14 September 1998

Submission to the Productivity Commission'
Inquiry into Nursing Home Subsidies

Eldercare is the second/third largest provider of residential aged care in South Australia. It is an independently incorporated community service of the Uniting Church and provides and manages a total of 644 high and low care places.

It is intended in this submission to present a few selected views. The resources needed to produce detailed financial arguments and cost comparisons are beyond us and we seriously question much of their relevance.

Are Costs Relevant?

Costs have some part in the discussion, but we suggest their part is limited. The facts remain that with the exception of a relatively small number of facilities providing "extra services", costs to a large degree become self fulfilling.

For example, Eldercare to encourage and reward initiative, enthusiasm and endeavour allows its facilities to retain and spend 'surplus above budget' on both service and capital "needs" or "preferences". This produces costs to equal available resources.

Similarly, in the private sector the legitimate 'costs' of servicing a debt, or making a return on equity at levels and rates determined by the owner set the funds available for the delivery of services or care. The costs therefore are determined by funds available.

The Commission is well aware that the residential aged care sector is not a market place; let alone a free market place. Numbers of places and their location are set by the Commonwealth. The prices able to be charged and the fees received are similarly set; as is the minimum quality of the outcomes.

Some facilities provide for commercial capital provisions, others do not. All of the variables and opportunities for different decisions, coupled to an extremely limited ability to measure comparative outcomes, make comparative costings next to meaningless without substantial, additional data down to almost the micro level.

To further highlight this I draw on the implications of building cost data presented by Robert Lister in March 1997. He demonstrated to a tri-State conference that recent nursing home building costs per resident varied from $23,667 to $91,111.

The cost of servicing the debt associated with the difference between these two building costs, even at today's low borrowing rate of 8%, is $5,395 p.a.

This amount for example: -

is equal to the annual difference between category 1 payments between Queensland and New South Wales.

is significantly greater than the total annual difference between the highest and lowest subsidy rates at the category 4 level.

There are numerous other areas where the elective care and business decisions within each facility almost totally invalidate the comparability of reported costs.

The Impact of Aged Care Reform

Aged Care Reform, and in particular the inclusion of "ageing in place" as an operating and philosophical concept, we believe almost totally breaks down the differences between nursing homes and hostels who offer "ageing in place."

The change has been more significant than envisaged by many. For example, in Eldercare our high to low care residents changed from 37.7% high and 62.3% low care in September 1997, to 53.5% high and 46% low care at 30 June 1998.

Low care facilities who have the capacity and capability to provide high care to low care residents who transition to the higher care level must have in place the infrastructure to instantly provide the higher care level at all times.

This therefore makes any differentiation between dedicated high care facilities and low care facilities that provide high care artificial.

It is therefore our strong view that the subsidy scale should be continuous and not differentiate between the two levels of care at a particular break point.

Infrastructural support costs have also become blurred and a low care facility prepared to provide ageing in place has to have a similar capital investment in plant and equipment and a similar human resource investment in training, staff development and support as does a high care facility.

Costs and Needs

As outlined earlier costs as generally recorded are of doubtful value for establishing comparisons. Similarly, costs and needs have a tenuous relationship, with the needs and service balance being found by organisations balancing the availability of resources and their capacity and capability to cross-subsidise between residents and facilities. The perception of need can therefore vary between organisations and individuals based on the funds available and the special interests and philosophies of the parties. For example religious based organisations would place a high need on chaplaincy. Others may prioritise areas such as dementia and even community based services.

Are Recorded Costs Actual Costs?

The residential aged care industry is notorious for its lack of business skills. Most are extremely small operations with many being marginally viable. Many also have their genealogy in the churches and charities where business acumen was not thought to be essential until relatively recently.

The industry typically does not benefit from economies of scale -
“example” - a recent exercise by the Hospitals and Health Services Association in South Australia has managed to achieve in a collective purchasing arrangement reductions in the price of disposable incontinence pads of between 21% to 46%. Incontinence products are a major cost item in residential aged care and have a volume of several $Ms per annum.

The industry typically does not make the financial provisions and accruals that would be considered in most business as costs -

“example” - the 1997 ACOA survey of 97.95% of South Australia's hostels, of which 68% were co-located with nursing homes, found that: -

20% of small hostels made no provisions for long service and annual leave

34% of small hostels made no provisions for the depreciation of plant and equipment

22% small, 21% of medium and 12% of large hostels made no provisions for the depreciation of buildings

36% of small hostels were not making a surplus.

Reported costs under these circumstances from this sector could not be regarded as representative or reliable in regard to a true picture of viability or durability.

Costs and Structure

The structure of the industry is a conflict between the structure of an efficient industry and the Department of Health and Family Services' endeavour to promote distribution and access. Many approvals have been issued with resident numbers that are known to be not viable in terms of an efficient mass, or not viable in terms of not being of sufficient size to be able to afford the skills and systems necessary to be effective.

The structural differences and outcomes between States were highlighted by the government's Certification of Residential Aged Care facilities during 1997. The outstanding outcome of that survey, which we believe had inadequately placed the pass mark at a low 57%, was that of the nursing homes in Victoria where 39% failed to reach the pass score.

