote, one didn't quote, and two others whacked a 50 per cent loading on us. Our claims experience in the 12 months prior to that was by no means unacceptable. There was one claim of any significance, and it was no more expensive than other claims that had previously got us a 20 per cent discount.

We went from a 20 per cent discount to a 20 per cent loading, and the point that you need to bear in mind is that we actually have to pay those premiums in advance. So you're talking about an annual indexation picking up at 12 months behind the play. We're to the extent of this year $50,000 out of pocket waiting for some adjustment along the track, and $50,000 with the smaller nursing homes is a killer. It's a huge amount of money.

Now, we've marketed ourselves around the industry. We have met all the requirements of occ health and safety. We have met all the requirements of occ health and safety to do with accreditation. There is nothing more - and none of our brokers or anybody else have been able to point to anything - that we should have done to minimise the impact of this, and yet we are still being absolutely crucified by that one cost issue. I don't suggest that there is collusion between the insurance companies, but it's almost like there is. They seem to be singing the same song at the same time. Perhaps it's just being placed with the same dividends.

MR WOODS: Thank you very much for that. I've been reluctant to actually draw on the detail of your submission because I note that it has been classified as confidential unless in terms of the evidence you're giving now you're happy for that classification to be removed or waived in part.

MR PHILIP: I didn't place a confidential classification on that myself, but I have no problem with it being discussed at all in detail in its full entirety.

MR WOODS: Thank you very much. I appreciate that. Are there other people who wish to speak on this workers compensation issue and their views or preferences for a subsidy that includes the state average perhaps, premium figure versus specific reimbursements.

MR TAYLOR: Jeff Taylor. I'd like to just make some comments on it. In your table 5.3 where you talk about the current arrangements in your proposal, I guess we're talking about your third point there as the regional differentiation in basic subsidies, and you talk about going to a uniform national rate. I would agree with that on some provisos, and those provisos would be that it be the required rate or a required level not at an average level because an average brings some people down and some people up, and there can be numerous reasons why some people are down and some people are up and all sorts of things.

As you have rightly said through your paper, there are numerous reasons for various differences, but overall you're looking at the fact that say the top category, category 1, is around a hundred dollars, and in some states it's 103 or 4 and in other states it's 98. So that overall there's, say, a 5 per cent difference. Bringing it to an average would not be the right thing to do. If that figure is say 101 or 102 as a median, then I would agree with that. On the proviso - and unfortunately the Prime Minister got it wrong on 5 November when he cancelled accommodation bonds. One component of the accommodation bond system was that there was no capped figure as to what a bond could be, and the accommodation charge came in and was capped which meant that we went back to the same system we've always had. The SAM fee was capped, the other items were cost reimbursement.

Prior to SAM coming in in 1987, we were all on a cost reimbursement, but the government set the fee that they would pay and then the resident paid the rest of the fee. Now, in a single room, a double room, a four-bed ward, etcetera, those figures were not based on what they could afford in the government's opinion. They were based on the balance left over after the government paid their subsidy. So to go to a standard fee would be reasonable as long as there was an uncapping of what the residents could pay, and part of that I believe should be an abolishing of means testing; not in its entirety, but we have a restriction in that we have to take on 27 per cent concessional residents, and I believe the real figures - there's about 23 per cent of people that are concessional residents which means they're well catered for.

The rest of the people who have means are able to pay for a single room or a double room or a better class of nursing home. You stay at a five-star hotel if you can afford it and stay at a three-star hotel if that's all you an afford. If those things were brought in and the government's fee was there as the base and the people could adjust the rest of it and charge accordingly and if their fees were too high they would have vacant beds at no cost to the government, and if their fees were reasonable and they

were providing the proper service and standard of accommodation, then they would be full. So on that basis, I think that having a median fee would be a good idea.

The means testing is a big problem to us all and the capping of the accommodation charge is a problem. I don't see why the government should cap a fee that people that can afford it can pay.

MR WOODS: Thank you. I'll sort of move back up to those broader issues in a minute, and I'd like to specifically address some of the points you raise, but if I can stay at workers compensation for a moment and conclude that - are there others that wish to comment?

MR PRIOR: Yes, Mike, there is. Just back to the issue which Jeff raised a few minutes ago about linking funding costs. Up until I guess mid-96 in this state, we had a situation where the cost movement in the award for labour was met by a follow-on effect to what funding fell from the Commonwealth in that financial year. That is a very good system, but what has happened since then of course is that we have been caught up in this reform of industrial relations program where government funding - federal government funding seems to follow the national federal award structure and doesn't follow ours over here. So I think your situation or your recommendation exploring a national payment or national award for RNs does make sense; it's worth looking at.

MR WOODS: What we recognise is particularly in view of the shortage of RNs across the nation anyway that there seems to be some development of a national labour pool at that level. We also recognise that that's different for the personal carers for instance who - their labour markets are much more regionally sort of intra-jurisdictionally based and reflect much more local circumstance. You would agree with that?

MR PRIOR: Absolutely. I mean, I guess it's the same market. If you go back to a comment you made earlier, we deal with the same market for the same supply of professionally-qualified labour. Whether you're the government of Western Australia, you're a large player in a very small pool in Western Australia or whether you operate a small nursing home, you are bidding for the same qualified person, and as you say that qualified person is very mobile in Australia. You can get a plane from Adelaide in 2 hours. Qualified labour does travel very quickly. If you can't match it, you can't attract it.

