Australian Catholic Health Care Association Submission to

Productivity Commission Nursing Home Subsidies Inquiry Public Hearing

Productivity Commission Public Hearing Room Level 26, Telstra Tower 35 Collins Street, Melbourne, Wednesday 18 November 1998

Introduction

The Catholic health and aged care sector is a significant part of Australia's overall health, aged and community care industry. It provides a wide range of care services to the community, specifically through:

public (including teaching) hospitals;

not for profit private hospitals;

teaching hospitals;

residential aged care through nursing home and hostel facilities;

community care through Home and Community Care (HACC) and Community Aged care Packages (CACPs);

medical research institutes; and

services and facilities for people with disabilities and special needs.

As a guide to the actual size of the Catholic health and aged care sector, it provides in the order of 17,000 nursing home and hostel beds, and 60 hospitals, comprising 22 public hospitals (7 with teaching facilities).

The types of services provided by the Catholic health care sector are similarly expansive, covering hospital, aged care, social welfare and community services; and various other services in order to provide an integrated health care service to the community. The hospitals within the Catholic health care sector also provide a substantial range of social welfare programs that are accessible to the wider community.

In the Position Paper the Commission argues that equity of access to quality aged care must be the main criterion for assessing alternative subsidy regimes. The need to encourage efficient and responsive service provision, to avoid unnecessary administrative costs and to promote transparency, are also relevant considerations.

The Position Paper goes on to state that available government funds should be used to support a uniform quality of care across Australia and, if the underlying costs of provision varies significantly Across regions, this will require higher subsides for services in high cost locations.

ACHCA recognises that the time frame available to the Commission to undertake its review mitigates it from being definitive in recommending an alternative subsidy regime.

The Commission Position Paper sets thirteen preliminary proposals and also invites specific comments on:

1 whether there are more efficient alternatives to varying payments to homes each time a new resident replaces a previous resident with a different RCS classification

1 whether the current two tier concessional resident supplement is appropriate, and on the implications of any changes in the structure of the supplement for the assisted resident and transitional supplements;

1 the impact of input taxes, other than payroll tax, on private providers costs and whether these should be recognised in the subsidy arrangements;

1 whether there are strong arguments against moving to a cost reimbursement system for payroll tax payments;

1 whether, in moving to a new subsidy regime, another round of changes to income and asset tested resident charges should be contemplated;

1 the merits of, and scope to combine the resident daily fee in the accommodation charge;

1 the likely effects of the Commission's preliminary subsidy proposals; and

1 an appropriate timeframe for implementation of the full proposals, the interrelationships with the residential aged care review, and whether new arrangements should be phased in or simply introduced after a grace period.

1. **Whether there are more efficient alternatives to varying payments to homes each time a new resident replaces a previous resident with a different RCS classification**

   In the longer term there may be more efficient alternatives but these would need to be developed in conjunction with how the residential aged care sector is to be better linked to the acute and community care sectors in order to achieve a seamless continuity of care for people with growing dependency and complex care needs.

   Additionally, as residential aged care services increasingly differentiate between short stay high dependency clients as opposed to those longer stay residents that 'age in place,' the funding system will need to change to better reflect the short stay high dependency linkage with the acute sector.

   The current subsidy regime is a payment to the provider based on the dependency level of the resident. ACHCA considers that any alternative funding arrangements should be centred around the needs of the individual.

   The introduction of a purchasing system based on groupings of predetermined dependency levels would lead to a tendering approach. This would result in reductions in service quality and reduced access for some types of residents. Access would cease to be based on need.

   The RCS is a robust assessment instrument that requires continuity before further significant change is thrust upon the sector. This should not mean that further changes should not be considered in the light of how the system will adjust to the changing environment.