We believe it is telling that the State with the second highest rate of resident subsidy had the highest fail rate, and significantly so - money therefore does not produce results.

South Australia, with the second lowest subsidy rate, managed under certification to achieve the second highest average score. South Australia in terms of outcome was second only to the Northern and Capital Territories, where the low age of facilities and funding issues set them apart anyway.

The journal, National Healthcare, recently reproduced data from the Department of Health and Family Services that showed in New South Wales and Victoria, in a nursing homes and hostels all States and Territories comparison, they rated: -

in the top three with facilities more than 30 years old (Tasmania with the highest subsidy was the third)

the top two with more than 4 residents in a room.

Higher subsidies do not translate to better outcomes as New South Wales and Victoria rate second and third behind Tasmania in quantum of subsidy per resident.

Equity

Eldercare strongly believes in equity for our elderly. The most fundamental element of equity is that any subsidisation by the Commonwealth should apply equally to all who are eligible.

In virtually no other area of social welfare, health or general support does the Commonwealth differentiate on the provision of resources to individuals. The arguments for rural and remote and targeted attention for special groups are accepted and apply elsewhere, but in the context of base funding age care stands by its unusual self

Supposedly the rationale lies in different wage rates and structures for professional care providers. Enterprise bargains, the use of salary packaging and a raft of other issues relating to the cost of labour have removed this as a valid argument. In some instances the award rates in the lowest subsidy States are now higher than the award rates in the highest subsidy States.

There is also no direct connection between the cost of labour and the outcomes achieved. The concepts underpinning the enterprise bargaining system of higher rewards for even higher outcomes recognise this.

In those cases where the arguments may have been prescribed staffing structures, this in itself created inequities to elderly care recipients across Australia in that some States were funded to be able to afford more staff, with higher qualifications, yet the outcomes expected to be produced by providers were to be the same.

In public health services the Commonwealth generally provides the same quantum for each individual for similar services in whichever State the service is provided.

In hostels, for the last decade, a standard national rate has applied and from this was to be funded all care staff. Many hostels have for many years employed qualified nursing staff to provide appropriate care; but from within the standard national rate. For example the 1997 ACOA hostel survey established that 31% of small, 79% of medium and 71 % of large hostels had registered nurses on staff.

The question is why care staff in nursing homes should be differentiated, when for hostels and for all non-nursing employment categories in nursing homes no case to differentiate between States has ever been seriously advanced.

<u>Preferred Outcome</u>

The outcome proposed is driven by the principle of equity. It is recognised, we believe, that the task of establishing definitive costs for identical services is impossible, because services are almost never identical.

There are too many factors in each calculation and components within existing operations to be accurate, or even meaningfully representative.

The only way to establish representative costs is by careful modelling of a limited number of the more frequently occurring resident profiles.

The Commonwealth can never fund unlimited care, and therefore the total funds to be distributed will always be limited.
Our preference therefore is to establish national rates of subsidy for defined levels of care and for these to be introduced quickly.

The arguments for prolonged transition do not stand scrutiny. Under the existing system facilities must alter on a daily basis their staffing arrangements and other elements generating costs as their income varies with changes in resident mix and classification.

There was no significant transition allowed for the introduction of the RCS, but the new RCS significantly altered the income available to many facilities even without a change in residents.

The dramatic changes to the high-low mix in Eldercare's operations as the result of ageing in place were expected to be accommodated by us, by government, within days of a resident's assessment.

These all instance that the industry does have the capacity to react quickly to funding changes. In every case of a high care resident under ageing in place being replaced by a new low care resident, the drop in subsidy/revenue is always greater than the maximum reduction that would be experienced in relation to a resident under an instant, let alone a graduated move to national rates. The current funding 'differential' between categories 4 and 5 range between $15 to $27 per day. The maximum reduction under coalescence experienced by the highest State moving to the lowest rate across the totality of categories 1 to 4 is $21. That is if Tasmania moved to the Queensland category 1 rate, and this has never been suggested.

With accreditation by 1 January 2001 being a funding imperative, to continue with different levels of resourcing puts those that are funded at a lower level at a disadvantage. Lower levels of funding result in fewer resources being available to achieve the required outcomes. In the area of capital upgrades those with lower subsidy levels have not only less capacity to undertake the upgrades, but also have a reduced capacity service borrowings.

The government received representations on the inequity of differentiated rates. They accepted the arguments and moved to correct through coalescence. Understandably those who stand to lose will complain and resist.

The answer lies in the middle ground because South Australia, Western Australia and most significantly Queensland have clearly demonstrated that it can be done with rates much less than the higher States receive. The adjustment is needed so that all of Australia's elderly have equal resources available to them.

Conclusion

Single, national rates by care categories, established by expert modelling and based on a balance of funds claimed to be needed and funds available, and implemented over a period not exceeding 12 months, is the approach proposed.

TERRY HEALEY
Chief Executive Officer

tth;jfproductv