17 September, 1998

Mr Mike Woods
Commissioner
Productivity Commission
PO Box 80
Belconnen ACT 2616

Dear Mr Woods

Inquiry into Nursing Home Funding

I have pleasure in sending you the attached submission on the Inquiry which has been developed in close consultation with our State Associations and has been unanimously endorsed by the Board of Aged Care Australia and its 6 State and Territory Associations.

Our submission includes an Executive Summary and 8 Appendices. The Appendices provide more extensive information and analysis upon which the recommendations and Executive Summary are based.

The submission canvasses a broad range of issues raised by the Productivity Commission and proposes 35 recommendations.

We wish to draw your attention to the following recommendations which deal specifically with the issue of coalescence:

Recommendation 31

Aged Care Australia recommends that high level care residents in those States and Territories which are relatively under-funded be funded at the national average rate for each applicable high care level with effect from 1 July 1999.

Recommendation 32

Aged Care Australia recommends that the review of the adequacy of residential care funding (to be undertaken in the context of the two year review of the restructure) be completed prior to any decisions being taken with regard to funding reductions for any high level care residents.

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Recommendation 33

Aged Care Australia recommends that the quantum of a national rate for each high level care classification under the RCS be determined in the context of the review of the adequacy of residential care funding, to be undertaken as part of the two year review of the restructure.
In addition, we would draw to your attention pages 9 and 10 of the Executive Summary regarding the purpose and limitations of the Relative Labour Cost Study undertaken for ACA by La Trobe University. Some of our State Associations will be providing complementary and supplementary material.

We trust that this submission will assist you in your deliberations and we would be happy to provide clarification or discuss any matters with you at any stage.

Yours sincerely

John Ireland
President

Aged Care Australia

Submission to the Productivity Commission

On Nursing Home Funding

15 September 1998

Executive Summary & Recommendations

Contents

Guiding Principles

In preparing this submission on the Inquiry, Aged Care Australia has been guided by three key principles:

Access - older people assessed as needing care in a residential aged care facility should be able to receive care appropriate to their needs on a timely basis, within their local community wherever possible, and irrespective of their financial status

Quality- older people should be able to receive the same quality of residential aged care throughout Australia; and the quality of care provided should be consistent with the standards for accreditation

Viability - residential aged care facilities must be able to operate as ongoing viable concerns.

These principles will also be used by Aged Care Australia to evaluate the outcomes of this Inquiry.

Recommendation 1

ACA recommends that in making its recommendations the Productivity Commission be guided by the key principles of access, quality and viability.

Desired Outcomes

ACA seeks the following outcomes from political decisions made as a result of the Inquiry.

Outcome 1: Funding Adequate for Quality Care for All Residents

Funding is sufficient to enable nationally agreed standards of care to be provided to all residents in nursing homes throughout Australia.

Outcome 2 Fair and Timely Access

There is timely and equitable access for all people assessed as needing residential care, including those who are living in rural/remote areas and/or those who are financially disadvantaged.

Outcome 3 Appropriate Indexation

Appropriate indexation arrangements are put in place to ensure that the value of funding reflects market costs and that the quality of care able to be provided is maintained over time.

There is a commitment to regularly review the funding arrangements to ensure that funding is adequate having regard to outcome standards and that any funding differentials to reflect relative costs beyond the control of service providers are appropriate and fair.

Outcomes 4 Flexibility to Manage Efficiently

Residential aged care service managers have the flexibility to manage their costs within a framework of adequate funding and effective quality assurance through the accreditation system.

Outcome 5 Managed Industry through Accreditation

Residential aged care continues to be a managed industry in order to safeguard the interests of older people who require care. However, the main vehicle for industry management should be via the accreditation system rather than other bureaucratic controls. Greater consumer access and choice should be promoted by allowing services which have a current 3 year accreditation to offer premium quality services on a structured fee-for-service basis.

Outcome 6 **Industry Stability and Viability**

The continuing stability and viability of residential aged care services are essential to safeguard the well being of residents in care. Changes arising from the Inquiry should be managed in such a way so as to promote the ongoing stability and viability of the industry. Given the major structural changes underway, further changes should be limited to those which add significant value in terms of equity, access, quality and/or viability.

Outcome 7 **Ageing in Place**

The objectives of the Aged Care Act 1997 to promote ageing in place and the development of a single residential aged care facility are not compromised.

(In this regard, any references to nursing homes throughout this submission also refer high level care places, whether they are in hostels or nursing homes.)

Outcome 8 **Charitable Status Protected**

The taxation status of church, charitable and not-for-profit providers of residential aged care is protected.

Outcome 9 **Administrative Efficiency**

Administration arrangements are streamlined so that the primary focus of accountability is through the accreditation system and transaction costs are minimised.

Recommendation 2

ACA recommends that the Productivity Commission put forward recommendations relating to the funding of nursing homes which are consistent with the desired outcomes identified by ACA.

Structure of the Nursing Home Industry; Its Context & Future Directions

***Refer to **Appendix 1** for a more detailed examination of these issues.

Facility Size

Since 1992, the nursing home industry has re-structured substantially with respect to facility size resulting in an average 41 % reduction in the number of facilities with less than 25 places. This has occurred fairly uniformly across jurisdictions.

There are significant differences among the jurisdictions in relation to the proportion of very small facilities (<25 places) reflecting differences in population distribution. The Northern Territory, Tasmania and Victoria have the highest proportions of small facilities.

Access to Nursing Homes

Access to nursing homes varies among the jurisdictions and is highest in the Northern Territory and NSW and lowest in the ACT and Victoria. In terms of location, access is best in capital cities and poorest in remote areas.

Access to permanent nursing home care has declined significantly over the past decade. Current policy in relation to the population planning ratios will see further declines in the future, resulting in an estimated shortfall of 12,500 places by 2011. Access has diminished most in major urban areas (not capital cities) and rural areas. In most States and Territories reduced access to permanent nursing home care has not been fully compensated by increased access to hostel care or Community Care Packages and this is especially the case for remote areas.

Nursing Home Residents

Nursing homes provide accommodation and care mainly for very frail, elderly people during the last months or years of life and are increasingly providing care (including palliative care) following discharge from hospital. They provide a cost-effective alternative to continuing care in acute hospitals in a more homelike environment. Given the high proportion of admissions to nursing homes from hospitals, any further decline in the accessibility of nursing homes will impact on the acute health sector.

The dependency profile of residents varies significantly among the States and Territories and has changed over the past 6 years. There has been no research to investigate the reasons for these differences which may possibly highlight implications for service provision and care practices.

Current Context

Supply controls on the provision of nursing home places since 1986 have curtailed expenditure by some $1 billion a year resulting in significant net savings for Government. By contrast, under-compensation of cost increases has resulted in a real reduction in nursing home funding of about $128 million since 1996.

The restructure of residential aged care services presents significant challenges and uncertainties for the industry. In particular, 39% of nursing homes face funding reductions as a result of the new funding allocation instrument (the Resident Classification Scale (RCS)). These reductions are occurring at a time when the industry faces significant new unfunded cost imposts associated with accreditation.

Aged Care Australia has worked assiduously on behalf of its members to ensure that the restructure will enable residential aged care services to maintain and enhance the quality of care they provide to residents. ACA's Strategic Management Development and Training Project will provide access to relevant training and management tools which will further enhance the management and planning capability within the industry.

Future Directions in Aged Care

More aged care services are required in order to address the current levels of unmet need, as well as to meet the increase in demand associated with population ageing.

The accessibility of nursing homes has declined since 1992 and further substitution of nursing home services would not be advisable. The supply of aged care services must be increased to meet the current and future demand and a range of services must be provided which are responsive to the diverse needs and aspirations of older people.

From a policy, planning and service delivery perspective, it would be beneficial to delineate the housing and care roles and to see them as separate but linked elements of aged care provision. For example, residential aged care has typically been perceived as a provider of care but it is also a major supplier of housing. Greater clarity about the different components of service provision would ensure, for example, that the housing implications of changes to accessibility of residential care is not overlooked. It would also be appropriate for the funding arrangements in respect of the housing and care components to be more transparent - this does not mean separate payment arrangements.

Such an approach would assist in promoting greater program flexibility and service innovation which would in turn increase the range of options available to older people. It would also encourage a greater focus on the housing needs of older people which are often overlooked.

Recommendation 3

ACA recommends that in making its recommendations the Productivity Commission take into account the 41% reduction in the number of small facilities between 1992 and 1997 and the decline in accessibility of nursing homes (particularly in rural areas).

Recommendation 4

ACA recommends that research be carried out to identify the reasons for significant differences among the jurisdictions with regard to the assessed levels of dependency of residents in order to highlight any implications for service provision and care practices.

Recommendation 5

ACA recommends that the Productivity Commission take into account the fact that supply controls on nursing home places since 1986 have resulted in reduced expenditure of $1 billion a year; and that under-compensation of cost increases has resulted in a real reduction in nursing home funding of about $128 million since 1996.

Recommendation 6

ACA recommends that the Productivity Commission take into account the significant challenges and uncertainties presented by the residential aged care restructure and, in particular, the fact that 39% of nursing homes are expected to receive reductions in recurrent care funding at a time when they are facing new unfunded cost imposts in relation to accreditation.

Recommendation 7

ACA recommends that the Productivity Commission note the efforts by the industry to further enhance its strategic planning and management capability.

Recommendation 8

ACA recommends that the Productivity Commission take into account in framing its recommendations: the need for more aged care services to address current and future needs; the importance of providing a continuum of care which is responsive to a diverse needs and aspirations of older people; the desirability of "unpackaging" the housing and care components in order to promote greater program flexibility, increased innovation in service provision and more adequate provision of housing options for older people who are homeless or living in insecure accommodation.

Labour Costs

*** Refer to **Appendix 2** for a more detailed examination of labour costs and related issues.

Variations in Award Rates

Comparisons of nursing staff award rates among the jurisdictions indicate that these vary among the jurisdictions. The relativities vary depending on the award level being compared and they also vary over time. This has implications for maintaining funding equity over time.

Variations in Regulations and Award Conditions

The average number of qualified nursing hours provided on a weekly basis to nursing home residents varies within and between jurisdictions and is not determined solely by minimum regulations or award conditions. The care needs of residents, facility size, management philosophy and the affordability of nurses also appear to be important factors in determining staffing mix (and hence labour costs).

Variations in Average Earnings of Non-Managerial Staff

The average weekly ordinary time earnings of full-time non-managerial employees of non-public sector hospitals and nursing homes in 1996 varied among the jurisdictions by around 7% compared with the national average. However, this is likely to result from a combination of price and staff mix differences and is also likely to be influenced by the relative proportions of hospitals and nursing home staff included in the Employee Earnings and Hours Survey in each jurisdiction.

Relative Labour Cost Study Undertaken by La Trobe University

*** Refer to **Appendix 3** for a detailed report by the Lincoln Gerontology Centre at La Trobe University on the relative labour cost study commissioned by ACA.

ACA commissioned La Trobe University to undertake a relative labour cost study using 11 notional baskets of staff mix.

The notional baskets of staff mix are <u>not</u> prescriptive but act as a proxy for determining whether there are cost differences in delivering the same standard of care (as measured by staff mix). The study therefore examines relative staff costs without the impact of differences in staff mix.

The relative labour cost study is <u>not</u> a costing study and therefore is only indicative of labour cost relativities among the jurisdictions, at this point in time.

There are limitations to the relative cost study, as indicated in the report. These include:

- it does not take into account known future increases in wages which will occur in the near future but which were not operative at the time the study was conducted

- it does not take into account differences in cost which would need to be researched, such as the cost impact of leave provisions which are determined by the actual incidence at which leave is taken. As the industry must pay for replacement staff as well as leave entitlements, the associated costs are significant

- it does not take into account differing legislative requirements or prevailing industrial practices which may mean that certain elements of one or more of the notional baskets of staff mix could not be applied in practice within a given jurisdiction. In this regard, it is appropriate for ACA's State Associations to note in their submissions to the Productivity Commission such differences which would have an impact on labour costs not reflected in the relative labour cost study.

It is therefore important that the limitations of this study are understood and recognised and that care is taken by the Productivity Commission in interpreting the findings. In particular, the relative labour cost study does not:

- indicate the actual costs of providing care among the jurisdictions
- indicate an appropriate quantum of funding
- indicate appropriate baskets of staff mix to provide quality care.

In these regards our State Associations may choose to present the Productivity Commission with the outcomes of their own particular studies.

Capacity to Control Labour Costs

Nursing homes have virtually no control over the price of qualified nursing staff as the price is determined by the public health sector which employs around 85% of qualified nurses.

There are very significant wage disparities between the public and non-public sectors of the hospital and nursing home industries and this disparity has increased since 1994. Non-government nursing homes are therefore price takers in relation to the cost of staff, particularly qualified nursing staff who are in short supply.

Public sector wage rates will drive further price increases for qualified nurses in nursing homes and unless funding arrangements permit greater parity, current recruitment, retention and morale problems will deteriorate with consequent detriment to care.

In relation to workers' compensation, nursing homes have limited ability to control their costs due to the impact of State and Territory Government policies and management practices on costs.

Scope for Productivity Increases

The opportunities for productivity gains by nursing homes through enterprise bargaining or through the substitution of labour inputs with equipment are extremely limited. This is due to: the nature of the industry, quality care standards, the high level of productivity and staff flexibility that already exists, and insufficient funding or productivity gains to offset further changes in working conditions. In addition, changes to funding under the RCS and the costs of the new accreditation system effectively impose unfunded productivity increases on nursing homes.

Recommendation 9

ACA recommends that the Productivity Commission takes into account the dynamic nature of varying relativities in award rates among the jurisdictions (within awards and over time) in considering appropriate nursing home funding arrangements.

Recommendation 10

ACA recommends that the Productivity Commission note that the care needs of residents, facility size, management philosophy and the affordability of nurses appear to be as important as minimum regulations and award conditions in determining staff mix in nursing homes.

Recommendation 11

ACA recommends that the Productivity Commission note the objectives, limitations and findings of the study of relative labour costs conducted for ACA by La Trobe University; this indicates that the range of funding relativities among the States and Territories for high level care residents is currently much larger (22%) than indicated by the study of relative labour costs (5% to 7%).

Recommendation 12

ACA recommends that the Productivity Commission note that nursing homes have virtually no control over the price of qualified nursing staff; that the more generous public sector award rates are likely to drive further price increases for qualified nurses in nursing homes; and that unless funding arrangements permit greater parity, current recruitment, retention and morale problems will deteriorate.

Recommendation 13

ACA recommends that the Productivity Commission note that the scope for productivity gains in nursing homes through enterprise bargaining and the substitution of labour inputs with equipment is extremely limited.

Non-Labour Operating Costs

Bentleys 1995/96 Survey

The Bentley's 1995/96 survey of nursing homes provides the largest set of available data on actual (SAM) operating expenditure by nursing homes. While it provides a good general picture of variations in expenditure (and, by implication, costs) the survey size is too small for very detailed analyses.

The variations in expenditure among nursing homes in the survey suggest that they occur for a range of reasons including:

- variations in facility size
- variations in ownership type
- variations in location - State or Territory and city/metro/rural
- variations in management practices
- variations in accounting practices.

Variations within the same categories (states, city/rural, facility size etc) seem to be as significant as variations between categories.

Recommendation 14

ACA recommends that the Productivity Commission note that the non-labour operating costs of nursing homes vary within and between jurisdictions and appear to be due to a range of factors including: facility size; ownership type; location; management and accounting practices.

Capital Costs

*** Refer to **Appendix 4** for a more detailed examination of capital costs and related issues.

Variations in Land and Building Costs

There are significant variations in building costs among the jurisdictions as indicated by:

- Consumer Price Index of housing costs among the capital cities
- the Housing Industry Association's Multi-Unit Building Cost Index.

The building costs of nursing homes vary considerably and are clearly influenced by the amount of space provided per bed and the level of fitout and technical sophistication. This reflects a relationship between cost and quality.

In the past, Commonwealth capital funding policies, such as the Locality Allowance, have in principle recognised that rural and remote areas face additional building costs due to their relative isolation from capital cities; however, it is not known to what extent any differential capital funding was adequate to cover the extra costs.

Land costs are highly variable within and between jurisdictions. However, they are likely to be relatively homogenous within a local community and this is a relevant consideration where there is a component of user-pays funding towards the capital cost of residential care accommodation.

Impact of Regulations and Certification on Building Costs

The current review of the Building Code of Australia as it applies to residential aged care facilities will put in place a national regulatory framework which will apply to all new residential aged care facilities in the future.

However, past experience would suggest that the State and Federal Government Agencies will continue to play a role in scrutinising building plans and specifications for facilities and they may continue to impose conditions and requirements which are not stipulated in the Building Code of Australia.

While the new Certification Instrument will apply in all jurisdictions, its cost implications for existing facilities are likely to vary depending upon the age of facilities and the past standards they were required to meet by the relevant State and local government bodies.

Improvements to fire safety, privacy and space standards will increase substantially the cost of building and upgrading residential aged care facilities. The resulting

increase in the capital funding requirements is in addition to the major backlog of upgrading identified in the Gregory Report.

In addition, the improvements to privacy and space standards will add to the recurrent funding costs of nursing homes - such as energy, insurance and staff costs.

Funding Implications

It is desirable for capital and recurrent funding streams for nursing homes to be separately identified in order to promote transparency, stewardship, and accountability.

It would be desirable for there to be greater flexibility so that accommodation charges paid by financially eligible residents requiring high level care can be more closely linked with their capacity to pay and the varying costs of land and building. This would provide for more adequate capital income streams for upgrading and rebuilding than at present.

In the short term, accommodation charges will not provide sufficient capital to undertake upgrading required for certification and accreditation - for this reason ACA has called on the Government to provide access to a capital loans fund.

Accommodation charges will also not address the need for up-front capital funding for new nursing home places to provide for growth in line with the population planning ratios. More adequate capital funding is also required for nursing homes in rural and remote areas and for nursing homes which cater predominantly for financially disadvantaged residents.

