VHA Submission to Productivity Commission

Inquiry Into Nursing Home Subsidies

The Victorian Healthcare Association Ltd
2 October 1998.

Contents

1. Introduction

The VHA welcomed the announcement of this inquiry. VHA has, for some time, been calling for modifications to the aged care reform program and the abandonment of coalescence is a high priority. VHA calculations suggest that the Victorian nursing home industry would suffer an 18% reduction in Commonwealth funding by 2004 if announced policies went ahead in current form. This may result in the possible closure of most public sector nursing homes beds and many other beds, unless the State Government provides additional assistance.

The Victorian residential care industry, particularly its large public sector component, is highly vulnerable because:

- Commonwealth funding policies over the past 10 years have effectively denied the Victorian industry about $200 million for infrastructure and non-nursing costs, leading to a relatively poor quality of infrastructure
- Victoria's industrial situation (particularly in the public sector) is such that despite major efforts, the certified agreement (essentially an award) governing registered nurses remains inflexible and costly to operate with
- Victoria's population distribution and geography with relatively more small rural towns make human services delivery in Victoria inherently more expensive than in other States
- Victoria already has the lowest number of nursing home beds (and acute hospital beds) of any State and a lower than average provision of hostel beds, so that Commonwealth aged care spending is less in Victoria per head than in other States, which is not fair or appropriate
- The rapidly decreasing length of stay in Victorian nursing home beds, particularly in the public sector, shows that the needs of the nursing home populations have changed greatly, with a much greater emphasis on, in effect, short-term pre-terminal care which is relatively costly.

2. Background

The VHA represents all public hospital, aged care and community health facilities in Victoria. It is the State Association member of the Australian Healthcare Association, with which the VHA works closely. The VHA is backed by the resources of its trading arm, Hospital Supplies of Australia, which enables us to be the largest health employer representative organisation in Australia.

The public sector has been particularly prominent in developing aged care services in Victoria for many years. Victoria was the first state to be completely covered by Geriatric Assessment Teams (now termed Aged Care Assessment Teams). It has highly developed domiciliary (HACC) services, comprehensive ambulatory (day) services for elderly and frail people and a series of regional aged care centres of excellence which has no counterpart elsewhere. Victoria's specialist extended care facilities include more than 800 sub-acute geriatric hospital beds, highly developed psycho-geriatric assessment and inpatient services, and a variety of inpatient, respite and assessment services.

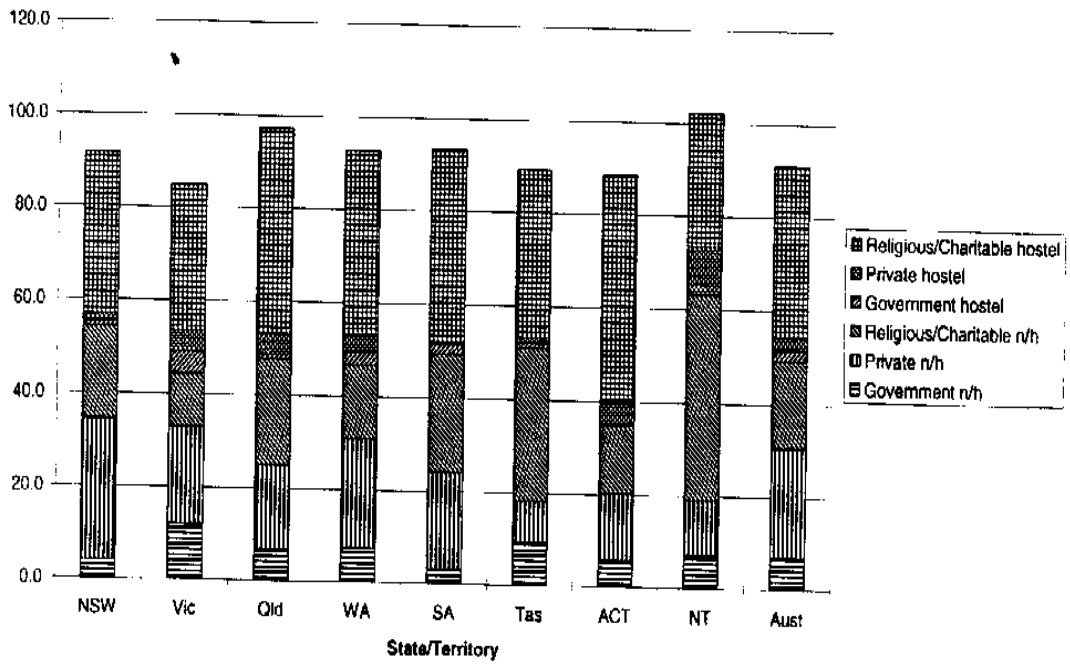
In recent years attention has focused on the integration of previously diverse assessment programs, such as HACC, ACATs and PGATs (psycho-geriatric assessment teams) and this has been achieved in several areas and work along these lines is continuing.

