QUEENSLAND GOVERNMENT

Minister for Health

Mr M. Woods
Commissioner
Nursing Home Subsidies Inquiry
Productivity Commission
PO Box 80
Belconnen ACT 2616

Dear Mr Woods

1 am pleased to provide the Queensland Government submission, as attached, to the Productivity Commission inquiry into funding methodologies for nursing home subsidies.

The Queensland Government recommendations are listed at the front of the submission. The first recommendation is a statement of the general principle that the funding model does not increase the proportion of care costs for which residents are responsible whilst ensuring equitable levels of Commonwealth subsidy for all State and Territory Governments.

The main recommendation is the progression towards a national rate of subsidy for nursing home care with the only differential being the level of dependency of the resident. The focus would then be on funding for a particular output and outcome as measured by the accreditation standards rather than funding on the difference in the cost of inputs.

The Queensland Government believes that this inquiry is of utmost importance for nursing home care providers and urges the scheduling of public hearings in Queensland. It is Queensland's preference that as a minimum a scheduled public hearing be hold in Brisbane. However, a hearing in North Queensland is also requested to grant au opportunity for all providers to voice their concerns.

If you require further information on the Queensland Government's submission, to the Productivity Commission inquiry into funding methodologies for nursing home subsidies please contact Ms J Root, Manager. Aged Care, Reform Project on (07) 3234 0660.

Yours sincerely

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QUEENSLAND
GOVERNMENT

Queensland Government Submission to

the Productivity Commission Inquiry into

Nursing Home Subsidies

QUEENSLAND GOVERNMENT SUBMISSION TO THE PRODUCTIVITY COMMISSION INQUIRY INTO NURSING HOME SUBSIDIES

RECOMMENDATIONS

The Queensland Government believes that an underlying principle for any funding model for nursing homes must be that the model not increase the proportion of care costs for which residents am responsible. Residents have *been* asked to bear an increased burden of the cost of their care through the introduction of income tested fees and accommodation charges.

This principle is consistent with the recent announcement by the Prime Minister that the proposed 4% increase in the pension (as part of the proposed tax system restructure) will not be eroded by a rise in nursing home fees.

Given this principle, Queensland makes the following recommendations to the Productivity Commission in relation to nursing home subsidies:

Industry-wide Issues

There should be a national rate of resident daily subsidy for nursing home care with the only differential being the level of dependency of the resident - as determined by the Resident Classification Scale (RCS). This approach would ensure that funding is focused on a particular output and outcome as measured by the accreditation standards rather than funding on the difference in the. cost of inputs.

The level of subsidy should be set at a rebased national average using 1997 costs for standard bundles of services within each of the dependency categories in the Resident Classification Scale). The subsidy should be indexed annually by a combination of the all capital cities Consumer Price Index for non-labour costs and movements in relevant award and agreement rates at the State level for labour costs.

The move to the national rate of funding should he linked to the timetable for Accreditation with no providers being expected to reach Accreditation until they are on the national rate of funding. Under current Commonwealth policy, all providers are required so meet Accreditation by 1 January 2001 while the target date for coalescence is 1 July 2005. It would be Queensland's preference that the movement to both a national rate of funding and Accreditation be targeted for 2001 thereby giving providers some certainty and sufficient time to prepare for Accreditation and to adjust to changed funding flows.

The period for implementing coalescence should be reduced to 2001 with annual adjustments being on an equal percentage basis.

Options to pay care subsidies as a percentage of nursing home costs or direct payment to residents are not supported.

State Government Issues

These include:

The discount of the daily subsidy rate paid to State Government nursing homes (SGNHs) should be removed. State Governments are required to meet the same accreditation standards as non-government providers and should be subsidised equally on competitive neutrality grounds.

In the event that the subsidy discount to SGNHs is not removed, the Commonwealth should review the discount, looking particularly at the following aspects:

The adjustment to the level of subsidy for SGNHs should be removed as soon as the approvals are transferred to the non-government sector, as the rationale for its existence is then no longer valid. This would assist State Governments to work with the Commonwealth to reach a more equitable allocation of approvals by distributing approvals from over-bedded to under-bedded areas.