There's one point to be aware of, Mike - I raised with you before - and that is in this state we only have 5000 high care beds, we have about 6000 low care beds. We as an industry are probably the same size or a bit smaller than the entire government of Western Australia's own health services. So they are a big player in a very small market. They set the price of labour, control the price of labour and they also supply that. So we have to follow in their footsteps and their wash so to speak. So what Jeff commented on before about the cost for labour, we should look at very carefully, and

go back to what the federal Industrial Relations Tribunal did agree to. They amended the awards in 1996 on the basis that federal funding would follow for the state.

It didn't follow. The ANF delivered a 14 per cent increase in wages for the public sector in February 96, of course we got left behind. Now, it's moved on from then from 10 to 12 to now 20 per cent in the last round negotiations with the ANF. We have no legislative capacity to deliver the similar result unless your reform or your review does deliver some kind of national outcomes.

MR WOODS: Thank you. Yes, we are very aware of the differentials applying in WA. Perhaps I can move back up to some of the points addressed earlier, and looking at the question of benchmarking. In the preliminary proposals that are put forward in the position paper, we're looking at devising a standardised input bundle which would identify the cost pressures experienced by the industry across jurisdictions, but ensuring that that input bundle delivers an appropriate benchmark level of care, and the question is is there is a benchmark that is appropriate and can be readily drawn upon for the industry?

The proposals that have been put to us to date suggest that the accreditation process is such an appropriate benchmark, although it requires assurance that the accreditation process will in an objective way identify a common minimum across homes and across jurisdictions, rather than rely more on the issue of continuous improvement which could suggest variable minimums that one starts with provided everybody is heading upward and onward. I would appreciate your reactions to whether the accreditation process to the extent you're across it - and we all understand yet to be sort of delivered in the field so to speak, but what are your views as to whether that forms an appropriate benchmark for establishing a subsidy?

MR RIDGE: Mike, Ken Ridge. I guess that's a bit difficult because each of us in our own organisations may be addressing accreditation in different ways, so I can only speak on I guess our own experience. For some time prior to accreditation, I guess the thing that I was trying to get across to the government whenever I had an opportunity was that we were being asked to respond to a national program but with state idiosyncrasies impacting on that, and let me just expand on that. What I mean by that is at the bottom of all that is a process which we have now got of course. We've moved into accreditation. We've got the same standards that we have to meet here in Western Australia that other providers meet in every other state.

That has been the case previously with the SMT visit situation, and I guess in this state we have had some issues that I put in our submission to you, that we've had a history in this state of low category 1's and smaller bed numbers and so on. Now, I raise that because I guess when you talk about benchmark, that's an issue in terms of how do you arrive at some sort of commonality when you're assessing organisations. Some of our rural and remote members for example have very few beds in terms of their numbers In our own organisation, we operate in two rural towns, and certainly if we don't know what we know now I guess, but even going back a couple of years, we certainly wouldn't have put our hand up to set up aged care facilities in country

towns, given the bed numbers that we're forced to operate with, given that you're still being asked to meet the same - and rightly so - levels of care for your residents.

I guess in returning to your question but with that sort of preamble in the background, I think from our own organisation's experience, we've certainly embraced accreditation, we've had to allocate funds to it. We're saying the government needs to realise the cost of this, but in terms of needing to I guess respond to your question, I think that our view would be the new accreditation agency and what it stands for and what it is attempting to do I think does create a common level of care that we're all required to address and respond to.

The white cane inference to that of course is how do rural and remote organisations respond to that compared to perhaps a multi-facility organisation? The agency has been assuring our members that in the rural and remote areas, they will be assessed according to I guess their means and what they can demonstrate they are doing given their environment, their locality, their numbers and so on. So I guess that needs to be highlighted. That does cause some concern I think for the smaller rural and remote providers, but I think that overall, speaking personally I feel that the new standards and the approach to that and the requirements that we are being asked to address that, that's keeping us busy enough without having to worry about being benchmarked against some other bundle of inputs if I can use that expression.

MR WOODS: Thank you for that, and I will - - -

MR RIDGE: Is that making sense to you?

MR WOODS: Yes, and I understand your points. I'd like to separately address the question of rural and remote because we do address that in a specific recommendation, and I would also like to touch briefly on the question of an efficient sized facility. I'm focusing particularly at the moment on the benchmarking and accreditation, and can I inquire whether Dr Flett is in the audience with you today?

MR PHILIP: No, she's not.

MR PRIOR: She was due here, but she couldn't make it unfortunately.

MR WOODS: It would have been interesting also, but I'll pursue that separately, and we are meeting with agency staff as part of this inquiry process, so we will be taking that avenue further. Further comments.

MR PHILIP: Bill Philip here, Mike. I take what you were saying is that you are looking at the annual increase based on some agreed level of care and looking at the accreditation as that point where you're meeting the agreed level of care. I can't see a difficulty with that except that there are a number of different levels at which one may achieve accreditation which would be 1 year or 3 years and depending on the number of points that you've got that require addressing. You can still be accredited and still have considerable problems.

If you hit on some sort of average level of accreditation within accreditation, then you would have a benchmark that at least would be reasonably consistent.

MR WOODS: We do intend to specify it and are conversant with the accreditation process, and whether you achieve standard or whether it's above standard and whether you receive the 1 year or 3 year. So, yes, we'll take that into account and we'll be discussing it with the agency and are receiving submissions on that issue. I will be addressing that in the final report. Thank you.