Victoria's advanced, comprehensive non-inpatient services allow the State to have the lowest provision of nursing home beds and the lowest number of acute hospital beds of any state. The Victorian hostel sector is only slightly larger than that of NSW in terms of provision per head of elderly people, and smaller than that in Queensland, South Australia and Western Australia. The following tables and graphs show the structure of the industry across all states.

As can be seen from the graph, Victoria has the smallest funded sector of any jurisdiction and fewer nursing home beds than any other State or the Northern Territory.

This paper is structured in a manner analogous to the PC Issues Paper.

Distribution of residential care places In Australia, by ownership class and number of places per '000 elderly, as of 30 June 1996



3. Nursing Home Costs

Considerable concern has been expressed by both Commonwealth and Victorian government officials about the precarious financial position of public sector nursing homes in Victoria. The VHA has collaborated with the Federal and Victorian departments[1] to develop a cost model. This model shows that on average, expenditures in the Victorian public nursing home sector in 1997-98 were about $15 a bedday higher than the model implicit in the Commonwealth funding system plus Victorian supplementation, that is, about $131 per bedday compared to revenues of about $116 a bedday. Given that the public sector produced about 1.7 million beddays, the overall deficit of the sector was thus about $25 million.

[1] References to the Commonwealth or Federal Department are to the Department of Health and Family Services (DHFS). Reference to the Victorian Department are to the Victorian Department of Human Services (DHS).

The Victorian State Government effectively subsidises the sector *by about $20 million. It provides additional funding to enable the public sector to provide complex care for extremely ill and frail people (who almost always would otherwise be in an acute hospital bed), a supplement to fill the gap left by the Commonwealth's long-standing 7% discount on SAM, and so-called Transitional funding to assist nursing homes with the transition to CAM/SAM funding. These subsidies have been included in the $116 a day revenue figure. In 1998-99 the State Government is attempting to wean agencies from transitional funding by the provision of generous Voluntary Departure Packages for staff of public nursing homes.

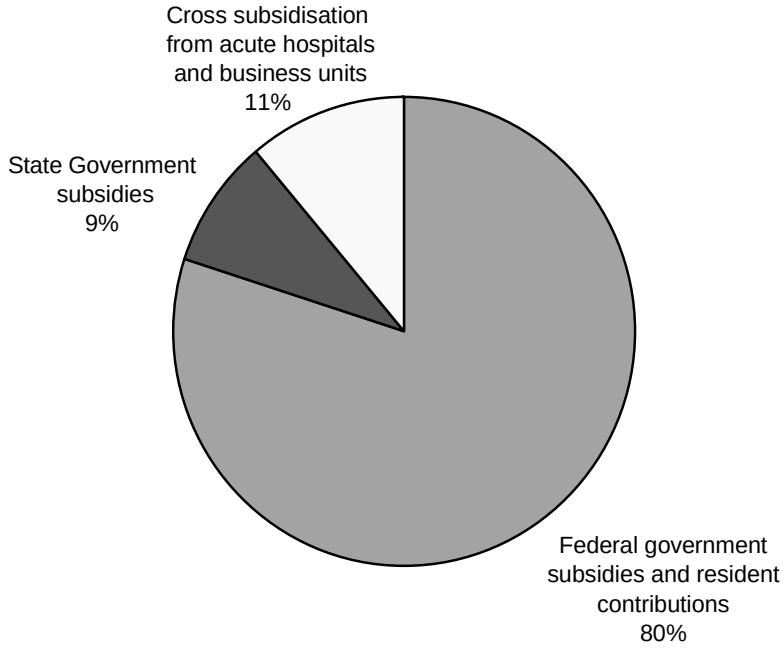
The overall deficit in the Victorian public nursing home sector of about $25 million is effectively a cross-subsidy from associated acute hospitals and other business units to public sector aged care programs.

This breakdown of income is shown graphically below.

Sources of Funds - Victorian Public Sector Nursing Homes

	$ / bedday
Federal government subsidies and resident contributions	104
State Government subsidies	12
Cross subsidisation from acute hospitals and business units	15

Sources of funds for Victorian public nursing homes, 1998-99



The Commonwealth expressed concern during the past 12 months that public sector nursing homes were, in general, overstaffed, had a mix of nursing staff which was too top-heavy, and subsidised non-nursing costs. Although the results of studies the Commonwealth, Victoria and 2 VHA have undertaken are not entirely comprehensive, some general conclusions can be drawn[2].

[2] About 10% of the data was unusable.

1. Most Victorian public sector nursing homes are small by national standards and small in relation to the other sectors in Victoria. The median size is only 30 beds, although the mean is nearly twice this due to the skewing effect on **the average** of a small number of large nursing homes run by regional health services. Only 10 of the more than 60 public nursing homes in Victoria are larger than 60 beds, which is widely considered to be the economic minimum. The average national size is 51 beds.