Recommendation 15

ACA recommends that the capital and recurrent funding streams for nursing homes be separately identified in order to promote transparency, stewardship and accountability.

Recommendation 16

ACA recommends that there be greater flexibility so that accommodation charges paid by financially eligible residents requiring high level care can be more closely linked with their capacity to pay and to variations in the cost of land and building.

Recommendation 17

ACA recommends that the Productivity Commission note in considering the future funding arrangements for nursing home that there is a significant and long-standing capital shortfall which will not be adequately addressed through accommodation charges; and that ACA has outlined policy recommendations to address this in its 1998 Federal Budget Submission.

Indexation

***Refer to **Appendix 5** for detailed report on indexation by Hal Swerissen, Director, Primary Health Care Research and Development Centre, at La Trobe University, commissioned by ACA.

Labour Costs and Indexation

Labour is the major cost component of aged care residential services and the sector has comparatively little capacity to improve productivity through labour replacing technology.

This means that unit labour costs are likely to increase over time. As this happens, governments must choose between increasing funding to maintain services, restricting access to services to fewer people, or reducing the quality of the services provided.

Increased unit labour costs in residential aged care are largely driven by the acute care sector which employs 85% of qualified nursing staff. However, the acute care sector is more technology oriented and has a greater capacity for productivity gains; whereas the opportunities for productivity improvements are extremely limited in the residential aged care sector. Consequently, unit labour costs for the residential sector are likely to rise more quickly than those for the acute sector. Without additional funding the only option is reduce the quality of care provided.

Impact of COPO Indexation

The primary purpose of the COPO wage cost indexing arrangements was to prevent supplementation for productivity based wage increases by discounting average wage costs. The difference between the Safety Net Adjustment (SNA) and the Average Weekly Ordinary Time Earnings (AWOTE) movement should reflect productivity offsets achieved through enterprise bargaining. However, in practice the opportunities for productivity offsets by residential aged care services are limited and are unlikely to match those in other sectors, particularly the acute care sector.

As a consequence there has been substantial under-compensation of nursing home subsidies for wage movements since the introduction of the COPO indexation arrangements in 1996. This is estimated to be $128 million (refer to Appendix 6).

It is inevitable that if the SNA continues to be used as the basis for indexation nursing homes will be forced either to reduce the standard of care provided by employing lower qualified staff or they will progressively become non viable.

Wage Cost Index

The introduction of the COPO indexation arrangements was intended as an interim measure. The use of the SNA was to be reviewed in the light of the development by the ABS of a Wage Cost Index (WCI) in time for the 1998 budget.

The Wage Cost Index measures changes in the price of labour for constant quality and takes account of workforce fluctuations. Specific industry indices have been developed within the Wage Cost Index and includes one for the Health and Community Services industry.

As the costs of the residential aged care services are primarily driven by wage outcomes in the public sector, the appropriate index is therefore the Health and Community Services Public Wage Cost Index.

Where differential rates of change in AWOTE among the jurisdictions are consistent and entrenched over time, the use of a national index would lead to the risk that the quality of nursing home care in under-compensated States may fall. In such circumstances, the relevant State/Territory Health and Community Services Public Index should be used.

A more comprehensive Labour Cost Index is under development by ABS and will include non-wage labour costs. This is expected to be completed in about 2 years. Consideration should be given to using the appropriate Labour Cost Index when it becomes available.

Recommendation 18

ACA recommends that the Wage Cost Index (Health and Community Services, Public Sector) be used to index the labour component of residential aged care subsidies; that where differential rates of change in AWOTE among the jurisdictions are entrenched over time, the relevant State/Territory measure of this index be used; and that consideration be given to using the Labour Cost Index (Health and Community Service, Public Sector) once it becomes available.

Recommendation 19

ACA recommends that the Treasury Measure of Underlying Inflation (TMU1) continue to be used to index the non-labour component of residential aged care subsidies.

Recommendation 20

ACA recommends that there be a one-off increase to the pool of funding for high level care residents in 1999/00 of $128 million in order to restore the funding lost through under-compensation due to the use of the COPO index.

Facility Size & the Viability Supplement

***Refer to **Appendix 6** for a more detailed examination of these issues.

Impact of Facility Size on Costs

Small nursing homes are more likely to face higher costs beyond their control, are less able to control factors which influence their income (such as resident mix) and are more vulnerable to fluctuations in income than larger nursing homes.

Consumer Access

It is important to ensure that consumer access to residential aged care is not further eroded due to the non-viability of small facilities.

Correlation Between Facility Size and Rural/ Remote Location

As there is likely to be a fairly strong correlation between small-sized nursing homes and location in rural and remote areas, it is considered that facility size rather than location would provide a better basis for differential funding in relation to inescapable cost differences.

The Viability Supplement

Currently around $6 million is allocated to the viability supplement which is payable in respect of eligible nursing homes and hostels. This does not even represent 1 tenth of one percent of the total funding on residential aged care.

While the eligibility criteria for the viability supplement are well-targeted, it is questionable whether the amount of funding assistance it provides is adequate and this should be investigated as a matter of priority.

24 Hour Top-Up Funding

The phasing out of 24 hour Top-Up Funding must be taken into account in considering the adequacy of the viability supplement.

Recommendation 21

ACA recommends that additional funding for small-sized residential aged care facilities be provided through the viability supplement; and that the Productivity Commission recommend that the adequacy of the viability supplement, taking into account the phasing out of the 24-Hour Top Up Funding, be reviewed as a matter of priority.

Quality Care, Consumer Choice & Funding Options

*** Refer to **Appendix 7** for a more detailed examination of these issues.

Quality Care

Optimal Staffing Mix

Research conducted by Alan Pearson et al in 1990 found that quality of care for residents is determined by a wide range of factors, including: the attitudes and motivation of staff, leadership and management style, and the physical and social environments. It concluded that it is difficult to produce defensible, prescriptive percentages for optimal staffing mix. There would be value in updating this research.

Accreditation Standards

The new aged care accreditation system provides a comprehensive and measurable framework for measuring the quality of care provided to residents. The four accreditation standards take into account the range of variables which contribute to quality care and therefore provide a much better basis for assessing quality than using a proxy such as staff mix.

Consumer Choice

Facilitating consumer choice is an important part of quality care and it should start from the time a person makes an inquiry about admission to a nursing home.

While it may not always be possible to meet the preferences of consumers, it is clear that more needs to be done to facilitate choice regarding the nursing home to which a person is admitted. The accreditation system will play an important role in enhancing consumer choice by providing better information about the quality of services and by not accrediting and not funding poor quality services.

However, there is also scope to refine the existing arrangements relating to consumer contributions and income testing in order to further facilitate consumer choice. This must be done, however, in the context of ensuring that there is universal access to quality care consistent with the standards for accreditation by all residents, irrespective of their location or financial situation. (This is outlined in more detail on page 21 and in Appendix 8).

Funding Options

Funding Adequacy

The two year review of the residential aged care restructure will examine the adequacy of funding to deliver quality care to the standards required for accreditation. As the standards for accreditation are raised over time, the adequacy of residential care subsidies must also keep pace with those improvements.

Funding Based on Assessed Care Needs

The new Resident Classification Scale (RCS) has recently been the subject of an extensive consultative review process and further refinements will take effect from 1 November 1998. The review found that the RCS is generally an effective discriminator of relative care needs and therefore achieves its objective as an instrument for allocating funding.

The allocation of residential care funding should continue to be based on the assessed relative care needs of residents.

Criteria for Evaluating Various Funding Approaches

The following criteria are suggested for evaluating various funding approaches:

1 . *Funding adequacy:* will the funding approach deliver funding adequate to provide quality care outcomes for consumers? Does it take into account the extent to which services are able to control and manage their costs and income?

2. *Funding equity: will* the funding approach enable services with different inescapable costs to provide the same standard of care for residents? Will it maintain funding over time as cost relativities change?

3. *Universal access:* will the funding approach ensure universal access by people assessed as needing residential care irrespective of their location or ability to pay? Will it ensure that a high quality of care, consistent with accreditation, is provided to all residents who are financially disadvantaged?

4. *Incentives for quality and efficiency:* is there scope within the funding approach to encourage and reward quality and efficiency? Does it provide flexibility to manage the funding to achieve quality and efficiency improvements?

5. *Administrative efficiency*: will the transaction costs of the funding approach be efficient and affordable? Will the funding arrangements be easy for consumers to understand? Will implementation costs be funded and will they be justified by ongoing overall improved outcomes from the funding arrangements?

Future Funding Methodology

Aged Care Australia intends to produce a discussion paper regarding funding methodologies for residential aged care services by the end of October. It is hoped that this will contribute to informed debate on an appropriate and rational funding methodology for residential aged care services.

Percentage Based Subsidy Arrangements

The option to fund nursing homes on the basis of a percentage of total costs (with or without a maximum $ cap) is not supported as the potential advantages are outweighed by the disadvantages. The disadvantages include: administrative complexity; focus on inputs rather than outcomes; pressure to impose a maximum $ cap would diminish its responsiveness to varying costs; potential variability and complexity in resident contributions; and price signals could be mistaken for quality signals.

Paying Subsidies Directly to Residents

The option to pay subsidies directly to nursing home residents is not supported as such a market approach does not take into account the special characteristics of nursing home residents or features of the nursing home market. It would not ensure universal access to quality care irrespective of capacity to pay. Quality care is best facilitated through the accreditation system rather than relying on the bargaining power of residents.

Resident Contributions and Income Testing

The role of resident contributions and income-testing in relation to residential aged care services needs to be reviewed in order to:

- generate income for improvements in the overall quality of accommodation and care services offered to all residents by residential aged care facilities

- enable consumers to exercise greater choice in relation to the quality of residential care services they receive and the quality of accommodation in which they reside

- ensure universal access to quality care and accommodation consistent with accreditation by all residents irrespective of their capacity to pay.

This could be done by:

- reducing or removing the resident contribution income-test so that more flexible extra services arrangements can apply, as outlined below

- increasing the scope for residential care facilities which have achieved 3 year accreditation to offer extra services to residents by reducing the minimum daily extra service fee which must be charged (currently $10 a day) and by removing the limit on the number of extra service places which may be approved, subject to requirements that Concessional residents ratios are met

- limiting the future approval or renewal of extra service places to residential care facilities which have a current 3 year accreditation

- according priority to approved providers which have achieved 3 year accreditation when considering applications for new residential care places.

Changes to the current residential care income test and extra services arrangements, as proposed above, would help to stimulate further increases in the overall quality of residential care and accommodation which would benefit all residents. The number of residents who could pay for extra services at any stage will be modest. However, limiting the ability to offer and charge for extra services to residential care services which have a 3 year accreditation would ensure that all residents in that facility are receiving quality services. It would also provide an incentive and a potential additional income stream for further quality improvements.

Continuous improvement is expected to drive the accreditation system and to deliver quality improvements over time. This will benefit all residents, especially as the residential care funding system must guarantee universal access to quality services consistent with accreditation to all residents, irrespective of their financial position.

Funding Methodologies to Promote the Integration of Support for Residential and Community Care

A primary objective of funding policy in aged care must be to enhance the care and accommodation options available to older people to ensure that wherever possible they receive the care they need in the place they would most prefer to receive it.

This does not necessarily require common funding approaches or integrated management. However, it would be desirable to facilitate greater flexibility and transparency with regard to funding arrangements so that the choices and options become more apparent to both consumers and providers.

The application of common principles (such as funding linked to assessed care needs and accreditation; access to quality care services based on need not capacity to pay, etc) and greater clarity regarding the components of funding (such as the component for care as distinct from board and lodging) may facilitate greater synergy between residential and community care services and improved flexibility and choice.

Recommendation 22

ACA recommends that the Productivity Commission note that a wide range of factors contribute to quality care; that all these factors are included in the accreditation standards; and that accreditation provides a much better basis for assessing quality care than using a proxy such as staff mix.

Recommendation 23

ACA recommends that the Productivity Commission note that the accreditation system will play an important role in enhancing consumer choice and in improving the quality of care.

Recommendation 24

ACA recommends that the Productivity Commission ensure that any new funding arrangements for high level care residents provide universal access to quality care consistent with the standards for accreditation, irrespective of their location or financial situation.

Recommendation 25

ACA recommends that the Productivity Commission note that the two year review of the residential aged care restructure will examine the adequacy of funding to deliver quality care to the standards for accreditation.

Recommendation 26

ACA recommends that the allocation of residential aged care funding should continue to be based on the assessed relative care needs of residents.

Recommendation 27

ACA recommends that in considering various funding approaches the Productivity Commission apply the criteria for evaluating various funding approaches outlined by ACA.

Recommendation 28

ACA recommends that the Productivity Commission note that Aged Care Australia intends to produce a discussion paper regarding funding methodologies for residential aged care services by the end of October.

Recommendation 29

ACA recommends that the Productivity Commission note that ACA does not support percentage based subsidy arrangements or paying subsidies directly to residents.

Recommendation 30

ACA recommends that the role of resident contributions and income testing be reviewed in order to generate income for quality improvements in residential aged care and to enable consumers to exercise greater choice in relation to the standard of care and accommodation they receive.

Implementation Issues

There are a number of important implementation issues to be considered with regard to changes to the funding arrangements for nursing homes arising from the Inquiry.

Timing of Any Funding Changes

There are two critical time frames which should be considered in relation to implementation:

- the accreditation date of 1 January 2001

- the completion of the two year review of the residential aged care restructure which will consider, among other matters, the adequacy of residential care funding to provide quality care consistent with accreditation - this is expected to be completed by the end of 2000.

These two time frames are important for the following reasons:

- residential aged care facilities in States and Territories which are currently under-funded through the subsidies they receive for high level care residents should not be disadvantaged with respect to their capacity to provide quality care and to meet the standards for accreditation. **This means that they must have received greater funding equity (at least the national average subsidy rates) with effect from 1 July 1999.** Further funding adjustments above the national average would be made pending the review of funding adequacy in the context of the two year review of the restructure, chaired by Dr Len Gray.

- there should be no reduction to the high level care subsidies payable in the other States and Territories pending the review of the adequacy of residential care funding in the context of the two year review of the residential aged care restructure

- the quantum of the national rate for each high level of care under the RCS should be determined in the context of the review of the adequacy of residential care funding to be conducted as part of the two year review of the residential aged care restructure.

Restoration of Lost Indexation Funding

An estimated $128 million has been lost to the nursing home sector due to under-compensation of cost increases through the use of the COPO index (refer to Appendix 5 on Indexation).

It is considered that the Government should restore this $128 million to the residential aged care funding pool for high-level care residents with effect from 1 July 1999 and that it should be used, in the first instance, to meet the following funding priorities:

1. To increase the residential care subsidies payable in respect of high level care residents in those States and Territories which are currently relatively under-funded compared to the national average rate with effect from 1 July 1999.

2. To provide more adequate funding to small-sized facilities through the viability supplement.

Funding Methodology Linked to Outcomes for Consumers

Any change from the current historical basis for funding implicit in the current residential care subsidy rates will require the development of a new funding methodology, so that there is a rational basis for funding in the future.

It is ACA's intention to develop a discussion paper which will consider a range of funding methodologies and their respective advantages and disadvantages with a view to stimulating an informed debate about possible and desirable future directions. Consideration will be given to ways of establishing a stronger relationship between funding and quality outcomes for consumers.

Whatever direction is ultimately chosen, further empirical work will be necessary and this could be done in the context of the review of the adequacy of residential care funding to provide quality care consistent with accreditation standards.

This would mean the development of a more appropriate funding methodology over the next two years. This would also fit in well with the fully-fledged operation of the new accreditation system.

Transition Management Assistance

A substantial proportion of nursing homes (39%) already face funding reductions due to the impact of the new Resident Classification Scale and this is occurring at a time when they are facing new unfunded cost imposts associated with accreditation.

For these reasons, it is important that the review of funding adequacy be completed prior to any changes and that it should determine the quantum of the national rate for each high level of care under the RCS.

Recommendation 31

Aged Care Australia recommends that high level care residents in those States and Territories which are relatively under-funded be funded at the national average rate for each applicable high care level with effect from 1 July 1999.

Recommendation 32

Aged Care Australia recommends that the review of the adequacy of residential care funding (to be undertaken in the context of the two year review of the restructure) be completed prior to any decisions being taken with regard to funding reductions for any high level care residents.

Recommendation 33

Aged Care Australia recommends that the quantum of a national rate for each high level care classification under the RCS be determined in the context of the review of the adequacy of residential care funding, to be undertaken as part of the two year review of the restructure.

Recommendation 34

Aged Care Australia recommends that the $128 million under-funding which has occurred since 1996 due to the under-indexation of high level care subsidies be restored with effect from 1 July 1999; and that it be used, in the first instance to meet the following priorities: 1) to fund the increase in high level care subsidies to the national average for residents in those States and Territories which are currently relatively under-funded; 2) to provide more adequate assistance to small-sized facilities through the viability supplement.

Recommendation 35

Aged Care Australia recommends that transition management assistance be provided to facilities providing high level care in the event that there are future funding reductions based on the study of funding adequacy; and that this include management advice and program flexibility.

Appendix 1

Structure of the Nursing Home Industry

Current Context and Future Directions

This paper examines the following structural aspects of the nursing home industry:

- facility size
- accessibility of nursing homes by location
- the role of the not-for-profit sector
- resident profile and lengths of stay.

It is important that the Productivity Commission has regard to these aspects of the industry in considering the funding arrangements for nursing homes.

It also considers the current context and the future directions of aged care provision, as these must be taken into account in determining appropriate future funding arrangements for the provision of high level care.

1 Structure of the Nursing Home Industry

a Facility Size

Nationally

As at 30 June 1997, there were 1466 nursing homes throughout Australia. The proportion of nursing homes by facility size was as follows[i].