MR .....: Mike, Murray (indistinct) Aegis Health Care. I spoke to you from NANH. Mike, it worries me just a little bit that accreditation is going to be seen as the benchmarking vehicle because of the problems that Bill as well as others have raised. My concern with accreditation is that I don't have a problem with the concept of people achieving standards, as long as the standards that - I think your commission did raise the issues about that the funding and subsidy should be commensurate with the expenses of accreditation which we don't know as yet entirely, but if accreditation was part of the government's incentive which is by virtue of the user-pay system, then funding and the capacity for people to reach certain standards of benchmark should be rewarded by way of some incentives associated with accreditation.

Ergo that means if you seek 3 years, your accreditation - the value of that accreditation and your benchmarking level should be far more valuable than somebody who possibly receives one. So I would say accreditation should be linked into incentives rather than the standard point of benchmarking, on an input bundle. That's what I'm talking about. I don't know how you could do that.

MR WOODS: Thank you very much for that comment. I noted in some earlier introductory comments concern about the costs of meeting accreditation, and of course that you can subdivide into two types of costs. There's the cost of the accreditation process to your own organisation, not only in terms of fees paid which as you say is yet to be finalised, but also the training and other costs for your staff to become familiar with the process, but there's also the costs of raising in some instances standards to meet accreditation.

On the basis that the proposal that we put forward here would recognise costs relating to the process of accreditation as being one of the input costs that you necessarily incur, that would be dealt with, but is there a view in Western Australia that within your jurisdiction there will also be sizeable costs met by many agencies in actually improving standards to meet the minimum of accreditation?

MR .....: I would say there would be, Mike, because accreditation goes along with building standards. It's part of certification.

MR WOODS: Yes.

MR .....: It's very hard to pick a figure, but in my experience in accreditation, it's very expensive, and nobody minds that I suppose if at the end of the day there are some real rewards associated with that. Yes, we expect the costs of trading, upgrading facilities, upgrading staff training, allocating somebody - normally that person would be more than likely a senior person of the staff, more than likely a senior nurse - to lead the process of accreditation, not to mention capital infrastructure, costs in equipment. So for small facilities that don't have the capacity of sharing resources, I feel quite sorry for them.

In one of our facilities of 44 beds, I have done a very rough - prior to actually allocating the cost of accreditation, the agency cost, but a dollar a day per resident, 44 beds. That's just in staff training and infrastructure costs, stationery. There's a list of about 10 items. So a dollar a day per resident. That suggests to me it's going to be quite - and that did not include costs of bringing the building up to certification standards or meeting certification standards, increases of 19 out of 25, and other issues in order to reach 60, just straight infrastructure costs and accreditation without fees, a dollar a day per resident, and I wouldn't hang my hat entirely on it.

MR WOODS: Is that a view shared by other operators?

MR COLLINS: Yes, Mike. There are a range of both direct and indirect costs of accreditation, not only in attaining accreditation, but equally importantly in maintaining accreditation. So there's an ongoing role in cost to the industry that's not reflected anywhere at this stage in maintaining those standards.

MR WOODS: Other comments?

MR PHILIP: Yes, I think it's hypocritical of the government to expect us to achieve accreditation which I have great empathy for their desires. I think it's a great idea, but at the same time as effectively if you look at the costs that we have been stuck with, they've taken money out of the system overall and expected us to achieve a great deal more with it. It is going to be a very expensive process. We are well along the track towards doing it and it has cost us a lot of money. We feel that it's important to be there and doing it and get our stuff together early so that we are well ready for it. We've spent a lot of money in it.

MR .....: Can I also say, Mike, the government has not reassured us that procedurally and legislatively they haven't placed a mechanism to offset those providers who because of a backlogging of people applying towards the end of 2000 it ought to be certified by 2001 that they can deal with someone who unfortunately misses out by 2001 either not to be inspected or, having failed the first round, not to get a reinspection. They can't reassure us that we will not lose funding levels by 2001 - 1 January. So I think there are fundamental problems that they have got to reassure the industry on.

MR WOODS: Yes. I have been brought across those particular difficulties, and no doubt Dr Flett is also very well aware of them.

MR DORRICOTT: Mike, Dorricott again. I don't know whether this is the proper time to talk about it, but the efficient size also relates to the allocation of beds and all sorts of things which in turn relates to accreditation because obviously larger individual establishments or in placed establishments, it will be virtually easier to spread the costs across the wider group than a small group, but this may not be the time to talk about it.

MR WOODS: No. I'm quite happy to talk about size of facility. Perhaps if I can make a couple of comments and then go back to you on that issue. In the preliminary proposals of the, we identified the need to identify something in the order of an efficient sized facility, and there has been evidence put to us that a facility of the size of say 60 beds is within that ambit, recognising that it also travels upward to 100 plus, but there might be inefficiencies then occurring once you start to reach 120 onwards.

The idea of identifying a particular sized facility was not then to be prescriptive as to what should be the future size of facilities, and it doesn't take many years to go back to note that the preferred size was somewhat smaller than that, but also that the state of the art ward were four-bed wards. So these views and matters will change over time, whereas if you constructed a four-bed ward facility some 20 years ago and now find that there is a change of view on that, it doesn't change the facility. You still have that which you built.

