SUBMISSION TO THE PRODUCTIVITY COMMISSION INQUIRY INTO NURSING HOME SUBSIDIES

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A EXECUTIVE SUMMARY

- The Nursing Home industry is highly controlled and regulated by interacting Commonwealth and State/Territory jurisdictions. It has been and still is a major growth industry, which is frustrated and burdened by legislation and regulation.

- In the industry there are significant cost components from multiple jurisdictions that are outside the Commonwealth's jurisdiction, which currently must be met from the Commonwealth constrained resources available to providers.

- The nature of these costs is diverse and complex. They are adjusted by mechanisms and in time frames which bear no relationship to any funding formulae used or generated by the Commonwealth. They do not lend themselves to a coalescence process.

- The quantum of these costs is of such diverse magnitudes that any proposals to average them or to subject them to artificial offsets would create structural disparate inequities which mitigate against the principles of sound care management as well as sound financial management.

- While Nursing Homes are businesses they are first and foremost the homes of frail aged Australians who have identified need for care services of a complex and intimate nature. The quality of these services should never be compromised or jeopardised merely to impose a uniform national formula of funding on the industry. The evidence and the arguments advanced show quite clearly that cross-jurisdictional costs are not amenable to a uniform reimbursement formula.

- The cost push forces (wages and associated on costs) which drive the major cost component of aged care delivery are enshrined in State/Territory legislation and jurisdictions which are sovereign and independent of the Commonwealth Government's jurisdictional powers. The major component of wages in Nursing Homes is Nursing Staff. Nursing Staff wages in Nursing Homes are determined by public sector hospital awards. The Nursing Home industry is a follower when it comes to wages and conditions.

- The geographic spread of the Australian population and therefore the distribution of Nursing Home facilities is related to human settlement and not to artificial or arbitrary administrative boundaries. Given these facts, the sensitivity of State/Territory variations in funding is a more precise tool than is offered by a single coalesced national payment.

- However, State/Territory jurisdictional divisions do not provide the ultimate tool for a proper reimbursement as they lack the capacity to identify the complete range of jurisdictional cost descriptions. They are the best available - indeed they form the basis of the existing subsidy payment system.

- Of the funding models examined the Association preferred model is an incentive based partially deregulated one. Such a model has features that provide consumer equity and access, guarantee basic provider funding but allow providers to respond to market demand. Shedding the yoke of totally prescribed funding can and would give the industry a new lease of life.

RECOMMENDATIONS

1. That the consistency and quality of nursing home care (accreditation) should be a higher Commonwealth priority than recurrent financial modelling.

2. That the proposed coalescence of nursing home subsidies be abandoned.

3. That the multijuristictional nature of nursing home costs be acknowledged, accepted and reimbursed to providers in full where these costs are imposed by law.

4. That the relative costs between the States and Territories of providing nursing home care continue to form the basis of payments to providers.

5. That the "underfunding" of states such as Queensland and South Australia be addressed as a separate issue from coalescence.

6. That partial deregulation of the industry be encouraged by allowing providers who achieve accreditation to charge a single ward supplement up to $12 per day.

B INTRODUCTION

B1.0 HISTORICAL BACKGROUND - SETTING THE SCENE

B1.1 The Beginning

Up until 1963 the aged care industry in Australia was a cottage industry. Individuals and or organisations provided what they believed to be appropriate care and services for their clients. There were no standards of any kind and care was variable in quality and quantity.

B1.2 Involvement of Commonwealth Government

A summary of the Commonwealth's increasing involvement in the funding of Nursing Homes from 1963 to 1993 and therefore active interference in the market place is documented 'n the Review of the Structure of Nursing Home Funding Arrangements, Stage 1 by Professor Bob Gregory and published in August 1993. A copy of the relevant reference is attached as Appendix 1.

The complexity of recurrent funding has grown as successive Commonwealth Governments have sought to more precisely target and fine tune the subsidy component of Nursing Home funding. In part this has been driven by rising demand for aged care places from Australia's ageing population and in part by the necessity to control total aged care outlays.

The increasing interest by Government in non residential aged care options (Community Aged Care Packages and similar), the ACAT screening network with its RCS care needs process, and the restrictions on resident catchment areas coupled with resident mix formulas to ensure equity of access have effectively capped provider income opportunities and options.

B1.3 The Stakeholders

The stakeholders in residential aged care include residents, their families, residential aged care service providers, staff, unions, consumer lobby groups and State and Territory Governments. The public at large also has vested interest in the budget allocation of some $2.7 billion annually to Residential Aged Care. As the issues of care delivery come under closer scrutiny by all groups and the media is brought into play, providers are under intense pressure to deliver a "service without fault" regardless of the adequacy of the funding.

B1.4 Providers

The providers in the industry are representative of the full spectrum of players which could be expected in a mixed economy. They include but are not limited to former practising registered nurses, husband and wife teams, church and community groups, entrepreneurs, investors, and State and Territory Governments. Each of these groups has made significant contributions to the present characteristics of the industry.

This complex mosaic of players, resource prescription and control, differential State and Territory charges, multiple Industrial Awards and Unions is further complicated by the varying suitability and age of the building stock which houses the 74,000+ nursing home beds in the system.

B1.5 Industry Capital Funding Requirements

The report, prepared by Professor Bob Gregory, known as "Gregory Stage 2" (published, May 1994) identified the then immediate capital funding needs of the industry. Some of those statistics make sobering reading. Appendix 2 details more information. At that date -

- 13% of Nursing Homes did not meet acceptable fire standards
- 11% of Nursing Homes failed Health Authority specifications
- 60% of Nursing Homes failed Design Standards (A.S. 1428 Design Access and Mobility)
- 15% of Nursing Homes required replacement
- 55% failed Outcomes Standards and only 15% can be rectified

- 5 1 % of all beds are in wards of 3 or more beds
- 79.5% of all Nursing Home stock was 20 years old or older
- 30% of all facilities (Nursing Homes & Hostels) are less than 20 places
- 50% of all facilities are less than 30 places

Professor Gregory estimated the cost of rectifying the above faults at more than $520 million. This figure is based on cost estimates that new Nursing Homes could be built for $50,000 per bed. A more realistic estimate in 1998 would be $60,000 per bed.

Since the publication of the Gregory Reports the Commonwealth Government has continued to make changes to the legislation governing the operational capital of nursing homes Aged Care facilities.

B1.6 Accommodation Bonds

The most telling of these changes followed the enactment of the Aged Care Act 1997. This legislation provided the opportunity for Nursing Home proprietors to charge Accommodation Bonds for those Nursing Home residents able to pay. This initiative would have given the industry the chance to modernise and meet market expectations.

The new Accommodation Bond arrangements had only been in operation a matter of weeks when the Prime Minister succumbed to consumer pressure and reversed the crucial funding part of the legislation. This action threw the industry into financial turmoil.

The Accommodation Bond proposal is inherently sound. The problem was that it was poorly marketed to the electorate, the frail aged and their families. Personal experience of the CEO as a community speaker on the Aged Care Reform program revealed that most frail aged people who require residential care are prepared to make a contribution and provide loan money towards the capital cost of their accommodation when they have the resources to do so.

B1.7 Adverse Impact

Following the Prime Minister's decision on Accommodation Bonds, financial institutions reacted swiftly, revising their estimates of the financial viability of the Industry downward. A number of the financial institutions went into damage control and called in recently approved loans. The impact on providers in some cases was catastrophic.

The Commonwealth Government may have temporarily gained some electoral relief by its capricious action but in the longer term the pressure will be back on as future residents are unable to find appropriate accommodation.

The Government may have also signed the closure notice for a number of Nursing Homes who were relying on Accommodation Bonds as a mechanism to upgrade, achieve certification and continued viability.

B1.8 Additional Recurrent Funding

Adding to the issues of concern to Nursing Home proprietors was and is the 1997 Budget initiative to discontinue Additional Recurrent Funding (ARF) to eligible Nursing Homes following their accessing entry contributions (Accommodation Payments).

The ARF was an attempt by the previous Commonwealth Government to inject much needed capital funding into the industry. The level of the ARF was set to closely equate to the capital grant over a period of 10 years, excluding interest and taxation issues.

The Association advocates incentive based partial deregulation for providers which have achieved accreditation. The mechanisms would allow nursing home providers to charge a of private room premium of up to $12 per day.

This premiums would be at 2 levels. $6 per day for a private room with shared amenities and $12 per day for a private room with exclusive use amenities. The revenue would be exclusively for capital works.