30 June 1997 Number of Places	Number of Facilities	Proportion
less than 10	14	1%
10 to 24	126	9%
25 to 49	749	51%
50 to 74	337	23%
75+	240	16%
Total	**1466**	**100%**

A comparison with the structure of the nursing home industry 5 years earlier shows that there has been a considerable reduction in the number of smaller sized facilities (less than 25 places):

30 June 1997 Number of Places	Number of Facilities	Proportion
less than 10	22	2%
10 to 24	217	15%
25 to 49	650	45%
50 to 74	310	21%
75+	245	17%
Total	**1444**	**100%**

Over the 5 year period, the proportion of small facilities (less than 25 places) declined by 41%. The number of new facilities increased by only 1.5%[ii].

States and Territories

Nationally, in 1997, 10% of nursing homes had less than 25 places. As the following table demonstrates, the incidence of small facilities varied significantly among the States and Territories:

	No facilities <25 places @ 30.06.97	Proportion
NT	4	57%
Tasmania	12	22%
Victoria	69	16%
WA	10	9%
SA	13	8%
Queensland	11	5%
NSW	21	4%
ACT	0	0%
National	140	10%

These state differences in the proportion of small facilities are likely to reflect variations in population distribution. However, to the extent that there are demonstrable economics of scale for larger sized facilities,
the differing proportions of small facilities among the States and Territories may be a factor contributing to differing costs.

While the proportion of small facilities varies among the jurisdictions, the decline in the number of small facilities since 1992 has been reasonably consistent across all States and Territories (with the exception of the ACT which had no small facilities and the Northern Territory which increased the number of small facilities from 3 to 4):

	Change in the % of Nursing homes (<25 places) since 1992
NT	+ 33% (1 new facility)
Tasmania	-40%
Victoria	-41%
WA	-50%
SA	-43%
Queensland	-39%
NSW	-44%
ACT	n.a. (no small facilities)
National	-41%

Since 1992, the nursing home industry has re-structured substantially with respect to facility size and
this has occurred fairly uniformly across jurisdictions.

b Accessibility of Nursing Homes by Location

Information regarding the number of permanent residents in nursing homes per 1,000 population aged 70+ provides a measure of the accessibility of nursing homes by location.

Nationally, as at June 1997, there were 46.7 permanent nursing home residents per 1,000 population 70+[iii]. However, this varied by State and Territory with the highest proportion of the aged population in nursing homes in the Northern Territory (57.7/1000 70+) and NSW (51.7/1000 70+) and the lowest proportions in the ACT (32.9/1000 70+) and Victoria (42.3/1000 70+).

There are also marked differences in the accessibility of nursing homes by location -ie capital city, other major urban, rural and remote areas.

Accessibility of nursing homes is highest in capital cities which in June 1997 had 51.5 permanent nursing home residents per 1,000 population aged 70+. The poorest level of access was in remote areas which had 35.1 permanent nursing home residents per 1,000 population aged 70+.

There are significant differences among the States and Territories with regard to nursing home provision by location. For example, Tasmania offers the highest degree of accessibility to nursing homes in remote areas (129.4/1000 70+ - a factor which contributes to the higher proportion of small facilities in that State) compared with only 7.5/1000 70+ in NSW and no access in remote areas of South Australia.

Recent Trends in Accessibility

The accessibility of permanent nursing home care has declined substantially since 1991/92,[iv] due to changes to the balance of care provision. Accessibility of permanent nursing home (high level) care is expected to decline further as provision is brought

into line with the revised population planning ratio of 40 permanent nursing home (high level care) residents per 1,000 population 70+ (compared with 47.7 in 1997). Even if nursing homes were to cater only for the most dependent residents (RCS levels 1 to 3), a significant shortfall of 12,500 nursing home places is projected to occur by 2,011.[v]

Nationally, the accessibility of nursing home care has declined by 6% since 1995 However, the greatest declines in accessibility have occurred in major urban areas (-7%) and rural areas (-7%). There have also been significant declines in accessibility in remote areas of NSW (-12%).

Diminished access to permanent nursing home care has not been fully compensated by increased access to hostel care or Community Aged Care Packages (CACPs) over the same period. Only two States (NSW and Queensland) have increased access since 1995 to the three forms of care provision (nursing homes, hostels & CACPs) and these gains have been modest (1%). Access to all three forms of care has declined in remote areas, by an average of 9%.

Overall access to permanent nursing home care has declined significantly over the past decade and current policy in relation to the population planning ratios will see further declines in the future, resulting in an estimated shortfall of 12,500 places by 2011. Access has diminished most in major urban areas (not capital cities) and rural areas. In most States and Territories reduced access to permanent nursing home care has not been fully compensated by increased access to hostel care or CACPs and this is especially the case for remote areas.

c The Not-for-Profit Sector's Role in Nursing Home Provision

As at June 1997, 74,013 nursing home places were provided nationally. The role of the various sectors in providing nursing home care was as follows:

	Proportion of Nursing Home Places as at June 1997
Not-for-Profit	38%
Private	48%
Government	14%

However, the roles of the various sectors in nursing home provision varies significantly among the States and Territories. The not-for-profit sector provides the majority of nursing home places in the Northern Territory (70%), Tasmania (64%), and South Australia (52%). The not-for-profit sector has the lowest levels of involvement in provision in Victoria (25%), WA (35%) and NSW (37%).

The Government sector plays the most significant role in Victoria, providing 27% of nursing home places. Changes are under way in that State to reduce the Government's

role in nursing home provision through privatisation. It remains to be seen what impact this will have on provision by the not-for-profit sector within that State.

d Resident Profile and Lengths of Stay in Nursing Homes

Typically, nursing home residents are widowed women, aged 80 years or more who, after living alone prior to admission, rely on a higher level of care than ever before and are in receipt of a pension. [vi]

An in-depth study of nursing home residents in 1995/96 found:

- 50% of nursing home residents needed more than 23 hours of care each week and a further 37% required 19 to 24 hours of care
- 50% of admissions were from hospitals
- 85% of separations from nursing homes were due to death (50% within 1 year of admission).[vii]

In June 1997, the length of stay of 34% of residents in nursing homes was less than 1 year and more than half of all residents had been resident for less than two years. [viii]

Nursing homes provide accommodation and care mainly for very frail, elderly people during the last months or years of life and are increasingly providing care (including palliative care) following discharge from hospital. They provide a cost-effective alternative to continuing care in acute hospitals and a more homelike environment. Problems with access to nursing home care will impact on the acute health sector.

Variations in the Dependency Profile of Residents

The dependency profile of residents in nursing homes, as measured by classifications of their relative care needs, has varied among the jurisdictions for some time. For example, as at 30 June 1992, the proportion of residents assessed as RCI 1 and 2 was as follows[ix.]

	RCI 1	RCI 2	Total
ACT	14.1%	44.0%	58.1%
NSW	4.7%	26.6%	31.3%
NT	10.8%	42.6%	53.4%
Queensland	3.3%	30.6%	33.9%
SA	3.4%	32.4%	35.8%
Tasmania	4.0%	30.2%	34.2%
Victoria	5.4%	36.8%	42.2%
WA	3.9%	33.3%	37.2%
National	**4.5%**	**30.6%**	**35.1%**

This shows that, with the exception of the smaller Territories, Victoria had a substantially higher proportion of more dependent residents than the other States; the proportion of more dependent residents was also above average in WA and SA.

By comparison, the most recent information available on the distribution of the most dependent residents using the new Resident Classification Scale is as follows[x]:

	RCI 1	RCI 2	Total
ACT	5.2%	21.6%	26.8%
NSW	7.4%	24.9%	32.3%
NT	3.5%	35.9%	39.4%
Queensland	7.8%	23.4%	31.2%
SA	5.1%	23.4%	28.5%
Tasmania	5.2%	21.6%	26.8%
Victoria	8.4%	25.6%	34.0%
WA	3.7%	22.9%	26.6%
National	**7.1%**	**24.3%**	**31.4%**

Among the States, Victoria still has the highest proportion of the most dependent residents; however, there have been marked declines in the proportions in WA, SA and Tasmania.

The reasons for this are not clear and there is a concern that this may be partly due to differing validation practices in relation to the classification instrument among the States and Territories. Although only 5% of classifications are subject to validation, the validation outcomes have a strong influence on subsequent classification behaviour.

Other factors which may contribute include:

- differences in the accessibility of nursing homes
- differences in the provision of alternative home-based care options
- differences in care practices among nursing homes - for example in relation to the role of nurses, and the focus on rehabilitation and maintaining function
- differences in competency in classifying residents.

It is considered that it would be worthwhile to research the reasons for the differing proportion of highly dependent residents in nursing homes. Such research may help to promote a better understanding of the dynamics at play which may in turn influence service provision and care practices.

The dependency profile of residents varies significantly among the States and Territories and has changed over the past 6 years. There has been no research to investigate the reasons for these differences which may possibly highlight implications for service provision and care practices.

2 Current Context

In considering any changes to the funding arrangements for nursing homes, it is important that due consideration be given to changes over the past decade and the current context.

Balance of Care

Since 1986, the Commonwealth Government has closely controlled the supply of residential aged care places. In particular, it has reduced the provision of nursing home (high level care) places and increased the supply of hostel (low level care) places, Community Care Packages and Home and Community Care Services. This has been managed through adjustments to the population planning ratios and by the development of the Home and Community Care Program.

By managing the balance of care provision since 1986, the Commonwealth has reduced expenditure by around $1 billion a year compared to the expenditure growth that would have occurred if the supply controls had not been applied[xi]. Not all of these savings have been invested in aged care services (as indicated by the Commonwealth funding of the HACC program which is $519 million in 1998/99), with the result that there have been substantial net savings to Government achieved through supply controls on nursing homes. Regrettably, very little of these savings have been used to address the capital funding problems facing nursing homes.

The use of the COPO index under-compensates for cost increases and has resulted in an estimated reduction in nursing home funding of around $128 million dollars since 1996."

Supply controls on the provision of nursing home places since 1986 have curtailed expenditure by some $1 billion a year resulting in significant net savings for Government. By contrast, under-compensation of cost increases has resulted in a real reduction in funding of about $128 million since 1996.

Industry Restructure

A major restructure of residential aged care services commenced on 1 October 1997. The changes impact on all areas of service provision and management, including:

- the introduction of a new Resident Classification Scale to determine the amount of recurrent care funding payable in respect of each resident

- the integration of the hostels and nursing homes within a single residential aged care system so as to facilitate ageing in place for residents

- new arrangements for capital funding based on accommodation charges (high level care) or bonds (low level care) paid by residents; the withdrawal of variable

fees payable by new (low level care) residents; and a significant reduction in the capital funding program for low level care facilities

- the requirement that services meet new certification requirements in order to be able to charge accommodation bonds or charges

- the development of a new aged care accreditation system; all residential aged care services must achieve accreditation by 1 January 2001 in order to receive recurrent funding and to charge accommodation bonds/charges.

The scale and complexity of the changes to be implemented within a relatively short period have presented significant challenges to the industry and the Department. There have been significant transition problems, particularly in relation to payments, which have added to the stress and workload.

Impact of the Resident Classification Scale

Changes to the allocation of funding, using the new Resident Classification Scale, have created considerable uncertainty. The final report of the Independent Review on the RCS has confirmed that there will be considerable variations in the impact of the new arrangements on services. For example, while funding overall for nursing home(high level care) residents is expected to increase by 1%, 38.7% of nursing homes are expected to receive funding reductions of which 8.7% will receive funding decreases of $5 or more per resident per day[xiii]. The study also found that Queensland and South Australia will face reductions in the funding they receive for high level care residents, whereas Victoria will experience the most substantial increase. Furthermore, nursing homes in capital cities will experience slightly better funding outcomes than those in other locations.[xiv]

The restructure of residential aged care services presents significant challenges and uncertainties for the industry. In particular, a significant proportion of nursing homes face funding reductions as a result of the new funding allocation instrument (the RCS). These reductions are occurring at a time when the industry faces significant new **unfunded** cost **imposts associated with accreditation.**

Strategic Management Development and Training Project

In order to facilitate the industry restructure, Aged Care Australia has negotiated funding from the Department of Health and Family Services to carry out a three-stage Strategic Management Development and Training Project. It will:

1. Identify a range of financial, organisational and quality benchmarks which will form the basis of a self-evaluation checklist which can be used by organisations to assist them in developing their own continuous improvement processes and targets.

2. Develop appropriate and relevant management tools and a planning framework to assist the industry to improve its strategic management capacity.

3. Offer a structured training course in every State and Territory, as well as opportunities for agencies to come together to pursue the application of the management and planning tools in ways which best meet their needs.

Aged Care Australia has worked assiduously on behalf of its members to ensure that the restructure will enable residential aged care services to maintain and enhance the quality of care they provide to residents. ACA's Strategic Management Development and Training Project will provide access to relevant training and management tools which will further enhance the management and planning capability within the industry.

3 Future Directions in Aged Care

The Productivity Commission has indicated that it wishes to consider the future directions in aged care provision in considering the funding arrangements for nursing homes. In particular, it has expressed an interest in views regarding the potential for further substitution of nursing homes with home care options.

Substitution of Nursing Home Care with Home Care Options

The discussion earlier in this paper on the balance of care indicates that there has been significant substitution of nursing home care over the past decade - by increased provision of hostels, community care packages and Home and Community Care (HACC) Services. This is also reflected in the decline in accessibility of nursing homes over the same period.

In considering the provision of aged care services, the balance of care provision must be considered in relation to the need for aged care services. Controls on the supply of residential aged care places have meant that provision relative to demand is tight and this is reflected in high occupancy levels and very limited choice in relation to available nursing home places. Further substitution of nursing home (high level care) places with hostel (low level care) places is also planned through the realignment of the population planning ratios (from the current level of around 47 places to 40 places per 1,000 70+).

With regard to home and community care services, there is considerable evidence that demand greatly exceeds supply. For example, in the 1993 ABS Survey of Disability, Ageing and Carers, 42,900 principal carers of people aged 65 years and over reported an unmet need for support. Insufficient funding to meet needs was also confirmed in the 1995 review of the HACC program which concluded that it was only half way towards meeting the current demand for services and faced the challenge of this demand growing at 2.7% a year.[xv]

More aged care services are required in order to address the current levels of unmet need, as well as to meet the increase in demand associated with population ageing.

A range of service options must be provided so as to facilitate consumer choice and to respond to the diversity of needs and preferences. Residential aged care services must continue to be part of the continuum of services offered and are particularly suited to meeting the care needs of very frail older people with significant care needs who were previously living alone, who are suffering from cognitive disorders, and/or who require post acute or palliative care on a 24 hour basis.

Home care options for very frail, dependent older people are generally more feasible when a carer is available and willing to partner in the provision of care. The contributions of carers must not be taken for granted.

Given the extent to which nursing home services have already been substituted by other forms of aged care services, the need to increase the supply of aged care services to meet current and future demand, and the importance of ensuring a range of services are available to meet the diverse needs and aspirations of older people and their carers, further substitution of nursing home services would not be advisable.

Greater Program Flexibility - Linking Housing and Care

Residential aged care services are major suppliers of housing and are as important in this regard as public rental housing and rent assistance for older people combined.

However, the housing role of aged care providers is generally overlooked due to the focus on their role as providers of care.

From a policy, planning and service delivery perspective, it would be beneficial to "unpackage" the housing and care roles and funding arrangements and to see them as separate but linked elements of aged care provision.

Such an approach would assist in promoting greater program flexibility and service innovation which would in turn increase the range of options available to older people. For example, there are a number of new initiatives which provide housing for older people and link in appropriate community care services as they are required.

It would also encourage a greater focus on the housing needs of older people which are often overlooked. For example, it is inappropriate to meet a housing need by providing residential aged care to older person who does not need personal care services. The removal of funding for hostel care only residents is designed to prevent this from happening, but no complementary initiative has been put in place to address the housing needs of older people who are homeless or at risk of homelessness.

[i] Data supplied by the Department of Health & Family Services, August 1998

[ii] Data supplied by the Department of Health & Family Services, August 1998

[iii] Steering Committee for the Review of Commonwealth/State Service Provision, Report on Government Services 1998, Volume 2 Community Services, Housing, Industry Commission, 1998, Table

[iv] ibid, page 581

[v] Gibson, Diane Aged Care Old Policies New Problems, Cambridge University Press, Melbourne, 1998, p 60.

[vi] Australian Institute of Health & Welfare, Media Release, 11 December 1997

[vii] ibid

[viii] Australian Institute of Health & Welfare Australia's Welfare 1997, Canberra, 1997, p 265.

[ix] Department of Health, Housing, Local Government and Community Services, Nursing Homes for the Aged: A Statistical Overview (1991-1992), Table 5. 1, p 52

[x] Cuthbertson, Sandy et al, Review of the Resident Classification Scale Aged and Community Care Service Development and Evaluation Report No 36, DHFS, July 1998, Table 2.10, p31

[xi] Andrew Podger, Secretary, Department of Health and Family Services, "Our Ageing Population: Implications for Policy Planning", Speech given to CEDA, 12 April 1998.

[xii] This is covered in more detail in Appendix 6 on Indexation

[xiii] Cuthbertson, op cit, p 40

[xiv] ibid, p32 and p 35

[xv] The Efficiency and Effectiveness Review of the Home and Community Care Program , Aged and Community Care Service Development and Evaluation Report No 18, DI-IFS, June 1995, p 15 and p ix.

Appendix 2

Labour Costs

State / Territory Variations in Nursing Home Labour Costs

There is a range of information sources about the labour costs of nursing homes nationally and in each State and Territory. These include:

a State Specific Award Rates

Different awards, rates and conditions apply to nursing home staff in each jurisdiction, contributing to variable staff costs. These have been summarised in the paper entitled "Variables Which Drive Nursing Staff Costs" sent to the Productivity Commission on 28 August 1998.