So the purpose is not to be prescriptive as to what should be the size, but to recognise that in designing a subsidy, you have to have some view in mind in devising your input bundle as to what it is drawn from, and it is possible to in fact have a range of facilities I would argue still within an efficient band which may go down as low a 40, 45 and up higher than 60, but I would also make the point that at the moment, irrespective of size of facility, you may be an operator of six beds, or you may be an operator of 140 beds, you still get the one subsidy figure depending on the RCS classification of your residents.

So the one subsidy size fits all facility size at the moment, so there would be no change in that respect other than that we recognise the inherent inability of rural and remote to provide large facilities, and we also recognise the inherent other structural features of rural and remote which are not just transport costs and costs of bringing up relief staff and the like, but dealing with greater intensity with those whole of life issues that are required when you are operating in those communities, but I will leave rural and remote to one side for the moment, and the size issue as it affects them and concentrate more on for the remainder of facilities.

We have taken evidence and see some merit in expanding the range of facilities that you would include in devising an appropriate standardised input bundle, but would still argue that those facilities must be within the broad limits of what constitutes efficient operation. I'd welcome your comments.

MR DORRICOTT: I think the point I have a concern for is that if there is an efficient size, then it seems reasonable that we should be able to proceed to that size by amalgamating beds available to us, but then we have the constraint of people saying, well, that's an under-bedded area and this is an over-bedded area, and all those sorts of comments which are legitimate things for them to say, but the fact remains that if we're promoting business, there have to be commercial decisions as well, and one can't - I have experienced in some places that people travel far and wide to get the services that they want.

We have a concern particularly in Western Australia where the allocation of beds has not been large so that there has been an encouragement - Ken mentioned you know, the number of beds you may get for a facility in a particular area isn't necessarily an economic size, but if you try to amalgamate other beds with them, you may be constrained because of the opinion that you are taking beds from one area that shouldn't be taken away, but after all you can only take beds that you've got. You can't manufacture some additional beds.

I think it would be necessary to try to find some way to enable us to bring together smaller groupings of beds to make them into one we the providers also consider is an efficient size which may be 60 beds or may be 80 beds because they are providing an environment in which the staff also gain benefit, an environment in which the residents and their families gain benefit.

MR WOODS: Thank you for that, and whereas I recognise the intent behind the current very tight regionally based allocation of beds, I also note your point that that doesn't easily allow structural change in the industry and a move to more efficient practice while still delivering sound quality care, and the final report will note that point. Are there other comments on this issue?

MR PHILIP: With regard to the determination of what is an efficient size, there are some givens which none of us can effect. One of them is this 168 hours in a week, and you've got to have registered nurse coverage. One of the things that determines efficient size is how many residents you've got to defray the cost of 168 hours of registered nurse coverage as a minimum, and that gives you a figure somewhere in the thirties as a very low minimum. Then there are areas like cooking where you can get one cook to cook for so many people but no more, and when you get to duplicating the number of cooks, then you've reached an inefficient larger size.

So I would take your points that there's a band of efficiency. From 20-something years' experience in the industry I would say that it starts in Western Australia at around about 40 to 45 beds and it probably goes up to around about 60 to 65. Any smaller is unviable. Any larger is unwielding, but the other point that needs focusing on in this day and age of changing the style of accommodation that we're giving and looking more at putting en suites and single rooms and things throughout is that the shape and nature of your building will determine to a large extent whether or not a particular size is viable for you.

There's one nursing home in Perth that we built about 10 or 12 years ago, and it was built as a series of cluster units. There was a vast amount of public area and an enormous amount of freedom and space for the residents, and it rapidly proved to be a black hole cost-wise because it was too expensive to clean. It required a number of extra staff to cover the ground that it occupied. It was about the same number of beds as ours - 45 - and it was more than twice the floor area. So we're now looking at bigger and flasher nursing homes with more facilities. We are looking at pushing up the costs per bed of running those facilities, and it's something that your commission needs to take into account when determining the band of efficient sizes; that it's not just the number of beds, but floor area that they have got to cover with the staff available.

MR WOODS: Thank you. I think we're conversant with those issues, but thank you for that. Are there other comments on this issue?

MR PRIOR: Mike, can I raise the issue again of benchmarking?

MR WOODS: Please do.

MR PRIOR: Where exactly is your thinking going on this, if you perhaps just divulge that on benchmarking?

MR WOODS: I had thought I had made it clear, but we are looking to designing the subsidy so that those facilities that meet the accreditation and certification standards would be considered appropriate for inclusion in the devising of an input - a standardised bundle of inputs. Is that not something that - - -

MR PRIOR: I guess I want to look at some to date, Mike; all the reform process has being very punitive in a sense that if you don't get accreditation, you lose your contract in 24 months. You've heard today that everyone is suffering because there is no increase in funding and it's all additional requirements at all levels by the Commonwealth to stay in business. My concern is that if you introduce this kind of measure too soon, it also becomes indiscretionary very punitive, too, or it may be.

MR WOODS: Could you elaborate on that for me?

MR PRIOR: Some nursing homes may meet accreditation, and say they do in the year 2001. Are you likely to benchmark them and not give them additional funding or exclude them from some sort of like process? Is that where you're going?

MR WOODS: From our point of view, the accreditation process is separate and outside of this inquiry, but where I am to look at an appropriate funding methodology, from my perspective the standardised bundle of inputs needs to be capable of delivering an appropriate level of care, and my thinking at this stage is that the appropriate level of care that should be settled on is that which receives certification and accreditation.