This premium arrangement would only apply to means tested non concessional residents who could afford to pay and would encourage proprietors to redevelop facilities and at the same time also provide the necessary funding stream.

Without a proper regard for the financial realities of the market place, the Government advised proprietors that effective from 1/7/97 they would have the option to either continue to receive the ARF payments for the ten (10) year period or forego those payments and charge entry contributions.

For reasons best known to the Commonwealth Government, it has failed to date to heed the combined voices of the, Industry to pursue the options put to it to solve the problem: -

- To cash out the unpaid ARF as at 1/7/97
- To continue ARF payments along with accommodation payments or
- To continue ARF payments for residents in each affected Nursing Home as at 1/7/97

B1.9 Certification & Accreditation

As if the above capital funding issues were not challenging enough, the industry is now grappling with Certification and Accreditation.

As processes, Certification and Accreditation have broad industry support. It is in large measure the uncertainty surrounding access to future capital funding; the as yet unknown cost of accreditation; the challenge of the "continuous improvement"; the uncertainty of funding the cost of achieving and maintaining accreditation once achieved which are causing concern.

From 2001 facilities which do not achieve accreditation will be ineligible for Commonwealth funding.

B1.10 The Legislative Setting

There are dozens of pieces of Commonwealth legislation which apply to Nursing Homes as businesses (A partial listing is given in Appendix 3).

The above list does not take into account individual State and Territory legislation or Local Government Ordinances or special requirements imposed by Insurance Companies and other external service providers to the industry.

Whilst legislative compliance is a feature of every business enterprise, the multi-jurisdictional nature of legislation for Nursing Homes is particularly onerous as it allows the Commonwealth Government to dictate many aspects of the business. This includes but is not limited to:

- the dependency levels of residents;
- the fees which these residents can by charged;
- the services with which they must be provided;
- the number of beds which can be occupied;
- the standards which must be met;
- the consultations which must be held, etc. etc.

B1.11 Return On Investment

A number of providers of nursing home services, such as religious and charitable organisations have a stated mission to look after the disadvantaged and the frail aged in the community, and are assisted with a range of tax concessions, and the opportunity of raising donations from the public to assist with meeting the costs of providing these services.

Whilst a large proportion of other providers and potential providers in the so called, "private for-profit" sector, have a professional and / or personal interest in the industry, they invest their risk capital and borrowed funds based on their risk / reward assessment of investing in the nursing home industry compared to other potential commercial investments.

The results of our member staffing cost survey confirm that current staff costs, together with related on-costs comprise around 76% of nursing home income, excluding accommodation related supplements, charges or bonds ("funding"). Other (non staff-related) infrastructure operational costs generally constitute between 11 % and 13% of funding. Accordingly, operators should expect "profit margin" in the order of 11% to 13% on nursing home funding, before tax, depreciation and amortisation, and interest.

Clearly, nursing home funding and staff related costs differ between States and Territories. As there is not always a direct correlation between nursing home funding and staff-related costs, such as in Queensland, operators in different States and Territories experience different profit margins. An operator in NSW with an average resident dependency profile, and achieving an average 98% occupancy, would expect nursing home funding per bed day in the order of $111 per bed day. An operator in Queensland, however, with the same resident dependency profile and occupancy levels, would expect funding of a little over $99 per bed day. When Award pay rate (and Payroll tax cost) relativities do not explain the difference, then either the home's financial viability is affected, or the staffing of the home has to be modified.

An operator in New South Wales achieving a 12% profit margin on daily funding of $111 per day (in the middle of the range identified above), could expect an annual profit per bed of $4,862, before tax, depreciation and amortisation, and interest.

Capital development costs, and infrastructure operating costs differ not only between States and Territories, but also within States and Territories, and within cities.

The replacement cost of a facility in major capital cities is in the order of $90,000 per bed comprising:

	Per Bed $
Land	10,000
Licence	25,000
Construction	55,000
Total	90,000

The above mentioned New South Wales operator achieving an annual profit per bed of $4,862, before tax, depreciation and amortisation, and interest ("EBITIDA"), would be generating a return of around 5.4% per annum, based on nursing home funding, excluding accommodation related supplements, charges or bonds.

Because this is a newly constructed facility, accommodation based supplements and charges need to be considered.

If the operator attracted an average concessional supplement / accommodation charge of $7.10 per resident per day, with 98% occupancy, EBITDA would increase by $2,540 to $7,402, increasing the return on their investment of $90,000 per bed to around 8.2% p.a.

An average concessional supplement / accommodation charge at the highest level of $12.17 per resident per day, with 98% occupancy, would increase by EBITDA $4,353 to $9,215, increasing the return on their investment of $90,000 per bed to around 10.24% p.a. Clearly, this is still not considered an attractive return for a commercial investment.

Benefits of gearing investments, marginal or non-existent at these profit margins, even in the historically low interest rate environment are limited.

The traditionally low risk nature of cash flows in the nursing home industry, due to being government funded have justified low profit margins in the past. The introduction of means testing, however, has increased the "private pay" proportion of funding, and therefore the bad debt risk, but without increasing profit margins to levels in competing industries, vying for scarce investor capital.

Accommodation bonds of sufficient size, can however, bring the capital cost / investment return equation into line with the expectations of financiers willing to invest capital.

The following example is provided with a list of assumptions:

1. 70% of residents paying an average accommodation bond of $40,000
2. 30% of residents attracting concessional subsidy
3. EBITDA of $4862 per bed used as base income
4. Retention Component of $2600 drawn

Example 1:

New 50 bed facility	($90,000x50)	Cost	$4,500,000
Bonds received	($40,000x50x70%)		$1,400,000
			$3,100,000
		Net Cost per bed	$62,000

Example 1: Continued,

EDITDA	Per bed (refer above)	$4,862
Concessional Income	(30%x$7.10x365x.98)	$ 762
Accommodation Bond Retention Component	$2600x70%	$1,820

Revised EBITDA per bed	$7,444
Return on Investment	8.3%

Example 2:

Same assumptions as Example 1, but with an average Accommodation Bond of $50,000.

New 50 bed facility	($90,000x50)	Cost	$4,500,000
Bonds received	($50,000x50x70%)		$1,750,000
			$2,750,000
		Net Cost per bed	$55,000

EDITDA	Per bed (refer above)	$4,862
Concessional Income	(30%x$7.10x365x.98)	$ 762
Accommodation Bond Retention Component $2600x70%		$1,820
Revised EBITDA per bed		$7,444
Return on Investment		13.5%

The above example accommodation bond receipts have been applied to offset debt to achieve a return on investment financiers and operators would seek in accordance with increased business risk and increasing market demands for quality facilities. The opportunities for operators to plan and develop quality facilities in response to such market demands can be more rapidly achieved with the availability of Accommodation Bonds.

Depreciation

It is now widely recognised that nursing home buildings do have an operating life of between 20 and 30 years, whereby replace of the facility is necessary or even warranted, as a result of the combination of market influences, building technology and legislative changes.

The cost of depreciating the asset over its operating life, as opposed to the rate applied for taxation purposes of 2.5% (40 years), has not been taken into account. Based on the above examples the return of investment affected as follows.

Return on Investment:
Effect of Depreciation

Assumption:	Cost of construction per bed	$55,000
	Cost of existing facility per bed	$48,000 **

			12% EBITA	8% EBITA	10.24% EBITA
Depreciation Period	Rate				
40 Years	2.50%		$1,375	$1,375	$1,375
25 Years	4%		$2,200	$2,200	$2,200
20 Years	5%		$2,750	$2,750	$2,750
EBITDA of			$4,862	$7,402	$9,215
EBITDA					
40 Years		1	$3,487	$6,027	$7,840
25 Years		2	$2,662	$5,202	$7,015
20 Years		3	$2,112	$4,652	$6,465
Return on Investment (%)					
Net Investment			**$48000	$62,000	$55,000
Percentage Return		1	7.26	9.72	14.25
		2		8.39	12.75
		3		7.50	11.75

B1.12 Coalescence

The announcement by the Commonwealth of a proposal to move to a uniform National rate of funding Nursing Homes subsidies (Coalescence) as from 1 July 1998 without any consultation with the industry was perceived as insensitive, inappropriate and inept.

The proposal was not discussed with the industry prior to its announcement. The most naive student of State Commonwealth relationships would have seen the folly of assuming State and Territory agreement with the Commonwealth trying to standardise what amounted to a national award for all Nursing Home staff. The multi-jurisdictional issues encompassed in the coalescence proposal for ongoing funding are inequitable.