The level of discount should be changed from a flat rate dollar amount, currently $8.93 per day, to a percentage of the relevant subsidy level. As the discount was originally designed to remove the profit element from the payment, the rate of discount should be related to current rates of return on investment which would need to be reviewed on an annual basis.

INTRODUCTION

The Queensland Government is interested in making a submission to this Inquiry for two reasons. Firstly, Queensland Health operates a number of nursing homes which receive Commonwealth funding and which are directly affected by the level and method of funding. Secondly, Queensland Health has a responsibility for health care in the State and is interested in ensuring that there is a viable residential aged care industry which is able to provide good quality residential care to all Queenslanders who need it. If funding for aged care providers is insufficient and they cease to operate then the State Government will he required to fill the gap in terms of providing services to the aged population.

The Queensland Government has a long standing policy of being the 'provider of last resort' for people who are unable to find residential places in the for-profit and not-for-profit sector.

For example, it is estimated that industry occupancy rates are more than 99% and that up to 700 beds are occupied at any time in Queensland public hospitals by patients who would qualify for nursing home admission if places were available.

This Inquiry is welcomed because it is an overdue opportunity to examine the level of subsidy for residential aged care paid to Queensland based providers; to argue the case for a national rate of funding; and, most importantly, to argue for a higher level of funding for Queensland based providers.

This submission seeks to address some of the questions raised in the Productivity Commission's Issues Paper by looking at the cost structure *of* SGNHs and how this has changed over time.

A case is then made for a national rate of funding, based on the principle that the Commonwealth should be funding for an output or an outcome (as measured by the Resident Classification Scale), rather than on the indexed costs of an historic, and not current, mixes of inputs.

The find part of the submission looks at alternative funding issues, including the discounted level of subsidy for SGNHs and argues that this discount is inefficient and inequitable and should be abolished or, if the discount is to be retained, be reviewed to make it more equitable across jurisdictions.

BACKGROUND

The Queensland Government through Queensland Health, provides 15% of the residential aged care places in the State. Currently Queensland Health has an allocation of 1729 high care places funded under the Commonwealth residential aged care program. The 1729 places are to be found in 20 SGNHs is located in 14 different district health services. The SGNHs vary is size from 400 places at Eventide-Sandgate in metropolitan Brisbane to 26 places at the Waroona Nursing home in Charleville.

When the Commonwealth introduced CAM/SAM/OCRE in the 1980's, nursing homes owned by State Governments did not move onto the new funding regime. Instead they stayed on a frozen level of benefit until they agreed to adopt the Commonwealth standards, planning and funding regime. In Queensland, agreement was not reached on these issues until 1995 with SGNHs moving onto CAM/SAM/OCRE over an eighteen month period from January 1996 to July 1997.

All providers, both government and non-government, moved onto the new funding regime which followed the introduction of the *Aged Care Act 1997*.

In 1997/98, Queensland Health received some $38 million in Commonwealth subsidies. In addition, $16 million was received in resident contributions - derived mainly from income support payments - with Queensland Health providing supplementary funding of $22 million to its 20 SGNHs.

The Queensland Government, through Queensland Health and other departments, has regulatory responsibility in relation to safe drug and medicine administration, building and public health standards and occupational health and safety.

NURSING HOME COSTS IN STATE GOVERNMENT NURSING ROWS

From 1 July 1998, all SGNHs received funding from the Commonwealth Government at the associated State specific funding rate. In response to moving to the full Commonwealth funding model and in recognition that there would need to be changes to the way SGNHs were operated and funded, Queensland Health appointed Ernst & Young Consultancy to undertake the development of a funding model for SGNHs. The initial study examined a sample of five SGNHs that represented a cross section of the various State facilities, as well as various private sector operators. This Consultancy commenced in March 1997 and a copy of the report is attached.

This Consultancy:

* identified the costs of operating SGNHs and analysed service/facility expenditure,
* benchmarked the costs of SGNHs against those. operating in the non-government sector;
* identified reasons for and costs of the variations between the sectors;
* identified benchmarks for service components and advised where expenditure could be reduced to achieve those benchmarks.