   There appears to be a strong inverse relationship between cost per unit of output and size in nursing homes. This is true, within certain limits, of all hospital type care and is caused by the so-called "lumpiness" of wards and their staffing which arises for safety and industrial reasons.

2. The requirement, under Victorian industrial provisions, to have Division 1 registered nurses available around the clock, in fixed minimum ratios of staff to residents of 1:10 during morning and afternoon shifts and 1: 15 during night shifts, is a major cost driver. This provision has existed since 1936 and has defied Government and industry attempts to improve the situation. Victoria is now the only State which has such a provision. The increased costs are felt especially in small nursing homes and for this reason there is an explicit Commonwealth supplement to normal funding for small nursing homes.

3. Other industrial arrangements work to the extreme disfavour of the public sector. Victorian public sector nurses receive about 15% higher pay than do their private sector counterparts. Their award contain more rigid provisions in relation to rostering, use of casual and part-time staff, the pay level of supervisory nursing staff such as charge nurses, and other relevant factors. Despite strenuous attempts to separate aged care nurses as a group from acute hospital nurses, this goal was not achieved in the last round of negotiations with the ANF in August 1997 and cannot now be achieved until the round due to be renegotiated in late 2000. It is far from certain that this aim will then be achieved.

Commonwealth officers have indicated scepticism about the 1997 certified agreement negotiations with the ANF before the AIRC but at the time Government officials and industry negotiators believed that the result achieved was reasonable and the best that could be negotiated. Victorian nurses had undertaken a major program of industrial action in the weeks preceding resolution of the dispute. The Commonwealth was not a party to the negotiations.

Other reasons for cost variations have been acknowledged. While roughly 70% of health resources in Victoria are spent in the metropolitan area, more than 70% of VHA's members are in the country. The extent of rural disadvantage is a controversial and unresolved issue, but studies of health outcomes show that people in the country, on average, suffer a markedly inferior health status to that enjoyed by people who live in metropolitan areas. They also tend to be older, poorer, less well educated and much less cosmopolitan. Studies by the Victorian Department into the extent of so-called "rurality" - the disadvantage suffered by rural residents - did not reach any published conclusions but it is understood some work is continuing. It is clear, however, that the distribution of aged care resources from state sources now favours the country significantly.

Much of Victoria also has a Mediterranean climate, with a short, hot summer and a long cool winter, which means that most public hospitals and nursing homes have to be mechanically heated and cooled, increasing costs significantly.

VHA's specialist extended care advisory committee reports that in many metropolitan public sector nursing homes the length of stay has fallen over the last two years because the style of treatment has changed considerably. The need is now to provide care for extremely frail, sick and dependent people in the last few months of life. AIHW data shows that the proportion of people being discharged dead from public nursing homes in Victoria is broadly similar to that from the other sectors both in Victoria and around Australia. Interestingly, in NSW and Queensland, less than half as many people are discharged dead from nursing homes, although the other States show a similar pattern to Victoria. NSW has 20% more nursing home beds overall per capita, although a much smaller public sector, than does Victoria.

3.1 Wage and Wage-Related Costs

Data from VHA's data research arm, suggests that at least in the public sector, the 75/25 wages/non-wages ratio is not appropriate to nursing homes, if capital is excluded, especially where the facilities are essentially stand-alone in nature. A more appropriate ratio of staffing to other costs in public nursing homes appears to be about 80/20. This estimate include non-nursing staff, such as cleaners, food preparation staff etc.

With regard to substitution, it has to be accepted that aged care is a highly labour intensive activity. There do not appear to be significant opportunities for labour-saving in wards, and savings by automation to non-care areas such as patient accounts have already been realised. The public healthcare sector in Victoria has already lost about 5,000 staff and a round of Voluntary Departure Packages are currently being offered in aged care facilities. The effect on overall cost structures in nursing homes is not yet known.

While VHA recognises the importance of having properly qualified staff available, VHA believes the workforce and education policies which have resulted in shortages of Division 2 Registered Nurses (which used to be known as State Enrolled Nurses) were flawed. For many years SENs were the bastion of the nursing workforce in public extended care agencies of all types and their declining importance and availability is much regretted. VHA believes that many tasks in nursing homes and hostels can be undertaken by Patient Care Attendants provided they have an appropriate TAFE qualification. In other States PCAs make up an appreciable proportion of the nursing workforce and the only reason they do not do so in Victorian public sector nursing homes is industrial. Attempts to change this situation are likely to meet with the strongest resistance.

3.1.1 Variations in State and Territory Award Rates

VHA has attempted to develop some comparative tables, which are based on data in each state and a model for a 30 bed nursing home. Unfortunately it has not been possible to complete this model in time for this submission. It is suggested that this would be an illuminating study for the Commission to undertake. It is understood that other Victorian representative organisations have provided considerable data.

It should be noted that at least under CAM arrangements which applied until last October, nursing staff in nursing homes operated to a rigid, fixed profile of staff. While the quantum of hours could increase or decrease with the dependency of residents, the proportion of hours provided by different classifications was largely pre-determined by the Commonwealth's funding.