2. **Whether the current two tier concessional resident supplement is appropriate, and on the implications of any changes in the structure of the supplement for the assisted resident and transitional supplements**

   The two tier supplement has been very successful in achieving access into nursing home care for financially disadvantaged. The Commission claims that some providers have argued that there is a 'major discontinuity in the level of support at the 40 per cent tier'. Apart from the additional financial support that the resident delivering the 40 per cent tier brings to the home, there does not appear to be any other 'discontinuity'.

   ACHCA does not accept the anecdotal evidence that access for non concessional residents is compromised.

   Any change in the current tier arrangement that results in less income than is currently the case will result in reduced access for concessional residents.

   As the large majority of aged care residents qualify as concessional, there seems no further purpose in continuing with the two tier. ACHCA recommends that the concessional resident supplement for all concessional residents be set at the amount of the supplement applying at the 40 percent tier.

3. The impact of input taxes, other than payroll tax, on private providers costs and whether these should be recognised in the subsidy arrangements

The Commission has not considered the changes to input taxes that will flow from the tax reforms and introduction of a goods and services tax.

The elimination of the wholesale sales tax and some state and territory taxes will, according to the Government, result in a lowering of costs to nursing homes. However, for the Church and charitable sector, the compliance costs imposed on meeting the Government's tax reform proposals will result in cost increases.

4. Whether there are strong arguments against moving to a cost reimbursement system for payroll tax payments

A cost reimbursement system rather than the current bed supplementation should be reinstated and it should also be available to charitable organisations that incur payroll costs in contracts.

Under Preliminary Proposal 6 where payroll tax supplement would be available only to facilities that are registered to pay payroll tax on their primary payrolls, facilities so registered and able to receive a supplement for the payroll tax component of contract labour, would have an income advantage over charitable sector facilities.

5. Whether, in moving to a new subsidy regime, another round of changes to income and asset tested resident charges should be contemplated

ACHCA does not support income testing existing residents that entered residential care prior to the introduction of income testing. Retrospectively charging frail and sick residents after entering care on a contracted basis is not acceptable.

The Position Paper mentions that a number of submissions drew parallels with the Medicare system, which provides free or heavily subsidised medical and public hospital treatment irrespective of a persons means.

It is disappointing that the Position Paper did not explore further the parallel between the very frail and sick entering nursing home care for short stay palliative care and the Medicare system with respect to public hospital treatment.

ACHCA considers that in view of the inequity between short stay high care nursing home residents and those entering the acute sector under the Medicare system that it is appropriate for adjustments to be made to the income and asset tested resident charges.

Short stay high care residents should not have to pay an income tested fee nor an accommodation charge. Government should meet this cost as a part of its commitment to providing access to universal health care. The accommodation charge and income tested fee would only apply once residents cease to be short stay.

There is also the issue that low care residents have the choice of paying the accommodation bond either as a lump sum or as a periodic payment. The periodic payment is very similar to the accommodation charge for high care residents. Unfortunately high care residents are not given the same choice, the only option for them regardless of their needs, is to pay the daily accommodation charge of up to $12 a day.

Many high care residents would prefer to convert this payment into either a lump sum or an annual payment.

6. The merits of, and scope to combine the resident daily fee in the accommodation charge

As the accommodation charge is intended to be an income stream for capital works, it is appropriate that it continue to be identified separately to resident daily fees.

These are both daily fees and currently paid together by residents when meeting their regular invoice payment commitments.

7. The likely effects of the Commission's preliminary subsidy proposals

ACHCA agrees that coalescence should not proceed in its current form. The question as to whether there should be nationally uniform basic subsidy rates would depend on how variations in cost structures between and within jurisdictions are addressed.

The Position Paper suggests that a basic subsidy regime would not make provision for the higher unit costs of small facilities. Where higher funding for small services is warranted, it would come through a special needs pool.

ACHCA does not support the use of a special needs pool as a process for providing for higher unit costs of small facilities. Such a pool would have a finite amount of money and would be subject to erosion over time or removal by a subsequent government.

ACHCA supports the proposal that government funding together with resident fees should be sufficient to support the level of care required to meet the accreditation and certification requirements.