The impact of coalescence on the present cost structures in the States and Territories would have NSW, Victoria, Tasmania and the Northern Territory "coalescing downwards". Queensland, Western Australia, South Australia and the A.C.T. would all be "coalescing upwards".

The Unions were quick to see the window of opportunity to press for substantial wage increases for their members in those States and Territories where the movement is upwards. In the converse situation Providers have no choice but to shed staff to equal their new reduced income. The impact on Standards and the level of care of residents will be adverse. The simplistic proposal as originally envisaged is unenforceable and contrary to sound aged care and financial management product.

The response from the Industry Peak organisations was swift and damning. A major media campaign was launched and pressure was put on the Commonwealth Government to abandon the proposal. The Industry recommended and achieved a halting of the coalescence process after the first tranche of 2% and the commencement of negotiations to find a workable solution (i.e. by referring the matter to the Productivity Commission).

B1.13 Reference to the Productivity Commission

The Commonwealth Government in its wisdom determined to defuse the issue by referring the question of coalescence of Nursing Home Subsidies to the Productivity Commission. The Industry can hope that the report when completed and forwarded to the Treasurer of the day does not gather dust like so many others but is acted upon in a positive manner.

The Nursing Home industry requires respite from continuous change. More importantly, the industry requires the opportunity to function in the market place and respond to market demand. It is hoped that the recommendations of the Commission reflect this need. This function hoped that the Government of the day is willing to allow the industry to grow and change to respond to the market.

This is where the Industry is now.

B2.0 THE SCOPE OF THE INQUIRY

The Commission is to:

(1) Report whether the proposed coalescence should proceed or whether it should be replaced by an alternative structure;

(2) Examine issues including the current and alternative funding methodology and report on:

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

(b) trends in wage costs and likely future directions;

(c) the extent to which, if any, subsidies for nursing home care should vary by State and Territory; and

(d) if differential subsidies are considered appropriate, possible methodologies for maintaining appropriate relativities over time.

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

B3.0 THE FUNDAMENTALS

- Australia has a mixed economy. There is a diversity of providers of all goods and services including Nursing Homes. Providers include State/Territory Governments, Religious and Community Groups and "for profit" operators. Within the "for profit" grouping are husband and wife teams, former Directors of Nursing, private and public investment and management companies.

- This diversity of service provision reflects the multicultural nature of Australian Society, religious preferences, urban/rural differences and the varying capacity and willingness of frail aged Australians to pay for Residential Aged Care services.

- An assumption is made that the Commonwealth Government wants to see most of the existing Nursing Home providers remain in the industry. Given that the statistical projections by the Australian Bureau of Statistics are for substantial growth in the number of frail aged Australians (Figure 1) and that a growing proportion will require Nursing home care, the 74,000 plus beds in the system, will, over time need to increase.

- The redefining of Nursing Homes and Hostels as Aged Care facilities, by the Commonwealth is a recognition of the increasing demand for higher levels of care. Some flexibility in resident mix has also been approved. The new definition means that potentially there are 150,000+ beds in the system to cater for higher dependency residents. To cope with projected peak demand (2012) it is likely that most Aged Care facility beds will be occupied by Category 1-4 residents.

- The capital and recurrent funding of these beds to enable the maintenance of diversity and availability of a range of Nursing Homes is of fundamental importance. The present restrictions on access to funding and other Commonwealth controls need to be wound back progressively. The impetus for change lies within the Certification process and is reinforced by the Accreditation process. The industry needs to be unshackled so that it can respond.

- The largest cost component in Residential Aged Care (Nursing Home) care delivery is the cost of care staff and the largest component with in this is the nursing staff. The cost drivers for. Nursing Staff wages across Australia are the Public Hospital sector Awards. Public Hospital rates for nurses have traditionally set the pace. Nursing Homes have always played "catch up" when it comes to wages and conditions.

- Given that Nursing Home wages are essentially driven by decisions taken in Public Sector awards in State/Territory jurisdictions, the capacity of the Nursing Homes sector to be creative by using enterprise agreements or similar is limited.

- Rapid growth rate until 2012 due to 'baby boomers'
- Then rapid decline in growth rate to less than 1997 rates by 2041

15A.

- The public and Providers in the industry want a Nursing Home system that is:
    - ❖ Easy to understand
    - ❖ Equitable and fair
    - ❖ Maintains freedom of choice
    - ❖ Accessible in their community
    - ❖ Provides continuous quality improvement

- The proposed National coalescence formula will not deliver fairness and equity, or provide continuous quality improvement across Australia. It will, in its present configuration cause staff shedding in States and Territories coalescing downwards and inspire union wage demands in States and Territories coalescing upwards. It is also doubtful whether in the longer term nursing home care would continue to be available to people in their own communities. In some States and Territories freedom of choice would be limited. This would occur as Providers coalescing downward are forced to shed staff to balance budgets or close.

- In States such as Queensland and South Australia, some fundamental adjustment is required to ensure appropriate care provision. This action should be taken independently of coalescence.

- One has to ask the question. Why does the Commonwealth want to impose a uniform funding rate across the country? Admittedly it is easier to adjust and administer a single figure than to adjust eight figures - one for each State and Territory, but is the issue a priority?

- The Association recommends that there be separate funding rates for each State/Territory jurisdictional area which reimburse the actual costs incurred.

- Moving to a funding model which rewards achievement of Certification and Accreditation will ensure:
    - ❖ Improved consumer acceptance
    - ❖ Continuous improvement
    - ❖ Resources to do the job
    - ❖ Enhanced capacity to meet demand
    - ❖ Increased flexibility in care delivery

- The Association advocates incentive based partial deregulation which:
    - ❖ Rewards accreditation
    - ❖ Improves the capital stock of aged care beds
    - ❖ Injects funds into the industry

B4 THE DATA

The process adopted by the Association commenced with the development of a nursing home roster data sheet (Appendix 4). This was circulated to all members.

The data was collated in the following categories:

- registered nursing homes/bed/day
- EN/AIN/therapy hours/bed/day
- domestic hours/bed/day
- Workers Compensation (light duties)

The data was analysed by

- State/Territory
- bed size
- RN Proportion of labour by State by bed/by size of facility
- EN/AIN/ therapy proportion of labour by State by bed/by size of facility
- domestic proportion of labour by State by bed/by size of facility

The aggregated figures are set out below. Where the sample was too small the data has been omitted:

- The proportions of "care hours" by classification/by State/facility size has been determined from the sample.
- State and facility size the percentage proportion of RN hours and EN/AIN/therapy hours/bed/day is reasonably consistent (RN hours range from 22.28% to 25.98%), (EN/AIN/therapy range from 51.03% to 52.98%).

The data provided obviously has some major deficiencies, which makes analysis difficult in terms of both:

1. Comparison of state costs, by size group, and
2. Comparison by size within a given state.

Some specific comments are:

30 Beds Highlights weakness of coalescence process in the Queensland had higher, dependency and use more staff hours, but had a lower RN ration which reduces costs significantly.

31-60 Beds The WA figures are surprising in view of the lower dependency profile, which are not reflected in lower nursing hours. The results for NSW and Victoria again highlight that higher funding in Victoria is absorbed by higher RN hours.

61-90 Beds The results are obviously affected by incorrect domestic hour details for Victoria. This set of results does highlight an inconsistency in funding, in that both Queensland and New South Wales have similar dependency profiles and labour hours/costs.

If the sample had been large enough (and therefore the data more representative) it was proposed to generate funding models using the Indexation concepts in Section C1.1.6.

Funding models were planned for a range of bed place sizes (<30, 31-60, 61-90 and >90) and for each State and Territory. These models would have highlighted the differences between the States and Territories and consequently the inadequacy of coalescence as an appropriate funding deal.

The Association would support the commissioning of such financial modelling and the consideration of such data by the Commission prior to shaping recommendations to the Treasurer.

It is an area which requires further evaluation as we move to a more free marketplace.

This approach has the ability to deliver a higher level of client privacy and dignity whilst at the same time delivering up improved trading surplus to the provider.

The difficulty, however, for the provider is in managing and containing the volatile Workers Compensation insurance factor which is now falling outside reimbursed funding levels.

Clearly the new scheme is aimed at removing the formerly intricate approach to client services by way of care and nursing care staff related costs.

The increased flexibility now ushered in by the Aged Care Schedule 1997 enables providers to introduce and manage resident care requirements on a more holistic basis.

