AUSTRALIAN NURSING HOMES AND EXTENDED CARE ASSOCIATION LIMITED

SUBMISSION TO PRODUCTIVITY COMMISSION

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Executive Summary

The Government's referral of the current funding arrangements for nursing homes to the Productivity Commission for report recognises that the proposal to coalesce State based nursing home subsidy rates to national subsidy rates would create staffing problems in those States and Territories coalescing down to the national rate. The issue of coalescence may also lead to an ambit log of claims by unions in those States and Territories coalescing upwards to national subsidies. Unions would see that any extra funds provided by way of subsidies in those jurisdictions as being fair game for increased wages.

The Government's referral also recognises that the subsidy levels for nursing homes had been set without acknowledging the current cost of providing aged care in nursing homes. This is a direct result of the changing award conditions over the past 10 years together with the Government's change to the indexation arrangements from 1 April 1996. The Commission must also report on the adequacy of the current indexation arrangements both in meeting increased wages movements and sustaining parity into the future.

The 1996-97 Budget provided for a substantial reduction in care funding in anticipation of the introduction of means testing in nursing homes. This alternate funding arrangement disappeared following the Prime Minister's announcement on 5 November 1997 that residents entering nursing homes would not be required to pay accommodation bonds.

The pool of funds available for the delivery of nursing and personal care in nursing homes is now less than it otherwise would have been. Yet from this diminished care funding pool the Government draws the capital supplement for concessional residents who are unable to pay an accommodation bond/charge. There is a resultant real threat to the standards of nursing and personal care not only in nursing homes but in all residential aged care facilities.

ANHECA has analysed the subsidies in relation to nursing and personal care wages. We consider that the component of the subsidies that could be attributed to NPC wages is relatively correct for all jurisdictions except Queensland, South Australia and Northern Territory. The position in both Queensland and South Australia is that they are underfunded to the extent of between 9% and 10%. This can be explained by incorrect calculations when the Standard Hourly Rates were set in 1988 combined with the indexation process not accounting for changes in award conditions. The Northern Territory is overfunded by approximately 19%, which can be attributed to the setting of the SHRs at 1 July 1988 at a level 26.4% higher than that in South Australia.

ANHECA considers the subsidies should be set and indexed on a State by State basis and should be calculated on a formula based system that takes into account the cost of delivering nursing home care combined with a return on providers' investment. ANHECA also considers that subsidies should be reviewed every three years on the same formula asis taking into account changes in economic trends over the period. This will ensure that subsidies keep place with costs.

The current system does not require concessional resident payment, a substitute for accommodation bonds/charges, to be earmarked for capital investment. Accordingly the income from this supplement has been designated as recurrent funding by the department when comparing the RCS against the RCI and capital income for political purposes. ANHECA considers that the concessional resident supplement should be earmarked for capital and not compared with recurrent funding as was done under the recent RCS Review.

The current system does not provide for entrepreneurial growth because aged care is totally controlled by the Government. The controls which the Government places on aged care is as follows:

- **Price Control** -The Government sets maximum subsidies and the maximum amount that the resident is required to pay. Therefore the income of aged care facilities is totally controlled by Government.

- **Growth Control** -The Government, through its planning arrangements, dictates the number of aged care facilities in various regions around Australia. Growth control limits the level of funding payable by the Government because it limits the demand for aged care places. Without growth control, the level of subsidy would be greater to meet the increased demand and to ensure the viability of the industry.

- **Admission Control** -No resident can enter into an aged care facility and receive government subsidies without first being assessed as requiring that level of care by an Aged Care Assessment Team (ACAT).

These controls totally limit the income of aged care facilities and consequently limit the services and accommodation which can be provided to Australia aged residents.

Apart from the coalescence problems, other funding problems, which could jeopardise care standards, are:

(i) the initiative to discontinue additional recurrent funding (ARF) to eligible nursing homes following their accessing accommodation bonds/charges,
(ii) funding arrangements for workers' compensation premiums, payroll tax and superannuation.

Of particular concern are the Government's treatment of ARF funding and the costs of workers' compensation premiums.

The Government's decision to provide proprietors with the option to either continue to receive the ARF payments, or to levy accommodation bonds/charges on incoming residents re-introduces an inequity into the system. Those nursing homes in receipt of a full capital grant, as opposed to ARF, have received all money payable up front and, therefore, do not have to forego any funding.

Assuming these nursing homes receive certification, they will be eligible to charge accommodation bonds to incoming residents. Continuation of ARF funding is necessary to allow those other proprietors to meet existing financial commitments associated with already completed capital works entered into on the basis of the arrangement committed to by the Commonwealth Government. Those proprietors, in common with all other proprietors, need to be able to access accommodation bonds in order to provide for future upgrading or refurbishment of the facility when required.

Workers' compensation funding remains a problem. Under the current arrangements, available funds will be pooled and no specific provision will be made for facilities unfortunate enough to be burdened with higher workers' compensation costs. Furthermore, the same funding level will apply across States, thereby ignoring the significant variation in the levels of premiums in different States. It is inevitable that the financial position of some facilities will be compromised under this system as one claim can dramatically affect (double or treble) premiums for the following three years. Without an upper cap on premium payments some homes will face the possibility of bankruptcy. Hence, workers' compensation costs should be funded such that the maximum amount payable by service providers is 5% of total payroll, with any costs over and above that amount being directly funded by the Government.

The treatment of payroll tax and superannuation should be on a cost reimbursed system to ensure that no provider is financially penalised or better off in relation to statutory costs.

ANHECA also considers that the introduction of accreditation and certification will add extra costs, both operating and capital. In relation to accreditation ANHECA considers that there will be a need for a high level of education in the first few years leading up to accreditation and that this will level off after that date. Accordingly ANHECA recommends that Government funding be available through the Agency to meet The "bubble" requirements and that the subsidy include a definite amount for education equal to 1.5% of wages.

ANHECA considers that the funding, set on a State by State formula basis, should include.

- The current **cost of Nursing and Personal** Care staff, based on an agreed mix between the different types of employees. ANHECA suggests, registered nursing staff (33%), non-registered nursing staff (60%) and therapy staff (7%).
- The current cost of non-NPC staff.
- The cost of award conditions (ie, leave, public holidays etc).
- The cost of non-wage expenditure.
- The cost of training, set at 1.5% of wages.
- The cost of Long Service Leave, set at 1 % of wages.

- A return on investment based on an imputed rental plus a reasonable return on the business.

ANHECA considers that the indexation arrangements should allow for the maintenance of parity between the public and non-government sectors. ANHECA would prefer an industry basket approach to indexation, however, if this approach is not acceptable, ANHECA would suggest that the aged care sector should be linked to the ABS index ABS index for Health and Community Services industry. This would provide a direct link to the public sector.

Maintenance of parity is one area that is vitally important to the sector. However, to ensure that parity is there in the first instance, ANHECA recommends that the subsidy levels reflect the level of wages in that sector.

ANHECA also considers that statutory costs such as payroll tax and superannuation should be cost reimbursed, as the provider has no control over the rates charged. In relation to the other statutory cost, workers' compensation, ANHECA considers that this should be cost reimbursed, within caps, to provide incentives for continuing good OH&S practices and to ensure that unavoidable workplace injuries do not force providers into receivership.

Finally, ANHECA considers that the funding arrangements should be reviewed every three years on an agreed formula basis to take account of various cost movements and to provide a certainty for parity.

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Introduction to ANHECA

The Australian Nursing Homes and Extended Care Association Limited (ANHECA) is a federal association representing private enterprise and religious and charitable aged care employers throughout Australia. The members of ANHECA are the various State associations that represent aged care employers across Australia.

ANHECA strives for and is committed to excellence in aged care in a commercially viable environment. The role of ANHECA in pursuing this objective is to:

- promote the commercial interests of aged care service providers,
- provide a forum for members to deal with current and future issues affecting aged care,
- formulate progressive, achievable and cost effective aged care policies for presentation to government and the community, and
- represent members to government, stakeholders and others interested in the Australian aged care industry.

2. Background

The 1996-97 Federal Budget delivered wide-ranging changes to aged care programs and funding. ANHECA generally welcomed the Budget aged care initiatives because they recognised that the previous funding system had failed and had resulted in the overall deterioration of the nursing home stock to an unacceptably poor standard. The new arrangements provide a funding framework with the potential to recognise the true costs of operation of aged care facilities.

ANHECA has also welcomed the fact that underpinning the reform process is a general reduction in bureaucratic interference and greater funding flexibility, which, over time, should provide aged care consumers with a greater choice of facilities offering quality accommodation standards. The Association generally believes that the proposed structure of the nursing home funding arrangements is intended as a means over time of, firstly, providing incentives for aged care service providers to invest in modern facilities offering a high standard of accommodation and, secondly, reducing the burden on the taxpayer by ensuring that those who can afford to contribute more to the cost of their care do so. The new arrangements recognise that the Government cannot continue to pretend that it is fully funding aged care.

The negotiations between the Commonwealth and the wider industry saw that the aged care reforms introduced on 1 October 1997 had as a core the following major reforms..

- Accommodation bonds;
- Accreditation/Certification,.
- Single Classification Instrument;

Given that the industry was to receive a major capital boost with the introduction of accommodation bonds, there were many concessions granted by the industry to secure a reasonable funding system. There were, however, some issues which ANHECA considered to be imperative to the ongoing viability of the industry. Examples include the Additional Recurrent Funding and the level of subsidies attached to the single assessment instrument.

The Prime Minister announced on 5 November 1997, some 5 weeks after the commencement of the scheme, that accommodation bonds were now not payable by residents entering nursing homes. The result of this was that part of the very core of the reforms was taken away with no consideration given to the industry concessions. The end result was that the aged care reforms began to crumble. ANHECA rightly considered that the industry concessions were also null and void.

ANHECA provided the Minister with a number of Position Papers (ANHECA's Blueprint for Quality Aged Care) setting out the problems and options to remedy the situation. A copy of this paper is attached at Attachment A. The announcement of the Productivity Commission Inquiry into Residential Aged Care Subsidies sets the framework for addressing some of these concerns. Two of ANHECA's major concerns; the coalescence to national subsidy rates for high care and the ongoing indexation arrangements are highlighted as integral to the inquiry.

3. Scope of the Inquiry

The Productivity Commission has requested to:

1 . Report whether the proposed coalescence should proceed or whether it should be replaced by an alternate structure;

2. Examine issues, including the current and alternate funding methodology and report on:

   - Relative costs between States and Territories of providing nursing home care, with emphasis on the relative wage costs of nursing and personal care staff;

   - Trends in wage costs and likely future directions;

   - If differential subsidies are considered appropriate, possible methodologies for maintaining appropriate relativities over time.

3. Make recommendations on the appropriate funding methodology and take into account the views of the sector.

4. ISSUES PAPER

In August 1998 the Productivity Commission released its Issues Paper which addressed certain Terms of Reference and raised many questions in relation to others. ANHECA takes this opportunity to address the matters raised in the Issues Paper.

Capital Investments

The Issues Paper provides a reasonable snapshot of the previous arrangements and also of the new arrangements. It also states that accommodation charges are payable by residents entering nursing home accommodation, however, residents have the option of continuing with the accommodation bond when moving from low care to high care and an accommodation bond was paid in the low care service. Accommodation bonds may also be payable where the resident enters an Extra Service facility.

The Commission correctly points out that a concessional resident supplement is payable by the Government where the resident does not have the means to pay an accommodation charge and states "although there is no requirement to spend the money on capital improvements". There is no requirement to spend either the accommodation bond, accommodation charge or the concessional resident supplement on capital improvements as the Act enables that money to be spent on care if required. Never the less, ANHECA considers that the concessional resident supplement should be earmarked for capital and not compared with recurrent funding as was done under the recent RCS Review.

Resident Contributions

Again ANHECA considers that the Commission has provided a reasonable summary of resident contributions. It is important to note that the charge is not linked to the quality of accommodation and care received and to also state that they are not linked to the cost of delivering the service. Residents may be required to pay more according to their means but this does not guarantee the resident higher accommodation. Care is delivered to all residents commensurate to their assessed needs.

Regulation

Whilst the summary provided by the Commission is accurate, it needs to be pointed out that the Government controls aged care through three controls:

- **Price Control** -The Government sets maximum subsidies and the maximum amount that the resident is required to pay. Therefore the income of aged care facilities is totally controlled by Government.

- **Growth Control** -The Government, through its planning arrangements, dictates the number of aged care facilities in various regions around Australia. Growth control limits the level of funding payable by the Government because it limits the demand for aged care places. Without growth control, the level of subsidy would be greater to meet the increased demand and to ensure the viability of the industry.