The Commission considers that the cost base of the basic subsidy regime should not make allowances for the proportionately higher costs incurred by small homes. The basic subsidy should be based on an 'efficient size facility' which has been suggested in the position paper as being 60 beds.

If the subsidy regime were to be based on this figure which is higher than the average size facility the result would be the demise of facilities of up to 55 bed size. Many of these smaller facilities were established as a result of Government policies which favoured small home-like environments. The organisations granted approval in accordance with Government policy should not be bankrupted by any subsequent change in policy predicated on notions of 'efficient size'.

If the Commission believes that subsidies should be based on the 'average' cost of providing the benchmark level of care, why not base this on an average size facility rather than an 'efficient sized facility'?

Efficiency of size of a nursing home as a concept for determining funding levels would disregard the factors governing size and would unfairly treat those homes for whom it would be impractical to reach the 'efficient size' level.

ACHCA agrees that subsidy arrangements should not indefinitely underwrite cost differences that reflect inefficient management or work practices, but the cost differences between small operators and large operators must be recognised otherwise the community will lose the benefit of a decentralised and localised availability of residential aged care.

To argue that a higher standard of care has to be funded from higher resident charges and/or savings made by providers is a position that should be vigorously opposed by providers, consumers and the community. Standards of care should be universal in terms of quality and should not be dependent on the person's capacity to pay. For the frail aged, good quality care is a right and not a commodity to be bought and sold.

ACHCA is disappointed that the Commission made no comment about the removal of $66M from the RCS funding pool for the concessional resident supplement.

The concessional resident supplement is intended to be a capital income item to replace the accommodation bond or the accommodation charge for financially dependent residents. As such the original money earmarked for this supplement should not have been removed from the care funding pool when the RCS subsidy levels were developed.

8. An appropriate time frame for implementation of the full proposals, the interrelationships with the residential aged care review, and whether new arrangements should be phased in or simply introduced after a grace period

The Commission proposes that subject to any recommendation from the residential aged care review for an increase in total Commonwealth funding for residential aged care, funds earmarked for indexing current subsidies should be redirected to increasing basic rates for the currently low subsidy states.

ACHCA supports this proposal, however this should not be at the expense of States such as Tasmania that still need to operate in an environment of cost increases. Ideally the Commonwealth would devote additional funds to correct the under funding of basic rates and correction would take place from 1 July 1999.

Substantial changes to the funding arrangements should be subject to any recommendations emanating from the residential aged care review. On this basis 1 July 2000 would be the earliest date of implementation other than for correction of basic subsidy rates and indexation.

In the absence of additionally funding, a phased introduction involving transitional subsidy rates would be more acceptable to the States subject to reduced indexation.

ACHCA recommends that the Commission undertake an impact analysis on the employment consequences of a redirection of indexation funds from the higher funded States to increase basic subsidy rates for the low subsidy States.

The Commission does not see a strong case for an interim change to the current COPO index arrangements. ACHCA disagrees with this position. ACHCA supports the use of Average Weekly Ordinary Time Earnings or the Wage Cost Index for Health and Community Services until a more appropriate measure is determined.

Conclusion

ACHCA welcomes the Commission's view that quality of care and equity of access must be the main criteria for assessing alternative subsidy regimes. In an environment where a nursing home's income is controlled by government, its costs not automatically reimbursed, then quality of care and access will become the balancing factors.

ACHCA considers that the Commission should undertake its own analysis of costs and not rely on the analysis contained in the various submissions. Issues such as what constitutes a 'benchmark level of care' and 'an efficient size facility' and 'an average input mix' clearly require substantial work and in the absence of this work it is difficult for the sector to be able to fully support some of the proposals outlined in the position paper.

There is also a need for a list of key quality indicators that can be measured and for an identification as to the measurement process.

In view of the size of the residential aged care sector and its contribution to the total health and aged care system, ACHCA considers that the Productivity Commission should continue to be involved in consideration of future changes in the financing of the sector.