Judicious management of non-registered care staff duties reflect the cost efficiencies detailed in the Commonwealth Audit Commission report, June 1996.

Some providers are beginning to achieve more operational cost savings in this area. (Victorian figures 61-90 beds domestic costs are nearly half the comparable costs in New South Wales, Western Australia and Queensland.

NURSING HOME WITH LESS THAN 30 BEDS

		VIC	QLD	Sum of hours per day	
Beds in sample		400	50		
RN hrs/bed/days		1.08	0.43	1.51	25.95
EN/AIN/Therapy hrs/bed/days		0.47	2.5	2.97	51.03
Domestic hrs/bed/days		0.65	0	0.65	11.17
Wcomp hrs/bed/days		0.03	0.66	0.69	11.86
		2.23	3.59	5.82	100.00
		%	%		
RN proportion of labour		40	21		
EN/AIN/Therapy proportion of labour		47	63		
Domestic proportion of labour		13	16		
		100	100		
		$	$		
Income	A	119.72	102.05		
Wages Expenditure					
RN cost		36.76	14.77		
EN/AIN/Therapy cost		42.14	45.43		
Domestic cost		11.83	11.24		
Wcomp cost		2.45	0		
	B	93.18	71.44		
Gross Profit (A-B)		26.54	30.61		
Costs other than wages @ 15%		17.96	15.31		
EBITDA		8.58	15.30		
		%	%		
		7.17	15.00		

NURSING HOMES WITH 30-61 BEDS

	NSW	VIC	WA	Sum of hours per day	%
Beds in sample	598	570	1222		
RN hrs/bed/day	0.84	1.01	0.73	2.58	22.23
EN/AIN/Therapy hrs/bed/day	1.95	2.06	6.06	6.06	52.22
Domestic hrs/bed/day	0.95	0.61	1.13	2.685	23.14
Wcomp hrs/bed/day	0.03	0.13	0.12	0.28	2.41
	3.77	3.81	8.04		100.00

NURSING HOMES WITH 30-61 BEDS (CONT)

		%	%	%
RN proportion of labour		33	38	29
EN/AIN/Therapy proportion of labour		46	50	55
Domestic proportion of labour		21	12	16
		100	100	100
		$	$	$
Income	A	103.171	119.721	104.49
Wages Expenditure				
RN cost		25.83	33.9	24.28
EN/AIN/Therapy cost		35.98	43.09	46.42
Domestic cost		16.38	11.14	13.01
Wcomp cost		0.43	3.78	1.75
	B	78.621	91.91	85.46
Gross Profit (A-B)		24.55	27.81	19.03
Costs other than wages @15%		15.48	17.96	15.67
EBITDA		9.07	9.85	3.36
		%	%	%
EBITDA Percentage Return		8.80	8.23	3.21

NURSING HOMES WITH 61-90 BEDS

	NSW	VIC	WA	QLD	Sum of hours per day	%
Beds in sample	3520	140	619	342		
RN hrs/bed/day	1.78	0.98	1.07	0.89	3.71	24.97
EN/AIN/Therapy hrs/bed/day	2.02	1.72	2.07	2.07	7.87	52.98
Domestic hrs/bed/day	0.92	0.00	0.70	0.84	2.82	18.98
Wcomp hrs/bed/day	0.01	0.38	0.07	0.00	0.46	3.06
Hours/Resident/day	4.71	3.081	3.901	3.801	14.861	100.00

		%	%	%	%
RN proportion of labour		34	45	27	34
EN/AIN/Therapy proportion of labour		48	46	56	49
Domestic proportion of labour		18	9	17	17
		100	100	100	100
		$	$	$	$
Income per day	A	106.34	118.03	106.39	103.37

NURSING HOMES WITH 61-90 BEDS (CONT)

Wages Expenditure					
EN/AIN/Therapy cost		20.14	34.51	35.76	41.34
Domestic cost		14.58	6.61	11.10	14.89
Wcomp cost		0.11	5.78	7.60	0.03
	B	61.23	80.50	72.06	84.54
Gross Profit (A-B)		45.11	37.53	34.34	18.83
Costs other than wages @ 15%		15.95	17.70	15.96	15.51
EBITDA		29.16	19.83	18.38	3.32
		%	%	%	%
EBITDA Percentage Return		11.46	16.80	17.27	3.22

C PRODUCTIVITY COMMISSION SUBMISSION

C1.0 OPERATIONAL FUNDING

C1.1 WAGE COSTS

C 1. 1. 1 INTRODUCTION

The major cost component of conducting a nursing home is wages. Wages together with wage on costs account for approximately 75 per cent of the total costs of operation of a facility. Given that wages are determined in State/Territory jurisdictions and that the Union movement is adroit and adept at using gains in one jurisdiction to advance the cause for increases in another the successive "leap frogging" of wage award conditions is set to continue. The Unions are also very capable of using special climatic or other conditions such as remoteness to improve the take home pay of their members.

A large part of this submission therefore is focussed on the issues of wages and wage related costs.

Given that wages "on costs" such as payroll tax superannuation and workers compensation are related to actual wages paid then short of the Commonwealth Government taking over the function of determining all wages in the industry in a single jurisdiction, there will continue to be differentials in the total remuneration payable to employees doing similar work but living in different parts of Australia. The cost burden that falls on nursing home operators varies accordingly.

Given the plans to increase employer superannuation contributions to 9 per cent of gross wages by 2001 and given that workers compensation premiums rise as the costs of claims, rehabilitation and occupation health and safety initiatives increase, the disparity of total actual wages costs between the jurisdictional areas in the States and Territories will continue to require proprietors operating in those States to meet those costs whatever they may be. No coalesced common subsidy will be adequate or appropriate and nor should it be.

A member (Proprietor A) has nursing homes of comparable size in Tasmania, Victoria, NSW and Queensland. Appendix 5 depicts the wage cost differentials in the four different jurisdictional areas. If Proprietor A were to receive a uniform subsidy payment then services in high cost States would be disadvantaged over the low cost States.

The acceptance of jurisdictional difference needs to be accepted. This should be coupled with the development of State/Territory indices and subject to special viability supplementation for remote Nursing Homes. Western Australia is an example. The index series for Western Australia should take into account the special

costs of doing business in Western Australia. In the case of Broome in the far north of the State, a special viability allowance should be paid as well.

C1.1.2 RCI To RCS

With the integration of Hostel-type residents and Nursing Home-type residents by the mechanism of a single assessment instrument, significant changes have occurred to the assessment process and also the funding.

The overall funding available to Nursing Home proprietors for providing care has been reduced. This in turn must be reflected in the capacity of proprietors to engage the full spectrum of staff and provide the diversity of services that are required.

Increasingly higher standards being required through the certification and accreditation processes. The administrative component of Nursing Home operations, and the new requirements of documentation have also increased significantly.

The above situation has occurred against a background of increasing resident dependency on admission to Nursing Home (aged care) facilities, a growth in the ageing population and a restriction on the number of available residential aged care beds. The combined effect of these processes is to focus provider attention on the most cost-effective mix of residents in the facility at any one time, as opposed to meeting the marketplace demands. Where these two factors coincide, then the result is positive for everyone. However, where cost pressures on providers are such that financial outcomes have to take precedent over care outcomes, then the result is less than satisfactory.

In recent times there has been a strong focus to use non-residential care as a substitute, with transfer to residential care for the very last phase of the care spectrum.

This King Canute-like process of holding back the demand for residential aged care places until the last possible moment has traumatic effects on residents themselves, negative morale effects on staff and dramatically increases the rate of turnover of residents in facilities it also is a contributing factor to staff turnover.

This process in turn exacerbates the volume of documentation and paperwork; provides little opportunity for staff to get to know and understand resident needs because the length of stay is so short; produces significant problems with the unseemly speed of dealing with relatives and families; and makes a joke of maintaining a home-like environment when the length of stay is more like a hotel guest staying for a week.

Income testing has increased cash flow risks through introducing private pay bad debt and delayed payment risks, without any compensatory increase in income in line with risk to return principles.

The funding is calculated without any reference to actual costs providing the required standard of care.

There is also a risk that the former low category residents who used to occupy hostel beds under the old PCAI Instrument, will now be denied a place in a Nursing Home as there simply are not enough places in the system.

One can only speculate that over a period of time a great number of retirement villages will become de facto low-care facilities and *in extremis* could become high care facilities as well.