A comparison of award rates for nursing staff at 8 comparable levels across the various jurisdictions was undertaken in mid August. It indicated that the award rates for qualified nurses were generally highest in NSW (6 out of 8 levels compared) and Tasmania (2 levels). WA had the lowest wages for 4 of the 8 levels compared; Victoria had the lowest wages for 3 levels and NSW for 1 level. Compared with the national average award rate for each of the levels compared, the range of variation among the jurisdictions was 22% (at the highest level) and 8% at the lowest levels.

However, since that comparison was done, the award rates have increased in Queensland and NSW. This emphasises the dynamic nature of labour costs and the fact that relativities among jurisdictions will vary over time, as award rates in one or more jurisdiction change.

Comparisons of nursing staff award rates among the jurisdictions indicate that these vary among the jurisdictions. The relativities vary depending on the award level being compared and they also vary over time. This has implications for maintaining funding equity over time.

b State Specific Staff Regulations and Award Conditions

Variations in regulations and award conditions may also contribute towards variable labour costs among the States and Territories. Examples include the stipulation of nursing staff: resident ratios in the Nurses (Victorian Health Services) Award 1992 and in qualified staffing requirements in regulations which govern the administration of drugs and poisons in each jurisdiction. These have been summarised in the paper "Variables Which Drive Staff Costs".

However, while awards and regulations may stipulate minimum requirements, they do not necessarily determine best practice to achieve quality care. While the nursing staff ratio requirements in Victoria do not apply in other jurisdictions, they impose

additional costs only to the extent that actual staffing practices in Victoria are different from those in the other States and Territories.

A comparison of typical staffing rosters provided by 41 nursing homes throughout Australia indicates that there is some variation in the use of qualified nursing staff (registered and enrolled nurses). For example, the following table indicates the average number of qualified nursing hours provided per resident per week:

	Hours per resident per week
State	**Average**
ACT (2 facilities)	10.0
NSW (14 facilities)	12.2
SA (5 facilities)	11.2
Tasmania (3 facilities)	14.1
VIC (7 facilities)	14.1
WA (10 facilities)	11.9

The above analysis suggests that many facilities determine their qualified nurse staffing having regard to the needs of residents and outcome standards rather than minimum regulations.

The use of qualified nursing staff also varies in relation to facility size, as the following table indicates:

	Hours per resident per week
Facility Size - No of Places	**Average**
< 40 (18 facilities)	13.2
40 to 59 (13 facilities)	12.1
60 to 79 (4 facilities)	12.3
80 + (6 facilities)	10.5

The above analysis suggests that there is a correlation between facility size and the number of qualified nursing hours provided per resident per week. [1]

The average number of qualified nursing hours provided on a weekly basis to nursing home residents varies within and between jurisdictions and is not determined solely by minimum regulations or award conditions. The care needs of residents, facility size, management philosophy and the affordability of nurses also appear to be important factors.

In regard to the use of qualified nursing staff, it is relevant to note that CAM (Care Aggregate Module) funding was based on the following notional mix of care staff :

Registered Nurse	32.5%
Enrolled Nurse / Assistant in Nursing	59.5%
Therapy staff	8.0%

In addition one hour of a Director of Nursing's time was included for each resident per week.

c Employee Earnings and Hours Survey

The Employee Hours and Earnings Survey (EEHS) conducted by the Australian Bureau of Statistics (ABS) in 1994, 1995 and 1996 provides industry specific information on employee hours and earnings. As such it provides the best available information on the average weekly wage costs of a selected sample of **all employees** in each industry. [2]

ACA has obtained customised data from the EEHS on the average weekly ordinary time earnings of private sector non-managerial full-time Employees of hospitals and nursing homes (a subdivision of the health and community. services industry). Community sector not-for-profit nursing homes are included in the private sector data.

The 1996 data indicates that there is a 7% range in AWOTE in each jurisdiction compared with the national AWOTE for all full-time non-managerial employees of private sector hospitals and nursing homes. This does not include the ACT. [3]

The EEHS does not give a precise indication of labour cost differentials for nursing homes because of the inclusion of hospitals. However, it does provide some indication of cost differentials among the jurisdictions for all staff employed within the industry. However, this will be determined to some extent by staff mix differences.

The average weekly ordinary time earnings of full-time non-managerial employees of non-public sector hospitals and nursing homes indicates varies among the jurisdictions by around 7% compared with the national average. However, this is likely to result from a combination of price and staff mix differences and is also likely to be influenced by the relative proportions of hospitals and nursing home staff included in the Employee Earnings and Hours Survey in each jurisdiction.

d Relative Cost Study of Notional Baskets of Staff Mix

ACA has commissioned the Lincoln Gerontology Centre at La Trobe University to undertake a relative cost study based on 11 notional baskets of staff mix.

The notional baskets of staff are not prescriptive but act as a proxy for determining whether there are cost differences in delivering the same standard of care (as measured by staff mix).

The 11 notional baskets of staff mix were selected from typical weekly staff rosters provided by 41 nursing homes throughout Australia. The selection was made having regard to:

- facility size - small, medium and large
- location - capital city, other metropolitan, rural and remote
- typical care needs of residents at the facility - mainly dementia care, mainly high level nursing care, mainly activities of daily living and personal care or combinations of these.

Our objective was to use a good range of notional staff mixes based on real situations in order to provide a robust methodology which would ensure that the relative labour costs identified were not an artefact of one particular basket of staff mix. It would also enable the relative labour costs due to labour price differences rather than differences in staffing models to be identified.

A report on the relative labour cost study undertaken for ACA by the Lincoln Gerontology Centre is included as **Appendix 3.**

e Labour On-Costs

Labour on-costs include:

- workers compensation long
- service leave
- superannuation
- payroll tax.

Up until 30 September 1997, these labour-related costs were funded under the OCRE (other cost reimbursed expenditure) funding component. The OCRE average bed day costs in 1994/95 indicate that on average nationally $7.06 per resident per day was funded for these costs. The proportion for the various on-costs components was as follows:

National Average	**$ per day**	**% of On-Costs**
Workers' Compensation	$2.62	37%
Payroll Tax (all homes)	$1.44	20%
Superannuation	$2.34	33%
Long-Service Leave	$0.67	10%
Total	**$7.06**	**100%**

In 1994/95 the average OCRE payments in each State and Territory varied considerably, as shown by the following chart:

OCRE Average 1994/95	$ per day	% variation from national average
ACT	$9.00	127.45%
NSW	$7.11	100.68%
NT	$6.83	96.76%
QLD	$4.99	70.73%
SA	$8.02	113.62%
TAS	$8.37	118.47%
VIC	$7.54	106.80%
WA	$7.36	104.26%
National	**$7.06**	**100.00%**

Four years ago, the average OCRE was lowest in Queensland and the Northern Territory and highest in the ACT and Tasmania.

Since the Department of Health & Family Services will not make available the average national and state OCRE payments for 1996/97 or 1997/98, it is not possible to measure the change in average OCRE payments over the period.

Workers' Compensation

Workers' compensation levies comprise a significant component of labour on costs (37% in 1994/95).

The following workers' compensation levies (not adjusted for claims history) apply to nursing homes as at 1 July 1998:

NSW	5.57%
QLD	4.40%
SA	6.90%
VIC	3.95%
WA	5.15%

A flat rate levy does not apply in Tasmania or the ACT. In Tasmania the workers' compensation levy charged to nursing homes varies from 5% to 6.5% and is typically closer to 6.5%.

Leave Provisions

OCRE provided funding for long service leave. However, all types of leave may contribute to differential labour costs among the States and Territories, depending on the extent to which the leave provisions are utilised.

Variations in the leave provisions in all current applicable awards are commented on in Appendix 3: The Relative Labour Cost Study.

Superannuation

While this is an important and rising component of costs, information provided by State Associations indicates that the Superannuation Guarantee Charge (SGC) applies in all cases. As this is a standard rate, superannuation contributes to relative costs only to the extent that there are differences in wage costs among the States and Territories.

To what extent can the labour costs of nursing homes be controlled?,

a Price of Qualified Nursing Staff

Qualified nurses constitute a significant proportion of nursing home staff. A survey of 21% of nursing homes in 1989/90 identified the following care staff mix in nursing homes: [4]

	Median - % of Staff	Average - % of Staff
Registered Nurses	28.9	29.2
Enrolled Nurses	12.4	19.7
Nurse Assistants	52.2	46.0
Therapists	5.0	5.1

Qualified nurses (registered and enrolled nurses) therefore comprise on average around 50% of care staff in nursing homes.

Nursing homes have virtually no control over the price of qualified nursing staff as the price is determined by the public health sector which employs around 85% of qualified nurses.

The public sector currently pays more for qualified nurses than residential aged care facilities in most jurisdictions. This is demonstrated in the following comparison of first year Level 1 Registered Nurses as at May 1998:

$ per fortnight	Public Hospitals	Non-government nursing homes	% Difference
NSW	$1123.20	$1101.20	2.0%
Victoria	$1103.80	$1007.40	8.7%
Queensland	$1089.60	$1064.30	2.3%
WA	$1075.80	$1011.20	6.0%
SA	$1058.40	$1058.40	0.0%
Tasmania	$1079.00	$1010.90	6.3%
ACT	$1156.70	$1011.10	12.6%
NT	$943.10	$1011.10	-6.7%

The disparity in wage rates for Level 1 Registered Nurses in May 1998 was most acute in Victoria, WA, Tasmania and the ACT. Changes in the public sector award

rates for nurses in SA since May 1998 have meant that there is now a 3.3% disparity in that State; also changes since May 1998 in the public sector award rates in WA since May 1998 have further increased the disparity in that State.

Examination of the average weekly ordinary time earnings for all non-managerial employees of hospitals and nursing homes recorded in the Employee Earnings and Hours Surveys in 1994, 1995 and 1996 indicate that public sector hospitals and nursing homes generally pay significantly higher average weekly ordinary time earnings than the private sector (including the community sector). In 1996, the public sector national AWOTE for all non-managerial full-time employees of hospitals and nursing homes was 19% higher than for the non-public sector. Furthermore, the disparity had increased since the earlier 1994 survey.

There are significant wage disparities between the public and non-public sectors of the hospital and nursing home industry and these have increased since 1994. Non-government nursing homes are therefore price takers in relation to the cost of staff, particularly qualified nursing staff which are in short supply. As current nursing home subsidies do not provide adequate funding for parity with the public sector, nursing homes are finding it increasingly difficult to recruit and retain qualified nursing staff. This situation will worsen as the value of funding erodes due to under-compensation of labour cost increases under present indexation arrangements.

b) Productivity Gains

The opportunities for productivity gains in the nursing home industry through enterprise bargaining or by substituting labour inputs with equipment are very limited for the following reasons:

- Nursing homes provide **personal care** to frail and highly dependent people on a full-time 24 hours 7 days a week basis - there must be staff on duty all the time and most of the personal care needs of residents require the delivery of care on a one to one basis.

- Compared to many other industries, it has a very flexible and committed work force and there is evidence that some staff already work unpaid overtime in order to keep up with the demands of their jobs.

- The scope for substituting labour inputs with equipment is very small given the personal service nature of the nursing home industry. For example, continence management programs should be used wherever possible to maintain function; labour saving devices (such as continence pads) should only be used when continence management programs (such as regular toileting) are not effective.

- In comparison with the public health sector, nursing homes are already achieving a much higher level of productivity from staff and there is already considerable pressure to address this by increasing remuneration for current productivity.

- The new accreditation system will require nursing homes to implement continuous improvement processes in all areas of activity; this will require a significant amount of additional work that is not funded and thus represents an implicit expectation of unfunded productivity increases within the industry.

- A significant proportion of nursing homes (39%) face funding reductions due to the new Resident Classification Scale [5] due to the redistribution of the funding pool; this represents an implicit expectation of unfunded productivity increases by these facilities.

The level of enterprise bargaining within the industry to date has been very modest (with the possible exception of Queensland). This has been hampered by the inability of the industry to come up with sufficient productivity gains to offset improved conditions and opposition to enterprise bargaining by some unions representing qualified nurses.

In at least one instance in NSW, a proposed enterprise agreement will be legitimising and rewarding staff for flexible working conditions under which employees have been working on an informal basis for some time. In that instance there will be no new productivity gains to offset the wage increase agreed to.

In another instance in NSW, proposals for an enterprise agreement have been abandoned because sufficient productivity increases could not be found.

The scope for productivity increases by nursing homes through enterprise bargaining and the substitution of labour inputs with equipment is extremely limited. This is due to the following factors: the nature of the industry - providing 24 hour personal care services; quality care standards; the high level of productivity that already exists; and insufficient funding or productivity gains to offset the cost of further changes in working conditions. In addition, changes to residential care funding due to the RCS and new unfunded imposts (such as accreditation) represent expectations for unfunded productivity increases by the industry.

c Cost of Workers' Compensation

Nursing homes have limited ability to control the cost of workers' compensation. To some extent they can reduce the rate of workers' compensation they pay by having a very good claims history. Effective occupational health and safety programs help to limit work-related injury and thereby contain costs. However, nursing homes still have limited control over these costs due to the policies and practices of State Governments.

For example, mismanagement of the fund by the NSW State Government is resulting in significant levy increases to cover debt. In that State, there is also a significant difference in the rate of workers' compensation charged to nursing homes compared with public sector hospitals. This is because there is an incentive for State

Governments to reduce the cost for State-funded services relative to those for Commonwealth-funded services.

[1] A survey of nursing homes conducted in 1989/90 found that there is a very strong relationship between the percentage of registered nurses and the size of the home. See: Pearson, Alan et al Optimal Skills Mix for Desired Resident Outcomes in Non-Government Nursing Homes, AGPS, Canberra, 1990, p 68.

[2] The size of the total sample for the EEHS is substantially larger than that used for the AWE. While the AWE collects information in relation to the total employment of organisations selected for inclusion in the survey, the EEHS collects information in relation to a sample of employees within each of the organisations selected.

[3] The ACT figure may be inflated due to the greater predominance of hospital compared with nursing home staff

[4] ibid, p 22.

[5] Cuthbertson, Sandy et al Review of the Resident Classification Scale, Aged & Community Care Service Development & Evaluation Report No 36, July 1998, DHFS, page 40.

Relative Costing Study Purposes

Purposes

- To develop a methodology for estimating relative labour unit costs in nursing homes, which would facilitate comparison of such costs across states.

- To apply this methodology to notional baskets of staff mix based on staff rosters in Aged Care Australia affiliated nursing homes, with the aim of estimating the extent of relative cost differences for the same baskets of staff mix.

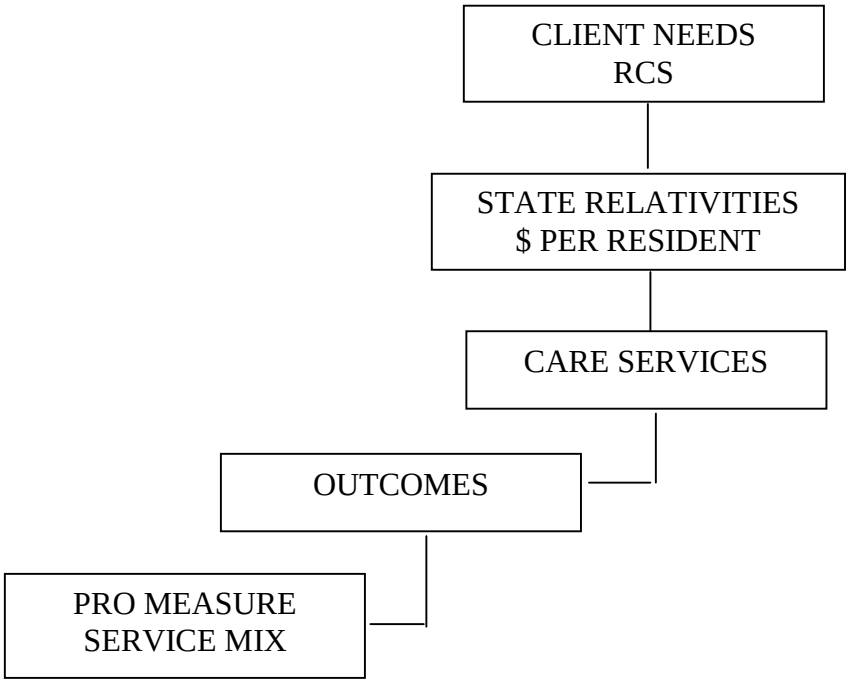
- To provide information to Aged Care Australia for its submission to the productivity Commission. The Commission is examining differential subsidies for high level care residents.

Method

In broad terms the method adopted involved the construction of notional baskets of staff mix which were then costed using state specific cost data. This approach helps to identify the extent to which there are relative cost differences between states for the same baskets of staff mix. The notional baskets of staff mix are not prescriptive: they act as a proxy for determining whether there are cost differences in delivering the same standard of care, as measured by staff mix.

The approach is illustrated in the following diagram which is based on one developed during a workshop involving Aged Care Australia, representatives from State Associations and La Trobe University.

CONCEPTUAL DIAGRAM



Client needs are the appropriate starting point for a funding system. As the diagram illustrates, client needs are established through the RCS. On the basis of the RCS result, per resident funding is provided to a nursing home. However, the amount provided to the nursing home for a resident at a specific RCS level is dependent on historically established relative costs of providing care in a state or territory. With the funds provided, the nursing home provides care services to residents. These care services are provided predominantly through care staff of different types and it is the staff and staff related costs which are the subject of this study. Non-staff costs are specifically excluded. Care services contribute to a range of outcomes in terms of quality of care. If data were available on these direct outcomes of care services, it would be possible to examine costs for similar outcomes. In the absence of such direct outcome measures, the approach taken in this study has been to use as a proxy measure of outcome., the mix of staff services provided per resident per week. By costing each staff service mix at the costs specific to a state or territory we are in effect controlling for differences in outcome and are then able to estimate the relative cost differences between states for equal outcomes. B choosing a range of typical staff mix baskets we are able to examine whether factors y such as location or type of care provided, influences the relative costs between states and territories.