- **Admission Control** -No resident can enter into an aged care facility and receive government subsidies without first being assessed as requiring that level of care by an Aged Care Assessment Team (ACAT).

These controls totally limit the income of aged care facilities and consequently limit the services and accommodation which can be provided to Australia" aged residents.

Nursing Home Costs

The Commission, in its Issues Paper asks three questions:

- **What are typical profiles of the costs of providing services to high care residents (including capital as well as recurrent costs)?**

- **What is the extent of differences in the cost of services across and within States and Territories and the reasons for those differences?**

- **What is the impact on service provision costs in any particular location of factors such as the size of the facility, its ownership and integration with other facilities?**

Awards vary across jurisdictions as do the mix of staff according to the resident mix. Analysis of rosters indicates the range of registered nurses to total nursing and personal care staff represents between 30% and 35% depending on the type of resident accommodated. For non-registered nurses the range is between 55% and 65% and the balance represents therapy staff. ANHECA has assumed a NPC staff mix of 33% RNs, 60% non-RNs and 7% therapy staff.

Domestic and clerical staff represent approximately 20% of total staffing costs.

This ratio is constant across States with the only difference represented by award rates. The average rates in each State for each category of staff (before costs of leave etc are added) are:

State	RN Rate	Non-RN Rate	Therapy	Domestics
NSW	$25.97	$14.50	$15.76	$13.94
VIC	$26.99	$13.70	$12.53	$12.85
QLD	$24.57	$15.03	$11.96	$12.84
SA	$25.49	$14.95	$13.71	$13.53
WA	$22.31	$14.20	$11.88	$13.29
TAS	$25.18	$15.75	$14.15	$14.51
ACT	$23.12	$14.20	$12.12	$12.64
NT	$22.75	$11.26	$11.54	$13.71

Within jurisdictions there are variations in the cost of rosters but this boils down to three areas, the size of the facility, the resident mix and the type of resident accommodated (ie dementia).

Wage and Wage Related Costs

The Commission asks a number of questions under this broad heading:

- **Is the commonly espoused 75/25 ratio of wage to non-wage costs reasonable?**
- **In the delivery of services, what is the scope for substitution between labour inputs and equipment?**
- **What proportion of total wage costs are accounted for by different types of employees?**
- **What is the scope to vary the proportions of different types of employees or to employ people to do more than one job?**
- **How significant are labour on-costs such as superannuation, payroll tax and workers' compensation premiums?**
- **How significant are current variations across States and Territories in award rates for nursing staff and personal carers?**
- **Are there similar variations in award rates for other categories of employees and in labour on-costs?**
- **Are over award payments common in the sector and what are the reasons for them? For example, are over award payments necessary to attract staff to more remote areas? Does the experience vary across jurisdictions and different types of employees?**
- **Are enterprise bargains or certified agreements becoming more common**
- **Is the small size of many providers an impediment to enterprise bargaining?**
- **Have pay rises under enterprise bargains or certified agreements been at least matched by cost savings for providers?**
- **Do differences in staffing profiles contribute significantly to differences in wage costs across and within jurisdictions?**
- **To what extent do differences in staffing profiles result from licencing, regulatory and award requirements as distinct from management prerogative?**
- **Are there any other factors leading to jurisdictional differences in wage costs? For example, how have wage outcomes for nurses in the hospital sector affected wage rates in nursing homes and consequent relativities between jurisdictions?**

The commonly espoused 75:25 ratio of wage to non-wage costs is reasonable provided that the ratio does not include the return on investment (ROI). A more appropriate ratio of wages to non wages, excluding ROI, is 80:20. The inclusion of the ROI would distort this figure to approximately 70:30. This ratio is only used in the calculation of the indexation and ANHECA would suggest that, as the ROI is part of the subsidy arrangements that the ratio be amended to 70:30.

When the CAM/SAM arrangements were introduced in 1987188, providers were forced to examine the efficiency of the delivery of services in nursing homes. This examination included:

- Whether it was more efficient to use in-house laundry or to contract out',
- Whether in-house laundry could be more cost effective with better machinery; Whether laundry could be done for other facilities;
- Whether cleaning could be contracted out rather than in-house;
- Whether food could be contracted out;
- Whether the facility could increase its kitchen and provide food to other facilities;

And so the list goes on. Many providers made changes only to revert to in-house or vice versa. Some providers have looked at the size of machinery and have installed larger, more appropriate machinery with an eye to improving output and saving labour.

Occupation Health and Safety has also become a large issue over the past 10 years and facilities, as well as implementing OH&S practices, have also introduced machinery, such as lifting devices, to compliment those practices.

Given the above, the bone is very lean as far as domestic wages and non-wage costs go. Under the current arrangements the real decrease in funding may lead to decreases in the injection of capital for labour saving devices with the result being an inefficient service.

Nursing and personal care staff represents approximately 75%-80% of all staff in nursing homes. This range would alter if the facility had a high use of contract services. Of the total NPC hours, registered nurses range between a representation of 30% to 35% (for this exercise we would say approximately 33%). Non-registered nurses range between 55% and 65% (for this exercise we will assume 60%). Therapy staff would therefore represent 7% of N PC staffing. This staffing mix is reasonably constant across States. Domestic staff represents approximately 20% of total staff.

Many domestic staff in nursing homes do more than one job simply because it is more efficient to have a full time member of staff than a number of part-timers. There is still a demarcation issue over nursing staff doing domestic duties. Most awards allow for nursing staff to carry out domestic duties in an emergency. This does not stretch to routine duties. Australian Workplace Agreements (AWAs) or Enterprise Bargaining (EBs) may be a way around the demarcation disputes, however, gearing up for AWAs or EBs is cost prohibitive for the majority of the sector. Also the unions would be involved in negotiations on EBs and may be involved in negotiations for AWAs.

Labour on-costs such as superannuation, payroll tax and workers' compensation premiums are very significant in the overall funding arrangements for aged care facilities. The current system provides funding for superannuation and workers' compensation through the subsidy arrangements and for a supplement to be paid in respect of payroll tax in accordance with the range of beds which the facility has.

To ensure that facilities are correctly funded for superannuation perhaps the best method would be on a cost reimbursed basis. The Government is committed to increasing the level of employer funded superannuation payments to 9% by the year 2002. Under the previous system of funding, superannuation payments for NPC staff was cost reimbursed under the OCRE component of the fee while the superannuation payments for non-N PC staff was included in SAM. Obviously the cost reimbursement system automatically picked up the gradual increases in superannuation for NPC staff, SAM was "opened up" each time there was a percentage increase in superannuation to provide a relative cost increase for non-NPC staff.

Under the current system the Government recognised the increase, however, applied an across the board increase of $0.52 per place per day irrespective of the resident category. This increase was to take into account the increase from 6% of wages to 7% of wages. The across the board increase did not recognise the vast difference in wage levels between nursing homes and hostels. If the government's espoused 75% of the subsidy is for wages then the increase for a category 1 resident represents a range between 0.64% and 0.79% of wages whilst it represents 3.25% in respect of a category 7 resident.

Payroll tax is only payable by private enterprise service providers, with religious and charitable providers being exempt. Under the previous funding arrangements for nursing homes, payroll tax for staff is a fully reimbursable expense. The 1996-97 Budget announcement of the new funding arrangements to apply from 1 July 1997 provided for payroll tax to also become part of the general funding pool for allocation across the industry.

Such pooling of funds for payroll tax would have been inequitable between private enterprise providers and would have provided a windfall gain to the religious and charitable sector.

The Minister for Family Services subsequently suggested a proposal, whereby a flat funding increment per bed be paid for the private enterprise sector to compensate for the requirement to pay payroll tax. However, this arrangement still discriminated between private enterprise providers. This is because providers with multiple facilities pay payroll tax on the total payroll across all their facilities and are not afforded the payroll tax free benefit for each facility. Hence, the unit bed payroll tax liability under this proposal is greater for providers with multiple facilities than for single facility providers.

Subject to the wider taxation reform issues, ANHECA maintains that the funding component for payroll tax should be pooled and provided to the States as a grant, in exchange for an associated exemption from payroll tax for all aged care facilities. To his credit, the Minister approached the Premiers and Chief Ministers with this proposal that they declined for various reasons.

The current supplementation arrangement whilst providing funding to those facilities which are required to pay payroll tax, on a three tiered basis, discriminates against providers failing just below the benchmarks and specifically those providers owning more than one facility. Providers owning more than one facility do not receive the same tax free threshold per head as single facility providers.

A further problem facing providers in certain States and Territories is the governments intention to coalesce payroll tax supplements to a national rate irrespective of the State government requirements and also irrespective of the residents' dependency and hence level of staffing.

ANHECA considers that as the cost of payroll tax is controlled by State Governments And that the provider has little if any control over the cost, then the cost of payroll tax should be cost reimbursed. Providers should not gain or lose because of statutory charges. This would provide the same level of funding, in real terms as was provided under the previous system and would be revenue neutral to Government.

Workers' compensation funding is a problem under the current funding arrangements.

The aged care industry is characterised by a largely unskilled workforce and a high incidence of lifting. Yet with the single non-acquitted subsidy, available funds are pooled and no specific provision will be made for facilities unfortunate enough to be burdened with higher workers' compensation costs. Furthermore, the Government's intention to coalesce subsidies to a national rate means that the funding for workers' compensation eventually will be identical in all States. This does not take into account the significant variation in the levels of premiums in different States.

It is inevitable that the financial position of some facilities will be compromised under this system as the potential for small businesses, such as nursing homes, to reduce workers' compensation costs is very limited. Claims commonly arise from gradual "onset injuries" as distinct from specific accidents attributable to incorrect occupational health and safety practices. One claim can dramatically affect (double or treble) premiums for the following three years. Without an upper cap on premium payments some homes will face the possibility of bankruptcy.

Representatives of the Department of Health and Family Services have argued that, where attention is paid to occupational health and safety matters, workers' compensation premiums could be reduced significantly. However, due to the nature of the workforce and the high incidence of lifting the implementation of safer workplace practices does not necessarily lead to lower premiums. Other matters affecting the level of workplace incidents are resident aggression, especially from dementia sufferers, and staff attempting to save residents from fails.

Workers' compensation premiums for a particular facility do not depend solely on the OH&S procedures that are developed and implemented by that facility. They are based substantially on industry risk, claims history and, in some cases, the viability of the State's Work Cover Authority.

ANHECA maintains that the Government should view this area of funding as a priority to avoid the risk that aged care service providers with higher workers' compensation premiums could be forced to reduce the level of care available in order to meet the statutory cost of workers' compensation.

ANHECA believes that a straight averaging approach to workers' compensation costs as part of a national funding strategy should be abolished unless a national system of workers' compensation is introduced. State borders need to be ignored (they are irrelevant for workers' compensation) and a competition policy implemented which will make State run workers' compensation schemes more accountable. State governments should not be allowed to rely on the non-government sector and the Commonwealth Government to fund the inadequacies and inefficiencies of their workers' compensation schemes.

In the meantime, ANHECA considers that workers' compensation costs should be funded on the same basis that they were under the previous system. This system provided for funding based on industry averages, on a State by State basis, with protective caps to ensure that the top 5% of facilities would not be unduly burdened.

Award rates vary significantly across States, as do conditions of the award. In most cases the wages and conditions for a particular State are peculiar to that State, however, in Queensland and Western Australia there are varying award rates and conditions in the majority of the State compared to the far north of the State. The variations within States are not significant but do have an effect on the overall expenditure of those States.

Over-award payments are not common in the sector, however, given that there is no parity between the public and private sectors, some providers are, of late, paying principal staff, such as the Director of Nursing at an amount in excess of the award. As stated, this over-award payment is an inducement to maintain good staff and, unless the issue of parity is fixed there will be a greater percentage of over-award payments to the overall detriment of resident care. Also, under the current taxation arrangements, nursing homes that are exempt from the provisions o Fringe Benefits Tax (FBT) are in a position to offer packages which include incentives or benefits such as motor vehicles, holidays, school fees etc to all staff. This cannot be offered in the private enterprise sector as the cost of the FBT would also have to be taken into account in the package.

In relation to remote areas, the same would apply to those facilities currently exempt from FBT; however, over award would not be an issue as nursing staff are thin on the ground in those areas.

As previously stated AWAs and EBs are not becoming common place in aged care facilities. The main reason for this is the prohibitive cost of implementation as well as the guaranteed nature of wage increases, which are written into the agreement. Providers, rather than entering into an agreement that contains automatic increases, albeit linked to competencies, are fearful of the effect of indexation and the fact that the agreement does not mean that good staff will be retained if award wages in the public sector increase to a greater degree than that contained in the agreement.