1.1.3 PAYROLL TAX

Payroll Tax is an inescapable burden on Nursing Home providers. It is a cost directly related to the wages paid by the facility. It should be fully cost-reimbursed.

Below is an example to highlight the inequity of funding by way of the payroll tax supplement which varies State to State. The current rates per bed day are shown:

PAYROLL TAX SUPPLEMENT
RATE PER CATEGORY 1 TO 4 RESIDENT PER DAY ($) FROM 1/7/98

	NSW $	**VIC $**	**QLD $**	**WA $**	**SA $**	**TAS $**	**ACT $**	**NT $**
61+ places or grouped*	4.61	3.83	3.31	4.58	3.11	4.85	4.79	5.29
31-60 places	3.15	3.24	1.27	0.99	2.33	4.85	4.79	5.29
1-30 places	1.41	2.08	1.03	0.55	1.19	4.85	4.79	5.29

It should be noted from the table that Tasmania as a uniform daily rate per resident of $4.85 and when compared to NSW, is seen to be considerably in excess of NSW over all ranges of bed groupings.

A comparison of the respective rates of payroll tax set by the NSW and Tasmanian state governments indicates only a slight variation between the two states (in fact NSW is 25% more costly than Tasmania). That being the case, it is fair perhaps to stay that not Minister Smith nor his senior bureaucrats could give any logical explanation as to why Tasmania is treated so generously particularly in the 1-30 places category where the supplement supplied for the payment of this tax is 3.5 times more than allowed in NSW.

This is just an example of the flawed methodology has been used. It also is illogical for a 60 bed facility in Western Australia to be funded at $0.99 per resident/day while with the same staff establishment a 61 bed facility receives $4.58 per resident/day!

In practice, having regard to the exemptions and rates applied by WA government for this tax, a 60 bed nursing home is about $80,000 per annum worse off that a facility of 61 beds. The 60 bed facility incurs a deficit of $18,000 while the 61 bed facility enjoys a surplus from this one item of funding of $61,000! The methodology is more than "flawed" - it is obscenely inequitable.

Another discrepancy with payroll tax funding is that residents who are categorised as Category 5 and above (lower dependency) apparently are seen by the Federal Government as undeserving of any labour involvement in their daily care. Why? -because the payroll tax supplement is payable only in regard to occupied beds for Categories 1 to 4. This again is an example of arbitrary cut-off points creating anomalies. The Payroll Tax Calculation Schedule used in the national skills mix model is attached as Appendix 6.

1.1.4 WORKERS COMPENSATION

In each state and territory of Australia workers compensation is payable to a statutory authority usually structured under the appropriate Work Cover legislation. The premium payable by an employer is related to the wages paid.

The nature and structure of workers compensation in each State and Territory is different. Information from selected States is set out below by way of example.

South Australia

The workers compensation premium rate for nursing homes in South Australia is 6.9 per cent. The South Australian Work Industry Code for Nursing Homes is 814301. The descriptor is "nursing or convalescent homes providing nursing or medical care". The relevant Act is the Workers Rehabilitation and Compensation Act of 1986. The amount payable by an employer in the nursing home industry is made up of 3 components. The first of these is the base class or industry rate. The second component is a bonus or penalty adjustment. The third component is a government registration fee paying for occupational health, safety and welfare.

The premium rate for each class of industry in South Australia is determined by the average claims experience of all employers within that particular class. In determining any rates, the number and cost of claims over a recent 30-month period are considered by the authority.

Victoria

In Victoria WorkCover insurance premiums are prescribed under the Accident Compensation (WorkCover Insurance) Act of 1993.

WorkCover insurance premiums for 1998-1999 is set out in a Victoria Government Gazette dated the 2nd of June 1998.

Appendix 7 reproduces the formula used to calculate WorkCover premiums in the state of Victoria.

Queensland

In Queensland the legislation is the WorkCover Queensland Act of 1996.

The situation in Queensland is that all the premium rates are subject to claims experience.

To calculate an approximate premium for a new policy in the nursing home industry, a proprietor would multiply the industry rate by the gross wages paid by PAYE taxpayers.

In 1998 this would equate to 3.907 per cent, which is the nursing home rate, multiplied by the gross wages.

It should be noted that this calculation is a base calculation only and each employer in the industry would have a unique industry rate, as the rate would be determined to the claims experience of that particular employer. Thus within the jurisdiction of Queensland the amount of workers compensation paid by different employers varies according to the claims experience. It should also be noted that in Queensland, claims experience is not necessarily a factor related to the willingness of an employer to embrace workplace reform and to be actively involved in occupational health. and safety initiatives.

Appendix 8 sets out relevant information.

Western Australia

In Western Australia the relevant legislation is the Australian Workers Compensation Rehabilitation Act of 1981.

Premium rates are determined in Western Australia by the Premium Rates Committee who review premiums and claims results provided by insurers. The nursing home industry currently attracts a premium rate of 5.65%.

The recommended premium rates are a base rate for each industry and insurers have the ability to discount by whatever percentage they consider applicable or to load the premium up to 50% if they consider the claims experience warrants this loading.

A statement concerning the situation in Western Australia has been provided by AON Risk Services and is attached as Appendix 9.

New South Wales

The New South Wales legislation is extremely complex and the current regulatory requirements are documented in NSW Government Gazette No. 97 dated 26 June 1998. A copy of that legislation is attached as Appendix 10.

Nursing homes have a prescribed rate. The rate number is 792, and the rate for 1998 is 5.57%.

The complexities of the rates paid by individual businesses depends on claims experience and a range of related factors which are documented in the legislation already referred to.

The NSW WorkCover Authority has produced a special publication outlining the workers compensation premium scheme for NSW for 1998/99, which can be tabled if required.

The diversity of rates and the range of complexity of formulae used for calculating workers compensation varies markedly from State to State as indicated by the examples already cited.

The workers compensation premium is not a cost input that readily lends itself to any form of universal coalescence.

SUMMARY OF WORKERS COMPENSATION BASE RATES* PAYABLE IN EACH STATE AND TERRITORY FOR NURSING HOMES**

STATE/TERRITORY	BASE RATE
Queensland	4.22%
-New South Wales	5.57%
A.C.T.	Privately negotiated - no base rate
Victoria	3.95%
Tasmania	Privately negotiated in the range of 5% - 6.5% - most at upper end
South Australia	6.9%
Northern Territory	N/A
Western Australia	5.65%

*Base Rate is subject to claims experience and/or any loadings (+ or -) which may apply.

**Nursing Homes are defined in different terms in different States and Territories. In some States they include Hostels and in others medical centres and convalescent homes.

C1.1.5 COALESCENCE

A legitimate question which needs to be asked in relation to the coalescence proposition is whether wage cost relativities are likely to remain the same in the future. Perhaps the best evidence of what is likely to happen is to examine the past history of wage movements in the States and Territories.

The plethora of unions both State and Federally organised in the aged care sector has resulted in a huge diversity of geographic and work function coverage in the different States and Territories.

The unions have negotiated specific loadings and conditions to protect their member's interests. Some of those loadings and conditions apply to employees working in isolated areas, employees working 24-hour rosters, etc. The industrial award coverage is further fragmented by the division of the Industry into public, private for profit and the charitable non profit sectors. Each sector has slightly different conditions.

The result of these negotiations over the years has been development of great complexities as the Unions review each other's achievements and seek to improve the relative position of "their members" at the next negotiating round.

Even with the amalgamation of Unions the likely future trend is likely to be more of the same, ie there will continue to be disparities in the wages paid to staff working in aged care in different parts of Australia, whether it be divided by States and Territories, by sector type, or by isolation versus metropolitan areas.

Given the decisions of the courts in setting wages and conditions it is highly unlikely that the Union movement would be prepared to accept any diminution in their remuneration or any loss of relativities.

In short, whilst there are ever different jurisdictions for labour to organise itself there will always be negotiated differentials in wages and conditions. The only possible answer for uniformity would be for the Commonwealth Government to assume control of the wage setting process and set a uniform figure Australia wide. Even if this improbable hypothetical situation were to occur it is still unlikely that the specific problems of distance, geography, climate, working conditions, continuous shifts, etc, would ever result in a uniform Australia wide position.

Given the wage component and wage on costs comprise 75% of all care costs in the nursing home then the answer must be that wage movements will continue to move out of kilter with each other and the sensibility of a single coalesced payment to cover wages components is unrealistic.