The method adopted involves a compromise between attempting to reflect differences between states in the levels at which employees are typically employed and achieving comparability in levels across states. The approach adopted in this study is to use the closest comparable level of employee in each state, based on years of experience. However, if a state typically employs staff at a higher or lower level than in other states, this real cost difference will not be reflected in the relative costs. Where such differences have been identified, they are mentioned in the commentary on specific models. In addition, two of the models have been run with higher salary levels applied to all states, in order to establish whether this results in different relative costs between states.

The method adopted has been designed to:

Provide a comparison of the cost of providing a specific basket of staff mix, across states, at comparable employee classifications.

Within a State, provide a measure of the costs of providing different baskets of staff mix. This in turn provides some information on the factors which influence the costs of different baskets.

The estimates presented in this report are designed to estimate relative costs of different staff mixes between states. They do not purport to estimate the full unit cost of providing services.

Data Collection

The method was operationalised by requesting State Associations to seek at least 8 high level care facilities in their state or territory to provide a sample staff roster for a typical week. In making this request, State Associations were asked to select at least one facility of each of the following types:

- one facility in a rural or remote area
- one small-sized facility (<25 places)
- one medium sized facility (25 to 74 places)
- one large sized facility (75 places or more)
- one facility which caters mainly for residents with dementia.

A proforma was developed for data collection. The first section collected information on the characteristics of the facility providing a roster. The characteristics were those thought likely to influence costs. They were:

- *Location :* capital city, other metropolitan, rural and remote;
- *Organisational arrangements:* stand alone or co-located with other facilities or services;
- The number of usual residents;
- The care needs of residents at the facility:

⇒ Mainly dementia care or behavioural problems;
⇒ Mainly a high level of nursing care;
⇒ Mainly activities of daily living and personal care.

The second part of the pro forma was the typical roster which asked, for each category of employee:

- the level or classification;
- total hours worked by shift on weekdays, Saturdays and Sundays.

A total of 39 rosters were received, of which 36 were useable. No rosters were received from Queensland. Information on the characteristics of the facilities providing rosters is included in Table 1.

Initial analysis of the hours of care provided by each facility was used to identify areas for further analysis in the modelling part of the study. Care hours were defined as those hours provided by health professionals. They excluded hours for hotel services and administration. In Table 1, the mean number of care hours per resident per week is given for a range of characteristics of the nursing homes included in the study. The strength of the relationship between average care hours and each characteristic was tested but no statistically significant result was obtained on any of the characteristics. This is partly a function of the small numbers in the study and partly of the method of selection. However, the size of the facility and the state in which it was located had the strongest relationship to the number of care hours provided.

TABLE 1: Hours of Professional Care [1] per Resident per Week

Organisational Arrangements	*Mean Hours*	*Number of cases*	*Standard Deviation*
Stand alone	23.2	11	7.5
Co-located	21.2	25	3.0
Location			
Capital City	22.0	12	4.1
Provincial City	24.0	7	8.0
Rural	20.2	13	3.4
Remote	22.3	4	3.7
State			
NSW	21.8	12	1.8
VIC	18.4	7	2.9
ACT	21.7	2	2.5
TAS	25.0	2	7.6
WA	25.3	8	7.2
SA	19.6	5	4.6
Care Type			
Dementia	22.1	8	4.9
High Level	22.4	18	5.3
ADLs	19.1	3	4.3
Dementia/high	21.3	5	4.1
All	20.1	2	4.7
Number of Beds			
Less than 40	20.8	13	4.4
40-74	23.4	16	5.4
75 or more	19.8	7	3.3

All State Associations provided award salary rates, together with information on award conditions for leave and superannuation. They also provided the rate for Workers' Compensation premiums in their states. Award salary rates were provided by the Northern Territory and the ACT, but arrived too late for inclusion in the modelling of relative costs. However, the method could equally be applied for the territories.

[1] Professional care is defined as the time provided by all health professionals from the DON to activity Officer. It excludes time provided for the provision of other services such as food services, cleaning etc. and administrative functions.

Data Limitations

The completed proforma's provided good information on the typical rosters requested. There were, however, some difficulties in the data collection which limited the scope of the study to some extent:

- Employee level was not consistently completed. This meant that it was not possible to model fine distinctions between, for example, more senior registered nurses and less senior. This has been handled in the modelling by taking a relatively low and a relatively high salary level in two separate models.

- During the course of the study, a number of states reported salary increases. All changes up to September 1, 1998 are incorporated in the model, but a state or territory in which there is a lag in award increases will appear with a lower unit cost than may be justified.

- Not all costs are included in all baskets, particularly catering and cleaning where these have been contracted out. However, as the interest is in the relative cost of each basket of staff mix across states and territories, this should not affect the results.

- Some apparent anomalies in the costs of co-located facilities suggest that costs may not have been accurately allocated between the parts of the co-located facility. Again, this is less significant when the interest is in relative costs across states and territories.

- Because of the need to use award rates of pay across states the modelling does not reflect any above award or other inducements which might increase costs in rural or remote areas.

Modelling

From the 36 rosters provided by facilities, 12 were chosen as representative of the range of facility characteristics thought to have some influence on relative costs. One basket was subsequently dropped from the study as the number of staff hours per resident recorded was well outside the range of the other baskets. The facilities chosen for modelling had the following characteristics:

- There are two from each mainland state (except Queensland), one from the ACT and three from Tasmania.

- Eight are in capital or provincial cities, three in rural areas and one in a remote area.

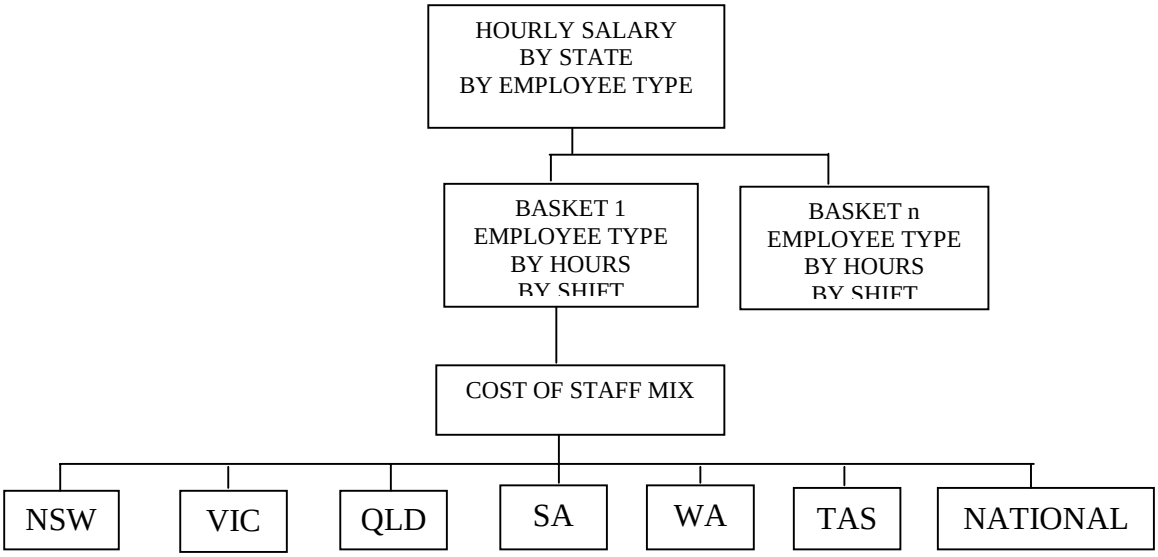
- They are almost equally divided between stand alone and co-located facilities.

- Two have less than 40 beds, two have over 100 beds and the remainder have between 40 and 60 beds.

- Four cater mainly for people with dementia, five for those with high level needs, one for lower level and two for all three.

Data from the rosters and salary levels from each State were combined to produce models of typical baskets of staff mix under a range of assumptions. The model building process is illustrated in the following diagram.

MODEL DEVELOPMENT



The first block in the diagram represents the salary levels used in the models. An hourly salary rate was identified for each employee category in each state and a national average for each category of employee calculated. These salary rates were applied to each staff mix basket in turn. For each basket the employee category, the total hours worked in a week by that category of employee and the shift during which those hours were worked, were fed into the model. The result is depicted in the last box, where the cost of each basket is calculated for each state, together with a national average.

The models explained

Four models were developed:

> The ***Base Model*** uses the total hours of service reported on the roster and costs these for each employee category at designated points on the salary scale which reflect years of experience. While this model does not reflect the true costs of providing care, it provides a base from which the influence of progressive refinements of the model can be measured.

The other models are progressive refinements on the base model.

> ***Model 1*** includes salary loadings for shift work and work at weekends. These loadings are calculated as weighted hours per resident per week. For example, an hour of care provided on Saturday would count as an hour and a half, as the loading for Saturday work is typically 150% of the weekday rate. It is therefore a closer reflection of the true costs of providing care. It was not expected that shift loadings, in themselves, would contribute to cost differences between the states, as the loadings,

Model 2 builds on Model 1 and adds the flat rate of Workers Compensation applying in each state in 1998-99. As there are differences in rates between states, it can be expected that the addition of this item will have some influence on relative costs. As Workers Compensation premiums are typically based on a percentage of payroll, the percentages used in this study are likely to understate the full cost of Workers Compensation premiums. However, the relative differences between states are likely to be a true reflection of the impact on relative costs. It was outside the scope of the present study to estimate the impact of premiums for individual facilities, based on claims history.

Model 2a is a variation on Model 2 which uses the OCRE (Other Cost Reimbursed Expenditure) for the last available year, 1994-95. The figures available are average Dollars per bed day, by state, for all nursing homes receiving reimbursement. The items covered are:

=> Workers Compensation, Superannuation, Long Service Leave and Payroll Tax. The latter is not included in calculations because of its limited significance in the private, not for profit sector.

=> Use of these items provides a more comprehensive coverage of total staff costs, but there are some difficulties in their use.

=> Workers Compensation rates have increased markedly in some states since 1994-95.

=> Although information from the State Organisations is that the Superannuation Guarantee Charge is the predominant form of superannuation provision, the $ per bed day figures differ by almost 30 per cent between the highest and lowest state, which is difficult to reconcile with a uniform rate of provision across the States.

=> Long Service Leave ranges from 36 cents per bed day in WA to 99 cents in Victoria. Although the amounts are not large, they do probably reflect differences in long service leave provisions and perhaps also in staff stability.

As the previous model more adequately reflects the present rates for Workers Compensation premiums, it was decided to use that approach rather than the inclusion of the OCRE rates. Superannuation is likely to introduce little if any relative cost differences. Variation in long service leave provision is also excluded from the model, but the provisions in each of the states is discussed below for this and other forms of leave.

Leave provisions

Differences in leave provisions between states and territories could be expected to influence relative costs. However, it was beyond the scope of the present study to model the effects of differing leave provisions. Instead, an analysis was undertaken of the leave provisions of categories of employees in each state. This analysis is not intended as a detailed review of leave provisions in the states and territories. Rather it identifies the major differences which are likely to influence cost differentials between states. The leave types examined were:

- annual leave and leave loadings;
- sick leave;
- long service leave.

Specifically excluded were:

- compassionate leave, because of inconsistent handling of this type of leave in different states. (In some the leave had been explicitly written into awards, while in others only general principles were included.)
- maternity/ paternity leave, because it is typically unpaid leave;
- public holidays, because the differences between states are small.

The major differences are:

- **Annual Leave;**

⇒ Annual leave for non-shift workers is generally 4 weeks., with the 17.5% leave loading uniform across all states and all categories of employee;

⇒ Victoria and Queensland have 5 weeks leave for registered nurses who are not working shifts, while Western Australia has 6 weeks for personal care staff;

⇒ Permanent shift workers typically have an extra weeks leave, in addition to the base provision. However, nurses in NSW, SA and WA doing permanent shift work have an additional 2 weeks annual leave;

- **Sick Leave;**

⇒ The most common entitlement for sick leave is 2 weeks. However, personal care staff in Queensland have an annual entitlement of only 8 days. At the other extreme, Victoria and Tasmania have annual entitlements of 4.2 and 4 weeks respectively for both nurses and personal care staff;

- **Long Service Leave;**

Victoria has provision, covering nurses and personal care staff, for 6 months long service leave after 15 years and 2 months for every 5 years beyond the first 15. This compares with New South Wales where long service leave entitlement begins after 10 years with 2 months leave. However, after another 10 years the NSW entitlement is 5 months. Therefore after 20 years service in Victoria total entitlement would be 8 months while in NSW it would be 7 months.

It is difficult to establish a consistent pattern of some states having more generous leave provisions than others. Without a detailed study of the leave taking patterns in the states and territories it is impossible to judge

Two other models (Models 3a and 3b) have been developed which use higher salary classifications. The classifications used were those suggested by state associations as reflecting typical classifications in their states. The models serve to establish whether the use of these higher salary levels significantly alter the relative costs between states.

Influence of Model Assumptions

The following Table provides a summary of the amounts and indices for the average cost of all baskets in each state. The indices in this table have as a base the cost per resident per week of the lowest cost state. As the cost per resident per week changes as cost items are added to the models, the indices provide a better method of comparison between the different models than the raw cost figures. It should also be noted that the cost per resident per week is an estimate based on the items included in the model and is not an estimate of the full cost per resident.

TABLE 2: Summary of Basket Average Cost per Resident per Week and Indices

		NSW	VIC	QLD	SA	WA	TAS	AVERAGE
Base Model		$390.05	$391.48	$397.77	$392.25	$379.77	$389.41	$390.12
Index	Base = lowest state	102.71	103.08	104.74	103.29	100.00	102.54	102.73
Model 1	Shift loadings	$460.96	$464.30	$470.61	$464.46	$448.56	$461.42	$461.72
		102.76	103.51	104.92	103.54	100.00	102.87	102.93
Model 2	WorkersComp	$486.64	$482.63	$490.64	$496.51	$471.66	$491.42	$485.72
		103.17	102.33	104.02	105.27	100.00	104.19	102.98
Model 2a	OCRE	$496.90	$508.62	$496.94	$513.38	$486.94	$514.67	$502.91
		102.05	104.45	102.05	105.43	100.00	105.70	103.28
Model 3a	Base Model /Higher salaries	$416.81	$417.80	$427.67	$430.42	$417.40	$431.39	$423.58
		100.00	100.24	102.60	103.26	100.14	103.50	101.62
Model 3b	Model 2/Higher Salaries	$521.01	$516.42	$528.49	$546.18	$520.02	$546.81	$529.82
		100.89	100.00	102.34	105.76	100.70	105.88	102.59

The table illustrates the following:

Although the cost per resident per week increases as items are added to the models, the differences in the indices between the first three models are minimal. Model 2a, which includes an average OCRE component, has most impact on Queensland: the state with the lowest OCRE average. For the reasons outlined above, use of OCRE averages is not recommended.

The last two models also produce small differences between states but alter the relative costs. NSW and Victoria, for example, join Western Australia among the lowest cost States, Queensland is close to the national average, while South Australia and Tasmania are the highest cost states. This appears to be due to changes in the relative rating of different employee categories. Registered Nurse salaries have been increased relatively more than other care staff. Therefore differences in staff mix between the states have a greater influence than in the four previous models which had a lower Registered Nurse salary.

Although the relative cost differences are small they need to be put in perspective. For example, a difference of 4 per cent between the highest cost state and the lowest represents around $80 000 of a $2 million budget.

Models for further analysis

Two of the models described above, are presented in more detail in the remainder of this report. However, knowledge of the factors to which the models are sensitive has been gained, in part, from experience with all of the models developed during the study. The two models represent an upper and a lower band for the estimates of relative costs, for the items included in the estimates.

Model 2: Shift loadings plus Workers Compensation

The assumptions for Model 2 are:

- Salary levels are based on years of experience for most categories of employee to achieve comparability.

- Directors of Nursing or Assistant DONs salary levels are based on the number of beds in those states and territories where this is the basis for salary classification.

- Common hourly rates are used where doubt existed on an appropriate level. Rates for therapists, for example, varied greatly, in part because they were sometimes engaged on a contract basis and also because it was not clear whether the person engaged was a therapy assistant or a therapist. Administrators and CEO's were similarly treated.

  Appendix A sets out the basis for salary levels used in this model.

- Common shift allowance rates were used for all states. It was assumed that the period covered included no public holidays. The rates used were

⇒	Evening Shift	12.5%
⇒	Night Shift	15.0%
⇒	Saturday	150%
⇒	Sunday	175%

This will slightly overstate the influence of shift allowances in Victoria, where allowances are a set amount based on a percentage of a base salary for each employee category. The percentages are close to those in other states, but become a smaller percentage as the salary rate increases. Weightings were applied to the hours of each category of employee on each of nine shifts. This gave weighted hours per resident per week, to which wage rates were applied.

⇒ Workers compensation rates for 1998/99 for each state were applied to base salary rates. The rates used were:

NSW	5.57%
VIC	3.95%
QLD	4.4 % Nursing Home staff 0.31% Clerical staff
SA	6.9%
WA	5.15%
TAS	6.5%

Appendix B contains a detailed summary for this model.

Table 3 provides a summary of state indices for each of the baskets of staff mix. The base for these indices is the cost per resident per week for the lowest state. In this way it is possible to make comparisons between baskets which vary in total cost. In this model, Western Australia is the lowest cost state for every basket.