The cost data used in this submission are based on the data from the Ernst and Young Consultancy.

In summary, the results show that the costs of operating SGNHs are and will continue to be significantly higher than the funding provided by the Commonwealth and higher than the costs experienced in the non-government sector. The study also showed that SGNHs face significant unavoidable costs because of government ownership, e.g. higher award wage and salary rates and superannuation provisions.

The present Commonwealth funding formula is considered deficient with its continued application resulting in the underfunding of residential aged care in Queensland. Significant changes within the industry since its introduction are not reflected in the formula and are identified below.

Labour/Non-Labour Division of Costs

The commonly espoused 75:25 ratio of wage to non-wage costs is considered reasonable in the provision of most health care services in Queensland. However, the ratio is likely to be closer to 80:20 in residential care services given the greater requirement for interactive personal care.

In delivering residential care services there is very little scope for directly substituting equipment for labour. (However, as will be argued later in this submission, there are good prospects of significant economics from reducing recurrent expenditures through facilities' replacement or upgrading). There is limited scope for increased use of equipment in the area of manual handling.

Any financial savings that may result from increased use of equipment in manual handling are likely to come from reduced Workcover premiums rather than reduced labour costs. The development of interpersonal relationships in the provision of care services and personal attention is fundamental to the quality of life for nursing home residents and limits the scope for labour replacement.

Queensland Health has identified a number of areas for improving the efficiency of labour utilisation. These include changes in the mix of care staff, increased training and the multi-skilling of some care and operational staff, together with an increased use of part-time employment. In consultation with staff representative groups, Queensland Health will consider the adoption of these changes where appropriate.

Wage and Wage Related Costs

Employees by classification in Queensland SGNHs

According to a snapshot of employees in SGNHs taken in September 1997, nursing staff account for approximately 70% of total employees (68% of total wage costs). Of the remainder, domestic staff account for 13 % (11 % of wages cost); orderly stall 6% (both); administrative staff 4% (5% of wages cost), food service staff 3% (both), therapists 2% (4% of wages cost) and other staff (including trades) 2% (3% of wage costs). Figure I of Attachment A depicts g breakdown of employees in SGNHs by staff category. Figure 2 illustrates the same staff categories considered as a proportion of total wage costs.

The mix of nursing staff in SGNHs is illustrated in Figure 3. Assistants in Nursing (AINs) account for 39% of staff (30% of nursing wages) while Enrolled Nurses (ENs) account for 28% (26% of nursing wages). Of the remainder, Registered Nurses (RNs) account for 20% (25% of nursing wages), Clinical Nurse Consultants and Nurse Managers (CNC/NMs) 12% (17% of nursing wages).

Directors and Assistant Directors of Nursing account for 1% of staff (2% of nursing wages). Figure 4 illustrates the same nursing staff categories considered as a proportion of total nursing wage costs.

CAM Funding embodies Nursing Profile of 1987/88

In 1987/88, the Commonwealth used a survey of costed rosters to set funding rates for nursing and personal care (CAM). These funding rates applied the award wage rate in each State and Territory multiplied by differential weights for the various categories of nursing staff to achieve a measure of "standard hourly rates" or SHRs. The differential weights were consistent across the States and Territories and included:

Registered Nurses:	32.5%
Enrolled Nurses and Assistant Nurses (EN/AIN):	59.5%
Therapists:	8%
	100%

In 1987/88 the EN/AIN ratio was 25:75. Effectively, this allocated one third of the effect of the weighting to the wage rate used for enrolled nurses. Conversely, in Victoria the ratio was reversed (i.e. 75:25) effectively tripling the effect of the weighting to the enrolled and assistant wages rates in that State. The effect of the EN/AIN ratio is further compounded by two other factors: firstly Queensland's lower award wages than other States and, secondly, the fact that the EN/AIN component contributes 59.5% of the total SHR.

Over the, last decade, increases in award rates of pay in Queensland have seen a convergence with rates of pay in other States - but no recognition within the current Commonwealth subsidy rates. Similarly, the composition of nursing staff employed has also changed. In September 1997, the EN/AIN ratio in Queensland SGNHs was 42:58 compared to the 25:75 ratio of 1987.