The State/Territory jurisdictional wages related on costs (Payroll Tax, Workers' Compensation, etc.) from the Association's research vary from 31.9% in Western Australia to 35.5% in Victoria (based on data collected for the States of New South Wales, Queensland, Victoria and Western Australia only).

C1.1.6 INDEXATION

Coalescence aside, appropriate indexation of payments to providers is fundamental. The reality is that the costs of care provided in Aged Care Nursing Homes have increased at a far greater rate than has been reimbursed in the past.

Under the SAM/CAM formula, SAM was never properly calculated right from the beginning. It was based on Departmental figures that were questionable. More importantly the increases in SAM have always been less than actual costs incurred. This is evidenced in the work of Alan Doobov and again in the work of Professor Bob Gregory.

The denial of reality of costs continues with current inadequate re-imbursement of the costs of such diverse items as banking and continence aids to name two items in the Non wages arena.

The above information is cited to make the point that selecting the right indexation formula is critical for future funding of services. Extensive calculations by Treasury and hypothetical formulas do not deliver aged care. Aged care delivery costs the wages of the required work force and the goods and services which residents need.

Policy makers and the public have to acknowledge this reality and the funding implications entailed.

The indexation of funding levels over time, to reflect the true changes in the cost of providing nursing home facilities and care, is as important as establishing base capital and operational funding mechanisms which realistically reflect the standard of accommodation and care expected by Australia's frail aged, and required by certification and accreditation standards.

Given that the Australian Bureau of Statistics (ABS) compiles wage cost index information on an Australia wide basis and also on a State by State basis by occupation, it is useful to review these indices with a view to finding a possible mechanism for appropriately indexing wages.

The wage cost index is relatively new, having first been established in September 1997. The background to its development is documented fully in publications 6345.0 and 6346.0. Copies of these documents are attached as Appendices 11 and 12.

Using the total hourly rates of pay, excluding bonuses by sector-and industry, the movements in costs are most appropriately identified under the heading "health and community services". In turn this is index dissected into the private sector and the public sector. It is also provided for the combined public and private sectors. A copy of this information is set out on page 6 of Appendix 11.

Whilst this index series is not precisely related to Aged Care, it does have the advantages of being:

- Readily available
- Produced by a Government Agency, A.B.S.
- Reflective of wage cost movements in the Health sector of which Aged Care is a part.

Given that there is no precise formula for the mix of direct care and indirect care costs, but that it is close to 75%, the Association proposes a model for indexing the quantum paid to providers which comprises 80% of the total hourly rate pay, excluding bonuses, for public health services sector, and 20% of Average Weekly & Overtime Earnings (female) [AWOTE (F)].

The attached tabulation depicts the proposed indexation:

<table>
<tr><th>1</th><th>2</th><th>3</th><th>4</th><th>5</th></tr>
<tr><td rowspan="3">All Costs</td><td>75% wages costs</td><td>80% public health services sector</td><td rowspan="3">Plus Adjustment for state differentials</td><td rowspan="3">Plus Adjustment for viability in remote areas</td></tr>
<tr><td rowspan="2">Other costs 14%-16% 11-13%</td><td>20% AWOTE(F)</td></tr>
<tr><td>CPI</td></tr>
<tr><td>Balance</td><td>ROI 12-14%</td><td></td><td></td><td></td></tr>
</table>

The Public Health sector index is used as the Nursing Home industry wages costs follow the Public Sector. To not use this index is to deny reality. The Nursing Home Industrial Awards are determined by rates and conditions in the Public Sector.

The above tabulation can be used to indexation calculate as a constant from columns 1 to 3 with add ons from columns 4 and 5 as appropriate. A more cost sensitive option is to adjust the CPI component in Column 3 by state CP1 before further adjustment of all costs by the appropriate State/Territory differential.

These figures are readily available at a national level, and available from the ABS as unpublished data at a State and Territory level.

As this information is compiled quarterly it provides the appropriate mechanism to adjust subsidy payments in line with costs. The Association recommends that payments to providers be adjusted six monthly in line with adjustments to the aged pension. The structural inequities in funding for Queensland and South Australia should be rectified by appropriate adjustments prior to applying indexation.

Cl. 1.7 ALTERNATIVE FUNDING MODEL

The existing arrangements for payment of nursing home subsidies are prefaced on the view that Government funding support recognises the differences in the cost of

providing care across the State and Territory jurisdictions. The Commonwealth has to date held the view that for individuals to enjoy comparable quality aged care, regardless of the city or town or village they live in, then the cost of providing that care should be reimbursed.

The growth and development of the State based jurisdictions for setting wages and conditions for care staff have developed in a complex manner as is discussed under Section C I. I. The wages component is by far the greatest cost component of Aged Care delivery being approximately 75%-76% of all costs.

Arguably an equitable funding system would recognise the cost differentials created by all jurisdictions.

If a new coalesced funding system fails to recognise the costs of providing comparable residential aged care, which maintains freedom of choice, is accessible to people in their community and is of a consistent quality then the residents or potential residents may find the facilities they require are no longer available in their State or Territory and will have to move elsewhere if they want a particular quality of aged care.

If the proposed coalescence in it's existing form proceeds there will be some States coalescing down and some States coalescing up.

Where the coalescence is downward and there is no opportunity for providers to access additional resources then the only choice available to the provider is to reduce the quantum and calibre of the staff so that he or she can produce a balanced budget. This must have an impact on the quality and quantum of the care that is delivered.

This approach and this outcome are contrary to the espoused standards that the Commonwealth wants to achieve. The Aged Care Standards Agency charter makes abundantly clear what is required.

For those States that are coalescing upwards the opportunity exists for the ever-vigilant union movement to take advantage of the situation and try and secure any increment in funding for the benefit of the care staff. Given that the wages are 75% of the total cost of aged care service provision then it is not an unrealistic scenario to imagine that the unions would be trying to achieve this proportion of any increment for the benefit of their members.

This would not necessarily be creating a situation where additional money was being expended appropriately from the tax payer purse to ensure best quality aged care at exist
across Australia. All this does is to further exacerbate the cost differentials that exist between the States and Territories and compromise the quality of care which is delivered.

The bottom line is that the Charitable sector and the "for profit" sector must achieve a positive bottom line to stay in business. If the Charitable sector wishes to provide additional services from its trading surplus then this is an acceptable outcome.

Equally the for profit sector is entitled to an appropriate Return on Investment which it can legitimately take as a dividend.

There are a series of taxation issues that characterise two of the three principal parts of the aged care sector. Government auspiced nursing home facilities are generally exempt from Commonwealth taxation and the charitable not for profit sector also enjoys significant concessions in the taxation area which it is claimed are offset by other benefits which apply to the so called for profit sector. (At the time of preparing this report a Federal Election is being conducted. The Coalition is going to the people with a proposal to remove a number of taxed and replace them with a Goods and Services Tax (GST). It is claimed by Treasury, but not proved that the cost of Nursing Home operations will fall under a GST regime).

There has been research done over the years which shows arguably that the net overall effect of the tax offsets makes for a level playing field in terms of the total resources available to the two sectors.

The issue of labour market flexibility has been raised and needs addressing.

Returning to the earlier consideration of the effectiveness of the union movement in negotiating benefits for its members in different States and Territories, the main driver for wage movements in aged care comes through the public hospital system in the States and Territories. Traditionally the unions have seen State Governments as soft targets for securing significant wage increments and benefits for their members.

In the case of registered nurses these particular qualified people are employed in both the public hospital system and also the aged care system across three sectors.

Once a significant increment has been gained in the public sector the unions then use this successful application as a template for negotiating a similar increment in the nursing home sector, whether it's the private for profit or the charitable non-profit. Although over the years the charitable non-profit has managed to maintain some slight differential on the increment.

The reality is that regardless of the wages that are negotiated and agreed, registered nurses know they can command the premium, which the public hospital system confers. Most employees try to maximise the value of their labour and therefore tend to gravitate to the public hospital system. The exceptions are those individuals who have a dedication to aged care (all too small and declining), where regardless of the money which is being offered will work in aged care because they regard it as a mission which transcends the monetary value of the wages.

The question as to whether Commonwealth subsidies have provided disincentives to improvements in nursing home care and delivery over the years is a highly debatable point. Today the controls on the nursing home industry are so great that the flexibility, which exists for proprietors and providers, is strictly limited.

Some of the constraints are:

1. The location of a facility is determined by the Commonwealth based on 100 people aged 70 plus per thousand people in the community.

2. The licence to operate beds is broken down into components - to so many nursing home (high care) beds, so many hostel (low care) beds and so many community aged care places.