Staffing profiles alter mainly from award, regulatory and managerial prerogative. In Victoria the award requires that during the day there be one registered nurse on duty for every ten residents and that at night there should be one registered nurse on duty for every fifteen residents. The award anomaly is currently being run in other states in an attempt to further regulate the industry and to ensure jobs for nursing staff.

In New South Wales, where a nursing home has more than 40 beds the facility is bound to employ a Deputy Director of Nursing. Many facilities in the voluntary sector employ extra nursing staff due to their charter. As non profit organisations they consider (rightly or wrongly) that they should utilise potential surpluses by injecting more nursing staff which would equate to more care.

There are a number of factors leading to jurisdictional differences in wage costs. The main factor would be the change to the indexation arrangements for nursing homes from 1 April 1996. This amendment meant that those States that had not finalised the nurses career structure increases by that date missed out on funding. Consequently, since that date, with decreased funding for staff wages the private sector has had to take a stance against the ever increasing demands by unions thus breaking the parity between wages in the public sector. An example is that currently NSW is 2.9% behind the public sector, Victoria is 12% behind the public sector, and Western Australia is 20% behind the public sector. South Australia and Queensland are also well behind the public sector.

Future Trends

The Commission asks two questions in this area:

- **Are current disparities in wage costs across and within jurisdictions likely to widen, narrow or remain the same?**

- **What factors will contribute to this outcome?**

Given the above and the current indexation arrangements in place the current disparities can only widen unless the funding system for nursing homes provides for a catch up to public sector rates and that the indexation formulae is such that it will allow a flow on from public sector awards. Unless this is an automatic process the gap will widen to an extent where nursing homes will find it impossible to maintain and attract good staff. That will be the death-knell for the industry.

Suppressing subsidies in some jurisdictions will not mean that wage increases will be suppressed. The aged care sector represents only 15% of the wider health industry and levels of wages are dictated by the public sector. Coalescence in those States coming down to the national average is simply a recipe for declining levels of care. Alternatively, for those States moving upwards towards the national average, increasing the level of income via the subsidies will not necessarily result in better care as the union movement will consider the situation as the green light for further ambit claims for increased wages.

Non-Wage Costs

The commission asks a number of questions under this sub-heading:

- **Do non-wage costs vary significantly within or across jurisdictions?**
- **Do such variations mainly relate to land and building costs, or are variations in non-wage recurrent costs also significant'?**
- **How much control do providers have over their non wage costs? For example, to what extent are they dictated by the various building and safety regulations?**
- **What impact will the new accreditation and certification requirements have on future costs?**

There are variations in non-wage costs across jurisdictions and also between sectors. The following is an analysis of the non-wage costs by State (excluding superannuation on non-NPC wages) for the year ended 30 June 1996 as provided by Bentleys Chartered Accountants.

	NSW		**QLD**		**SA**
Private	Total	Private	Total	Private	Total
$14.52	$21.11	$15.86	$19.79	$18.03	$20.31

	TAS		**WA**		**VIC**
Private	Total	Private	Total	Private	Total
$14.29	$18.20	$13.17	$13.57	$14.86	$21.53

The above figures exclude depreciation on buildings, interest and rent as well as Non-NPC superannuation payments. Also there are no OCRE costs included as the survey was in comparison to SAM.

SAM was indexed by; 1.8% for 1996-97, 1.7% for 1997-98 and 1.4% for 1998-99. The accumulative effect of the increases is that the above costs would require to be increased by 4.98%.

The variations above indicate that there is a small variation between most States however South Australia has a high variation. Analysis indicates that the total level of non-NPC wages in SA are lower than in other States and that can be explained by a greater reliance on contract staff.

The variation between Private and Total indicates the fact that the voluntary sector use any surplus to provide more staff and services. This does not necessarily lead to a better quality of care.

Using the beds per State as detailed in the Review of the Structure of Nursing Home Funding Arrangements - Stage 1, the weighted average non-wage cost for 1995-96 is $15.03 calculated as follows.

NSW	$14.52	X	29,105 beds	=	$ 422,605
VIC	$14.86	X	16,928 beds	=	$ 251,550
QLD	$15.86	X	12,145 beds	=	$ 192,620
SA	$18.03	X	7,110 beds	=	$ 128,193
WA	$13.17	X	6,106 beds	=	$ 80,416
TAS	$14.29	X	2,189 beds	=	$ 31.281
TOTAL				=	$1,106,665
Weighted Mean ($1,106,665 divided by 73583)				=	$15.03
Expressed in current terms ($15.03 x 1.0498)				=	$15.78

Whilst providers have a reasonable amount of control over their non-wage costs particularly the operating costs, ten years of SAM funding, with indexation not directly linked to the cost of living increases, has seen providers deliver services in the most cost effective manner possible. Providers in most States are dictated to in relation to costs by building and health and safety regulations. This has seen a regular increase in costs over the years especially in the areas of maintenance and occupational health and safety. Since the introduction of SAM there have been a number of cost centres where nursing home costs have increased at a greater rate than the cost of living. Examples are:

Laundry - Prior to the introduction of SAM, the extent of incontinent residents in nursing homes was approximately 40%. Over the past ten years this has increased steadily to the current level of approximately 80%. Also prior to the introduction of SAM providers were permitted to charge residents $2.50 per week for personal laundry. Under the prescribed services arrangements providers were required to provide personal laundry at no extra cost to the resident.

Chemist Supplies - Due to the increased level of incontinent residents in nursing homes, the average per diem cost of chemist supplies has increased dramatically

Toiletries - Again, prior to the introduction of SAM, nursing homes required residents to provide their own toiletries, such as toothpaste, toothbrush, shaving gear, combs, brushes etc. Under the Prescribed Services Arrangements these items are to be provided to the resident at no extra cost.

Clinical Waste - This cost was introduced for nursing homes after the introduction of SAM and requires that providers keep clinical waste (which includes continence pads) separate from other waste matter for safe disposal. This cost is ever increasing due to the nature of residents accommodated in nursing homes.

Dependency - In the SAM Review of 1991 the Department recognised that there was an extra cost involved on non-wage items for increasing dependency. Whilst the 1992 Federal Budget put in place an extra component of indexation to account for increased dependency, ANHECA has always maintained that the base cost should have been increased to allow for the increased cost in the first instance.

OH&S - The requirements of OH&S has meant that providers are to implement and maintain safety practices within the facility, and rightly so, However this comes with an extra cost over which the provider has no real control.

Certification and Accreditation come at a major cost to the facility, if not in the short term, in the long term. However, the majority of that cost is of a capital nature and the introduction of the user charge by way of accommodation charges assists in providing towards that capital. ANHECA considers that the $12 per day charge is insufficient, however that is outside the terms of reference of this review and is an argument for another forum. At least the charge provides a reasonable base, and cashflow to facilitate borrowings.

The major cost involved with accreditation is education and training as well as the cost of implementing, and maintaining, policies, practices and procedures. ANHECA considers that this cost will be very high in the first instance and then plateau at a reasonable level. ANHECA would recommend that Government funds be provided through the Agency in the short term (say three years) and that the subsidy be increased by 1.5% of wages to cover the on-going requirements for training.

The Merits of Alternative funding Methodologies

In this section the Commission is looking at exploring options for better funding outcomes for high care residents by comparison to two current methodologies. These methodologies are'. ,

(a) State Based Arrangements

- **Are subsidy arrangements that recognise differences in costs across jurisdictions an effective way of promoting equitable access to quality residential aged care services?**

- **Would this rationale also extend to differentiating within States and Territories as well as between them?**

- **Are there any other rationales for such subsidy arrangements?**

- **Would the objective of equitable access be better served by taking into account differences in total costs, rather than primarily differences in wage costs for nursing and personal care staff?**

- **Alternatively, should state based subsidies only reflect cost differences beyond the control of the providers?**

- **Does a State based regime necessarily promote equitable access to services over time?**
- **Should indexation arrangements take account of changing cost relativities between and within jurisdictions?**
- **Does a State based regime tend to lock in the quality relativities across jurisdictions that prevailed at the commencement?**
- **Should a differential subsidy regime also take account of differences across government, church and private providers in liability for sales tax, fringe benefits tax, payroll tax and the like?**
- **Are there other ways of addressing tax related cost differences? For example, should governments be applying competitive neutrality principles to eliminate any tax related cost differences for government run homes?**
- **Has the state based subsidy regime reduced incentives for cost effective service delivery?**
- **If so, is this a function of the form of subsidy, or of the previous acquittal system which required nursing home operators to return some unspent funding to the Commonwealth?**
- **Have constraints on the overall level of Commonwealth support offset any such disincentives for efficient provision?**
- **Has the State based subsidy regime had other efficiency impacts?**
- **How well correlated are the current subsidy rates to jurisdictional wage costs?**
- **Could changes to the indexation formulae produce a better match in the future?**
- **Will access to more flexible labour market arrangements and possibly greater reliance on enterprise based wage deals make it more difficult to link subsidy rates to wage costs in the future?**
- **Do such considerations suggest that the information requirements and administrative costs of the state based subsidy regime will increase in the future?**
- **Are there other administrative considerations impinging on the use of state based subsidies, or cost based subsidies more generally?**

ANHECA considers that subsidies should be set at a level equivalent to the cost of providing care (including a R01) and if this means that there are variations between States then so be it! Based on the current system of resident contributions, this will have no effect on the equitable access. Experience indicates that there is no reason to have varying subsidies within States other than in accordance to the residents' dependency. There could be differences to this theme in the two larger States, Queensland and Western Australia, where there are separate awards. However the variance would be only in respect to wages.

ANHECA considers that the State based differences should be reflective of the wage variations as well as the Statutory costs, superannuation, workers' compensation and payroll tax, which ANHECA considers should be funded on a facility by facility basis, see above.

Indexation arrangements should take into account the changing relativities between States in order that each State maintain parity with the public sector within that State. It can be said that access to facilities would not be jeopardised nor would it be enhanced by State based subsidy arrangements. However, it must be said that if there were a parity arrangement there would be the less likelihood of forced closures due to an inability to attract the level of staff to appropriately care for residents.

Quality relativities are dependent upon the income available to provide the quality care. State based arrangements will mean that for those facilities in States that were to lose funding quality can be maintained. For facilities in those States which were to receive extra under the coalescence arrangements, movement to a subsidy level correctly reflecting the level of wages would increase quality. The introduction of parity together with a more appropriate indexation mechanism will ensure that that quality is maintained.

The current subsidy arrangements currently cater for a variation in respect of Government homes whereas voluntary sector facilities plough any extra funding back into the provision of Staff and services. Under the Governments Tax Reform package there will be neutrality between the voluntary sector and the private sector with the exception of payroll tax. ANHECA's recommendation in respect of payroll tax overcomes this issue. ANHECA would also recommend that where a Government nursing home is purchased by a non-government entity then subsidy be paid at the full rate after taking into account any equalisation grant paid by the government to the purchaser to account for that variation.

The SAM/CAM arrangements reduced incentives for cost effective service delivery due to the Government imposed demarcation between SAM and CAM duties. In some cases the CAM system was also an encouragement to spend on CAM staff even if not required to meet care standards. This was done to meet the targeted spending levels at the end of the year in order to receive the CAM bonus. Due to the decrease in funding and the grossly incorrect indexation arrangements this is now not occurring.

The current subsidy levels bear no similarity to jurisdictional wage costs. The setting of the CAM Standard Hourly Rates has not been reviewed in ten years and whilst the indexation arrangements kept pace until 1 April 1996, award conditions were ignored. In some States, specifically South Australia and Queensland this had a debilitating effect on the ability to meet the requirements of care staff.

Changes to the indexation formula would assist, however, what is needed is firstly an examination of the base costs and an examination of the indirect labour costs such as annual leave, sick leave, public holidays etc. Wages should then be brought into line with what is payable in the public sector with a commensurate increase in the subsidy. This should be followed by the implementation of an indexation arrangement that will allow the industry to maintain that parity.

Access to more flexible labour markets in the future and a greater reliance on AWAs or EBs is yet to be seen and is probably a long way off in this industry. However there will always be a base award for comparison purposes. The award must stay as AWAs and EBs cannot be negotiated at a lower level than the award. There has to be a benchmark. Therefore there will always be a base for comparison. AWAs and EBs may not protect the provider against large increases in the award because it will all come down to what the staff could get working in a public sector facility.

State based subsidies will not require any greater administrative work than is currently the case. With varying indexation arrangements there may be slightly more government administration, however, this was the situation prior to 1 April 1996.

(b) Proposed National Subsidies

- **What impacts would coalescence to national average subsidy rates have on access to, and quality of, residential aged care services across Australia?**

- **Would there be significant differences in impact between regions within States or Territories?**

- **What impact would coalescence have on the wages and conditions of employees in nursing homes and hostels?**

  What impact would it have on the market value of bed licences?