While wage increases have been included in revised SHRs for Queensland, the effect is offset by the fixed EN/AIN ratio of 25:75. As the staffing profile of ENs and AINs has not been revised since 1987/88, the historical underfunding of SGNHs has been perpetuated - even though the basis of those differences has long since changed.

From the Ernst and Young study, there is evidence that other staffing ratios have also changed since the SHR formula was adopted in 1987/88. While the proportion of registered nurses in total care staff has remained constant (although there have been significant changes within RN levels), the proportion of enrolled nurses/assistant nurses has increased significantly (to around 65%) and the proportion of therapists has declined (to around 3%).

These changes highlight the difficulty in maintaining the integrity of an input-based subsidy model which has not been adequately revised over time.

MOVEMENT TO A NATIONAL RATE OF SUBSIDY

Funding for Outcomes

The point has often been made that lower Commonwealth funding is justified on the basis that Queensland has lower input costs. Similarly, it is argued that lower funding has not hampered Queensland nursing homes as Queensland homes have frequently performed well in the Commonwealth Outcome Standards. These arguments are difficult to maintain in the face of additional information about both levels of funding and the standards.

Queensland Homes - Level of Funding.

The distortions in the subsidy which results from the 1987/88 cost base were detailed above. As a result, the Queensland Government has been required to contribute a further $22 million per annum. to enable SGNHs to continue to provide acceptable levels of service to residents.

Homes operated by the religious and charitable sector are effectively operated through internal cross-subsidisation from the organisations' fundraising and other activities. It is noted that the proportion of nursing home places provided by for-profit organisations in Queensland is the inverse of the proportions in other States such as New South Wales, Victoria and Western Australia (where for-profit providers have the highest market share).

It is understood that there is a significant degree of cross-subsidisation by for-profit operators from retirement villages and other commercial activities to nursing homes, This suggests that nursing home profitability is low and in some cases negative in Queensland, which has significantly affected the incentives to supply residential places in for-profit homes.

The 1997/88 funding formula institutionalised service quality differences as well as unit input cost differences between the States. The Queensland Government proposes that the funding should reflect the provision of efficient, quality care which meets the requirements of Commonwealth Accreditation. To that end. it is proposed that the Commission should attempt (or recommend that work be undertaken) to rebase the costing of nursing home services to reflect the contemporary mixes of inputs and Accreditation.

It is noted that major costing studies were commissioned by the Commonwealth Department of Health and Family Services in 1996 and 1997 as part of developing the Residential Aged Care Reform Package. These studies could provide a significant starting point for a cost analysis by the Productivity Commission.

Based on the cost modelling suggested above, it is proposed that a new basic subsidy rate calculation should be made which..

* retains the present eight categories of the Resident Classification Scale; and

* determines funding based on the average costs across all States of an agreed 'bundle of inputs / services' required to meet the outcomes of RCS categories 1-4, (This approach is consistent with Accreditation which is directed at achieving a standard set of national outcomes).

A major issue in a new approach would be to determine a benchmark for efficient service provision. It is proposed that the benchmark should be set at the average costs of the 'bundle of inputs / services' in the profit and not-for-profit sectors, and include the government sectors in all States.

As outlined above,, the subsidy should be based on the average costs of efficient cue within each dependency category for all States and Territories. This approach would not allow for differences between jurisdictions in unit input costs. While such differences do still exist they are converging, particularly for wages and salaries, and should not supersede the objective of a uniform national funding regime. (Differential indention of wage and salary costs would be justified to allow for occasional large increases in awards or agreements at the State level.)

Queensland considers it important that, in developing a new methodology, particular attention be given to revising the cost relativities between the various care categories which would be embodied in the, new subsidy rates. There is anecdotal evidence that the high cost RCS 1 category is under-funded under the existing formula and that some lower categories may be over-funded. This is a particularly important consideration as distortions in the funding between categories have the potential to affect the viability of individual nursing homes.

The funding structure outlined above would revise the outdated current formula while encouraging operators to improve their efficiency and effectiveness.