TABLE 3: State Index for each Basket by size of facility
(Base = total costs of lowest state)

Basket	Location	Type	Organisation	State	Beds	NSW.	VIC	QLD	SA	WA	TAS
38	REMOTE	HIGH LEVEL	STAND ALONE	TAS	25	104.08	101.44	103.97	105.32	100.00	103.29
37	CAP CITY	DEMENTIA	STAND ALONE	TAS	32	102.56	102.77	104.66	106.10	100.00	104.60
6	CAP CITY	ALL LEVELS	STAND ALONE	WA	40	104.57	102.87	105.58	106.18	100.00	105.12
10	RURAL	ALL LEVELS	COLOCATE	VIC	40	104.45	102.45	105.01	105.83	100.00	104.53
21	CAP CITY	DEMENTIA	STAND ALONE	VIC	43	101.71	101.03	102.97	104.38	100.00	102.63
25	RURAL	DEMENTIA		WA	44	101.56	101.03	102.60	104.23	100.00	102.74
39	RURAL	ALL LEVELS	STAND ALONE	TAS	45	102.81	100.84	103.59	103.63	100.00	102.76
9	CAP CITY	ADLS	COLOCATE	SA	48	102.86	102.97	103.33	105.57	100.00	104.42
29	CAP CITY	HIGH LEVEL	COLOCATE	ACT	60	102.18	102.01	103.65	104.71	100.00	104.02
33	CAP CITY	HIGH LEVEL	COLOCATE	VIC	60	105.58	103.24	104.24	104.19	100.00	104.87
34	PROV CITY	HIGH LEVEL	COLOCATE	NSW	120	103.42	102.60	104.04	105.78	100.00	104.50

Model 3b: Higher salary levels on Shift Loading and Workers Compensation model.

The assumptions for Model 3b are:

- Salary levels were adjusted to reflect concerns that, for some categories of employee, the levels based on years of experience were lower than those typical of employees in the sector. The employee categories changed were:

⇒ Registered Nurses were increased to the nearest equivalent of a Year 2, 4a RN in Victoria.

⇒ Enrolled Nurses were increased to the nearest equivalent of the highest classification in NSW ("Thereafter").

⇒ Assistant in Nursing and Personal Care Assistants were increased to the nearest equivalent of the third year and after level in Victoria.

⇒ Cooks were based on the rate for trade cooks were this classification existed in a State.

⇒ Clerical hours were increased to the nearest equivalent of Administrative / Clerical Services 5, Year 3.

Other levels remained unchanged.

Appendix C provides a summary of the salary levels used in the model.

- Shift allowance rates remain the same.
- Workers Compensation rates remain the same.

Appendix D contains a detailed summary for this model.

Table 4 provides indices for each basket of staff mix.

TABLE 4: Model 3b: State Index for each Basket by size of facility (Base = total cost of lowest state)

Basket	Location	Care Type,	Organisation	State	Beds	NSW.	VIC	QLD	SA	WA	TAS
6	CAP CITY	ALL LEVELS	STAND ALONE	WA	40	100.71	100.00	103.22	107.35	100.21	107.24
9	CAP CITY	ADLS	COLLOCATE	SA	48	100.00	100.46	101.42	105,74	100.51	106.29
10	RURAL	ALL LEVELS	COLLOCATE	VIC	40	101.80	100.00	103.17	106.55	100.77	105.87
21	CAP CITY	DEMENTIA	STAND ALONE	VIC	43	100.90	100.00	102.26	105.26	101.26	105.39
25	RURAL	DEMENTIA		WA	44	101.13	100.00	102.03	105.48	101.56	105.52
29	CAP CITY	HIGH LEVEL	COLLOCATE	ACT	60	100.76	100.00	101.87	104,95	100.59	105.84
33	CAP CITY	HIGH LEVEL	COLLOCATE	VIC	60	100.98	100.00	102.75	105.42	100.67	105.49
34	PROV CITY	HIGH LEVEL	COLLOCATE	NSW	120	100.00	100.41	102.62	106.17	100.83	107.18
37	CAP CITY	DEMENTIA	STAND ALONE	TAS	32	101.28	100.00	102.08	105.89	100.24	105.74
38	REMOTE	HIGH LEVEL	STAND ALONE	TAS	25	101.57	100.00	103.71	107.06	101.67	105.86
39	RURAL	ALL LEVELS	STAND ALONE	TAS	45	102.79	100.00	103.19	105.60	101.72	105.18

Conclusions

There are three broad conclusions which can be drawn from the study:

1. The costs generated through the modelling exercise vary within a narrow range. For the lower salary level model these are within a range of 4 to 5 points above the index base of the lowest cost state, which in this model is consistently Western Australia. While there is some variation in the order of states from lowest to highest cost across baskets, Queensland is consistently either the highest or second highest cost state on a basket, South Australia, Victoria, New South Wales and Tasmania are approximately in that order from higher to lower cost.

   The model using higher salary costs for some categories of employee produces total costs which vary over a slightly wider range of approximately 7 points above the lowest state. It also produces a different ordering of states. Victoria, New South Wales and Western Australia are at the lower end of unit cost, while South Australia, and Tasmania are at the higher end. With this model, Queensland falls in the middle range of costs.

   This suggests that results are sensitive to changes in the assumptions on salary levels.

2. There is a reasonable level of consistency between states in the baskets of staff mix which are expensive and those which are less costly. However, some variation exists which is probably due to differences in the relative costs within a state of different categories of employees.

3. The relative cost differences between states identified in this study are far less than those existing in the present subsidy rates for residential aged care. Applying the method of comparison used in this study to the subsidy rates for RCS category 1, as set out in the Productivity Commission's Issues Paper, gives the following indices from the lowest subsidy state, which in this case is Queensland:

NSW	**VIC**	**QLD**	**SA**	**WA**	**TAS**	**ACT**	**NT**
116	121	100	108	111	122	111	118

   These differences in index from a base of 100, compare with a range of 5 to 7 points in the present study. The order of States on unit salary costs is also different from that of the present subsidy scheme. This is true whichever salary rates are modelled.

Appendix 4

Capital Costs

Introduction

While capital funding is not central to the Inquiry which deals with recurrent nursing home funding, the Productivity Commission has asked that submissions consider:

- whether there are variations in relation to land and building costs
- to what extent building costs are dictated by various building regulations
- what impact certification requirements will have on future costs.

This paper deals with these issues and then goes on to consider the funding implications.

Variations in Land and Building Costs

Consumer Price Index

Housing costs as measured by the CP1 vary significantly among the capital cities. The variance in June 1998 is about 27% of the average housing cost for all capital cities. Housing costs were highest in Darwin and lowest in Perth.

The CP1 indicates that there are significant housing cost differences among the capital cities.

Multi-Unit Building Cost Index

The Housing Industry Association produces building cost indices. The most relevant one is probably the Multi-Unit Building Cost Index. The index commenced in 1989/90 and shows movements in costs since that time. It also allows cost comparisons to be made among the jurisdictions. As at March 1998 the Multi-Unit Building Cost Index was as follows:

NSW	101.7
VIC	87.3
QLD	106.5
WA	110.3
SA	115.8

The Housing Industry Association's Multi-Unit Building Cost Index indicates that there are significant variations in building costs among the jurisdictions.

Residential Aged Care Facilities

With regard to residential aged care facilities, Tasman Asia Pacific, in its assessment of the capital needs of the residential aged care industry, used the following assumptions on land and building costs for nursing homes, based on the advice of a valuer.

The estimated average costs for new residential aged care facilities operated by the not-for-profit sector in 1996/97 was as follows: [1]

- average building cost per nursing home bed $43,000
- average land cost per nursing home bed $13,600

Thus the average total land and building cost per nursing home bed operated by the not-for-profit sector was estimated at $56,600 in 1996/97.
However, as the new privacy and space requirements for certification will bring nursing homes closer to the current standards of hostels, it is relevant to compare the above average land and building costs with those for hostels, as follows:

- average building cost per hostel bed $70,000
- average land cost per hostel bed $15,600

Thus the average total land and building cost per hostel bed operated by the not-for-profit sector is estimated at $85,600 in 1996/97.

Health Science Planners, an architectural firm which has undertaken a substantial amount of work in the aged care industry, advises that the average cost per square metre for a 3 0 bed facility with individual en suites is between $ 1,100 and $1,200.

These are estimated average costs. Actual costs will vary depending on the floor area per bed and the level of fitout and technical sophistication.

The building costs of nursing homes vary considerably and are clearly influenced by the amount of space provided per bed and the level of fitout and technical sophistication. This reflects a relationship between cost and quality.

Rural and Remote Areas

Locality Allowances have been used by the Commonwealth to adjust capital funding having regard to the variation in costs (from the capital city in each State and Territory) for transporting and obtaining labour, material and equipment from the capital city. The allowances are based on a locality index which provides a measure of the distance (or remoteness) of a particular locality from the capital city. While the locality index provides a measure of remoteness from the capital city, it does not include any information on the cost (or funding) variations.

Locality Allowances indicate that Commonwealth capital funding policies have in principle recognised that rural and remote areas face additional construction costs due to their relative isolation from capital cities; however, the adequacy of locality allowances is not known..

Variation in Land Costs

While it is not possible to cite data which indicates variations in land costs, this fact is widely understood and accepted. The cost of land is significant and varies considerably within the same city as well as within and between jurisdictions.

An important objective of aged care is to provide access to people assessed as requiring residential aged care within their local community wherever possible, so that older people in care are able to keep in touch with their social support networks.

Accordingly, it is not feasible to propose that residential aged care facilities should be built in areas where land costs are relatively low. However, land values within a local community are likely to be relatively homogeneous and this is relevant where there are contributions by residents towards the capital cost of residential care accommodation.

Land costs are highly variable within and between jurisdictions. However, they are likely to be relatively homogenous within a local community and this is a relevant consideration where there is a component of user-pays funding towards the capital cost of residential care accommodation.

The Impact of Regulations and Certification On Building Costs

Regulatory Requirements

The Productivity Commission asks whether variations in capital costs are dictated by variations in building and health and safety regulations among the jurisdictions.

With regard to building regulations, the Building Code of Australia applies to residential aged care facilities in all jurisdictions. However, in the past there have been significant variations imposed by State and local governments. The Board of the Building Code of Australia, in consultation with the industry, is currently undertaking a major review of the BCA as it applies to residential aged care facilities. The review will also address state and local variations in order to ensure that there is a truly national regulatory framework for new residential aged care facilities in the future.

The current review of the Building Code of Australia as it applies to residential aged care facilities will put in place a national regulatory framework which will apply to all new residential aged care facilities in the future.

However, past experience would suggest that the State and Federal Government Agencies will continue to play a role in scrutinising building plans and specifications for facilities and they may continue to impose conditions and requirements which are not stipulated in the Building Code of Australia.

Certification Requirements

All residential aged care were required to achieve certification by 1 October 1997 in order to be able to receive accommodation bonds and/or charges from residents (facilities in receipt of Additional Recurrent Funding were required to elect either to retain that funding or to become certified and charge accommodation bonds or charges).

Initially, 370 services were refused certification but this number has since been reduced through the review process. The highest incidence of certification failure was

among private nursing homes in metropolitan Victorian, a significant number of which are leasehold.

A review of the Certification Instrument is nearing completion and once finalised will apply to all new assessments for certification (probably from 1 December 1998). Those facilities certified under the previous certification instrument will not be required to undergo a new assessment for certification until after the accreditation date (1 January 2001).

The revised Certification Instrument will significantly increase the requirements, including:

- *Fire safety* - a new mandatory pass mark of 19 out of a possible 25 will apply to all facilities assessed for certification

- *Privacy and Space* - for new facilities, a mandatory standard of a maximum average of 2 residents per room will be introduced (up to 4 residents per room will be allowed where it can be demonstrated that cultural preferences would make this appropriate on an ongoing basis); for existing facilities a mandatory standard of a maximum of 4 residents in any room must be met by 2008.

While the new Certification Instrument will apply in all jurisdictions, its cost implications for existing facilities are likely to vary depending upon the age of facilities and the past standards they were required to meet by the relevant State and local government bodies.

Significant improvements to fire safety, privacy and space standards will increase substantially the cost of building and upgrading residential aged care facilities. The resulting increase in the capital funding requirements is in addition to the major backlog of upgrading identified in the Gregory Report.

In addition, the improvements to privacy and space standards are likely to add to the recurrent funding costs of nursing homes - such as energy and insurance costs.

Funding Implications

Separation of Capital and Recurrent Funding

It is desirable for capital and recurrent funding streams for nursing homes to be separately identified for the following reasons:

- to provide greater transparency regarding the purposes for which funding is provided

- to ensure that recurrent and capital funding needs are each considered and addressed thereby ensuring that short term needs are not addressed at the expense of long-term needs and capital needs are not addressed at the expense of quality of care

- to facilitate a much closer relationship between recurrent funding and care outcomes for residents;

- to facilitate long-term stewardship of funds which will ensure that capital is available to maintain, upgrade and rebuild nursing homes.

Capital Funding Shortfall

In 1993 Professor Bob Gregory undertook a major review of the capital funding of nursing homes. He examined a range of options for generating the $125 million a year he identified at that time as needed on an ongoing basis in order to address the 2 backlog in upgrading and to maintain the quality of building stock. [2]

He identified the following reasons for the lack of investment in the upgrading of nursing homes:

- SAM funding had included no depreciation in the funding to provide for the replacement of buildings

- there was no financial incentive to upgrade or replace nursing homes as no extra income was forthcoming to cover these costs

- the Government contribution towards capital funding was too low - Gregory estimated that a contribution of around 2/3rds of the capital costs was required.

Gregory noted in 1994 that voluntary sector nursing home beds should be replaced at the rate of 670 beds per year to ensure that all beds are replaced over their lifetime; however applications for capital funding had come close to that level only twice in 8 years. [3] (This did not include the level of investment required to provide new nursing home beds in order to keep pace with demand due to population ageing).

The funding options Gregory examined included:

- deregulated fees whereby residents were income-tested in relation to the "hotel" component of care and the income-tested contributions were used to provide a pool of funding for capital purposes

- entry contribution arrangements similar to those applying in hostels (now called accommodation bonds)

- a combination of both the above.

He concluded that a combination of deregulated fees and entry contributions (based on nursing homes whose residents have an average mix of incomes) would <u>not</u> deliver a sufficient return on capital. [4]

Accommodation Charges

As from 1 October 1998, accommodation bonds were to have been charged to new nursing home residents who met the financial eligibility criteria. This was in line with the policy which had applied to residents in hostels for 10 years (however, variable fees could no longer be charged to new hostel residents and $170 million was cut from capital funding for hostels over 3 years). The accommodation bonds policy for nursing homes was rescinded shortly afterwards and replaced by a maximum accommodation charge of up to $12 a day for a maximum of 5 years for new nursing home residents who met the financial eligibility criteria.

According to the Government's estimates, accommodation charges paid by nursing home residents will yield $405 million over the 3 years to 2002. However, it is questionable whether this will provide adequate capital funding for those facilities which must undertake substantial upgrading in the short term in order to achieve certification. In addition, it does not address the capital funding requirements for new places in order to keep pace with demand due to population ageing.

Gregory argued that $12.15 a day would enable a nursing home to be upgraded once at 20 years and replaced after 40 years. He indicated that this would mean the proprietor would not receive any return on equity for the first 7 years and the eventual return on equity would be 8% (before tax). [5] However, in his explanation of the modelling, Gregory notes that it over-estimates viability for the charitable sector and that the return on equity would therefore be much lower. [6] In addition, Gregory's modelling is based on average nursing home building and land costs of $56,500 per bed which is very conservative (particularly in view of the new certification requirements) and they assume that $12 is paid in respect of every resident whereas once fully operational the accommodation charge is likely to be paid by about 66% of residents.

The maximum accommodation charge of $12 a day will not adequately meet the capital funding requirements of the nursing home industry even compared with Gregory's pre-certification estimates in 1994. In the short term, accommodation charges will not provide sufficient capital to undertake upgrading required for certification and they do not address the need for up-front capital funding for new nursing home places to provide for growth in line with the population planning ratios.

Because the maximum accommodation charge is a flat $12 rate, there is no provision for funding to vary in relation to the varying costs of land and building.

Variable Accommodation Charges

The capital funding arrangements for residential aged care should take into account the variable costs of land and building due to location.

As indicated earlier, the majority of residents prefer to be admitted to residential aged care facilities within their local community and land values within a local community are likely to be relatively homogeneous.

This suggests that there should be the capacity for accommodation charges to be more closely related to the capacity of residents to make a contribution towards the capital cost of residential care accommodation. Residents from local communities with relatively low real estate values are generally in a position to contribute less than residents from local communities with relatively high real estate values.

This flexibility exists with the accommodation bond arrangements charged for residents requiring low level care.

By contrast, accommodation charges for residents requiring high level care are limited to a maximum of $12 a day. There is no good rationale for limiting the accommodation charges in this way, particularly when there remains a significant capital funding problem for the industry which, if not addressed, will result in continuing problems with the quality of accommodation offered to residents.

The financial eligibility criteria for accommodation charges ensure that financially disadvantaged residents are not required to pay the accommodation charges (or only a small contribution). The mandatory ratios for concessional residents also ensure that their access to appropriate care is not impeded by their financial status.

The removal of the $12 cap on accommodation charges would enable resident contributions towards the capital costs of care to be more closely linked to their capacity to pay and the cost of land and building; this would increase the scope for capital income to be generated via accommodation charges.

However, facilities in rural and remote areas and those which cater predominantly for financially disadvantaged residents would require access to additional capital funding. This need has already been recognised by the Government through the provision of capital funding of $ 10 million a year for 4 years. However, the level of this funding will need to be increased (to at least $45 million a year) in order to ensure that there is sufficient capital funding for upgrading and building residential aged care facilities in rural and remote areas and for facilities which care for predominantly financially disadvantaged residents.