The process of accreditation is separate from my inquiry, but I would want to ensure that any base upon which a subsidy is built is sufficient to meet accreditation and certification standards. Are there other comments on those issues at this stage? If not - yes?

MR COLLINS: Mike, I've got a general comment. Geoff Collins here.

MR WOODS: Yes, Geoff.

MR COLLINS: Mike, do you propose to actually test some of your precepts and concepts prior to finalising your report? Some of these concepts that you are dealing with are in some regards very, very nebulous. The variables are almost mind-boggling when they're actually applied on the ground. You've heard many examples of those variations; building design, depreciation, capital refurbishment. There's a whole raft of variables. What I would strongly encourage the commission to do is to actually go out and test some of these precepts and concepts with actual living establishments, and just see whether they actually produce the - you know, shall we say the model outcomes that are envisaged from this.

MR WOODS: We have been talking particularly with peak bodies as to the greater detail of these design features, and they're certainly giving thought and input to us on what that means on the ground. So I do understand your point and certainly wish to ensure that our recommendations can have practical implementation and don't in that detail suffer design failure. So to the extent we are able within the time that we have, I certainly strongly desire that the recommendations are robust and have practical intent.

MR DORRICOTT: I think it's important to add to the comments you made with regard to the change in standards that have occurred over a period of time, and I come back to the question of stability. It was not many years ago I applied to build something and have a series of single rooms. I was not permitted to do that because at that time the decision was you could have one single room for eight residents. Recently we have built a kitchen to comply with all the regulations of some 3 years or 4 years ago, but now find that there is a whole new raft of regulations and this kitchen which was said to be a state of the art kitchen is now not good enough after 4 years.

It's very difficult to operate as a business where this sort of attitude is prevailing. Most of our laundries in the state facilities will not pass the new regulation for laundries even if you built them just recently. This is a great difficulty when we start talking about standards, and it leads us to have some lack of confidence as to what standards will prevail in 3 years time or 4 years time. We need some period of stability. We need to have standards that were set that we can live with for a period of time. I ask you to think about this in some way.

MR WOODS: I understand the consequences of those changes and I note your very heartfelt plea in that respect, and I'm happy to pass on that view by way of this report, but there are certain matters of jurisdiction that are well outside the scope of this

inquiry as you would appreciate. Could I come to the question of extra services. We make some recommendations in this position paper which to date have generally been receiving some support. What I'm interested in is not only your views on the preliminary proposal that is currently in the position paper, but also your view on the future for extra services.

If I can preface that in part by noting that for many providers who have no desire or intention to provide extra service places are in fact building facilities of single-bed wards with either dedicated or shared en suites and providing food standards and the like which may have the effect in part of undermining what might have otherwise been the extra service market, but nonetheless are to the benefit of the residents living in those facilities. I'd welcome your views on that particular issue.

MR TAYLOR: Jeff Taylor here. We have an extra service place in Western Australia, and we generally agree with your proposal regarding the extra service places. The only problem we've found, we've had no problem getting the people to pay accommodation bonds, we've had a problem with people where there's the claw-back to the government which you recommend abolishing, but as I said before, the needs testing coming on top of the fee that they're paying means that they can be paying up to 75 per cent of their extra income in extra service fee and means testing.

The means testing itself is a problem, and perhaps if you can look at the extra service fee you've deducted off that income before they look at the means testing to make it more reasonable because we have had many people say, "Yes, the accommodation bond is fine. Yes, I'll pay the extra service fee because I realise I am getting extra," and then when it comes to the means testing they say, "Hang on, this is all getting too much," and then they look at going somewhere else that provides a similar service, and they pay no bond and they pay no extra service fee. They're still means tested, but that means testing amount is exactly the same as it is in the extra service facility.

So it's meant that it has been very difficult - not very difficult; it has been more difficult to get the people in because of that means testing. Prior to it coming in when we had that period of time where it wasn't in, we at that same time had a large turnover of residents and filled the beds quite quickly with new people coming in, paying the extra service fee and the accommodation bond. So to encourage people to take up extra service places and for them to be successful, we think that they need to look a bit further at the means testing part of it.

MR WOODS: Are there other views from providers on this field?

MR .....: Just supporting Jeff, but the extra services fee which is paid at the point of entry and the accommodation bond, but unfortunately for residents, it could be 28 days or 30 days after admission before they find out what their income-adjusted fee is. So it becomes a bit of a shock because we can't tell them what the full amount is at the point of entry. It comes later.

MR WOODS: Yes.

MR DORRICOTT: I think you've raised the issue, Mike, about the competition that could exist between places that provide somewhat similar accommodation, and this was brought about to a large extent in this state because of the capital grants system that existed where people were assisted; had considerable grants given to them and could build to a very high standard; often the standard that the primary operators couldn't build to, so they are placed in a position where they have facilities that are sometimes very much better or of a better standard in building than has been the case with private operator.

The question now of course is without capital grant system, whether that is going to persist in the future is unknown. I think philosophically there seems to me to be a reticence in people in Western Australia to make any contribution or any extra contribution towards their (indistinct) visiting the eastern states and going to extra service facilities there and comparing it with - and the willingness of people to pay for the services and comparing it to what exists in this state, there is a quite different market. Those are more readily acceptable, and we found this in the retirement villages that we run; the amounts many people are willing to pay in the eastern states is quite different to that which they are willing to pay in Western Australia. This may just be a temporary thing or it may be a different culture; I don't know.