3.1.2 Over-Award Payments

As far as is known, over-award payments are uncommon in the Victorian public sector. A small number of relatively senior nursing positions may offer packaging, which is effectively a form of over-award payment, and in a limited number of cases other benefits may be offered in country areas in the residential care field.

3.2 Non-Wage Costs

VHA does not have any relevant data on non-wage costs.

4. The Merits of Alternative Funding Methodologies

4.1 State Based Arrangements

The VHA believes that, while there are significant differences in costs and standard of living between the States, that national funding systems should reflect such differences. The obvious way to do this is to establish the cost of a basket of goods and services, for which the funder is paid, with an allowance for capital, which could itself be indexed to reflect variations in the cost of land and buildings. Such an approach is powerful, flexible and ensures residents in different parts of the country are not disadvantaged (effectively) merely because they happen to live in Sydney or Melbourne.

The US Medicare system uses more than a dozen variables in its funding model, one of which reflects the cost of local goods and services. Ellis et al (1996) compute a Geographic Input Price Index (GIPI) using input prices (wages, building rental rates etc) measured by US Medicare's prospective payment system area hospital wage index and another factor which takes into variations in the Medicare medical fee schedule. Using this index, cost weights can vary from a relative 0.785 in rural Mississippi to 1.272 in Oakland, California. Differences in cost of living in Australia probably lie within similar bounds, ranging from around 0.75 in Tasmania to perhaps 1.15 in NSW and possibly WA and perhaps 1.05 to 1.08 in Victoria. It is understood the ABS has ready access to such cost data and that a health cost index is prepared on a State basis.

Problems with the "basket" approach are acknowledged. In particular, the ABS finds, for example, that the constituents of the basket vary across the country. The spending patterns of people in Cape York differ markedly from those in Tasmania. The high cost of freight in remote areas itself is a major determinant of spending patterns. Although the differences in costs in the nursing home environment are likely to be less marked than those for well adults and children, they are still likely to be substantial.

VHA believes that subsidy arrangements which recognise these differences are essential to ensuring equitable access to high quality nursing home care. VHA watched with increasing concern over a long period as nursing home operators, both public and non-public, have been forced to resort to desperate and unpalatable measures, including considerable cross-subsidies, merely to stay in business. Such differentials should, VHA believes, reflect the total costs, rather than primarily differences in wages costs for nursing and personal care staff, although these comprise more than half the total costs of running such facilities.

One suggestion is to quarantine the State based component of funding to factors outside the control of proprietors. The argument about quarantining costs within the control of proprietors is a difficult one to accept. Which costs are "within control"? Labour costs would be an obvious target, and while proprietors should be encouraged to be innovative and to examine various forms of substitution, the average nursing home proprietor is generally a price taker, certainly in relation to any professionally qualified staff., ie they are not in a position to negotiate on remuneration and conditions. Despite the overall high unemployment levels, virtually all hospital and aged care facilities are finding it difficult to recruit staff, especially nursing staff.

The Productivity Commission issues paper raises the legitimate concern of the Commonwealth that any indexation arrangements should not lock in cost relativities. This could be ensured by regularly reviewing the composition of the indices representing costs in each jurisdiction.

The question of funding and cost differences between different sectors is a complex one. It is true, for example that when the SAM/CAM funding system was introduced, the charitable sector found CAM restricting while the private sector found SAM a problem. It was VHA's contention at the time that the Commonwealth erred in the way the SAM component was designed. SAM was not indexed to reflect variations in the cost of goods and services between the States. VHA calculations suggest this has led to a $200 million shortfall in the 10 years since the system was introduced and the impact is reflected in the relatively poor score Victorian agencies received in the certification process[3]. CAM, the nursing component of the funding system, was modified to reflect wages and salary costs in each state. VHA believes this practice should continue.

In VHA's view, the system should be seen in a holistic light. The different tax treatments of various sectors need to be analysed carefully. For example, while it is true that the public sector does not pay a number of taxes, the public sector has much less access to needed capital, works under less efficient and more restrictive nursing awards, and cannot claim depreciation. Through the depreciation mechanism the Commonwealth effectively pays for a substantial proportion of private nursing home capital. The public sector cannot emulate this mechanism and the charitable sector can only to a limited extent, although the Commonwealth has in the past assisted both with capital grants.

Favourable FBT arrangements for public sector entities allowed them to attract staff whom they would otherwise be unable to remunerate appropriately, in a competitive market. It is now clear that, whoever wins the 3 October 1998 election, a cap on FBT will be instituted in the near future. A GST will also reduce private sector costs while increasing public and charitable sector costs, since some inputs on which agencies in those sectors now pay no sales tax will probably attract a GST.