The timing of any change in funding will be important. In a real sense, the current inquiry is premature in that it will be difficult to estimate to likely cost impacts of Accreditation. These impacts may take some time to become settled, possibly up to two years. However, any deferral of new funding arrangements beyond 2001 would seriously disadvantage a large. proportion of providers and seriously impede their ability to make the investments required to achieve Accreditation.

It is proposed that the following steps be included in new arrangements:

* a revised funding model based on the principles outlined above should be implemented as soon as possible;

* that wage and salary costs should be indexed each year for State movements in relevant awards and agreements and that non-labour costs be indexed by the all capital cities CP1; and

* that the model be reviewed and revised within two years of the completion of Accreditation and thereafter at five yearly intervals.

The daily rates for each RCS category would be calculated on the assumption of current forms and levels of resident contributions and allowing for current levels of cross-subsidisation by proprietors.

Coalescence

The Queensland Government supports the current Commonwealth policy of coalescence compared to maintaining the current differentiated rates. The Queensland Government's preferred option is the revised funding model outlined earlier.

If a decision is made to resume implementation of the coalescence policy. it is considered that it should be subject to a number of amendments.

As coalescence will be cost-neutral to the Commonwealth, the primary effect of the phase-in will be on providers, and particularly in a negative sense, on providers in the high subsidy States (New South Wales, Victoria, Tasmania and the Northern Territory). Aside from the profitability of proprietors in high subsidy States, the main impact will be on planning and investment decisions by providers about the future supply of residential capacity. (subject to the constraints of the Commonwealth approvals process for capacity). The planning horizons of providers could be expected to be significantly less than 7 years. Historically, the Commonwealth has not sought such lengthy periods for structural adjustments programs: phase-down arrangements for bounties and other economic subsidies have typically been quite short.

On this basis, it is proposed that the achievement of coalescence should be reduced to a target date of 2001.

There seems to be little economic justification for the low coalescence rate during the first years and which appears to serve only the interests of the high subsidy States. It is proposed that, if coalescence is resumed, the movement to the national average should be in equal annual percentages.

ALTERNATIVE FUNDING OPTIONS

Adjusted Subsidy for Government Owned Nursing Homes

The Queensland Government considers that the adjusted subsidy reduction in respect of SGNHs should be restored.

The basis for this view is that:

* there is an opportunity cost of capital infrastructure to government; and

* covering the costs of capital is justified in order to meet the continuous improvement process envisaged under Commonwealth Accreditation.

A major element of Commonwealth initiated microeconomic reform has been to seek competitive neutrality, particularly where publicly provided services are competitive or contestable. The main provisions have been tax equivalent payments, removal of any implicit or explicit advantages with regard to borrowings and to require that all of the costs of capital are covered, including an acceptable return on assets employed.

While a competitive market for nursing home services does not exist because, inter alia, of Commonwealth controls on supply and on pricing it is important that appropriate incentives for improving efficiency be reflected in the pricing/subsidy method particularly for replacement and upgrading of the capital stock.

The Ernst and Young study identified significant efficiencies which could be attained in non-care operating costs within SGNHs. Some of the gains relate to management and operating procedures and Queensland Health is committed to achieving these efficiencies to the maximum extent possible. Other costs relate to SGNH infrastructure which, because most of it was built to earlier building standards, provides an average 60 square metres building space per resident compared with private nursing homes' average of 25 square metres per resident Also, areas of grounds and gardens am higher in SGNHs than in nursing homes in the private sector.

Significant savings in recurrent costs (cleaning, heating/air conditioning, lighting and building and grounds :maintenance) are achievable from rebuilding or upgrading SGNH infrastructure. To that end, the Queensland Government is examining options for facilities improvements. Accordingly, the Queensland Government considers that appropriate capital provisions should be included in the subsidy by removing the discount to SGNHs.

While removal of the discount is Queensland's preferred position, it is also the Government's view that, if the discount is not restored, the method of calculating it should be reviewed and revised to a more equitable basis.

As indicated in Table 1 of Attachment B, the current residential care subsidy daily reduction of $8.93 per resident for SGNHs has a greater effect on Queensland than other States. When shown as a percentage of the basic subsidy amount the progressive effect of the flat rate of $8.93 has a bigger impact on the lower funded States, particularly Queensland. It is also apparent from Table 2 that the flat rate is a larger proportion of the subsidy for residents in the lower RCS classifications.