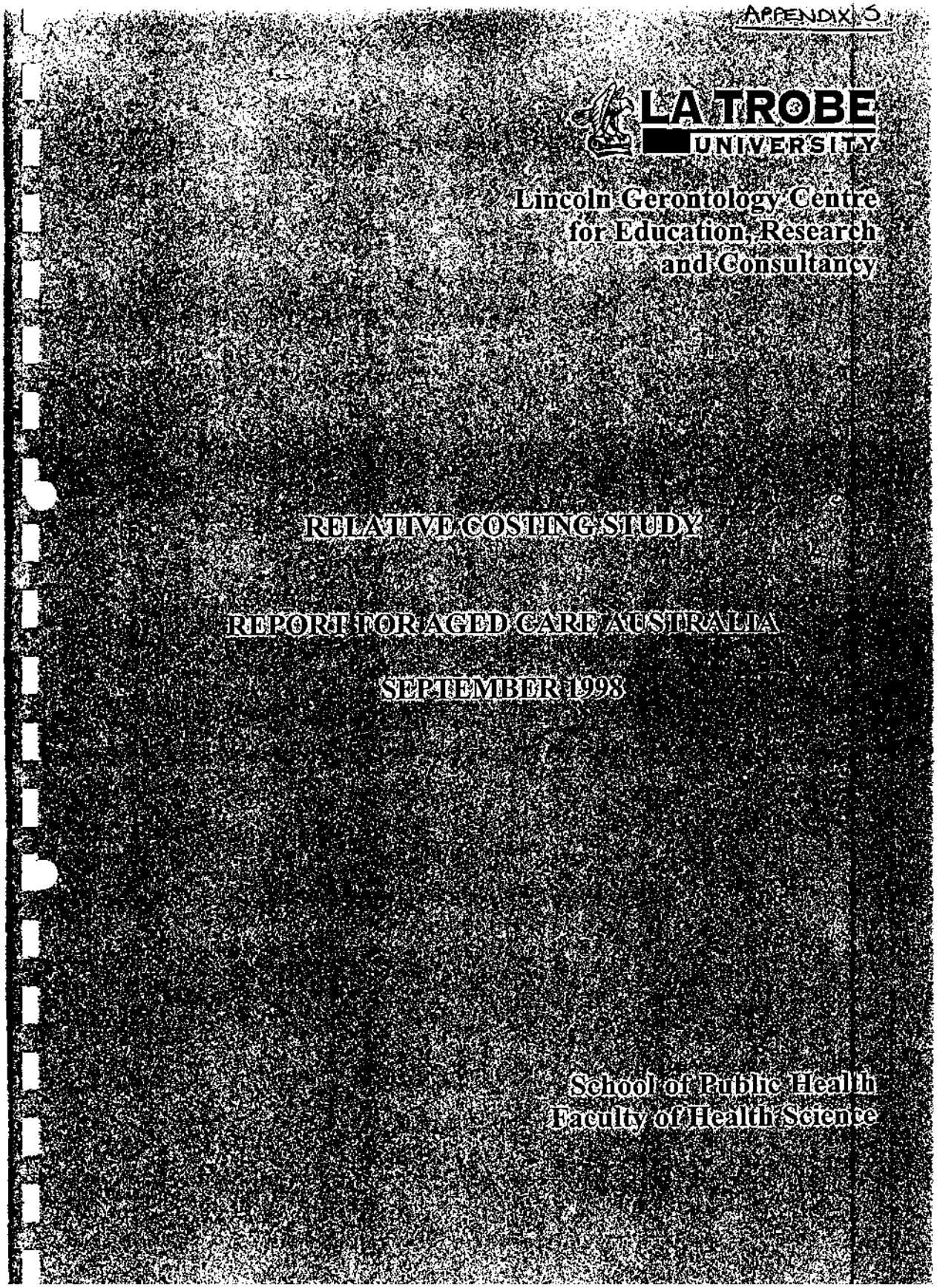
Greater flexibility is required so that accommodation charges paid by financially eligible residents requiring high level care are more closely linked with their capacity to pay and the cost of land and building. This would provide for more adequate capital income streams for upgrading and rebuilding than at present.

Additional capital funding is needed for facilities in rural and remote areas and for facilities which cater predominantly for financially disadvantaged residents.

Given the difficulties in generating sufficient capital via accommodation bonds to undertake major upgrading within the time-frames required for certification, the Government should also provide access to capital loans - a proposal outlined more fully in ACA's 1998 Federal Budget Submission.

[1] Tasman Asia Pacific, Hesta Report Into Strategic Capital Needs of the Residential Aged Care Industry 1997-2003, Tasman Asia Pacific, June 1997, pp 18 & 19
[2] Gregory, Professor B, Review of the Structure of Nursing Home Funding Arrangements, Stage 2, Aged & Community Care Service Development and Evaluation Report No 12, AGPS, May 1994, p5.
[3] Ibid, p 13
[4] Ibid, p 33
[5] Ibid, p 27
[6] Ibid, p 95

APPENDIX 5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PRIMARY HEALTH CARE RESEARCH AND DEVELOPMENT CENTRE

An Analysis of the Implications of Commonwealth Own Purpose Outlays Indexing for Aged Care Residential Services

September 1998

FACULTY OF HEALTH SCIENCE

1 INTRODUCTION

Changes to indexation arrangements for aged care residential outlays have to be seen in the context of the Commonwealth's overall aim to restrain growth in outlays while maintaining the quality and quantity of outputs. This fiscal objective is a central component of the Commonwealth's overall approach to macro economic policy.

The Commonwealth has systematically sought to contain outlays as a proportion of GDP. In order to do so without comprising its social objectives the Commonwealth has progressively targeted its social expenditure and introduced a range of measures to force improved technical efficiency (increased productivity) from service providers receiving Commonwealth funding. The Commonwealth has progressively limited eligibility through means testing and it is driving service providers to produce more output of the same quality with the same or less funding in order to meet its macro economic objectives.

The Commonwealth has generally attempted to drive increased productivity through a deregulation and competition based micro economic reform agenda. For Commonwealth funded services this has seen the introduction of a range of initiatives to improve efficiency including privatisation, the introduction of purchaser - provider arrangements, reduced controls over inputs, increased focus on output based purchasing and greater labor market flexibility.

Unfortunately for human services generally and aged care in particular, there is little empirical evidence that these measures will lead to improved productivity without reductions in quality and quantity of outputs. The indexation of Commonwealth outlays for aged care residential services is a case in point.

2 CHANGES TO 1NDEXATION ARRANGEMENTS

The Commonwealth introduced new indexation arrangements for its own outlays in the 1995 budget. The Commonwealth Own Purpose Outlays (COPO) index sought to introduce a consistent, simple and robust arrangement for adjusting budget outlays for inflation that maximised efficiency incentives while protecting the quality and quantity of outputs produced. In particular the new indexing arrangements sought to include only those wage increases that were not offset by productivity improvements.

The COPO index replaced a raft of indexing arrangements that had evolved to adjust outlays across Commonwealth programs. The common approach of adjusting separately for movements in wage and non-wage costs was standardised using the Safety Net Adjustment (SNA) for wage movements and the Treasury Measure of Underlying Inflation (TMUI) for non-wage movements. The COPO index manages variations in the relative contribution of wage and non-wage costs across outlays by adjusting the relative contribution of the SNA and TMU1 components to the index in four 'cocktail indexes'.

The Industrial Relations Commission determines the SNA as a flat dollar value for lower paid workers who have been unable to achieve wage increases through enterprise bargaining. The TMU1 adjusts the CP1 basket of goods by removing items with highly volatile price changes, marked seasonal variation and which are heavily influenced by government policy.

Prior to the introduction of COPOs aged residential care outlays had been indexed at 55 percent of Average Weekly Earnings (AWE) and 45 percent of the Consumer Price Index (CP1). With the introduction of the new wage cost indexing arrangements for COPOs it was initially recommended that a 60/40 SNA/TMU1 split be used although this was only applied to the hostel sector. This arrangement was subsequently revised to a 75/25 split for all aged care residential services.

3 INDEXATION ISSUES

In the past, centralised wage fixation led to increased wages in industry sectors with the greatest productivity growth (e.g. capital intensive manufacturing, mining and agriculture) flowing through into sectors with lower productivity growth (e.g. services). Where the introduction of new technology results in high productivity growth, unit labor costs generally fall *even though individual wages increase* (i.e. increased wages are more than offset by increased outputs). However, this tends not to be the case where these wage increases flow through to low productivity growth areas where it is difficult to replace labor with new technology. In these sectors, unit labor costs tend to increase as wages increase (i.e. increased wages are not offset by increased outputs).

The impact of unbalanced productivity growth on unit labor costs (and wage outcomes) is particularly problematic for government outlays in the service sector where unit labor costs tend to grow over time. This has become known as the Baumol problem following his analysis of the macro economic effects of unbalanced productivity growth for US cities (Baumol 1967). [2] As unit labor costs for services grow, governments must choose between increasing taxation to maintain their services, restricting access to services to fewer people, or reducing the quality of the services provided. The Baumol problem has significant implications for service provision in aged care.

Labor is the major cost component of aged care residential services. The aged care residential sector has comparatively little capacity to improve productivity through the introduction of labor replacing technology. Alternatively, it has been argued that residential care productivity might be improved through the introduction of larger organisational units and by reducing the hours of more costly nursing service provided to residents. However, there are significant concerns about the impact of changes in staff mix and larger organisations may have on the quality of outcomes for residents.

Changes to aged care policy have restricted entry to nursing homes to an increasingly dependent group of people who have greater care needs. There are significant government regulatory controls on staffing arrangements in order to maintain the quality of care provided. The relationship between staff and residents is central to the quality of care in nursing homes. In the absence of clear client based quality of care measures there are concerns that quality of care for residents will fall if there is pressure to reduce unit labor costs. Similarly, smaller organisational arrangements have often evolved to address particular geographic, cultural and linguistic needs. Changes to these arrangements are likely to have a detrimental impact on the quality of service for residents.

Increased unit labor costs for aged residential care are largely driven by the acute care sector. The acute sector is more technology dependent and has a greater capacity for productivity gains. It has progressively reduced patient length of stay. The residential care sector has little option but to match the pay rates of the acute sector for nursing and other staff.

[2] Baumol, W. (1967). Macroeconomics of unbalanced growth: The anatomy of a crisis. The American Economic Review, 57, 3, 415-526.

If it does not, it is unable to attract appropriate staff and quality of care necessarily declines. But it is not able to match the productivity improvements possible in the acute sector, consequently, the unit labor costs for the residential sector are likely to rise more quickly than those for the acute sector. Without additional funding the only option is reduce the quality of care provided.

This is not to say that productivity gains are not possible in aged care residential sector. However, no reliable and valid studies of productivity changes in nursing homes which could resolve this issue are available. In order to conduct such a study it would be necessary to specify both the quality and the quantity of outcomes and to examine the potential impact of various staffing and organisational arrangements that could be applied to these measures.

The experience of the nursing home sector to date has been that little enterprise bargaining has been achieved. One of the major factors affecting the limited success of the bargaining process has been the inability to identify productivity offsets for wage increases.

Nevertheless, general changes in indexing arrangements for COPOs have been applied. It is therefore important to examine how these changes impact on residential aged care.

4 IMPLICATIONS FOR AGED CARE RESIDENTIAL SERVICES

The current COPO indexation arrangements for nursing home subsidies include SNA (75%) and the TMUI (25%).

A comparison of the Consumer Price Index (CPI) and TMUI was under taken.

The TMUI excludes items from the basket of goods used to measure the CPI for the following reasons:

- government policy - publicly provided goods and services are excluded from the measure as well as those whose prices are heavily influenced by government policy, such as tobacco and alcohol, and mortgage interest charges

- volatility - items whose prices are subject to sharp swings (such as food prices following drought and floods or petrol prices in response to world oil price developments)

- seasonality - items which have a marked seasonal pattern such as holiday travel and clothing.

A comparison of the CP1 and TMU1 for the 38 quarters between March 1990 and June 1998 shows that the TMU1 yielded a higher index 55% of the time and an equivalent index 22% of the time. The TMU1 component of the COPO indexation arrangements does not disadvantage the aged care residential sector.

However, the primary purpose of the COPO wage cost indexing arrangements was to prevent supplementation for productivity based wage increases. Wage indexes like the Award Rates of Pay Index (ARPI), Average Weekly Earnings (AWE) and Average Weekly Ordinary Time Earnings (AWOTE) are not discounted for productivity (i.e. reductions in unit labor costs).

In response to these problems the ABS has developed a Wage Cost Index (WC1) based on a basket of jobs. The WCI adjusts changes in the price of labor for constant quality. It is adjusts for changes in factors such as hours worked, overtime penalties, bonuses and changes in job roles. Unlike the ARPI it is a direct measure of wage costs and unlike the AWE measures it adjusts for workforce fluctuations. A WCI for health and community services has been developed. However, the WCI does not include non wage labor costs and it does not adjust for productivity changes resulting from capital investment, technological change, entrepreneurial activity and organisational restructuring. The ABS is developing a Labor Cost Index (LCI) to address non-wage related labor costs, but it is likely that the LCI will take a further two years to complete.

The use of the SNA in the COPO indexation arrangements addresses the problem of productivity offsets by discounting average wage costs. It applies indexation for lower paid workers to increase wages for higher paid workers as a flat dollar amount. The SNA indexation factor used for COPO indexation is calculated as a ratio of the SNA to AWE for the relevant time period to which the index applies. The SNA substantially under estimates real movements in AWE. In the difference between the SNA adjustment and the AWE movement should reflect productivity offsets achieved through enterprise bargaining.

In practice, for aged care residential services the Baumol problem applies. Productivity offsets for these services are unlikely to match those in other sectors and particularly the acute sector

A comparison of the use of the SNA and various AWOTE measures for different occupational groups presented in table 1 indicates that there has been substantial under supplementation of nursing home subsidies for wage movements since the introduction of the COPO indexation arrangements.

Although data are limited, it is unlikely that nursing homes can match the productivity offsets achieved in other sectors and particularly in acute care. The nature of comprehensive nursing and personal care, the necessity for providing access to services in more remote regions, the highly dependent and vulnerable nature of the resident group (which is increasing) and the regulatory and funding constraints over staffing mix militate against significant flexibility over staffing arrangement or the replacement of staff with new technology. Consequently, it is inevitable that if the SNA continues to be used as the basis for indexation that nursing homes will be forced either to reduce the standard of care provided by employing lower qualified staff or they will progressively become non viable.

5 REVISED ARRANGEMENTS AND RECOMMENDATIONS

The introduction of the COPO indexation arrangements was intended as an interim measure. The use of the SNA was to be reviewed in the light of the ABS development

of a Labor Cost Index (LCI) for the 1998 budget. Consideration was to be given to using the WC1 component of the LCI. The WC1 component of the LCI has been completed.

The purpose of indexation is to maintain the real value (quality and quantity) of outputs produced by residential aged care outlays. The aged care industry has limited capacity for improvements in productivity (technical efficiency) through labor replacement strategies such as the introduction of new technology.

There are significant constraints on funding inputs which limit the capacity of operators to vary the hours of care provided or the number of residents who receive care. Unit labor prices continue to rise as a result of wage movements for nursing and care staff in related sectors which have greater capacity for productivity offsets. The SNA significantly under supplements the sector for these factors. Consequently, over time, it is likely that operators will have little option but to reduce costs by employing less qualified staff and thereby reduce the quality of care provided.

Consequently it is **recommended** that the health and community services WCI measure should be used with TMU1 to maintain the quality (value) of the outputs produced by the aged care residential sector. The costs of the residential aged care services are primarily driven by wage outcomes in the public sector, the appropriate index is therefore the Health and Community Services Public WCI. Consideration should be given to using the appropriate LCI when it becomes available.

The analysis of indexing arrangements described in this paper suggest that the current indexing arrangements have significantly under supplemented the nursing home sector since the introduction of the COPO formula. It is unlikely that the Commonwealths policy intentions to maintain the value of the outlays for nursing home care have been met. If the AWOTE (all persons) index had been used instead of the SNA the value of nursing home subsidies for 1997/98 would be $128 million higher that the actual funding provided. It is therefore **recommended** that a one off adjustment to base value of nursing home subsidies of $128 million be made to ensure the restoration and maintenance of nursing home quality of care.

Although the capacity for nursing homes to achieve significant productivity savings as offsets for enterprise bargaining appears limited, it is nevertheless **recommended** that a study of potential productivity gains should be conducted. The study needs to consider regulatory constraints (particularly staffing), organisational scale (taking into account issues of access and equity), and the quality (value) of the outputs provided for residents.

Finally, it is clear that there are state-based variations in the cost of providing nursing home services. AWOTE rates of change differ across the states. Some states will therefore be under compensated where subsidy adjustments for nursing homes are based on average national wage movements. Where differential rates of change in AWOTE are consistent and entrenched over time, the use of national indexation leads to the risk that the quality of nursing home care in under compensated states may fall. Consequently, it is **recommended** that state based indexation measures are used to adjust nursing home subsidies.

Australia Trend	Full-Time AWOTE Female	75%	TMUI	COPO if AWOTE Female Used	Effective	Actual COPO Used	Difference	Australia Trend AWOTE Females	Nursing Home Subsidies	Under-Compensation
May 1995/96	3.5%	2.63%	0.83%	3.5%	1996/97	1.80%	1.66%	1996/97	$2,161,400,000	$35,771,170
May 1996/97	4.6%	3.45%	0.53%	4.0%	1997/98	1.70%	2.28%	1997/98	$2,338,100,000	$53,308,680
May 1997/98	4.1%	3.08%	0.38%	3.5%	1998/99	1.40%	2.06%	1998/99	$2,261,700,000	$46,477,935
Source: ABS Average Weekly Earnings, 9302.0, May 1998, Table 1										**$135,557,785**

Australia Trend	Full-Time AWOTE All Persons	75%	TMUI	COPO if AWOTE All Persons Used	Effective	Actual COPO Used	Difference	Australia Trend AWOTE Females	Nursing Home Subsidies	Under-Compensation
May 1995/96	3.9%	2.93%	0.83%	3.8%	1996/97	1.80%	1.96%	1996/97	$2,161,400,000	$42,255,370
May 1996/97	4.0%	3.00%	0.53%	3.5%	1997/98	1.70%	1.83%	1997/98	$2,338,100,000	$42,787,230
May 1997/98	3.9%	2.93%	0.38%	3.3%	1998/99	1.40%	1.91%	1998/99	$2,261,700,000	$43,085,385
Source: ABS Average Weekly Earnings, 9302,0, May 1998, Table 1										**$128,127,985**

Appendix 6

Facility Size and the Viability Supplement

Impact of Facility Size on Costs

In considering the various factors which contribute to inescapable cost differences among nursing homes, facility size has been a recurring issue.