MR WOODS: Thank you very much. Are there any further comments that people wish to raise on extra service or have we canvassed that issue? Perhaps if I can look at the recommendation on special funding for services in rural and remote, and I will perhaps take it as given your view that as many of you have expressed in your written submissions that this should be funded by additional funds, not some form of rebalancing of the existing pool of funds, and remind you that my terms of reference relate to the form of funding and not the quantum of funding. So perhaps we can put that debate in its context and look particularly at whether in our judgment there are needs that extend beyond that which could be constituted by national average subsidy in those rural and remote areas. Have we got it right there?

MR COLLINS: One of the key factors, Mike, is the ability to attract quality staff to these localities. There's quite often a problem in definition of shall we say other than capital cities' locations, and I think I may have encouraged you to look at this principle of regional locations as well because they suffer some of the same shall we say disadvantages, but certainly one of the key ones is a regime that would attract and sustain staff to those locations. It's a bit like the doctors in remote localities syndrome as well. So the same principle very much applies not only to qualified staff, but even unqualified staff to maintain those.

I had 6 years in the federal Department of Aboriginal Affairs, and the experiences that we're experiencing here in terms of attracting and maintaining staff are the same. So that's a key issue; you know, the subsidies related to staff should provide some sort of incentive to keep attracting and maintaining these people.

MR WOODS: And is the extra effort required to attract them not only in terms of their lifestyle living in some of those areas, but in the demands placed upon them in the workplace as to the much broader level of whole of life care that is required to be delivered?

MR COLLINS: Absolutely, and there are other issues - cultural and other issues relating to for example Aboriginal groups and things like that that find themselves, you know, perhaps disproportionately represented in these places. So, yes, there is a whole range of issues, but I understand that you have been visiting these sorts of places, and you would have very much got it at first hand the peculiarities and uniqueness of some of these locations.

MR WOODS: We've ensured we've not just visited the metropolitan areas, but have also - yes - travelled as extensively as the time would permit within sort of a reasonable bound.

MR COLLINS: So once again, looking at a model, Mike, you're looking at infrastructure costs, operational cost differentials - - -

MR WOODS: We've had a blackout on your screen at this stage. If you are still there, if you could hold and we'll attempt to remedy the situation. We are back on air. Apologies for that disruption. I don't know at what end that was occurring. We'll just wait till I reappear. As I understand it there I am. Very good. Nice to be back. We were finalising a discussion on extra service places. Are there any concluding comments on that issue that people wish to make?

MR PRIOR: No.

MR TAYLOR: Can I just in closing - your proposal 12 dealt with it, and besides the point that I said about means testing, we totally agree with the three issues that you've got there. We have made those sort of comments ourselves, so we commend you on what you've got there.

MR WOODS: Thank you. A matter that was raised a little earlier if I could just return to it, and that's looking at the profile of the RCS scales as they apply in the different jurisdictions, and you make the point about Western Australia having very low representation at RCS1 in particular, but also in RCS2. The Aged Care Australia submission suggested that in part that may be due to different validation practices in the different jurisdictions, and then offered a range of other factors that it may relate to. Are there any views within Western Australia as to the reason for that particular outcome?

MR COLLINS: Mike, I can give perhaps a guide here. It could be purely related to demographics; in other words access to the pool of persons within that aged demographic. So in other words you'd expect by definition that a location in Sydney or an older developed area would have access - you know, with a population of a million people would have access to a far greater pool of people that were in the level

1, 2 category whereas obviously in the smaller demographic areas where you had small pools of people - say 500 people - the level 1's would be therefore proportionally not represented as highly. So I think some testing of the demographic distribution of the aged might provide a guide there.

MR WOODS: Other comments?

MR DORRICOTT: I find that argument difficult because if you have a proportionate number of places to accommodate the size of the population, then the distribution within the size of the population should tend to be similar. At the same time, there has been a lot of (indistinct) about why it happened, and I think I would support the view that ACA put up, that there seems to be a different methodology or attitude about what would properly constitute (indistinct) but I must admit that in our experience we are being more successful in getting high classifications under the new instrument than we were under the previous instrument.

MR WOODS: Thank you very much. If I could just towards the end of this hearing ask of Mr Philip a couple of questions in relation to Valencia Nursing Homes - and again thank you for the (a) of lifting the confidentiality tag - and I note that as you say that didn't come from you in the first place, but also of the way in which you have set out the position of the home. I notice in your cost structure a number of areas which I find not unsurprising in relation to your food services and wages and laundry and the like.

There are a couple of items that I would like to understand a little further, and one is consultants' fees. What sort of costs are borne by agencies to meet those consultants' fees?

MR PHILIP: The consultant fee in our case is the director of nursing, who is my wife, and myself working for another company and charging our services to the nursing home. So that effectively would equate to an administrator and a director of nursing's wages.

MR WOODS: So they would be on top of the wages component that you have got there; you just add the two in another circumstance.

MR PHILIP: Correct, yes. In those predictions, the agency staff which includes subcontracted paramedical staff from a crowd over here called Agency Health Services who have supplied OTs and physios to a number of places are shown as agency staff, not consultants.