  Would the proposed introduction of nationally uniform subsidies improve the incentives for cost effective provision, and if so, how?

  Would there be other efficiency benefits or savings in administration costs?

  Would coalescence simply speed up or slow down expected structural reform in the residential aged care sector, or would it substantially alter the shape of the sector in years to come?

Under the new arrangements, the RCS subsidy for high care (categories 1-4) currently vary between States and Territories because of the historical award variations which were included in the CAM arrangements under the old scheme. It is the Government's intention to coalesce these State variations to national subsidies over 7 years commencing from 1 July 1998. The first year adjustment will be 2% of the variance, then in subsequent years 4%, 8%, 14%, 24%, 24% and 24%.

In States where the subsidy is currently below the national average the coalescence of the variation will be added to the subsidy rates. In States where the subsidy is currently above the national average, the coalescence of the variance will be subtracted from the subsidy rates.

The coalescence affects different States in different ways. New South Wales, Victoria, Tasmania and the Northern Territory will be coalescing down to the national average with variations being as follows:

CATEGORY	NSW	VICTORIA	TASMANIA	NT
1	$1.82	$6.76	$8.26	$3.73
2	$1.82	$6.20	$7.82	$3.62
3	$1.24	$4.96	$6.68	$2.74
4	$1.14	$3.62	$5.50	$2.07

All other States and the ACT will coalesce upwards to the national average with variations being as follows:

CATEGORY	QLD	WA	SA	ACT
1	$12.03	$1.42	$4.74	$1.61
2	$10.85	$1.15	$3.91	$1.07
3	$9.76	$1.39	$3.48	$0.88
4	$6.88	$0.91	$1.75	($0.29)

The subsidy rates have been set taking into account the CAM funding arrangements which were set based on various State awards in 1988 and were indexed based on award movements until 1996 when the COPOS arrangements were introduced. Obviously, under a COPOS style indexation, those States which are coalescing upwards towards the national average would like to be coalesced quicker and those States which are coalescing down to the national average would not like to be coalesced. at all.

In those States where the movement is upwards towards the national average, the unions are pushing heavily for wage increases as they anticipate that providers will be flush with funds and that if so they want it for their members.

Also the coalescence will work adversely against those facilities in States above the national average and the facilities will have no alternative but to gradually shed staff to equate with the loss of income. This will have an adverse effect on the standards and level of care which can be provided in those facilities.

A further problem is that it will adversely affect the parity between the public and private sectors. This parity needs to be maintained otherwise the aged care sector will not be able to maintain and retain the high level of staffing required to meet standards resulting in the aged care sector becoming the poor cousins in health care delivery.

ANHECA considers that as award movements in each State will vary there is no reason why there should be a national rate, other than to make the Department's administration slightly simpler in the longer term. Accordingly, ANHECA opposes coalescence in its current form.

ANHECA recommended that the Government put in place a 12 month moratorium on the application of coalescence to those States that are above the national average to allow time for a review of the actual costs based on award rates and conditions in each State. The result of this recommendation, together with an industry campaign to stop the coalescence arrangements, was this announcement of this review.

Access to facilities in States coalescing down to the national average would be affected because the decreasing level of funding, combined with the level of wages in the State, would mean that many facilities would face liquidation and possible closure. This would place undue burden on other facilities in that State. The States most affected are Victoria and Tasmania. Given that many facilities in Victoria are currently in jeopardy due to the greater percentage of certification failure, this situation would simply exacerbate the problem and create a major access problem in that State.

There would not be a major discrepancy on the impact within States as the major variance, other than award variations in Queensland and Western Australia, is the fact that the voluntary sector spends more on staff and services across the nation. As previously stated, this is not an indicator of better care, but simply the philosophy of that sector in relation to surplus.

Employees in aged care facilities would find it more difficult to maintain positions in those States coalescing down to the national average because finances would dictate that the staffing levels would need to be lean and mean. In those States coalescing up to the national average, the respite from the same situation would be short-lived because the union movement, being the creature that it is, would continue to press for wage increases which would consume any extra funds available for increasing the quality of care.

Closures of aged care facilities would, in the long term, force the value of bed licences higher. With the beds still being counted and the Government not releasing more beds, combined with a greater demand than supply the value of bed licences must increase.

In normal circumstances the decreased income levels would tend to promote increased cost effectiveness. However, this is not the case. As previously explained the standard costing arrangements have been in place for some ten years now and the majority of the cost effectiveness has already been achieved. This does not mean that there are no savings to be made. However, the industry is totally controlled as to the income that facilities receive and therefore, with the great percentage of costs that are outside the control of the provider, coupled with rising expectations of Government and consumer, Means that there is very little scope for further cost effectiveness.

The only savings in administrative costs resulting from national subsidies are for the government with greater administrative costs being incurred by providers in relation to juggling staffing levels to fit the funding levels.

Coalescence would definitely slow down structural changes to aged care facilities, especially in Victoria and Tasmania. The accommodation charge would have to be utilised in maintaining the provision of care and therefore funds would not be available to be spent on structural change or for securing borrowings for that purpose.

(c) Alternative Funding Arrangements

- **Are there alternatives to the current and proposed subsidy regimes which would promote more equitable access to nursing home services, a greater range of choice for residents and/or more efficient service provision?**
- **Are there other criteria which are relevant in comparing alternatives?**
- **What weighting should be given to the various criteria?**
- **Would any proposed alternatives be consistent with the current resident charging arrangements?**
- **Would a "pure" percentage-based subsidy be sensible, or would there be a need for some maximum dollar caps to avoid taxpayers subsidising unnecessary embellishments to services?**
- **With residents meeting a percentage of total costs, would there be a greater incentive for providers to deliver services more cost effectively?**
- **Under a percentage-based scheme, would some additional "special needs" funding be required to keep services affordable in very high cost locations?**
- **Would paying subsidies direct to residents rather than homes increase the pressure on providers to deliver "the right service at the right price"? Or would it simply involve an additional administrative cost, with little or no offsetting efficiency gain?**
- **How important is resolution of the funding methodology issue for providers and their residents? Will its significance increase or diminish over time?**
- **Will it continue to be appropriate to separate funding for residential care from funding for other forms of aged care?**
- **What sort of funding methodologies would help to facilitate the integration of support for residential and community based care?**

The current system whereby the resident pays a basic contribution plus an income tested amount and the Government subsidises the resident to the tune of the subsidy minus the income tested amount is cumbersome and fraught with administrative problems both on behalf of the provider, Government and the resident. The major problem is the income tested amount. The following process indicates this problem.

- The resident pays a basic fee dependant upon whether or not they are a pensioner or a non-pensioner.

- Centrelink income tests residents and advises the extra amount payable (hopefully within 28-days of admission).

- The income tested fee is payable by the resident from the 29th day after admission with a corresponding decrease in subsidies.

- The resident is billed, at least monthly, by the provider for the basic fee plus the income tested fee.

- The resident is under the impression that the provider is receiving the income tested fee whereas the income tested fee is going straight to the Government via decreased subsidies.

- There is a greater administrative burden on the government to do the income testing.

- There is a greater administrative burden on the provider in the billing process with a minimum 3,765 possible scenarios, which increases each time there is a pension increase.

- There is a greater administrative burden on the resident especially where the income testing is based on deemed assets as the resident may not have the ready cash to meet the resident contribution.

- The provider faces a greater propensity for bad debts especially where the resident passes their financial affairs to a relative, who then has access to the pension etc.

The income tested amount would create an access barrier for some. To overcome this ANHECA recommends that the resident pay the basic amount only depending on pension status. As the vast majority of residents who would have to pay an income tested fee would also have to submit a tax return at the end of each financial year. Those residents would be able to claim as a medical rebate:

- The basic fee.,
- The income tested fee;
- The accommodation charge,'
- If a bond was payable, the retention from the accommodation bond.

The rebatable amount is $0.20 for each dollar over $1250 and this threshold includes all other medical expenses.

Therefore it appears that the Government is taking with one hand and giving back with the other. ANHECA recommends that:

- to remove the uncertainty for residents;
- to remove the administrative burden for residents;
- to remove the administrative burden for providers;
- to remove the propensity for bad debts for providers;
- to remove the administrative burden for government; and to avoid the problems with Centrelink,

the Government dispense with income testing and remove nursing home and personal care fees from the medical rebate section of the Income Tax Assessment Act.

Funding the Facility V Funding the Resident

ANHECA considers that the subsidy payments should continue to be paid to the facility. To empower the resident with the payment of the subsidy would lead to massive administrative problems both for the provider as well as the Government.

ANHECA considers that although the Productivity Commission has been requested to comment on alternate funding methodologies, radical thoughts of this nature are stretching the Terms of Reference. The Productivity Commission was requested to undertake this review following ANHECA's and the industry's challenge to the policies of coalescence and indexation. The timeframe available for the review is insufficient for any realistic and systematic consideration of the issues involved in a totally different funding methodology. A study of this nature would require extensive research, including full consideration of other programs and overseas trends.

There are massive administrative problems attached to the idea of funding the resident in lieu of the facility. If the payment was made to the resident:

- The provider would receive payment on various days of the month depending on the time when the resident actually paid the account;

- The providers' propensity for bad debts would increase;

- The Government's administrative process would increase to pay 131,000 payments per month at current levels and increasing to a much greater amount;

- Government administrative costs would further increase in seeking to recover funds following a resident leaving an aged care facility;

- User rights principles would need to bee amended bearing in mind the larger amounts that would be owed by residents;

- Fees would need to reflect the fact that there may not be regular payment of subsidies including the extra administrative burden and bad debts;

- The subsidies would have to reflect the probable decrease in occupancy as residents' relatives would attempt to care for their aged relative themselves with little regard to care standards;

- Legislation would need to be re-written as the partnership would then be between the Government and the consumer.,

- Controls over aged care facilities would not be enforceable as providers would not be subsidised by the Commonwealth; and

- Access to aged care facilities may not be assured.

Due to the above, ANHECA considers that it would be a retrograde step to provide funds for subsidy payments to the resident.

In the future there would be a possible benefit in integrating residential care funding with funding for community care. Given the push towards community care, it is plausible that in the future facilities will have a flexible approval from which they can offer a mixture if residential care (both high and low care) and community care (CACPs EACH and HACC). Whilst this is not going to happen overnight, it is something which the Government can work towards especially with the growing percentages of aged people in Australia, a greater awareness of providing care in the community at all levels and vital links between residential aged care and Housing.

5. ANHECA's Proposal

Having stated above that the process of coalescence to national rates would create major problems in those States coalescing down to the national average, which in turn would create quality and access problems, ANHECA has looked at the relative costs of providing care in each State based on costs at 1 July 1998.

ANHECA has taken the hourly rates of pay mentioned earlier in this submission and has calculated the on-costs (leave components) as per the award. Based on that data and the skills mix from those rosters detailed below, ANHECA has calculated the level of subsidies for each State and Territory.

5.1 National Skills Mix

To analyse the level of funding on a national basis and to consider future increases via indexation arrangements it is necessary to establish a national skills mix. This mix should be based on the average hours from a number of NPC rosters around the States. Average staffing requirements for administration/domestic staff is also required. The result is:

Nursing and Personal Care (80% of staffing costs):

Registered nursing	-	33%
Non-Registered nursing	-	60%
Therapy staff	-	7%

Domestic staff represents approximately 20% of staff costs.

5.2. Average Mix of Residents

To assist with the production of rosters, it is necessary to establish an average mix of residents between categories 1-4. The Centre for International Economics has recently completed the Review of the Resident Classification Scale. That review contained extensive data on the distribution of the RCS by category on a National and State basis. It is considered that this is the best data available. Table 2.5 on page 18 of the exposure draft sets out the following:

State	Cat 1	Cat 2	Cat 3	Cat 4	Cat 5	Cat 6	Cat 7	Cat 8	Total
NSW									
No.	3952	11744	10833	2682	4071	4355	8621	2154	47762
%	8.3	24.6	21.3	5.6	8.5	9.1	18.0	4.5	100
Vic									
No.	3031	8365	5401	1225	2476	3284	6748	1613	32143
%	9.4	26.0	16.8	3.8	7.7	10.2	21.0	5.0	100
Qld									
No.	1937	5636	4479	1473	2288	2616	4404	1453	24286
%	8.0	23.2	18.4	6.1	9.4	10.8	18.1	6.0	100
WA									
No.	483	2528	2180	570	858	1171	2798	633	11221
%	4.3	22.5	19.4	5.1	7.6	10.4	24.9	5.6	100
SA									
No.	824	1040	2731	711	1096	1553	2751	426	13132
%	6.3	23.1	20.8	5.4	8.3	11.8	20.9	3.2	100
Tas									
No.	178	761	818	286	408	438	632	141	3662
%	4.9	20.8	22,3	7.8	11.1	12.0	17.3	3.9	100
ACT									
No.	84	252	247	107	112	146	344	16	1308
%	6.4	19.3	18.9	8.2	8.6	11.2	26.3	1.2	100
NT									
No.	10	116	88	24	27	38	43	-	346
%	2.9	33.5	25.4	6.9	7.8	11.0	12.4	-	100
Total									
No.	10499	32442	26127	7078	11446	13601	26341	6436	133860
%	7.8	24.2	19.5	5.3	8.5	10.2	19.7	4.8	100

There are some nursing home residents who will be in low care categories due to transitional purposes. As this review is considering the high care subsidies and therefore the transitional anomalies need to be ignored and we need to concentrate on the effect of the subsidies if all residents in high care facilities were high care.