[3] SAM started at approximately $35 a bedday in 1987. At that time Victoria's costs were approximately 15% higher than the average for all Australian states and territories and thus it should have been about $40. Victoria's cost disadvantage fell to about 5% in 1997. See Appendix one for a spreadsheet which explains our calculations in more detail.

If governments are minded to apply competitive neutrality principles to eliminate any tax related cost advantages which publicly run homes are perceived to enjoy, VHA would argue that this should be done on a fair and comprehensive basis. For example, the new privately owned public hospitals in Victoria are being offered multi-year contracts, their service contracts with the Victorian Department of Human Services are legally enforceable and they have ready access to capital markets. Publicly owned public hospitals are effectively on single year contracts, their service contracts are not legally enforceable against the Department and they have only limited access to capital, which is in chronically short supply. Under Loan Council restrictions public agencies are effectively prevented from issuing bonds or otherwise raising their own capital funds throughout Australia. VHA has already made the point about depreciation: the question of a taxation 'level playing field' is not as straightforward as some private sector proponents would have the community believe.

VHA does not accept that the linking of subsidies to average state costs mutes incentives for providers to look for cost savings. The experience of Victoria over the past 11 years strongly refutes such an argument. Victorian operators, in all sectors, have been forced to look for cost savings in the most strenuous fashion, simply to survive. The Commonwealth subsidies are so meagre, in relation to costs, that it is virtually impossible to make a good return except in large purpose designed facilities.

VHA does support, however, a merger of subsidies into one pool. The old SAM/CAM/OCRE split is not appropriate, since it discourages innovation and substitution. Line item funding for long service leave and superannuation and WorkCover etc is also not generally supported, although if funding on an averaged basis is provided, a pool arrangement to cater for individual agencies with special needs might be appropriate. Such a scheme was recently set up for long service leave in the Victorian community health centre sector. The concept of acquittals is also not supported, since it discourages efficiency.

To ensure accountability and quality in a largely deregulated environment, VHA cannot see any alternative to monitoring of service standards, accreditation and certification. VHA also would encourage the publication of "1eague tables" to enable prospective residents to make informed choices about quality and cost, but only so long as the industry was consulted about the nature and quality of the data used.

The cost of maintaining State-based systems need not be great. VHA understands that the ABS already maintains a health costs index by State and this could be used as the basis of both the starting point and indexation. A complex formula is not required - the imponderables and variations already existing make too detailed a system not worth the effort in VHA's view. The costs of the DH&FS need not increase one cent: VHA is only arguing about the distribution of existing funds, which VHA has believed for more than 10 years is inappropriate (at least in relation to SAM). Continuing down the coalescence path will, VHA believes, bring about disaster in the sector, for the reasons discussed throughout this paper.

4.1.1 Intra-State Variations

Logically, differences within the States should also be recognised. To some degree they are already recognised by the rural and remote subsidies which exist but few Victorian nursing homes appear to meet the existing criteria. VHA has no difficulty with recognising intra-state variations provided they are soundly based and take into account a wide variety of factor such as discussed above.

VHA believes institutions in country areas suffer many additional costs, principally for telecommunications, transport and freight. Utility prices also now vary considerably within Victoria. Patient transport (in ambulances) is a particular concern and many rural hospitals and aged care facilities pay hundreds of thousands of dollars a year in ambulance transport fees. Even fees for technicians to service mechanical and electronic devices are higher in the country. Other significant costs can accrue from the necessity to accommodate staff who are receiving training away from their place of residence. Staff travel can also be a significant cost, particularly for centres which may be providing regional or sub-regional services.

On the other hand, it is true that rural agencies tend to enjoy a lower staff turnover rate than their metropolitan brethren, although even this can have disadvantages, since it often means long service provisions have to be more generous in country areas. Many basic commodities, such as petrol, are also dearer in the country, although housing and building costs are lower.