MR WOODS: Yes. I notice you've got agency staff as a separate item, but you also have subcontractors as a separate item, and I was wondering what that related to given that things like laundry and food services are separately identified. Subcontractors, are you suggesting, might also be of the agency staff variety? I notice that under agency staff you have a very low figure there, whereas it's much higher under subcontractors.

MR PHILIP: Basically, yes, that's the case. Agency staff fit into one or other of those categories. That's actually prepared by our accountant and he seems to vary from time to time a to where he puts things. I offer no comment.

MR WOODS: Me neither. Thank you. It has helped us gain an understanding, and a number of agencies have provided us with that level of information, and where they have done so it has been very helpful. Spanning across the various submissions and opening comments that you have made, I think I've covered in large part the areas I wish to pursue further. Are there matters that you wish to deal with in any greater length before we conclude this hearing?

MR PHILIP: Payroll tax is not one that you've mentioned at all, Mr Commissioner, but it is something that is of great significance to the smaller independent nursing homes, and particularly again in Western Australia, that the level of under-funding is very significant indeed, as you will see by the table that I sent to you, and it's something that every month is taking a bigger chunk or another chunk out of our viability, and it's one that there are concerns about; the fact that places that don't pay the full measure of payroll tax are getting a full measure of subsidy, and places that do pay a full measure of payroll tax aren't getting the full measure of subsidy.

MR WOODS: I didn't raise it in that I had taken it that there was a general consensus of views with that put forward by the commission, but I'm happy to test that further. You'll note our recommendation that payroll tax supplement payable to facilities that are registered to pay payroll tax, and in the body of the submission to identify payroll tax is one area that is worthy of warranting a reimbursement.

When you look at the three areas of payroll tax, workers compensation and superannuation, superannuation hasn't been dealt with in the sense that it is a national rate and it is non-discretionary, and therefore in any development of an input bundle at a standardised rate, superannuation would be a common element across all agencies. Payroll tax is similarly non-discretionary, but does have both jurisdictional and within-sector variations, and hence the views in this paper that perhaps reimbursement is the appropriate way to go.

Although there then is the question of do you reimburse payroll tax only as it relates to your primary payroll, or do you expand it to include agency staff? If so will those who choose to outsource their food delivery and laundry also wish to have the payroll tax element of those payments included, in which case then those who have a handyman on their pay staff will have it reimbursed, but those who hire in a plumber for fixing the taps won't, and should that element of that invoice be identified? You can pursue that down to its nth degree, and to some extent you actually have to draw a line as to what constitutes a reasonable approach, otherwise you're going to get yourself into a very high cost administrative process for very little gain.

Then we've dealt with workers compensation and recognising that there is a non-discretionary component in the sense of the base premium, but a discretionary element in the sense of good practice can be rewarded. So in that sense - - -

MR PHILIP: That actually isn't true. That good practice can be rewarded with regard to workers compensation classically doesn't work because you don't have an awful lot of scope to muck around any more. Perhaps 10 years ago none of us had the occupational health and safety supervision or requirements that we have got now, but nowadays I don't believe there's a nursing home in Australia that isn't paying proper attention to its workers compensation costs. We're not getting rewarded for it because the insurance companies who are interested in writing the business are few and far between and can basically say what they want to say and do what they want to do, but there isn't that discretionary element. There maybe was 10 years ago. We've been thrashed into submission, there isn't a doubt.

MR WOODS: Would you as an extension of that therefore be advising the commission that all homes have equally good occ health and safety practice?

MR PHILIP: I would say they have at least some sort of a basic standard of good occupational health and safety practice. There would be of course some that would be better than others, but I don't think that there are any that pay no attention to it and deserve to be punished, but there are a number of things that can happen to you on any given year that are completely outside of your capacity as an occupational health and safety manager to predict or to counteract that will affect your premium. In other words the down side of it is considerably bigger than is warranted by any sort of improvement in premium.

MR WOODS: Thank you. I understand your view on that one. If we can just conclude the discussion on payroll tax and people noting what was put in the position paper, are there any views either in support or in opposition to that?

MR PHILIP: I believe that the system that worked prior to 1996 for reimbursement of invoices that included a payroll tax component which was basically agency staff and various contractors such as agency health services over here, plus the straight costs of your nursing home or your hostel payroll tax worked quite well and was probably fairly cheap to administer. I take your point that it would be ridiculous to go to the fridge mechanic and get him to stick a payroll tax component in there.

There are excesses that one would eliminate, but I think that the line that was drawn in the sand previously worked pretty well. It wasn't an item that we could avoid, it wasn't an item that we were burdened by. Now it's an item we are burdened by.

MR WOODS: Is that a common view?

MR PRIOR: Yes.

MR WOODS: Thank you very much. Are there any other matters that people wish to raise that haven't been dealt with already?

MR TAYLOR: Can I just raise the point in your proposal 4 about the productivity discount - - -

MR WOODS: Yes.

MR TAYLOR: There hasn't been any support for that, except from the Commonwealth government, and how would you see that coming about? I mean, we would be totally against the productivity discount considering all the efforts that we make just living within the fees that we receive.

MR WOODS: I have during the course of this inquiry received what I would describe as support from a number of bodies including some peak bodies who have said that they understand that productivity gains need to be shared between interested parties, and those interested parties constitute the providers, the employees who actually carry out the productivity improvements in the workplace, and the taxpayers who fund the service, recognising in all instances as ACA reminded me in hearings yesterday that the intention of all of the productivity gain is to improve the quality of service delivered to the residents.