Therefore, the above table needs to be converted to high care only. This would provide a resident mix of approximately; Category 1 - 14%, Category 2 - 42%, Category 3 -34%, Category 4 - 10%.

The weekly hours per resident are estimated as follows:

- A Category 1 resident will require 27 hours of NPC staff;
- A Category 2 resident will require 23 hours of NPC staff;
- A Category 3 resident will require 20 hours of NPC staff; and
- A Category 4 resident will require 12 hours of NPC staff.

Domestic and clerical hours will represent 5 hours per week per resident regardless of category.

5.3. Labour Costs

The greatest cost in the provision of nursing home care is labour. This represents approximately 75% of operating costs and by far the major proportion of labour costs is devoted to the provision of nursing and personal care staff as distinct from domestic/administration staff. To assess the variances, if any, between States, ANHECA has costed rosters on a State by State basis based on Awards as at 1 July 1998. The standardisation of these rosters is based on the resident and staffing mixes detailed above. The costing also takes into account.

- State variations from the norm eg. the Victorian 10/15 rule, and the NSW requirement for a Deputy Director of Nursing in a nursing home with 40 or more beds;
- Allowances as per award;
- Rostered days off; and
- Other jurisdictional variances.

ANHECA has differentiated between NPC staff and other staff due to the different award coverage. A further reason for this differentiation is that there are different conditions in relation to the calculation of the on-cost factor. The on-cost factor takes into account, on a State by State basis, costs such as,

- Staff on annual leave;
- Staff on sick leave;
- Staff on other leave;
- The extra cost of public holidays; and
- The extra cost of replacing staff on leave with casual/agency staff.

5.4. Training

A major new cost arising since the introduction of CAM and which will continue under the aged care reforms is the cost of training. With the on-going requirement for accreditation staff will require training both in-house and external. Both have a cost component in relation to registration or consultant trainer fees and also in relation to the cost of replacing staff whilst undergoing training. It is necessary to identify this as a direct cost to the facility. ANHECA has estimated this cost to be 1.5% of wages, equivalent to the old TGL?

5.5. Long Service Leave

The previous funding system provided dollar for dollar funding for long service leave for direct care NPC workers with a component included in SAM for the non-NPC staff. In view of the rules and wage levels between the States for the application of long service leave, the funding mechanism devised needs to identify this as a percentage of wages. The approximate amounts for LSL included in the subsidies for NPC staff at 1 October 1997, are..

NSW	VIC	OLD	SA	WA	TAS	ACT	NT
0.59	1.04	0.45	0.94	0.38	0.66	0.52	0.62

On the assumption that NPC wages represents 80% of total wages, it would be reasonable to assume that the above amounts would increase as follows:

NSW	VIC	OLD	SA	WA	TAS	ACT	NT
0.74	1.30	0.56	1.17	0.48	0.82	0.65	0.77

The above amounts represent approximately 1 % of total wages.

5.6. Non-Wage Costs

To ensure that the subsidies cover all costs on a relative basis, it is necessary to establish the cost of Non-wage costs (other than Long Service Leave, Superannuation, Workers' Compensation and Payroll Tax). This needs to be done separately for the private and voluntary sectors to ensure that indirect taxes paid by the private sector are fully costed.

There are variations in non-wage costs across jurisdictions and also between sectors. The following is an analysis of the non-wage costs by State (excluding superannuation on non-NPC wages) for the year ended 30 June 1996 as provided by Bentleys Chartered Accountants.

	NSW		**QLD**		**SA**
Private	Total	Private	Total	Private	Total
$14.52	$21.11	$15.86	$19.79	$18.03	$20.31

	TAS		**WA**		**VIC**
Private	Total	Private	Total	Private	Total
$14.29	$18.20	$13.17	$13.57	$14.86	$21.53

The above figures exclude depreciation on buildings, interest and rent as well as Non-NPC superannuation payments. Also there are no OCRE costs included as the survey was in comparison to SAM.

SAM was indexed by., 1.8% for 1996-97,1.7% for 1997-98 and 1.4% for 1998-99. The accumulative effect of the increases is that the above costs would require to be increased by 4.98%.

The variations above indicate that there is a small variation between most States however South Australia has a high variation. Analysis indicates that the total level of non-NPC wages in SA are lower than in other States and that can be explained by a greater reliance on contract staff.

The variation between Private and Total indicates the fact that the voluntary sector use any surplus to provide more staff and services. This does not necessarily lead to a better quality of care.

Using the beds per State as detailed in the Review of the Structure of Nursing Home Funding Arrangements - Stage 1, the weighted average non-wage cost for 1995-96 is $15.03 calculated as follows:

NSW	$14.52	X	29,105 beds	=	$ 422,605
VIC	$14.86	X	16,928 beds	=	$ 251,550
QLD	$15.86	X	12,145 beds	=	$ 192,620
SA	$18.03	X	7,110 beds	=	$ 128,193
WA	$13.17	X	6,106 beds	=	$ 80,416
TAS	$14.29	X	2,189 beds	=	$ 31.281
TOTAL				=	$1,106,665
Weighted Mean ($1,106,665 divided by 73583)				=	$15.03

Expressed in current terms ($15.03 x 1.0498)	=	$15.78
Expressed as prior to 1998-99 indexation ($15.78 divided by 1.014)	=	$15.56

5.7. Return on Investment

The fundamental approach of ANHECA in the preparation of this part of the submission is to see that providers are able to survive financially. There needs to be a recognition on the Government's part that in its partnership arrangement with each provider there is a need to construct a ROI in a sound, practical and technically correct fashion. To do so the approach needs to be on the following basis.

- Standard Australian business practices must be used, without qualification by the Commonwealth.,
- Correct accounting principles must be used without qualification by the Commonwealth;
- Uniform and national criteria must be applied in respect of this component;
- The Accommodation charge needs to be ignored in the exercise as this relates to future works and the ROI needs to be set based on the average facility;
- The ROI needs to be realistic.

The ROI must cover the provider for the capital invested and the exercise needs to ensure that: an appropriate method of capitalisation is used; all capital costs have been recognised and included; movement in rent or interest rates have been accounted for; and that the limited life of the building is recognised.

The methodology developed needs to be structured to allow for future review taking into account plant and equipment, furniture and fittings, working capital and amortisation of the value of the freehold due to reduction in the useful life of the buildings. Special regard needs to be given to changing Commonwealth, State and consumer expectations.

In endeavouring to determine what is a reasonable return for a business, nursing homes are similar to any other Australian business: there is a component that relates to the property and there is a component that relates to the business.

There is always a range of options for calculating the method that might be used in calculating the level of Return on Investment. ANHECA has always embraced a return based on imputed rental values and the value of the business.

The imputed rental for a 20-year old nursing home can be calculated as follows:

	Total	Adjusted
	$	$
Current Building Cost	70000	35000
Land Cost	10000	10000
Plant and Equipment	8000	5333
Cost of approval/Licence	-	-
Total	88000	50333

The figures of $70000, $10000 and $8000 represent the current average cost per bed of building, purchasing land and equipping a nursing home.

The current cost of the business ranges between $25000 and $30000 per bed. ANHECA has shown this as Nil in the cost of the building, however, a return on business will be calculated based on the lower of the range, ie $25000.

The capitalisation rate that should be utilised to calculate the imputed rental should be based solely on current market evidence and having regard to the most recent sales evidence, such capitalisation rate should be in the range of 11.5% to 12% for a 20 year old nursing home in Australia.

Therefore:

Value of premises	adjusted value minus the value of the business $50333 - $25000* $25333
Imputed Rental @ 11.75%	$2977 $8.16 per bed per day

*The Department places no value on the licence because it provides a limited number free of charge. However, there is a very real value to the purchaser and that is recouped on sale. The figure of $55,333 equates with the current market for sales for the average nursing home, which includes the value of the licence.

The value applicable to the business must be based on current market evidence and in this regard evidence over the past few years has indicated that sales are constantly around the $25000 per bed mark. Some sales have exceeded this, however, $25000 will be taken as the average national figure.

The return on capital should be based on the Statex Beta formula that is supported by a range of yields calculated from analysis of relevant sales evidence. The Statex Beta formula calculates the expected rate of return taking into account the rate of return available on funds deposited and the risk analysis of the business at pre interest and tax rates. The formula is:

R = Rf +B(Rm - Rf)

Where,

Rf = the risk free rate for the investment period (the long term bond rate).

Rm = what an investor would expect as a return from a normal business investment.

B the degree of risk in the project, being the normal business risk.

The long-term bond rate is currently 5.56% and the normal return an investor would expect from a business is 25% before interest and tax. Nursing homes are considered a reasonable risk due to the accommodation charges and the controls of Government (price, growth and admission control). Accordingly the risk factor has been reduced. The normal business risk has a factor of 1 and the Beta book does not specifically mention nursing homes. Accordingly a reduction to the risk has been applied to take into account Government controls and a risk factor of 0.6 has been used.

Using the above, the rate of return on the business should be 17.22% calculated as follows:

R	=	5.56 + 0.6(25 - 5.56)
	=	5.56 + 0.6 x 19.44
	=	5.56+ 11.66
	=	17.22

However, that rate of return includes an inflation factor, ie the subsidies are indexed and therefore this rate needs to be adjusted to account for this factor. The subsidies currently include an indexation rate of 1.4% and therefore the adjusted figure is 17.22% divided by 1.014, which equals 16.98%.

The return on the business is therefore calculated as follows:

Value of the business	:	$25000
Return on capital	:	16.98%
Return on business	:	$4245
Return per bed day	:	$11.63

The total return on investment is therefore $7222 per bed or $19.79 per bed day

5.8. Statutory Costs

There are three main cost centres which are fully controlled by Government and, over which, the provider has little, if any, control. These cost centres are:

- Payroll tax.,
- Workers' Compensation; and
- Superannuation.

Each of these costs was funded, under the previous scheme, via Other Cost Reimbursed Expenditure (OCRE). Under the OCRE arrangements, the cost of payroll tax and workers' compensation premiums was funded for all staff whilst the cost of superannuation and long service leave was funded for nursing and personal care staff only. The amount of payroll tax payable by nursing home operators was reimbursed fully by the Commonwealth Government under the previous financial arrangements, as was the superannuation payments to nursing and personal care staff. Workers' compensation premiums were reimbursed with reference to State average costs with protective caps to ensure that a spate of claims did not severely affect the provider in financial terms.

Under the previous funding arrangements, specific recognition is given to the various OCRE costs, some of which are only incurred by private enterprise providers. Loss of specific recognition of OCRE has had adverse financial implications for nursing home operators.

5.8.1 Payroll Tax

Payroll tax is only payable by private enterprise service providers, with religious and charitable providers being exempt. Under the previous funding arrangements for nursing homes, payroll tax for staff is a fully reimbursable expense. The 1996-97 Budget announcement of the new funding arrangements to apply from 1 July 1997 provided for payroll tax to also become part of the general funding pool for allocation across the industry.

Such pooling of funds for payroll tax would have been inequitable between private enterprise providers and would have provided a windfall gain to the religious and charitable sector.

The Minister for Family Services subsequently suggested a proposal, whereby a flat funding increment per bed be paid for the private enterprise sector to compensate for the requirement to pay payroll tax. However, this arrangement still discriminated between private enterprise providers. This is because providers with multiple facilities pay payroll tax on the total payroll across all their facilities and are not afforded the payroll tax free benefit for each facility. Hence, the unit bed payroll tax liability under this proposal is greater for providers with multiple facilities than for single facility providers.

Subject to the wider taxation reform issues, ANHECA maintains that the funding component for payroll tax should be pooled and provided to the States as a grant, in exchange for an associated exemption from payroll tax for all aged care facilities. To his credit, the Minister approached the Premiers and Chief Ministers with this proposal that they declined for various reasons.