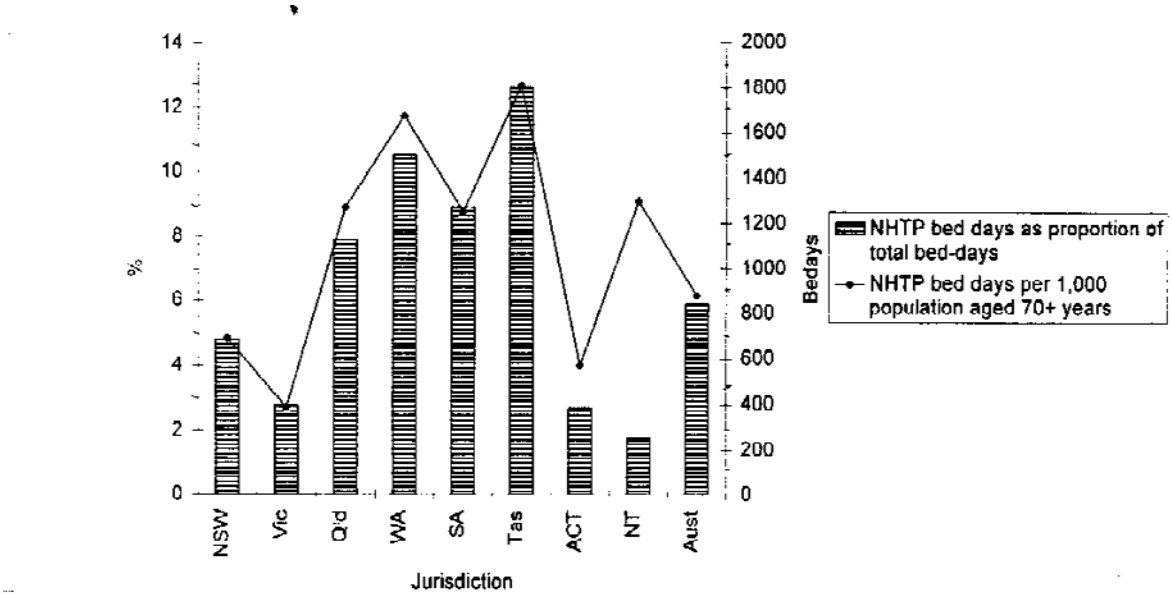
Staff costs can also be higher in the country, because of the need to pay competitive salaries to attract professionals in short supply, particularly some specialist nurses, such as those with a geriatric care background.

The question of whether, logically, difference between sectors should be recognised (in terms of tax, occupancy costs etc) is a difficult issue. On balance, the VHA does not support such a recognition, although to a limited extent the existing discount to the disfavour of the public sector does so. VHA's view is that, in general, there are "swings and roundabouts" between the sectors and the that the system should be as simple as possible and that complexities such as indexes between the states, and within states, are only justifiable on access grounds, i.e. that local communities would suffer without them. We do not believe this argument can be made in relation to inter-sectoral differentiation's.

4.2 Proposed National Subsidies

The VHA believes that if coalescence proceeds, up to one third of Victorian nursing home beds would be forced to close. If anything like this number of beds (5,000) were to close, the effects on the acute hospital system would be catastrophic, since this represents about 27% of the 18,000 or so acute hospital beds available in this State and the effect would be much greater than this because of the high average length of stay of NHT patients. For many years Victoria has had the lowest proportion of nursing home type patients in acute hospitals of any State (see GSP97 Table 7A.8). In 1994-95 Victoria had only 2.8% of acute hospital beddays classified as NHT, compared to more than 12% in Tasmania and more than 10% in Western Australia. Victoria also has fewer acute hospital beds per head and fewer nursing home beds per head of elderly population of any State, excluding the ACT. Thus the effect of a significant reduction in the number of nursing home beds would have the most extreme effects in Victoria.

Bed days for nursing home type patients, 1994-95



In the public sector, 90% of nursing homes are being cross-subsidised by their parent hospital. If coalescence continues, this will result (with other relevant factors) in a decrease in nursing home revenue of approximately 25% by 2004, which would increase the effective bedday subsidy required from the current $15 per bedday to about $54 a bed day. On this basis only a handful of Victorian public sector nursing home could afford to operate without external assistance, given current arrangements and virtually all 4,800 public sector beds would have to close or be transferred to other sectors.

Already one-third of Victorian nursing homes, including about that proportion of public sector nursing homes, have failed certification, which means they cannot charge the new accommodation charges. Thus do not have access to a secure revenue stream to finance rebuilding or conversion. The Commonwealth is so concerned about this situation that it has eased the rules for certification and increased the time period for compliance with building standards, but these measures have had little immediate effect. They have merely stopped the situation getting worse.

Coalescence would catalyse massive change, particularly in 2002. Since public sector nursing homes could not continue to operate, it would force the privatisation of virtually all public sector nursing home beds. The private sector believes that the minimum effective size is 60 beds, but the average size of public sector nursing homes outside Melbourne and four regional centres is only 28.9 beds. These are now in more than 70 locations. VHA's calculations suggest the number of locations would have to fall by more than half. So, even making generous assumptions about public sector beds being added to existing voluntary or private sector nursing homes (of which there are relatively few in the country), access would fall significantly. VHA calculations suggest that about 10% of Victorians would lose any nursing home facility in their town of residence. This is not a desirable public policy outcome. It should be noted that while the public sector provides more than 25% of all nursing home beds in Victoria, in non-metropolitan Victoria the proportion rises to more than 60%. Although about two-thirds of public sector beds have been certified by the Commonwealth, a much higher proportion than the balance of one-third (believed to be about two-thirds by the DHS) of rural public sector nursing home beds would have to be rebuilt to meet private sector viability requirements.

4.3 Alternative Funding Arrangements

The PC issues paper raises several alternatives, some of which are based on existing practices in other human services programs.