3. The admission of residents into aged care is controlled through a Commonwealth process of Aged Care Assessment Teams (A.C.A.T.S.). These teams determine the level of average daily living skills which an individual has and therefore the Resident Classification Scheme (RCS) rating which attaches to that person. In turn this determines the subsidy payment which that person can attract in a Nursing Home or Hostel (now Aged Care Facility).

4. The mix of residents in terms of their financial capacity to pay is also controlled with a prescription that every facility except those that are exempt shall have 40% of its places for people who are on the pension.

These effective constraints on resident mix and access to resources force the situation on providers whether they are in the charitable non-profit sector or in the private for profit sector of being unable to negotiate flexible remuneration arrangements, such as enterprise agreements with the unions, because they simply do not have access to the resources to do so.

One of the arguments that has been advanced is the trend to a uniform coalescence of funding for aged care facilities will expedite restructuring of the industry. Brutally restructuring can be seen as a process of culling inefficient operators from the industry, or as a process of forcing smaller operators out of the system, or of forcing the aggregation of smaller licence holdings into larger ones and reconstruction of new facilities, or it can be seen somewhat cynically as a process of removing beds from the system in those areas where the Commonwealth Government regards that the provision of aged care based on its figures of 100 people aged 70 plus per thousand as being excessive.

Whilst there is some merit in restructuring the industry, the reality is that changes to the funding system, however done, are going to cause restructuring and will cause a number of providers to leave the industry.

Depending on the timetable of the coalescence and the contractual obligations that exist between different providers and their financial institutions, restructuring could be very swift indeed. In the case of small leaseholders in Victoria, a number of these could face extinction in a very short period of time through bankruptcy or closure by lessors. The loss of bed places to the industry could create a significant electoral backlash. A positive approach is required which recognises community, proprietor -lessee/lessor and Government agendas.

Partial Deregulation

The Association believes that the most appropriate funding option for ensuring the future viability of the Nursing Home industry and meeting the multitudinous demands of the various stakeholders, is to move to a partially deregulated model.

The model would envisage:

- the continued contribution by residents of 85% of the pension the Commonwealth Government paying to the industry the total quantum of money currently paid by way of recurrent funding to Nursing Homes, expressed as dollars per bed per day, and indexed according to the formula outlined in section C1. 1.6 (Indexation) on a six monthly basis in line with adjustments to the pension.

- In addition to the above, the Commonwealth would allow all Nursing Home proprietors who achieved accreditation the right to charge a private room premium of up to $12 per day as detailed in Section B 1.9.

The constraints which would continue to apply are:

(a) ACAT assessment of incoming residents;
(b) the ongoing requirement for the prescribed percentage of concessional residents;
(c) compliance with certification;
(d) compliance with accreditation; and
(e) the Commonwealth planning ratios of 100 places per 1000 people aged 70+ per Local Government area continue.

Such an approach,

(a) circumscribes the total commitment the Commonwealth Government pays to the Nursing Home industry;
(b) consumers know that their commitment is 85% of the pension regardless. of their financial status;
(c) consumers who have resources in excess of the means tested pension can be approached by proprietors to make an accommodation payment which still leaves the consumer with the equivalent of two year's of the pension annualised by way of capital.
(d) further, eligible providers can access other forms of funding outside the jurisdictional constraints of the Commonwealth;

- Examples of funding options include:
- the Health Employees' Superannuation Trust of Australia;
- major life insurance companies;
- overseas borrowings;
- innovative models such as an industry trust fund.

The benefit of moving to a partially a deregulated model is that it would allow the industry to continue to meet Government demands, but at the same time be responsive to the market forces which are demanding enhanced Nursing Home services.

If Australia is to continue to show a leadership role in residential Aged Care the straightjacket of Government funding needs to be relaxed to the extent that the industry can operate to provide the full spectrum of services which the client group increasingly requires.

The Association believes that partial deregulation which it espouses should be incentive-based and incentive-driven.

The opportunity should exist for those providers who have met certification and accreditation to further access resources to upgrade their facilities and develop new programs and facilities.

Such an approach requires a delicate balance between Government funding and market opportunities.

A possible scenario is for eligible organisations to rebate up to 15% of recurrent per bed per day Government funding in exchange for the right to charge single room premiums. This rebating would only apply to funding for charged single ward rooms.

With the proposed deregulation, the Association accepts there must be continued compliance with the requirements already identified. The rebate of money back to the Commonwealth must be conducted in a manner which does not jeopardise the quality of services to the residents or the financial viability of the organisation.

1.2 NON-WAGE COSTS

C 1.2.1 LAND TAX

New South Wales

In NSW land for the purposes of nursing homes is exempted from land tax under Section 10(I)(g)(x) of the Land Tax Management Act of 1956.

Reference is also made to the definition of a nursing home under the terms of the Nursing Homes Act of 1988.

Victoria

In Victoria Land Tax is payable by nursing homes unless they are charitable, non-profit or public benevolent institutions. All other frail aged hostels and nursing homes are subject to land tax, but significantly retirement villages are exempt.

Queensland

In Queensland, the Queensland Land Tax Act of 1915 prescribes under Clause 13 Section 2(c)(5)(e) that nursing homes would be exempt if they met the criteria of qualifying exempt purpose being for the care of the sick, aged, infirm, inflicted or incorrigible persons or of children.

Tasmania

In Tasmania under the Land and Income Taxation Act of 1910, Section 10 on Land Tax, Sub-Section (e) provides for the exemption of land tax for land owned by or entrust for or invested in a hospitals board or any person or body of persons having the ownership, management, or control of a private hospital, a rest home or a convalescent home.

The above examples are sufficient to identify the differences in State legislation which again indicate that land tax is a cost to nursing home proprietors in some States but not others. Land Tax is not a cost which readily lends itself to any form of coalescence.

Further examples of other State imposed jurisdictional costs can be identified, but the total effect of all of these is to render any form of national coalescence of these costs inappropriate and not in the best interests of proper financial or . care management. These include but are not limited to:

- environmental protection measures as implemented by Water Supply Authorities, Environmental Protection Agencies, Local and State Governments;
- Occupational Health and Safety;
- Increased bank fees and associated Federal and State taxes (FID and BAD);
- Local Government rates and taxes rises resulting from Valuer General revaluation's;
- General insurance's premium increases due to crime etc well in excess of the rate of inflation.

C2.0 CAPITAL FUNDING

C2.1 INTRODUCTION

The cost of acquiring property to construct nursing homes varies markedly between the States and Territories. Sydney is the most expensive city to acquire land, and even though Melbourne and Brisbane land costs are edging up, there is still a huge disparity between the costs of land in Sydney and Hobart.

Nursing homes are required wherever the population is located. Proprietors and providers must acquire land and construct buildings to provide residential aged care services where there is identified need.

The State and Local Government authorities that regulate the construction requirements to be observed are tending to move to uniformity as is evidenced by the work of the TRG and the Building Code of Australia. Despite this apparent moving closer together, there are still some very strongly held varying opinions in State and Territory jurisdictions. Such matters as fire specifications and environmental issues are two examples. These are reflected in turn in costs and also in building design and style requirements.

An area where equity does not prevail is where older facilities are required to make significant capital investment in order to upgrade the facilities. In some cases such as the St Vincent de Paul facility, Loreto Nursing Home in Sydney (250 beds), the cost of the upgrade is so great that the proprietor, a religious order, has determined that it is more appropriate to close than to keep trying to upgrade to ever changing levels of building standard.

It is arguable that whilst the very best quality in buildings should be a target, the reality is that 90% of the population live in accommodation throughout their lives which they would like to upgrade but cannot afford to do so. Five star is not always affordable.

The fact that one moves ones place of abode from a private home to a nursing home should not make it necessary for five star accommodation to be provided at all times if this was not enjoyed by the resident during the course of their entire life. The issue of certification of buildings as part of the accreditation process should be seen in a proper perspective. Buildings should be appropriately safe and secure with upgrading taking place as resources permit.

The accreditation of aged care facilities will have significant cost impacts on providers, however these impacts, from what we have seen in the way of information to date will comprise a two tier fee system where all facilities pay a flag fall and a bed fee. If this is the case then some equity will prevail.

The Health Employees Superannuation Trust of Australia (HESTA) has commissioned Tasman Asia-Pacific Economic Management Policy Consultants to

prepare a briefing paper on options to address the capital funding crisis in the residential aged care industry.