The current supplementation arrangement whilst providing funding to those facilities which are required to pay payroll tax, on a three tiered basis, discriminates against providers failing just below the benchmarks and specifically those providers owning more than one facility. Providers owning more than one facility do not receive the same tax free threshold per head as single facility providers.

A further problem facing providers in certain States and Territories is the governments intention to coalesce payroll tax supplements to a national rate irrespective of the State government requirements and also irrespective of the residents' dependency and hence level of staffing.

ANHECA considers that as State Governments control payroll tax, and the provider has little if any control over the cost, then the cost of payroll tax should be cost reimbursed. Providers should not gain or lose because of statutory charges. This would provide the same level of funding, in real terms as was provided under the previous system and would be revenue neutral to Government. To this end, individual nursing homes should be funded throughout the year on the last known levels of payroll tax expenditure and this should be reconciled at year end. Providers should be requested to provide a certified statement of payroll tax expenditure for the financial year and this could be reconciled against the level of income received.

It is impossible to gauge the level of payroll tax per bed day due to the State arrangements of allowing only one payroll tax-free threshold per provider regardless of the number of facilities owned. The payroll tax rates for each jurisdiction are as follows:

STATE	THRESHOLD	RATE
NSW	$600,000	6.85%
VIC	$515,000	6.25%
QLD	$825,000	5.00%
SA	$456,000	6.00%
WA	$675,000	3.65%
TAS	$600,000	6.60%
ACT	$750,000	6.85%
NT	$600,000	6.00%

5.8.2. Workers' Compensation

Workers' compensation funding is a problem under the current funding arrangements.

The aged care industry is characterised by a largely unskilled workforce and a high incidence of lifting. Yet with the single non-acquitted subsidy, available funds are pooled and no specific provision will be made for facilities unfortunate enough to be burdened with higher workers' compensation costs. Furthermore, the Government's intention to coalesce subsidies to a national rate means that the funding for workers' compensation eventually will be identical in all States. This does not take into account the significant variation in the levels of premiums in different States.

It is inevitable that the financial position of some facilities will be compromised under this system as the potential for small businesses, such as nursing homes, to reduce workers' compensation costs is very limited. Claims commonly arise from gradual "onset injuries" as distinct from specific accidents attributable to incorrect occupational health and safety practices. One claim can dramatically affect (double or treble) premiums for the following three years. Without an upper cap on premium payments some homes will face the possibility of bankruptcy.

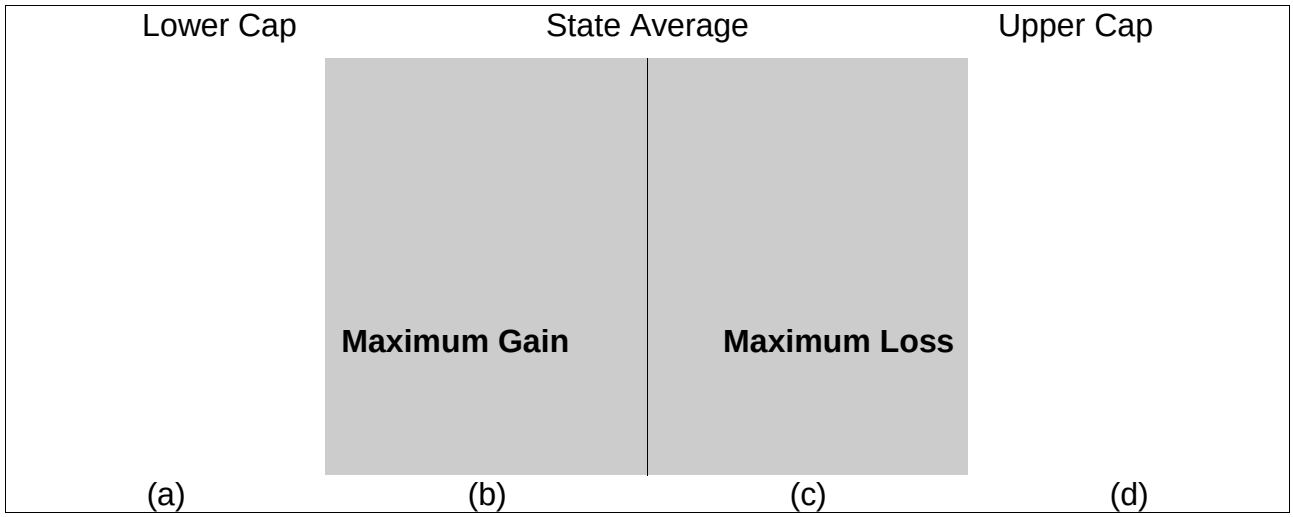
Representatives of the Department of Health and Family Services have argued that, where attention is paid to occupational health and safety matters, workers' compensation premiums could be reduced significantly. However, due to the nature of the workforce and the high incidence of lifting the implementation of safer workplace practices does not necessarily lead to lower premiums.

Workers' compensation premiums for a particular facility do not depend solely on the OH&S procedures that are developed and implemented by that facility. They are based substantially on industry risk, claims history and, in some cases, the viability of the State's Work Cover Authority.

ANHECA maintains that the Government should view this area of funding as a priority to avoid the risk that aged care service providers with higher workers' compensation premiums could be forced to reduce the level of care available in order to meet the statutory cost of workers' compensation.

The Association believes that a straight averaging approach to workers' compensation costs as part of a national funding strategy should be abolished unless a national system of workers' compensation is introduced. State borders need to be ignored (they are irrelevant for workers' compensation) and a competition policy implemented which will make State run workers' compensation schemes more accountable. State governments should not be allowed to rely on the non-government sector and the Commonwealth Government to fund the inadequacies and inefficiencies of their workers' compensation schemes.

In the meantime, ANHECA considers that workers' compensation costs should be funded on the same basis that they were under the previous system. This system provided for funding based on industry averages, on a State by State basis, with protective caps to ensure that the top 5% of facilities would not be unduly burdened. The following graph illustrates how the system works.



The State average is calculated from certified returns provided by the provider. The upper cap is set at a level that would protect the 5% of providers paying the highest levels of workers' compensation premiums in each State. Once that cap is set the lower cap is set at the corresponding level.

The following explains the payment on reconciliation.

(a) Facilities with workers' compensation premiums failing in (a) are funded at the actual premium paid, plus the difference between the State average and the lower cap, thereby ensuring that the provider receives only the maximum gain (the difference between the State average and the lower cap),
(b) Facilities with workers' compensation premiums falling in (b) are funded at the State average,
(c) Facilities with workers' compensation premiums failing in (c) are funded at the State average;
(d) Facilities with workers' compensation premiums failing in (d) are funded at the State average plus the difference between the actual payment and the upper cap, thereby ensuring that the provider is penalised only the maximum loss (the difference between the State average and the upper cap.

If the nursing home had an annual payroll of $2 million and the State average was 6% with the upper cap being 7% and the lower cap being 5%, the following scenario would take place.

(a) Premiums of $90,000, or 4.5% - this home would be funded at $90,000 + ($120,000 - $100,000), or $110,000.
(b) Premiums of $110,000, or 5.5% - this home would be funded at $120,000, the State average.

(c) Premiums of $130,000, or 6.5% - this home would be funded at $120,000, the State average.
(d) Premiums of $150,000, or 7.5% - this home would be funded at $120,000 + ($150,000 - $140,000), $130,000 thus limiting the loss to the maximum level.

The amount included in the subsidies at 1 October 1997 was $3.29 per bed day based on the latest known figures, which were 1994/95 figures. Industry tariff rates have increased markedly in some States since that time. Industry tariff rates at 1 July 1998 are as follows..

NSW	-	5.57% of total wages;
VIC	-	3.95% of total wages;
OLD	-	4.4% nursing home wages, 0.31 % clerical staff (say 3.39%);
SA	-	5.15% of total wages;
TAS	-	6.9% of total wages;
WA	-	6.5% of total wages.

ANHECA is not aware of the rates in ACT and NT, however, for this exercise they will be costed at the NSW and SA rates respectively. Given the number of facilities in those Territories any over/under statement will not affect the budget.

Therefore, the per resident per bed day funding for workers' compensation for 1998-99, subject to reconciliation should be:

NSW	-	($79.86 x 5.57%)	=	$4.45
VIC	-	($80.34 x 3.95%)	=	$3.17
OLD	-	($74.79 x 3.39%)	=	$2.54
SA	-	($77.60 x 6.9%)	=	$5.35
WA	-	($74.80 x 5.15%)	=	$3.85
TAS	-	($82.62 x 6.5%)	=	$5.37
ACT	-	($73.66 x 5.57%)	=	$4.10
NT	-	($65.94 x 6.9%)	=	$4.55

5.8.3. Superannuation

To ensure that facilities are correctly funded for superannuation perhaps the best method would be on a cost reimbursed basis. As stated above, the Government is committed to increasing the level of employer funded superannuation payments to 9% by the year 2002. Under the previous system of funding, superannuation payments for NPC staff was cost reimbursed under the OCRE component of the fee while the superannuation payments for non-NPC staff was included in SAM. Obviously the cost reimbursement system automatically picked up the gradual increases in superannuation for NPC staff, SAM was "opened up" each time there was a percentage increase in superannuation to provide a relative cost increase for non-NPC staff.

Under the current system the Government recognised the increase, however, applied an across the board increase of $0.52 per place per day irrespective of the resident category. This increase was to take into ac ' count the increase from 6% of wages to 7% of wages. The across the board increase did not recognise the vast difference in wage levels between nursing homes and hostels. If 75% of the subsidy is for wages then the increase for a category 1 resident represents a range between 0.64% and 0.79% of wages whilst it represents 3.25% in respect of a category 7 resident.

If the Government cannot agree to the equitable proposal detailed above, and it agrees to a cost reimbursement methodology in relation to payroll tax, then it would make sense to have superannuation payments cost reimbursed.

The amount included in the subsidies at 1 October 1997 was $2.81 per bed day based on the latest known figures, which were 1994/95 figures. Rates have changed since then increasing from 1 July 1998 to 7% of wages. The level of superannuation was increased by a mere $0.52 per bed day from 1 July 1998 to supposedly cover the 1 % increase from that date, making the amount for superannuation equivalent to $3.33 per bed day. Based on that data the 1998-99 rates should be as follows:

NSW	-	($79.86 x 7%)	=	$5.59
VIC	-	($80.34 x 7%)	=	$5.62
QLD	-	($74.79 x 7%)	=	$5.23
SA	-	($77.60 x 7%)	=	$5.43
WA	-	($74.80 x 7%)	=	$5.24
TAS	-	($82.62 x 7%)	=	$5.78
AC	-	($73.66 x 7%)	=	$5.16
NT	-	($65.94 x 7%)	=	$4.62

It can be seen from the above and from the chart on workers' compensation that providers have been grossly underfunded through the RCS arrangements. It is definitely this area that prompted the call from providers that the RCS provided less funding that was received under the RCI arrangements.

5.9. Indexation

The indexation arrangements for the subsidy levels are applied at 1 July each year. The subsidies and supplements are indexed based on a cocktail of wage and non-wage costs using the Treasury Measure of Underlying Inflation for non wages and the Industrial Commission's Safety Net Adjustment for wages. This is commonly referred to as COPOS arrangements. The cocktail used for both high and low care categories is 75% wages and 25% non-wages.

The COPOS arrangements were introduced under the previous scheme for nursing homes on 1 April 1996 following The 1995 Keating Government budget announcement that all schemes would be indexed under the same arrangements. The current government implemented this approach for nursing homes amid a barrage of complaint from all sectors of the industry. Previously the care component of the nursing home arrangements was indexed based on State by State movements in the awards covering care staff.

There was no justification for the imposition of these new indexation arrangements; it was simply a saving to Government. This saving was at the direct expense to the industry with no regard to the actual cost of staffing an aged care facility. It was this process which has led to the differences in award payments between the public and non-government sectors over the past 2 years.

Under this system the indexation does not cover specific wage rises in the industry and the Government has maintained price (fee) control for high care facilities and has introduced that policy for low care facilities. This means that where costs increase to a greater degree than the indexation level the provider is required to meet such costs from the diminishing returns of the organisation. The corollary is that there is a reduction to staffing levels commensurate with the loss in revenue in order to continue to meet overheads that will have an adverse effect on standards of care.

Downsizing staff may not be possible in some facilities due to State and award requirements. The process of downsizing also carries a cost which can be quite burdensome to providers and for which there is no recompense.

Of course the major issue is that of PARITY. The non-government sector of aged care is a much smaller voice than is the public sector in the overall health field. The level of wages and the increases to that level are dictated by the public sector. If the non-government sector is to oppose wage increases that have not been opposed by the public sector, weight of numbers and parity will ensure the passage of the claim. The non-government aged care sector represents only 15% of the wider health care field. As such it is not a price setter and in most cases is forced to follow the lead of the public sector.