The PC alternatives might be characterised as:

- cost-reimbursement based
- voucher based

In devising a framework for a payment system, it is necessary to take a step back and think about the aims of the system. The Commonwealth, as the funder, wants to ensure that:

- services provided are of good quality and offer a good quality of life
- a comprehensive range of services is offered
- that services are distributed on a fair basis.
- resident and carers have a range of choices
- services are constructed in such a way as to encourage non-residential care, which is both cheaper and preferred by elderly people
- encourage innovation and substitution are encouraged
- services are well-integrated
- overall costs are capped
- that services are efficient
- that individual agencies are encouraged to care for a wide range of residents
- if co-payments are required, that these are reasonable and not a deterrent to entry to the system

These aims are hardly unique to residential aged care: they are a list of desirable characteristics of virtually any healthcare system. The dimensions are ranked in the above list in approximate order of importance. The tension between different parts of the framework is an inevitable consequence of differing perspectives coming from the resident/patient, the funder/insurer and the provider.

The VHA has undertaken a significant amount of work into payment systems and examined all those now practised in Australia, almost all practised in other jurisdictions and some which have been proposed in theory but not implemented for various reasons. In addition, the funding system for nursing homes has to take into account the fact that providers range in ownership modalities significantly, from private for-profit to public sector.

Alternatives to the current prospective output based system include:

- outcome based
- health status
- some form of population funding based on estimated need or demand
- fee for service
- line item or historical cost plus (the cost reimbursement proposal would probably fit into this category)

There are wide range of possible permutations, variants and combinations.

Since nursing homes generally offer terminal care, the first two are difficult to apply. The fifth alternative is difficult to justify intellectually. Arguably, casemix is a form of fee-for-service for hospitals and nursing homes, although where it has been applied in Australia there are strict caps on volume, whereas the major fee-for-services systems which operate in Australia (the MBS and the PBS) are not capped.

The voucher proposal is interesting, although VHA believes the alternative types of care vary so much in cost that it is difficult to see how such a system could operate in aged care. If a person is so ill that they require round the clock nursing, caring for them at home is an extremely expensive business, much more so than in either a hospital or nursing home unless family carers are available and prepared to undertake this arduous task. The alternatives are usually hospitals and nursing homes, the former of which are generally free or with minimal co-payments, and the latter with a capped co-payment. If home-care is a reasonable alternative, then an individual might still have gone to a nursing home but in a low dependency category.

Vouchers would have to be renewed regularly and arrangements made to change them if a person's condition changed significantly. There are also questions about what to do if someone dies or if someone's condition changes before the end of the voucher's currency. Presumably vouchers would not be tradable nor redeemable for cash, since this might encourage improper or inappropriate activity. VHA cannot see any real advantages for vouchers. Although VHA acknowledges that existing case management, brokerage and provider liaison can be improved, people who require residential care generally already have a range of choices.

The obvious alternatives are some form of output based funding system and some sort of population based funding system, although the latter is generally applied to areas or regions, not individual agencies. A population based funding system for residential aged care might be based on Victorian DHS regions, with the regional administration negotiating with individual agencies, or administering an output based funding system which might use a national instrument for determining dependency, but hold back some funds for service development. The Victorian DHS does this with many of its programs now, although only mental health has an overt population basis. Nationally, the Commonwealth could pool aged care funding programs and allocate these to the States on a population basis, giving the States broad outcome standards but allowing them to distribute funds according to local needs. The VHA is not necessarily in favour of population based funding generally but work along these lines would certainly be worth considering seriously.

Overall, with the caveat about some population basis, some form of output based funding system seems the most appropriate, especially given the framework described at & beginning of this section. With output funding, the range of services offered is determined by the funder. Quality is determined by standards, which are monitored, although competitive pressures also tend to improve standards. Arguably, greater choice could be achieved by deregulating fees further, although extensive care beds are available now. It should be noted that only very wealthy individuals could afford the full the $35,000 a year cost of nursing home care without government assistance. Non-residential care is encouraged mainly by the tight cap on residential care implied by restricted growth in the overall number of beds.

The lack of integration in the current system is probably its biggest single failing, but this is slowly improving. Proposed reforms to primary care and assessment in Victoria will advance this cause significantly. Overall costs are capped by the RCS mechanism and the regulation of bed numbers. Co-payments are fixed by the Commonwealth except for exempt beds, although the new entry contributions appear already to be acting as a disincentive to entry to the system: for the first time in living memory, there are significant numbers of vacancies in many nursing homes. Efficiency is encouraged by the operation of the funding system. Agencies are encouraged to care for a wide range of residents, in terms of dependency, by ensuring that the RCS accurately reflects costs. It should be noted that there are special supplements for particularly costly care, such as for enteral feeding. The distribution of beds is determined by the Commonwealth, on the basis of population.

VHA does not believe a cost-reimbursement system would achieve the efficiencies of the output system and has reservations about a voucher system for this particular program.

In relation to some of the specific comments in the issues paper, VHA believes that some type of special needs funding will always be required to keep services affordable in high cost locations, especially remote areas.