The rationale for the reduction in the subsidies paid to SGNHs is unclear. If it is intended to reflect a return on investment, the rates of 10% to 18% applying to SGNHs (as shown in Table 2 of Attachment B) are excessive and bear no relationship to any feasible returns.

The Queensland Government's view is that a more rational basis for the discount would be to calculate it as a fixed percentage reduction for all States and Territories. Such a method would remove the large distortions in the current method.

Subsidy as Percentage of Costs

The Commission's Issues Paper raises as a possible option the payment of the Commonwealth subsidy as a percentage of nursing home costs with the remaining costs to be met by residents (or by cross-subsidy from proprietors' other activities or State Government general revenue).

While there may be some benefits in encouraging different price/quality mixes, the ability to create a market to which consumers (residents) or their representatives could respond would be very limited. The major quality variable is intensity of care required (as reflected in RCS or similar categorisations) which is invariably dictated by medical or social necessity rather than consumer choice.

Given that many residents are at a stage of their lives where they are unable to exercise their consumer power strongly (or do not have representatives to do so on their behalf), the incentives for providers to deliver services more cost effectively (because residents are meeting a percentage of costs) will be weak. In view of the very tight Commonwealth control on the supply of resident places, the ability to 'shop around' prior to nursing home entry is likely to be very limited.

As most residents are income support recipients with low disposable income, the option would benefit only the small proportion of residents with significant personal incomes or those whose families would be prepared to subsidise higher quality care. The extent to which residents' families would be prepared to provide such subsidies, if given the opportunity, is untested.

The Queensland Government does not support any option to base subsidy payments on a percentage of costs.

Subsidy Paid to Residents

The Commission's, Issues Paper suggests a possible option of paying the subsidy directly to residents, presumably on &c grounds of increasing consumer choice. A number of the arguments in the previous section would also apply to this option:

* many residents we unable to exercise their consumer power strongly. (There are significant numbers who are not competent to handle their financial affairs or do not have representatives to do it for them and whose affairs are handled by the Public Trustee under the Queensland Power of Attorney Act), and

* care options are frequently dictated by medical and social necessity rather than consumer choice.

The subsidy would presumably be paid only after entry to a residential care facility. In order to provide a choice between entering a residential care facility and other care options which are mostly

covered by the Home and Community Care program (HACC), entitlement to the subsidy would have to be integrated in some way with HACC entitlements. Because of the quantum difference in funding per recipient between HACC and residential care, a fundamental rethink of the philosophy and objectives of both programs would be required.

Because of political considerations, direct payment to residents would have to be at a uniform national rate. This would remove any flexibility to adapt subsidy rates for state or regional differences in costs.

Also, the double handling of funds implicit in this option would increase transaction costs for care providers as well as residents.

On these grounds, the Queensland Government does not support the direct payment of subsidy to residents.

Figure 1 depicts a breakdown of employees in Queensland State Government Nursing Homes by staff category. Figure 2 illustrates the same staff categories considered as a proportion of total wage costs.