But I would say that I haven't found universal objection to the concept that there are other than for the residents three broad stakeholders who should be recognised in this process.

MR TAYLOR: So how would you quantify it?

MR WOODS: Well, that's what we have been exploring, and in our preliminary discussions, the idea that the ABS were producing a productivity index found its way into this paper because at that stage that may have identified the way to go through this. Subsequently in further discussion, it appears that that may not be an appropriate way of identifying it, and I'm looking for further submission from industry as to how they would put forward ways of sharing that productivity between the stakeholders.

MR PRIOR: Mike, just on this whole issue of return to stakeholders, do you intend to include some sort of dynamic there which allows some differential that already exists on a return to stakeholder vis-a-vis those who do pay income tax? There is by definition or there is by in fact legislation a return already to one stakeholder, the federal government, through that process. Would you have some sort of capacity under point 4 here to recognise that this is an inherent issue?

MR WOODS: Do I take it you would be suggesting in some form that the private for-profit sector would have a lesser discount under point 4 recognising that some of the distribution of surplus is returned to the taxpayer through the income tax system?

MR PRIOR: That's right.

MR WOODS: I took that to be the position. We certainly on that question of distribution of surplus see that that is outside the scope of the question of identifying the bundle of inputs at a standardised level. How the surplus wherever generated is distributed between owners, equity providers, reinvested in the industry, etcetera, is from my perspective a separate issue, but I do note your view that in one sector at least some of that surplus is redistributed back to the taxpayer. So I take that on board, but I don't have a view on its treatment at this stage.

MR PRIOR: That's of course understandable from your point of view. When you and I met in Perth, we discussed the whole issue of efficient allocation of Commonwealth resources on a longer term basis. It would seem to me that point 4 in its generic sense has to be extremely (indistinct) I mean if that's the direction you're looking at and of course benchmarking, that is the only way the Commonwealth of this country and its taxpayers are able to look for some indicative measure of either allocation of resources or longer term efficiency gains in this whole micro reform process.

Last year my organisation paid approximately $4000 per bed in return back to the Commonwealth of Australia in the form of sales tax or income tax, and it seemed to me that point 4 would need to take into consideration maybe some discussion along those lines. I hear your comment; it is outside your brief, but it's not outside the spirit of what you and I discussed back in Perth.

MR WOODS: Thank you. Any further comments?

MR PHILIP: One quick comment about any kind of productivity distribution, and that's that if you are going to recommend that to the government, please recommend it in such a way that it's both transparent and very, very much fixed because with the government fiddling with those things, the devil is always in the detail, and we usually find out that we've ended up with the hind kicked.

MR WOODS: I take your point, and can I assure you that transparency rates very highly in our considerations as it does in our processes that throughout this inquiry we trust we've demonstrated transparency, and we will certainly be recommending it in terms of the form of subsidy design. The transparency if I can comment there will be that the process will through identifying a standardised bundle of inputs, a cost relating to those that will provide a benchmark level of care, and in all probability relating to accreditation, the government will then need to determine a price for the outputs - ie the RCS levels 1 to 4 that it is purchasing from you - and to the extent that there is any variation between the factually-based material showing the input cost pressures and the output price that the government then chooses to apply to it will allow the industry to closely question government on the decisions it has made.

So we're wanting to ensure that there's as great a transparency as possible in the process so that there are no underlying issues of why was this particularly chosen; you will have the information as an industry before you on what the input costs are, you'll

have the decision of the government on the output price, it's determined, and you will be able to pursue with government any variation between the two.

MR DORRICOTT: I think I would like to see a distinction made between the not for profit or the profit (indistinct)

MR PHILIP: The private which should be getting charitable consideration, yes.

MR WOODS: Thank you. If there are no further comments and contributions, I will thank the witnesses for the evidence they have given. I have found it a very useful opportunity to test ideas, and I do appreciate the particular circumstances of Western Australia, and I find this a useful follow-up to the visit and the very many submissions that we have had from you. So thank you very much for that. Can I ask whether Western Health Care is in the audience and are to give a separate submission in this hearing this morning?

MS .....: Mike, Lyn Bray is ill and is not able to be here today.

MR WOODS: So will you be passing back to Western Health Care the matters that we raised? I invite them that if they wish to put forward any further submission to us directly, while reminding you of our 27 November deadline which is a week away, they are most welcome to do so.

MR PHILIP: Mike, Mr Bray has done a considerable amount more work than any of the rest of us in the areas of infrastructure costs. I touched upon it with the incontinent absorbent aids which is only one of a number of significant costs, but I will certainly be encouraging him to send you chapter and verse of what he has done because it basically sets out that we're about $12 per day per resident worse off than we should be covering the costs that we are now.

MR WOODS: Let me assure you I have chapter and verse which - - -

MR PHILIP: Would you like it again?

MR WOODS: No, but quite seriously I did find it very, very helpful and, yes, it does go to the very detailed level of aspects on those infrastructure financings of the other cost categories. If there are further matters that on reflection he would wish to send to us or the organisation, then I would receive them and welcome them, but I have appreciated that material and have gone through it, as have the staff. That being the case, and if there are no further witnesses who wish to come forward, I will conclude the hearing with representatives from Western Australia, and thank you for your attendance and contribution.

AT 3.10 PM THE INQUIRY WAS ADJOURNED ACCORDINGLY

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