The voucher system proposed (without being named such) has the attraction of increasing competition between providers, but resident choice of nursing home probably already achieves that aim. It has been noticeable that as occupancy rates have fallen, the level of competition between providers has increased dramatically.

The lack of integration of services, particularly residential and non-residential services, is an important one. The aged care sector is not alone in having essentially separate structures for residential and ambulatory care: such is the case in the general healthcare field also, although public hospitals are a notable exception, since they provide substantial outpatient (specialist) services, and GP type services in their Accident and Emergency Departments. If anything, it could be argued that the non-aged sector is even more fragmented than aged care, since at least in the case of the latter the funder is the same. In the case of the public hospitals and Medicare, the funders are different entities who have, over the past seven or eight years, engaged in large-scale cost shifting.

Having considered the questions of horizontal and vertical integration at some length, the VHA believes the important thing is not integration (in the sense of ownership or funding models) but good communications between different providers. Often, when good communications are established, providers realise that some form of area-based care concept becomes more feasible. One problem with vertically integrated area-based services is that they appear to be inimical to competition policy, but that is a question to be resolved here.

Population and area-based methodologies seem the most likely to encourage integration of services.

5. Implementation Issues

VHA firmly believes coalescence is inappropriate, both intellectually and practically. Its continuance would have the gravest effects on most nursing homes in all sectors in Victoria and inevitably lead to the closure or massive cross subsidies, of the order of $60 a bed day (or roughly half their running costs) by the Victorian State government, in the absence of extremely large-scale microeconomic reform. Reform which involves reducing costs by half in the remaining five years is physically impossible. There is thus no point in proposing different phasing arrangements, unless the phase in period was extended to an absurd length of time.

If major changes are countenanced, such as a population based funding system, then the consequences, particularly on infrastructure, may well be significant, and thus a minimum of three years and preferably five should be allowed.

VHA does not believe that funding drives wage outcomes. Significant rises for public sector nurses in Victoria were *not* accompanied by funding increases, and the thought of significant rises being provided in advance of wage increases is not believable. No Australian Treasury Department would agree to such a proposition. Indexation of the type VHA has proposed would not result in major resource shifts either between or within jurisdictions.

Conclusion

VHA welcomes this opportunity to argue the case for the abandonment of coalescence and the adoption of a new, properly indexed funding system for the nation's nursing homes. VHA believes the Commonwealth should seek to purchase outcomes defined in terms of a basket of goods, services and infrastructure and this should be properly costed, acknowledging variations in the local costs of goods, services and capital.

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Appendix 1

The costs of not indexing SAM

Financial year	Real SAM/ bed day	Notional Victorian SAM	Bed days	Victorian costs as an indice	Notional disadvantage	Total loss
1987-88	35	40.25	4,380,000	1.15	22,995,000	22,995,000
1988-89	35	39.90	4,423,800	1.14	21,676,620	44,671,620
1989-90	35	39.55	4,468,038	1.13	20,329,573	65,001,193
1990-91	35	39.20	4,512,718	1.12	18,953,417	83,954,610
1991-92	35	38.85	6,077,127	1.11	23,396,941	107.351,551
1992-93	35	38.50	6,137,899	1.10	21,482,645	128,834,196
1993-94	35	38.15	6,199,278	1.09	19,527,725	148,361,921
1994-95	35	37.80	6,261270	1.08	17.531,557	165,893,478
1995-96	35	37.45	6,323:883	1.07	15,493,514	181,386,992
1996-97	35	37.10	6,387,122	1.06	13,412,956	194,799,948
1997-98	35	36.75	6,450,993	1.05	11,289,238	206,089,186

This table acknowledges the fact that the public sector did not adopt the SAM/CAM funding system until 1991-92. For simplicity, it assumes the number of beds grew steadily by 1 % a year from 16,000 and that Victorian costs as an indice compared to the national average fell steadily

Appendix 2

Projected impact of Commonwealth funding reductions on public sector residential care funding in Victoria 1997-2004

	1997/ 1998	1998/ 1999	1999/ 2000	2000/ 2001	2001/ 2002	2002/ 2003	2003/ 2004	2004/ 2005
Revenue								
Coalescence	0.0%	-0.1%	-0.2%	-0.4%	-0.8%	-1.3%	-1.3%	-1.3%
Estimated indexation	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
Total	1.5%	1.4%	1.3%	1.1%	0.7%	0.2%	0.2%	0.2%
Costs								
Labor cost increases	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Wages as % of costs	80.2%	80.3%	80.5%	80.6%	80.8%	80.9%	81.1%	81.2%
Other costs increases	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Total cost increases	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%	2.9%
Total cumulative cost increase	102.9%	105.9%	109.0%	112.1%	115.4%	118.7%	122.2%	125.7%
Gap	1.4%	1.5%	1.6%	1.8%	2.2%	2.7%	2.7%	2.7%
Cumulative gap (1996/97=100%)	101.4%	102.9%	104.6%	106.5%	108.8%	111.7%	114.8%	117.9%