The paper defines five options to address capital funding needs of the industry, including resident contributions, Commonwealth Government capital subsidies, debt, equity and fundraising through bequests and gifts.

Significantly, the paper goes on to say that if these five sources cannot meet the industry's funding needs, there are two possible scenarios:

1. The current practice of running down the capital stock will continue to the next century, involving closures and the contraction in the supply of residential aged care beds; or
2. The Government could allow the industry access to alternate funding sources. On that basis facilities would be able to meet rising building standards without closure.

As already canvassed in this report, - partial deregulation of the industry - it is significant that there is strong support from the industry generally, that the Commonwealth Government should allow the industry access to alternate funding sources.

The Association favours four funding options:

1. Amendments to accelerate the depreciation of residential aged care facilities for tax purposes
2. The introduction of an aged care infrastructure fund
3. Interest-free or subsidised interest capital loans that are repaid by the proceeds from service provider revenue streams
4. The right of accredited providers to charge premium payments on single ward accommodation in exchange for a rebate of up to 15% of Commonwealth funding.

C2.2 ADDITIONAL RECURRENT FUNDING

Parts VAB and VAC of the National Health Act 1953 provide for payment of additional Recurrent Funding (ARF) for a period of ten years based on 65% of the long term bond rate applied to the lesser of either:

- the cost of the project; or

- The difference between the average building cost per bed and the value per bed of an existing nursing home.

These payments recognise that the level of SAM is (and was) insufficient to provide an incentive to build or upgrade a nursing home. The ARF was accessed mainly by an
private enterprise service providers but it was available to d has been accessed by church and charitable organisations when funding for capital grants has not been available.

Non-profit organisations were also eligible for a capital grant under the Aged or Disabled Persons Care Act 1954. The introduction of the ARF was an attempt to introduce a more equitable funding situation across the sector.

There was therefore an agreement between the Department of Family Services and Health and certain eligible nursing home proprietors for the payment of ARF for the upgrading, rebuilding or building of nursing home premises.

Payments of ARF did not commence until the financial year 1991/1992.

An example of an ARF is a letter dated 8 December 1995 from the Commonwealth Department of Human Services and Health to a member (A), which approved a final grant for new and rebuilt nursing homes for the sum of $654,508 over ten years with a payment of $5,454.23 per calendar month paid through the recurrent funding payments system for the next ten years. Another nursing home to obtain an ARF was a member (B), which is also part of the member (A) Association.

Section s57-59 of the Aged Care Act 1997 introduced accommodation bonds. Nursing home providers with approval for ARF, and with facilities that meet specified building and care standards, have the option of retaining that funding or seeking accommodation bonds and receive a higher rate of subsidy for concessional residents. Providers who choose to continue to receive ARF will not be eligible for the concessional resident supplement.

The National Association has three members where nursing homes were sold prior to the Aged Care Act 1997. For example (see the letter of 11 December 1997 from member (C) who purchased the Nursing Home on 1 July 1996 from member (D) who received and continued to receive ARF of $2,217 per month until October 2004. If member (C) nominates to participate in the new Aged Care Act accommodation bonds the ARF payment will be deducted from the monthly funding advance. A similar problem appears to have been encountered by member B.

After various letters the Minister for Family Services on 22 May 1998 sent a letter to member (B). By this letter he agreed to pay out the full amount of the ARF owing to the previous proprietor so that no subsidy reduction will be necessary should member(B) seek certification (ie adopts new accommodation bond system). The problem of nursing homes acquired before the Act has been resolved.

Whilst this problem appears to have been resolved, the National Association letters of 15 June 1998 and 14 July 1998 to the Minister explain that there is still the problem for those nursing homes which have borrowed moneys to pay for improvements relying on ARF payments. If the nursing home wishes to be certificated under the Aged Care Act accommodation bond scheme it would have to give up its ARF. It was suggested that aged care facilities in receipt of ARF be allowed to maintain that level of funding for residents accommodated prior to 1 October 1997 should certification be accepted. Those residents entering a certified facility after that date should either pay an accommodation charge or receive concessional resident funding.

Certificated nursing homes receive a payment of $12 per resident per day. However, the National Association considers that this payment is for future work and the position is inequitable. Hunt & Hunt raised this matter in their letter of 30 April 1997 to the Minister and the Department's response of 23 June 1997 in the second paragraph of the second page states:

> "The requirement that that providers choose between additional recurrent funding and charging accommodation bonds recognises that both approaches have the same aim: to offset the cost of capital investment. The position of a provider who upgraded in 1995 and now has to service the cost of borrowing over 10 or more years, will not be significantly different to the position of a provider who undertakes work in 1997 or 1998 and has to service capital costs over a similar period."

The Association is pursuing the issue and has retained the services of an eminent QC and former Attorney General and Solicitor General.

3.0 OTHER SIGNIFICANT ISSUES

3.1 Future Demand Predictions

Whilst it is generally accepted that the Australian population is ageing and that a greater proportion of the population will reach 70 years plus, and indeed 80 and 90 years plus in the decades ahead, the evidence indicates this cohort moving through the system will be a much healthier cohort than has been the case in the past. This is due to a number of factors including nutrition, lifestyle, physical activity, the application of technology, medical advances and an increasing knowledge of the ageing process.

The public at large, and the baby boomers generation in particular, are far more inclined to seek out individual care services and in many cases pay to have these services in their own homes, rather than want to move to residential aged care facilities. The Commonwealth Government's commitment to increasing the number of community aged care packages and similar "at home" services is indicative of the pressure of the market place in wanting options for aged care service delivery, apart from specialist residential care.

There is also an industry providing "at home" services for ageing Australians who do not wish to move to specialist residential care.

All of that being acknowledged there will still be a long term steady growth for specialist residential aged care establishments.

There is also the prospect of increasing dependency of frail aged Australians as the very old cohort of the population ages in place. This is quite apart from any mental conditions that may arise as a result of dementia's or other mental disturbances.

The long term trend, at least until 2012 will be for increasing demand for all aged care services and residential aged care services in particular.

The focus of the inquiry into Nursing Home subsidies has been predicated on the assumption that a progressive increase in quality of services, and indeed the style and shape of services, will be looked after by the accreditation process. Nowhere does provision exist for consumers to actively challenge the style, shape, configuration, availability or affordability of residential care.

An aspect of the Association's argument for partial deregulation is to improve the residential care options, and provide opportunity for consumers to select from a range of options.
Arguably, the exempt beds process addresses this problem. For the upper end of the market this may be true, but for concessional residents and self-funded retirees of restricted means, the system provides very little choice. The Association would submit that a partial deregulation of the market would allow providers to talk to

consult with consumers and tailor residential care facilities in line with consumer desires.

There have been enough years of experience to know what can be delivered for what price. There is also enough data to identify the construction costs of residential care beds in aggregations of different sizes.

To provide greater variety and choice there is merit in establishing a joint consumer/provider mechanism to pilot some experimental models in residential care developments.

A positive role can be taken by the peak consumer groups in identifying changes which residents and potential residents would like to see in residential care. Such a group should be balanced to include participants who can cost the options that are desired and still meet accreditation standards.

The culture of residential care provision to date has been reflected in a fairly narrow range of building types, styles and services. What is required is the opportunity for input from a wide cross-section of people and disciplines to see whether the industry can deliver better care in better ways.

D. APPENDICES

Appendix 1	*Review of the Structure of Nursing Home Funding Arrangements Stage 1, Chapter 1 pp 1-8*
Appendix 2	*Review of the Structure of Nursing Home Funding Arrangements Stage 2, Chapter 1, pp 3-5*
Appendix 3	*List of Legislation Applying to Nursing Homes*
Appendix 4	*Staff Payroll Data - Explanation Sheet and Forms*
Appendix 5	*Wage Cost Differentials in the Four Different Jurisdictional Areas*
Appendix 6	*Payroll Tax Calculation Schedule*
Appendix 7	*Victoria State Government Gazette - Work Cover Insurance Premiums Order (No 6) 1998/99*
Appendix 8	*WorkCover Queensland letter on premium calculation*
Appendix 9	*Workers Compensation Insurance - WA*
Appendix 10	*New South Wales Government Gazette No 97 Insurance Premiums Order 1998-1999*
Appendix 11	*Australian Bureau o f Statistics - Information Paper - Wage Cost Index, Australia 1998 No 6345. 0*
Appendix 12	*Australian Bureau of Statistics - Information Paper - Wage Cost Index, Australia 1998 No 6346. 0*

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