When the Government sector is approached by the unions for salary increases, their decision to grant such increases is made without consultation with the rest of the industry and invariably results in granting the increase for minimal trade-off in conditions in return.

The effect of this decision result in the wider industry being forced to agree to the increase when approached by the union in order to maintain parity and attract staff.

It is important to remember the words of Justice Cahill in his 1971 ruling that "a nurse is a nurse is a nurse". That being the case, if the level of wages paid to staff in the non-government aged care was to be less than that in the public sector, the non-government aged care sector would not be able to attract or to maintain the high calibre of staff required to meet the standards of care and to show continual improvement.

The non-government aged care sector would simply become the poor cousin in health care delivery and the Federal Government would be held responsible for reducing, in real terms, the funding available for the provision of care whilst at the same time increasing the requirements which must be met by providers. Furthermore, the Government has reduced the level of funding in favour of the income tested arrangements to simply increase consolidated revenue.

It is simple to say that the current indexation arrangements are unworkable, untenable and a recipe for industrial disaster and conflict within the industry.

ANHECA recommends that the subsidy levels be reviewed for indexation purposes on a basis similar to the system that prevailed under the CAM arrangement between 1989 and 1996. That process provided certainty in funding for aged care facilities and ensured that facilities could encourage and maintain the staff required to meet Standards.

Such an indexation approach should be on a State by State basis to allow for the variations in award movements on that basis. ANHECA believes that a national indexation policy would prejudice facilities in States where the subsidy levels are below the national average as there is greater propensity for award increases in those States.

Other options that could be considered include.

- Changing the calculation of the current indexation to take into account the highest tiered level of the Safety Net Adjustment (SNA), this would have provided for an increase of 2% at 1 July 1998 instead of the 1.4% that was applied.

- Calculating the SNA as a percentage of Average Weekly Earnings (females) as the majority of aged care staff are female.

- The increase in the Average Weekly Ordinary Time Earnings (Female), AWOTE (F).

- The increases in the all industries (State) index across Australia.
- The increase in the ABS Wage Cost Index which is desegregated by both industry and State

The first four of the above options provide no certainty for the industry as they are not linked to the public sector and they do not protect the industry against heavy increases, outside the level of indexation increases granted to the non-government sector. They do not allow for parity between the sectors, which means that the aged care sector will be dictated to by the public sector simply because it represents 85% of the wider health industry.

The indices do not ensure that cost increases are covered by way of indexation. The result would be the same as the current inequitable COPOS arrangements**,** but on a different scale.

There also needs to be an indexation process that is differentiates between States. A national indexation arrangement will not pass on the increases required in certain States at the required time. In some States the increases may be lower than in other and to apply an average across all States is disproportionate.

If ANHECA's preferred option of an industry basket indexation arrangement, similar to that which operated under CAM, is not acceptable, ANHECA would prefer the last option indicated above, ie the increase in the ABS Wage Cost Index which is desegregated by both industry and State. This wage cost index for Health and Community Services Industry is provided by State and Territory and also provides a Public sector break down which ANHECA considers is appropriate given that the public sector dictates the level of wages in the wider health arena.

This would cover nursing staff (approximately 80% of wages) and ANHECA would consider that a similar appropriate indexation process be included for non-NPC wages. Indexation for non-wage costs and the R01 should remain as the Underlying Treasury Measure of Inflation.

ANHECA considers that to ensure ongoing equity and parity, the subsidy needs to be fully reviewed every three years. This review process will pick up any costing problems that will occur if costs vary outside the indexation arrangements. To do so a formula base needs to be settled.

It needs to be considered in the first instance that the public sector wages are currently higher than non-government wages and therefore the base cost needs to be increased to reflect this disparity.

6. Relative Funding Levels

Based on the above the subsidy levels for each category is calculated at Appendix and is as follow.

NPC Wages

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
Cat 1	85.46	86.79	80.48	83.39	79.68	88.18	79.07	68.55
Cat 2	72.80	73.93	68.56	71.04	67.87	75.12	67.35	58.48
Cat 3	63.31	64.29	59.62	61.77	59.02	65.32	58.57	50.85
Cat 4	37.98	38.57	35.77	37.06	35.41	39.19	35.14	30.51

NPC and Domestic Wages

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
Cat 1	97.46	98.21	91.26	94.77	91.21	100.78	89.95	80.22
Cat 2	84.80	85.36	79.34	82.41	79.41	87.72	78.23	70.05
Cat 3	75.30	75.71	70.40	73.15	70.55	77.92	69.45	62.42
Cat 4	49.98	50.00	46.55	48.44	46.95	51.79	46.02	42.08

Total Wages plus Training

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
Cat 1	98.66	99.42	93. 08	95.93	92.33	102.02	91.05	81.04
Cat 2	86.00	86.57	80.46	83.57	80.53	88.96	79.33	70.89
Cat 3	76.50	76.92	71.52	74.31	71.67	79.16	70.55	63.27
Cat 4	51.18	51.21	47.67	49.60	48.07	53.03	47.12	42.97

It is simply not good enough to address the issue of parity through indexation without first ensuring that the base also reflects that parity. The public sector, which represents 85% of the wider health industry, pays nursing wages in excess of the aged care sector. If this is not rectified the aged care sector will eventually lose staff to the public sector and will not be able to offer pay rates to attract staff in the future.

This problem is twofold as the subsidy and indexation arrangements are insufficient to sustain the higher wage levels and qualified nursing staff are in short supply. It is not known at this stage whether the latter is a direct result of the former.

The shortfall in wage costs are:

NSW	VIC	OLD	SA	WA	TAS	ACT	NT
2.91%	8.7%	2.3%	3.3%	6.0%	6.3%	12.6%	0

On the assumption that NPC staff represents approximately 80% of all wages, total wages would need to increase by the following:

NSW	VIC	OLD	SA	WA	TAS	ACT	NT
2.33%	6.96%	1.84%	2.64%	4.8%	5.04%	10.08%	0

Allowing for increases to the level of the Public Sector award would require the following.

Wages plus Training plus Parity

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
Cat 1	100.96	106.34	94.79	98.46	96.76	107.16	100.23	81.04
Cat 2	88.00	92.60	81.94	85.78	84.40	93.44	87.33	70.89
Cat 3	78.28	82.27	72.84	76.27	75.11	83.15	77.66	63.27
Cat 4	52.37	54.77	48.55	50.91	50.38	55.70	51.87	42.97

An amount for Long Service Leave needs to be included. ANHECA has calculated this cost earlier in its submission as:

NSW	VIC	OLD	SA	WA	TAS	ACT	NT
0.74	1.30	0.56	1.17	0.48	0.82	0.65	0.77

The inclusion of these costs in the above figures results as follows:

Wages plus Training plus Parity plus LSL

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
Cat 1	101.70	107.64	95.35	99.63	97.24	107.98	100.88	81.81
Cat 2	88.74	93.90	82.50	86.95	84.88	94.26	87.98	71.66
Cat 3	79.02	83.57	73.40	77.44	75.59	83.97	78.31	64.04
Cat 4	53.11	56.07	49.11	52.08	50.86	56.52	52.52	43.74

Non-wage costs, other than payroll tax, workers' compensation and superannuation has been calculated earlier in the submission and represents $15.56 per bed day prior to 1998-99 indexation. Including this figure in the category calculations reveals the following:

Wages plus Training plus Parity plus LSL plus Non-Wage Costs

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
Cat 1	117.26	123.20	110.91	115.19	112.80	123.54	116.44	97.37
Cat 2	104.30	109.46	98.06	102.51	100.44	109.82	103.54	87.22
Cat 3	94.58	99.13	88.96	93.00	91.15	99.53	93.87	79.60
Cat 4	68.67	71.63	64.67	67.64	66.42	72.08	68.08	59.30

The final inclusion is the return on investment and this has been calculated earlier in this submission as representing $20.12 per bed day. The inclusion of this cost into the category calculation gives the following results:

Wages plus Training plus Parity plus LSL plus Non-Wage Costs plus R01

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
Cat 1	137.05	142.99	130.70	134.98	132.59	143.33	136.23	117.16
Cat 2	124.09	129.25	117.85	122.30	120.23	129.61	123.33	107.01
Cat 3	114.37	118.92	108.75	112.79	110.94	119.32	113.66	99.39
Cat 4	88.46	91.42	84.49	87.43	86.21	91.87	87.87	79.09

To include the current year's indexation (1998-99) the above figures have to be multiplied by 1.014 representing the indexation of 1.4%, which was applied at 1 July 1998. This changes the category calculations as follows:

Wages plus Training plus Parity plus LSL plus Non-Wage Costs plus R01 Plus Indexation

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
Cat 1	138.97	144.99	132.53	136.87	134.45	145.34	138.14	118.80
Cat 2	125.83	131.05	119.50	124.01	121.91	131.43	125.05	108.51
Cat 3	115.97	120.59	110.27	114.37	112.49	120.99	115.25	100.78
Cat 4	89.70	92.70	85.65	88.65	87.41	93.16	89.10	80.20

The above figures represent total income required and therefore include the resident contribution. The amount that needs to be deducted is $26.40 per day which represents the level of the resident contribution as at 1 October 1997 when the subsidies were first set. Taking this into account the category calculations are as follows..

SUBSIDY

Wages plus Training plus Parity plus LSL plus Non-Wage Costs plus R01 Plus Indexation minus Resident Contribution

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
Cat 1	112.57	118.59	106.13	110.47	108.05	118.94	111.74	92.40
Cat 2	99.43	104.65	93.10	97.61	95.51	105.03	98.65	82.11
Cat 3	89.57	94.19	83.87	87.97	86.09	94.59	88.85	74.38
Cat 4	63.30	66.30	59.24	62.25	61.01	66.76	62.70	53.80

Using NSW as the base, the relative costs are as follows:

RELATIVITIES

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
Cat 1	112.57	118.59	106.13	110.47	108.05	118.94	111.74	92.40
	100.00	105.35	94.29	98.14	95.99	105.66	99.26	82.09
Cat 2	99.43	104.65	93.10	97.61	95.51	105.03	98.65	82.11
	100.00	105.26	93.63	98.17	96.06	106.63	99.22	82.58
Cat 3	89.57	94.19	83.87	87.97	86.09	94.59	88.85	74.38
	100.00	105.15	93.63	98.21	96.12	105.60	99.20	83.06
Cat 4	63.30	66.30	59.24	62.25	61.01	66.76	62.70	53.80
	100.00	104.75	93.59	98.35	96.39	105.46	99.05	84.99

ANHECA recommends that the subsidies be immediately increased to reflect parity at a cost of approximately $100,000,000. ANHECA also recommends that the subsidies be varied to reflect the above over the remaining 6 years of the coalescence period.

To assist in supplementing the above ANHECA considers that the subsidies could be supplemented in the coalescence period by the introduction of a private room premium. Prior to the introduction of the SAM/CAM scheme on 1 July 1987 Nursing homes had varying fee structures so residents who wish to pay a little extra for more private accommodation could do so.

Following the introduction of the SAM/CAM system by the Hawke Government that choice was denied the resident. It is no co-incidence that this heralded the commencement of the general decline in building standards across the nursing home industry.

The current Government acted positively to arrest this decline by introducing the accommodation bond arrangement. This had the ability to ensure that if a resident wished to pay for more private accommodation they could do so and the provider would be able to continually modernise the building using all the funds at his/her disposal.

The Prime Minister's announcement on 5 November 1997 effectively meant that the offer of better accommodation was again not something that could be offered to residents wishing to pay for a higher level of accommodation.

The introduction of income testing again does not offer residents any choice. Residents with the means to pay are required to pay extra to merely supplement the subsidy payments of the Commonwealth and are not guaranteed something better (accommodation wise) in return.

With the decreases in funding via the RCS and the amount of payroll tax which private providers receive, together with the taxation requirements for private operators, the income received via the accommodation charge arrangements will provide little funds towards capital works. The balance of the $12.00, after tax, will be used to supplement the level of care required by the residents.

Obviously the industry, residents, Government and the community would like to see the aged care industry as one which offers the best level of care in the best facilities and that those facilities are constantly maintained or upgraded.

To do so the Government needs to work with the industry, not wield the Sanctions stick" if something is not to the required standard. Therefore some type of inducement is needed and this could be in the form of Private Room Premiums, which would cover single and twin bed rooms.

There are many residents, or relatives of residents, who would be willing to pay for a more private style accommodation. The income gained from this could supplement the capital works required. It would also act as an inducement to providers to provide more of that type of accommodation and therefore facilities, especially nursing homes, would reach the required average number of residents per room on time. It would also mean that residents who are paying a little extra are receiving something extra for that payment, unlike the income test arrangements.