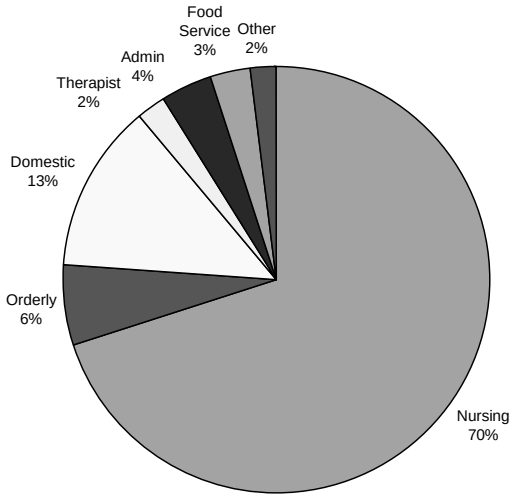

Figure 1 – Staff Categories by Employees

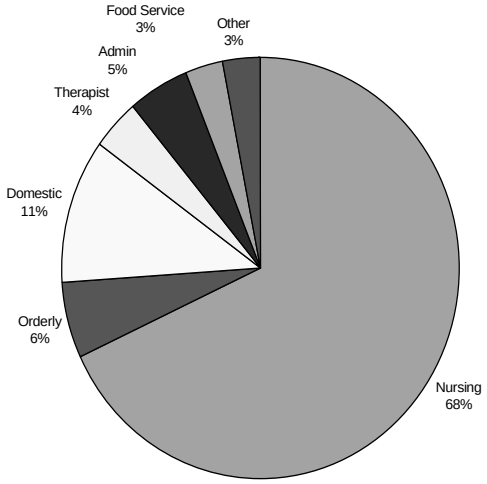

Figure 2 – Staff Categories by Wage Cost

The mix of nursing staff that account for 70% of the staff in State Government Nursing Homes is illustrated in Figure 3. Figure 4 illustrates the same nursing staff categories considered as a proportion of total nursing wage costs.

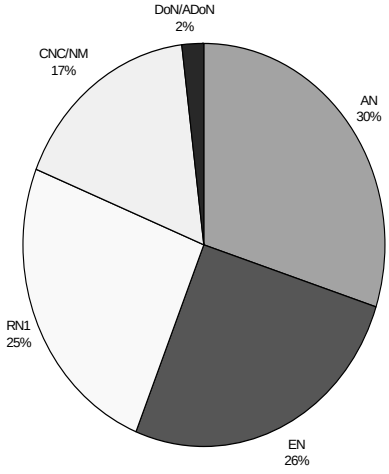

Figure 3 – Nursing Staff by Employees

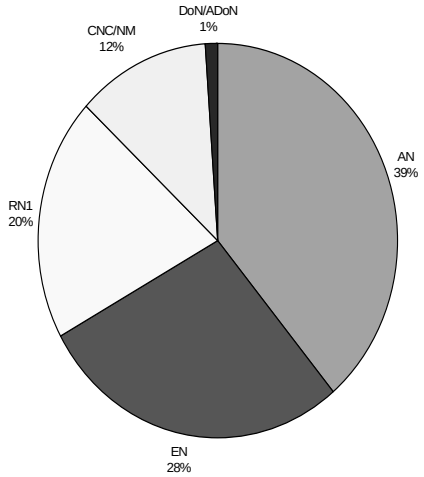

Figure 4 Nursing Staff by Wage Cost

Attachment B

Adjusted Subsidy for Government Nursing Homes

Table 1. Rank order of subsidies for RCS categories of residents

Category	1	2	3	4
TAS	$109.99	$99.55	$85.98	$61.65
VIC	$108.60	$97.94	$84.28	$59.78
NT	$105.49	$95.38	$82.07	$58.24
NSW	$101.50	$95.59	$80.68	$57.31
TAS Public	$101.06	$90.62	$77.05	$52.72
WA	$100.38	$90.63	$77.97	$55.28
ACT	$100.19	$90.72	$78.48	$56.46
VIC Public	$99.47	$89.01	$75.35	$50.85
SA	$97.08	$87.90	$75.89	$54.44
NT Public	$96.56	$86.45	$73.14	$49.31
NSW Public	$94.66	$84.66	$71.65	$48.38
WA Public	$91.45	$81.70	$69.04	$46.35
ACT Public	$91.26	$81.79	$69.55	$47.53
QLD	$89.74	$81.00	$69.65	$49.34
SA Public	$88.15	$78.97	$66.96	$45.51
QLD Public	$80.81	$72.07	$60.72	$40.41

Table 2. The $8.93 reduction as a % of the Basic Subsidy Amount (by RCS categories)

Category	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
1	8.62%	8.23%	9.95%	8.90%	9.20%	8.12%	8.91%	8.47%
2	9.54%	9.12%	11.02%	9.85%	10.16%	8.97%	9.84%	9.36%
3	11.08%	10.60%	12.82%	11.45%	11.77%	10.39%	11.38%	10.88%
4	15.58%	14.04%	18.10%	16.15%	16.40%	14.48%	15.82%	13.33%