ANHECA recommends that a maximum private room premium be set for single bed rooms and that a lower premium be set for twin share accommodation, and that residents be charged up to these rates at the discretion of the provider.

7 Other Issues

7.1 Capital Arrangements ARF

Of particular concern are the Government's treatment of ARF funding and the costs of workers' compensation premiums.

The Government's decision to provide proprietors with the option to either continue to receive the ARF payments, or to levy accommodation bonds/charges on incoming residents re-introduces an inequity into the system. Those nursing homes in receipt of a full capital grant, as opposed to ARF, have received all money payable up front and, therefore, do not have to forego any funding. Assuming these nursing homes receive certification, they will be eligible to charge accommodation bonds to incoming residents. Continuation of ARF funding is necessary to allow those other proprietors to meet existing financial commitments associated with already completed capital works entered into on the basis of the arrangement committed to by the Commonwealth Government. Those proprietors, in common with all other proprietors, need to be able to access accommodation bonds in order to provide for future upgrading or refurbishment of the facility when required.

7.2 Taxation reforms; variations to indirect taxes and the effect on the voluntary sector in particular and the effect on the industry in general;

If the Coalition Government is returned following the 3 October 1998 Federal election there will be a change in the cost structure for nursing homes following the introduction of the GST. All nursing homes will be GST exempt and the current indirect taxes paid by private sector nursing homes will disappear. Also all facilities will have the same arrangements for FBT. This should be taken into account in the first review of subsidies as recommended in this submission.

7.3 Future Demand and Dependency;

Dependency in nursing homes will continue to rise given the reform to ageing in place and the Governments reliance on caring for residents at home. Admission to nursing homes will be delayed until the resident requires more of a palliative care arrangement. Accordingly, the increased dependency will increase the cost of care. This phenomenon should also be considered in light of the first three-year review.

7.4 Extra operating costs imposed by the reforms (extra clerical hours to reconcile claims, co-ordinate the income testing arrangements and to chase up debts); and

If the current arrangements for income testing remain, nursing homes and hostels for that matter, will be required to utilise extra clerical hours to sort out the mess and the billing problems involved with ensuring that residents pay the correct amount of resident contribution. It is not uncommon for residents and providers to be advised of a number of varying levels of contribution in a very short period. This is not income for the provider but goes directly to the Government. ANHECA suggests that if the income testing arrangements are to remain unaltered, the residents' income testing should be fixed at the level originally assessed for a period of 12-months and is reviewed on their anniversary date.

ANHECA is also concerned that the increased level of resident contribution with no direct benefit to the provider will result in increase instances of bad debts. This will also add to the cost of operating a nursing home.

7.5 Increased operating costs brought about by the structural changes (larger rooms/facilities and decreased beds per room).

The increasing building and certification requirements for nursing homes will have an enormous impact on nursing homes. The move towards single and twin accommodation together with en-suite ablution areas will require a greater capital cost. This could be covered in part by the accommodation charge in the long term. However, that style of accommodation will require a greater level of nursing care and a greater cleaning component. Existing facilities will not be requested to meet these more stringent building and certification requirements in the short term, however, it is something that needs to be considered in future reviews.

8. Recommendations

Recommendation 1

ANHECA considers that funding should be set on a State by State formula basis and should include.

- The current cost of Nursing and Personal Care staff, based on an agreed mix between the different types of employees. ANHECA suggests; registered nursing staff (33%), non-registered nursing staff (60%) and therapy staff (7%).
- The current cost of non-NPC staff.
- The cost of award conditions (ie, leave, public holidays etc).
- The cost of non-wage expenditure.
- The cost of training, set at 1.5% of wages.
- The cost of Long Service Leave, set at 1 % of wages.
- A return on investment based on an imputed rental plus a reasonable return on the business.

Recommendation 2

ANHECA considers that the indexation arrangements should allow for the maintenance of parity between the public and non-government sectors. ANHECA would prefer an industry basket approach to indexation, however, if this approach is not acceptable, ANHECA would suggest that the aged care sector should be linked to the ABS index ABS index for Health and Community Services industry. This would provide a direct link to the public sector.

Recommendation 3

ANHECA recommends that the subsidy levels reflect the level of wages in the public sector. This will be the first step in restoring parity in the first instance.

Recommendation 4

ANHECA considers that statutory costs should be outside the subsidy arrangements and funded as follows:

Payroll tax - This is a cost outside the control of the provider. The provider should be funded, throughout the year, at the latest known rate for the facility and the exact amount payable by reconciliation at the end of the year. This will overcome the problems faced by providers owning more than 1 facility.

Superannuation - This is a cost outside the control of the provider. The provider should be funded, throughout the year, at the latest known rate for the facility and the exact amount payable by reconciliation at the end of the year.

Workers' compensation - This is a cost outside the control of the provider. The provider should be funded, throughout the year, at the State average for the year and reconciled at the end of the year, within caps, to provide incentives for continuing good OH&S practices and to ensure that unavoidable workplace injuries do not force providers into receivership.

Recommendation 5

ANHECA considers that the concessional resident supplement should be earmarked for capital and not compared with recurrent funding as was done under the recent RCS Review.

Recommendation 6

ANHECA considers that the level of subsidy could be supplemented with an increased resident payment that will give them the choice of accommodation.

Recommendation 7

ANHECA considers that the current control over price totally limits the income of aged care facilities and consequently limit the services and accommodation which can be provided to Australia" aged residents. ANHECA therefore recommends a slight relaxation in price control so that the resident can be offered a choice in the type of accommodation.

Recommendation 8

ANHECA recommends that where a Government nursing home is purchased by a non-government entity then subsidy be paid at the full rate after taking into account any equalisation grant paid by the government to the purchaser to account for that variation.

Recommendation 9

The income tested amount would create an access barrier for some. To overcome this ANHECA recommends that the resident pay the basic amount only depending on pension status. As the vast majority of residents who would have to pay an income tested fee would also have to submit a tax return at the end of each financial year, ANHECA considers that nursing home and personal care fees should be deleted from the medical rebate for residents entering care after 1 March 1998.

Recommendation 10

ANHECA also considers that the subsidy payments should continue to be paid to the facility. To empower the resident with the payment of the subsidy would lead to massive administrative problems both for the provider as well as the Government.

Attachments

1. ANHECA's Blueprint for quality Aged Care
2. Wage Calculations
    a) State Based Hourly Wage Rates
    b) Wage Calculation
3. Calculation of On-Costs - NSW Nurses
4. Calculation of On-Costs - Victorian Nurses
5. Calculation of On-Costs - Queensland Nurses
6. Calculation of On-Costs - SA Nurses
7. Calculation of On-Costs - WA Nurses
8. Calculation of On-Costs - NSW Domestics
9. Calculation of On-Costs - Victorian Domestics
10. Calculation of On-Costs - Queensland Domestics
11. Calculation of On-Costs - SA Domestics
12. Calculation of On-Costs - WA Domestics
13. Bentleys 1995/96 Aged Care Survey

State Based Hourly Wage Rates

State	NSW
Average RN Hourly Wage	$25.97
Average Non-RN Hourly wage	$14.50
Average Therapy Hourly Wage	$15.76
Average Domestic Hourly Wage	$13.94

State	Victoria
Average RN Hourly Wage	$26.99
Average Non-RN Hourly wage	$13.70
Average Therapy Hourly Wage	$12.53
Average Domestic Hourly Wage	$12.85

State	QLD
Average RN Hourly Wage	$24.57
Average Non-RN Hourly wage	$15.03
Average Therapy Hourly Wage	$11.96
Average Domestic Hourly Wage	**$12.84**

State	SA
Average RN Hourly Wage	$25.49
Average Non-RN Hourly wage	$14.95
Average Therapy Hourly Wage	$13.71
Average Domestic Hourly Wage	$13.53

State	WA
Average RN Hourly Wage	$22.31
Average Non-RN Hourly wage	$14.20
Average Therapy Hourly Wage	$11.88
Average Domestic Hourly Wage	$13.29

State	TAS
Average RN Hourly Wage	$25.18
Average Non-RN Hourly wage	$15.75
Average Therapy Hourly Wage	$14.15
Average Domestic Hourly Wage	$14.51

State	ACT
Average RN Hourly Wage	$23.12
Average Non-RN Hourly wage	$14.20
Average Therapy Hourly Wage	$12.12
Average Domestic Hourly Wage	$12.64

State	NT
Average RN Hourly Wage	$22.75
Average Non-RN Hourly wage	$11.26
Average Therapy Hourly Wage	$11.54
Average Domestic Hourly Wage	$13.71

These figures were calculated from actual nursing home rosters, in each State, as at 1 July 1998

WAGE CALCULATION

	NSW	VIC	QLD	SA	WA	TAS	ACT	NT
RN HR RATE	25.97	26.99	24.57	25.49	22.31	25.18	23.12	22.75
ON-COST	1.21	1.25	1.16	1.18	1.24	1.22	1.21	1.18
TOTAL RN RATE	31.32	33.74	28.52	30.05	27.60	30.70	27.88	26.87

NON-RN RATE	14.50	13.70	15.03	14.95	14.20	15.75	14.20	11.26
ON-COST	1.21	1.25	1.16	1.18	1.24	1.22	1.21	1.18
TOTAL NON-RN	17.49	17.13	17.45	17.62	17.57	19.20	17.13	13.30

THERAPY RATE	15.76	12.53	11.96	13.71	11.88	14.15	12.12	11.54
ON-COST	1.21	1.25	1.18	1.18	1.22	1.22	1.21	1.18
TOTAL THERAPY	18.99	15.60	14.06	16.13	14.43	17.25	14.60	13.63

DOMESTICS RATE	13.94	12.85	12.84	13.53	13.29	14.51	12.64	13.71
ON-COSTS	1.21	1.25	1.18	1.18	1.22	1.22	1.21	1.18
TOTAL DOMESTICS	16.80	16.00	15.09	15.92	16.15	17.64	15.23	16.19

NPC RATES

CLASS	**RATE**	**NSW**	**VIC**	**QLD**	**SA**	**WA**	**TAS**	**ACT**	**NT**
RN	0.33	10.34	11.13	9.41	9.92	9.11	10.13	9.20	8.87
NON-RN	0.6	10.49	10.28	10.47	10.57	10.54	11.52	10.28	7.98
THERAP	0.07	1.33	1.09	0.98	1.13	1.01	1.21	1.02	0.95
NPC RATE PER HR		22.16	22.50	20.87	21.62	20.66	22.86	20.50	17.80

NOTIONAL NPC HOURS AND RATES PER WEEK

		NSW	**VIC**	**QLD**	**SA**	**WA**	**TAS**	**ACT**	**NT**
CAT 1	27	598.24	607.51	563.38	583.76	557.73	617.27	553.47	480.58
CAT 2	23	509.61	517.51	479.91	497.28	475.11	525.82	471.47	409.38
CAT 3	20	443.14	450.01	417.32	432.41	413.14	457.24	409.97	355.98
CAT 4	12	265.89	270.00	250.39	259.45	247.88	274.34	245.98	213.59

NOTIONAL NPC HOURS AND RATES PER DAY

		NSW	**VIC**	**QLD**	**SA**	**WA**	**TAS**	**ACT**	**NT**
CAT 1	3.857	85.46	86.79	80.48	83.39	79.68	88.18	79.07	68.65
CAT 2	3.286	72.80	73.93	68.56	71.04	67.87	75.12	67.35	58.48
CAT 3	2.857	63.31	64.29	59.62	61.77	59.02	65.32	58.57	50.85
CAT 4	1.714	37.98	38.57	35.77	37.06	35.41	39.19	35.14	30.51

NOTIONAL NPC HOURS AND RATES PER WEEK (ALL CATEGORIES

HOURS	**NSW**	**VIC**	**QLD**	**SA**	**WA**	**TAS**	**ACT**	**NT**
5	83.99	79.99	75.47	79.61	80.74	88.22	76.16	80.96

NOTIONAL DOMESTICS HOURS PER DAY (ALL CATEGORIES)

0.7142857	12.00	11.43	10.78	11.37	11.53	12.60	10.88	11.57

TOTAL RATES PER DAY (NPC AND DOMESTICS WAGES)

	NSW	**VIC**	**QLD**	**SA**	**WA**	**TAS**	**ACT**	**NT**
CAT 1	97.46	98.21	91.26	94.77	91.21	100.78	89.95	80.22
CAT 2	84.80	85.36	79.34	82.41	79.41	87.72	78.23	70.05
CAT 3	75.30	75.71	70.40	73.15	70.55	77.92	69.45	62.42
CAT 4	49.98	50.00	46.55	48.44	46.95	51.79	46.02	42.08