Small nursing homes (30 places or less) are more likely to face higher costs in the following areas:

- *labour* costs - providing 24 hour qualified nursing is more expensive for small facilities because it means that they must provide proportionately more qualified nurse hours per resident per day than larger facilities; the 24 hour top up funding payable to nursing homes recognised this (however, it is currently being phased out)

- *non-labour operating* costs - small facilities are unable to take advantage of the economies of scale available to larger facilities; in addition, to the extent that small facilities tend to be located in rural and remote areas, they face higher costs due to lack of competition and the impact of freight charges

As well as being more likely to face higher costs beyond their control, small facilities are less able to control factors which influence their income and are also more vulnerable to fluctuations in income. For example:

- *managing resident mix* - in implementing the new RCS, the Department has highlighted the importance of managing resident mix in order to achieve viability (for example, nursing homes which have a preponderance of residents assessed at either RCS 1 or RCS 5 will lose funding under the new arrangements). It is very difficult for a small facility, which may be the only one in a rural or remote community, to manage its resident mix in order to ensure viability

- *impact of occupancy levels* - most nursing homes operate with very high levels of occupancy (around 98%); however, the impact of one unoccupied place is much greater for a small facility than for a large one; to the extent that small nursing homes are located in small rural and remote areas, they have a much smaller potential client group to draw on than their counterparts in urban areas.

Small nursing homes are more likely to face higher costs beyond their control and are also less able to control factors which influence their income and are more vulnerable to fluctuations in income than larger nursing homes.

Consumer Access

There has already been a substantial restructure within the nursing home industry with respect to facility size, resulting in an overall 41% decline in the number of small facilities (>25 places) since 1992. In addition, the accessibility of nursing homes in rural areas has declined. (Refer to Appendix 1 of this Submission).

It is important to ensure that consumer access to residential aged care is not further eroded due to the non-viability of small facilities.

Correlation Between Facility Size and Rural / Remote Location

It is reasonable to expect that there will be a fairly strong correlation between small-sized nursing homes and location in rural and remote areas. The one general exception to this is likely to be nursing homes which cater for groups with special needs (for example, people from specific cultural or linguistic backgrounds).

ACA does not have access to information which would confirm this hypothesis; however, the Department of Health and Family Services should be able to provide such information to the Productivity Commission.

It is considered that if this hypothesis is correct, it would be more appropriate to use facility size rather than location as the basis for differential funding in relation to inescapable cost differences.

As there is likely to be a fairly strong correlation between small-sized nursing homes and location in rural and remote areas, it is considered that facility size rather than location would provide a better basis for differential funding in relation to inescapable cost differences.

The Viability Supplement

The viability supplement currently provides differential funding to small facilities; eligibility is assessed on the basis of the following criteria:

- *remoteness of the service's location* - eligibility is highest for remote areas and lowest for large rural centres

- *the size of the facility* - eligibility is highest for facilities with less than 15 places and lowest for facilities with less than 30 places

- *not co-located or unable to be co-located*

- *cater for residents with special needs* - including financially disadvantaged residents, groups with special cultural or linguistic needs.

Currently around $6 million is allocated to the viability supplement which is payable in respect of eligible nursing homes and hostels. This does not even represent 1 tenth of one percent of the total funding on residential aged care.

The maximum amount of viability supplement currently payable is $16.50 per resident per day (at most 17% of daily subsidy) and the minimum amount is $1 per resident per day (less than 1% of the daily subsidy).

It is not clear on what basis the levels of the viability supplement were determined; however, it is questionable whether the levels of assistance it provides are sufficient to ensure viability. The adequacy of the viability supplement should be investigated as a matter of priority.

While the eligibility criteria for the viability supplement are well-targeted, it is questionable whether the amount of funding assistance it provides is adequate and this should be investigated as a matter of priority.

24 Hour Top-Up Funding

The purpose of the 24 hour Top-Up Funding was to allow small nursing homes to provide registered nurse coverage on a 24 hour basis.

This is to be withdrawn over a three year period and viability supplement will be paid if an entitlement exists.

However, the amount of funding available through the viability supplement is considerably less for some facilities than that provided through 24 hour Top-Up Funding. For example, a 15 bed facility in rural Victoria will lose over $40,000 a year.

The phasing out of 24 hour Top-Up Funding must be taken into account in considering the adequacy of the viability supplement.

Appendix 7

Quality Care, Consumer Choice and Funding Options

Introduction

This paper deals with the broad issues of quality care, consumer choice and funding options. They are also closely linked with the issue of accountability.

Quality Care

The Productivity Commission has asked whether quality of care can be defined in terms of staff or skills mix. This question can be answered with reference to the following:

a) Research into optimal skills mix for desired resident outcomes in non-Government nursing homes completed in 1990[1]

b) The Accreditation Standards outlined in the Quality of Care Principles of the Aged Care Act 1997.

a Optimal Skills Mix for Desired Resident Outcomes

In 1990 Alan Pearson et al reported on quantitative and qualitative research of a representative sample of nursing homes in 4 States which examined this question.

The study found that "skills mix and resident outcomes are not two discrete phenomena which can be related to each other within a simple framework. There are a large number of other variables which may impact on the end results in nursing home care."[2]

Quality of care was measured using the resident outcome standards and the research examined the impact of a range of variables on resident outcomes including:

- staff deployment
- skills mix - staff characteristics including: qualifications, experience, attitudes, expectations, participation in inservice training
- management and leadership by Directors of Nursing
- the relative dependency of residents
- health care
- residents' rights
- social environment
- physical environment.

The main findings of the study were as follows:

- there were differences in the dependency levels of residents across States

- there was a significant relationship between the percentage of therapists and the outcome measure of variety of experience

- there were significant relationships between the outcome measures of health care and the dependency of the residents

- there were significant positive relationships between the level of inservice training activity and all the outcome measures (except for privacy and dignity)

- there were positive relationships between the variety of experience outcome measure and medium and large nursing homes (41 to 60 places, 61 places or more)

- there were significant positive relationships between the measures of social independence and home-like environment and ownership of the nursing home by a not-for-profit organisation

- the following factors were identified as facilitating a high quality of resident care/life:

    - ✓ the attitude, commitment and interpersonal skills of the Director of Nursing
    - ✓ the ideology, team cohesiveness and positive attitude of staff
    - ✓ an overall staffing environment which adheres to an agreed philosophy and is stable, satisfied and friendly.

The following strategies to achieve desired resident outcomes were recommended:

- maintain registered nurses at current levels

- increase therapists (physiotherapists, occupational therapists, diversional therapists etc), particularly in the area of diversional therapy, to at least the notional eight percent

- clarify the role of the enrolled nurse in nursing homes

- review the role of nursing assistants

- a higher profile and additional resources should be given to inservice training to ensure that nursing homes achieve desired resident outcomes

- there should be continuing investment in the preparation of Directors' of Nursing for leadership and management.

The research study concluded that a number of variables contribute to quality of care/life outcomes for residents and that it is difficult to produce defensible, prescriptive percentages for optimal staffing mix. Quality of care for residents is

determined by a wide range of factors, including: the attitudes and motivation of staff, leadership and management style, the physical and social environments.

There may be value in updating this study, particularly in relation to work force planning and development implications for residential aged care services .

b Accreditation Standards

The Accreditation Standards set down in the Quality of Care Principles provide the framework for measuring quality of care.

There are four Accreditation Standards and they each specify a range of expected outcomes:

1. Management systems, staffing and organisational development (9 expected outcomes)
2. Health and personal care (17 expected outcomes)
3. Resident lifestyle (10 expected outcomes)
4. Physical environment and safe systems (8 expected outcomes).

Continuous improvement, staff training and regulatory compliance are expected outcomes in each of the four standards.

The new accreditation system requires residential aged care facilities to take responsibility for the quality of care they provide to residents. The focus is on continuous self-managed improvement which will be subject to independent assessment by trained quality assessors. That independent assessment will determine the accreditation status of the service and, if accredited, the period of accreditation. All residential aged care services are required to be accredited by 1 January 2001 and failure to be accredited will result in the withdrawal of subsidies.

The new accreditation will be very different in culture and focus from the standards monitoring system:

- the focus is on self-managed continuous improvement rather than externally imposed sanctions for poor performance

- all services must be active participants in the new accreditation system whereas standards monitoring applied mainly to "homes of concern"

- the emphasis will be on outcomes for residents and these will be assessed in relation to measurable criteria

- positive incentives rather than negative consequences will drive the new accreditation system; services will be able to be differentiated in terms of the quality of service they provide.

The new accreditation system provides a comprehensive and measurable framework for measuring the quality of care provided to residents. The four accreditation standards take into account the range of variables which

contribute to quality care and therefore provide a much better basis for assessing quality than using a proxy such as staff or skills mix.

Consumer Choice

The choices available to older people who have been assessed as requiring care in a nursing home (high level care) have been very limited due to a number of factors:

- close control on the supply of nursing home places means that occupancy levels are high and many prospective residents have little choice about which nursing home they are admitted to; this is compounded by the fact that around 50% of applications for admission are made from hospital and prospective residents are often required to take the first available bed nursing home bed

- the level of regulation and government control of fees has inhibited the development of a wider range of options and in conjunction with the decline in the accessibility of nursing home places has resulted in limited opportunities for prospective residents to exercise choice based on the quality of care provided or other considerations such as: proximity to family; whether it provides culturally appropriate care; compatibility with the care needs of existing residents (such as dementia care); and/ or the quality of the physical environment

- notwithstanding the high quality of care offered by many nursing homes, the lack of investment in upgrading nursing homes due to insufficient capital funding over the past decade or more has meant that many nursing homes are unable to offer a standard of physical accommodation which is consistent with privacy or a home-like environment; as a consequence, many older people have little choice about the environment in which they will receive care during the last months and years of life. For example, the majority of nursing homes do not offer single room accommodation and an estimated 38% of residents share accommodation with three or more other residents.

The limited choice available to prospective residents is compounded by the needs of services to manage their resident mix and to ensure access is provided to concessional residents.

Facilitating consumer choice is an important part of quality care and it should start from the time an inquiry is made about admission to a nursing home by the resident or his or her representative. It is a very difficult transition for most people and the perceived loss of independence is reinforced by the lack of choice at that critical stage.

The new accreditation system will provide much better information about the quality of care offered by residential aged care services. It is also expected that the accreditation system will result in the de-funding of poor quality services and a substantial improvement in the overall quality of care provided by the industry over time due to the requirement for continuous improvement.

In addition, the opportunity for prospective residents to test out a nursing home on a respite basis prior to permanent admission would increase their capacity to exercise choice.

While it may not always be possible to meet the preferences of consumers, it is clear that more needs to be done to facilitate choice regarding the nursing home to which a person is admitted. The accreditation system will play an important role in enhancing consumer choice by providing better information about the quality of services and by not accrediting and not funding poor quality services.

Funding Options

A close link between the funding arrangements for residential aged care services and the quality care outcomes for consumers is desirable. It is also appropriate that funding arrangements facilitate consumer choice wherever possible without eroding the principle of universal access to quality care which is responsive to the needs of residents.

The new funding arrangements introduced from 1 October 1997 would benefit from fine-tuning in the context of the new accreditation system which provides the basis for measuring quality and for ensuring accountability for funding in relation to outcomes for residents. In addition, the new accreditation system has a strong consumer focus and emphasises the importance of involving residents in their care.

As the vast majority of residents (around 92%) are pensioners or part pensioners, it is essential that the standard pensioner contribution (85% of pension plus the pensioner supplement) plus the residential care subsidies paid in accordance with the assessed care needs of the resident (using the Resident Classification Scale) provide adequate funding to provide the same standard of quality care consistent with accreditation to every resident.

The two year review of the residential aged care restructure will examine the adequacy of funding to deliver quality care to the standards required for accreditation. As the resident focused outcome standards for accreditation increase over time, the adequacy of residential care subsidies must also keep pace with those improvements.

Funding Based on The Care Needs of Residents

The current system of funding nursing homes is primarily based on the care needs of residents as assessed by the Resident Classification Scale (RCS). The RCS is a new assessment instrument which replaces the previous instruments used to assess hostel (low level care) and nursing home (high level care) residents.

The RCS has recently been the subject of an extensive consultative review process and further refinements are expected to be introduced from 1 November 1998. However, the review found that it is generally an effective discriminator of relative care needs and therefore achieves its objective as an instrument for allocating funding.

The review of the RCS prefigured the potential for a further large scale revision of the RCS which would use a reduced number of questions which are very good discriminators of care need. In the interests of providing some stability and certainty for the industry, the Review Team recommended that a large scale revision be considered in the context of the two year review of the restructure. This was supported by ACA.

Currently there are 7 funded classifications under the RCS and these are used to allocate funding to around 130,000 residents. While there have been concerns about the administrative requirements in relation to the RCS, the Review Team's recommendation that these be limited to the appraisal period only should ease the problem, along with improved training and greater clarity regarding interpretations and documentation requirements.

ACA supports the continued use of the Resident Classification Scale as the basis for allocating residential aged care funding. The adequacy of funding is a matter for review in the context of the 2 year review of the restructure.

It is feasible to use the RCS as the funding allocation system within a range of funding approaches. Criteria for evaluating various funding approaches are outlined and some options suggested by the Productivity Commission are discussed.

Criteria for Evaluating Various Funding Approaches

The following criteria are suggested for evaluating various funding approaches:

1. *Funding adequacy:* will the funding approach deliver funding adequate to provide quality care outcomes for consumers? Does it take into account the extent to which services are able to control and manage their costs and income?

2. *Funding equity:* will the funding approach enable services with different inescapable costs to provide the same standard of care for residents? Will it maintain funding over time as cost relativities change?

3. *Universal access:* will the funding approach ensure universal access by people assessed as needing residential care irrespective of their location or ability to pay? Will it ensure that a high quality of care, consistent with accreditation, is provided to all residents who are financially disadvantaged?

4. *Incentives for quality and efficiency:* is there scope within the funding approach to encourage and reward quality and efficiency? Does it provide flexibility to manage the funding to achieve quality and efficiency improvements?

5. *Administrative efficiency*: will the transaction costs of the funding approach be efficient and affordable? Will the funding arrangements be easy for consumers to understand? Will implementation costs be funded and will they be justified by ongoing overall improved outcomes from the funding arrangements?

Funding Methodology Based On Outcomes

Aged Care Australia intends to produce a discussion paper regarding funding methodologies for residential aged care services by the end of October. It is hoped that this will contribute to informed debate on an appropriate and rational funding methodology for residential aged care services.

Percentage Based Subsidy Arrangements

The Productivity Commission asks whether a subsidy based on a percentage of total costs would be an acceptable approach to funding, with residents also meeting a percentage of total costs.

While there are some merits to this option (such as a degree of responsiveness to varying costs) it also presents aspects which are problematic. For example:

- administratively it would require some validation (and potentially acquittal) of costs - this was a requirement under the preceding CAM/SAM system of funding and was administratively complex and inefficient; there was also a significant backlog of validations creating funding uncertainties

- a maximum cap would inevitably be placed by Government on the value of subsidies in addition to the percentage limit in order to control expenditure and create incentives for efficiency; once a maximum $cap were established, the advantages of this approach in responding to variable costs which are unable to be controlled would diminish significantly

- under this approach it would be possible to have either fixed or variable levels of contribution by residents towards costs; if the resident contribution were determined as a fixed percentage of costs (rather than a fixed proportion of resident income) there would be a high degree of variability in the amounts to be paid by residents, irrespective of their income - this would lead to a very complex system for administration and for residents to understand and may also compromise the principle of universal access irrespective of capacity to pay. There is also the added problem that cost differences may be taken to imply quality differences but that may not always be the case and they may send the wrong signals to residents. Furthermore, independent accreditation rather than price is a better indicator of quality in a system which cares for vulnerable people

- funding up to a fixed percentage of costs (and possibly a $ cap) continues an input focus on funding whereas it would be preferable for funding to be much more strongly aligned with quality outcomes for consumers; the new accreditation system provides a framework which will facilitate a much closer relationship between funding and outcomes in the future. (For example, it is possible that in future funding could vary in relation to the level of accreditation achieved.)

On balance, the option to fund on the basis of a percentage of total costs (with or without a maximum $ cap) is not supported as the potential advantages are outweighed by the disadvantages.

Paying Subsidies Directly to Residents

The Productivity Commission asks whether paying subsidies directly to residents rather than homes would increase the pressure on providers to deliver "the right service at the right price".

There are a number of characteristics of the nursing home market and residents which mitigate against the use of this kind of market approach to generate quality and efficiency. They include the following:

- typically, older people assessed as needing nursing home (high level) care are very frail and a significant and growing percentage have cognitive disorders (such as dementia) which limit their capacity to make decisions; in addition, the majority are on low fixed incomes; these factors place them at a disadvantage in terms of shopping around for quality care at a price they can afford

- the effective functioning of a market approach to funding requires a degree of information symmetry between buyers and sellers; the frailty and vulnerability of older people requiring nursing home care and the frequent need for urgent admission to a nursing home from hospital mean that older people are generally not well informed enough to be able to exert influence to the extent required for this funding approach to be effective

- the excess of demand relative to supply means that the choices available to consumers are limited; in such a market universal access irrespective of ability to pay must be protected; the proposed funding approach would not provide this

- paying subsidies directly to residents would be administratively inefficient given that the characteristics of residents and the nursing home market are quite different from those required for such a funding approach to work efficiently; furthermore, in many cases the funding would be managed by the resident's family or representative and this would further complicate administrative arrangements as well as raising problems in relation to non-payment.

The option to pay subsidies directly to nursing home residents is not supported as such a market approach does not take into account the special characteristics of nursing home residents or features of the nursing home market. It would not ensure universal access to quality care irrespective of capacity to pay. Quality care is best facilitated through the accreditation system rather than relying on the bargaining power of residents.

Resident Contributions & Income Testing

New funding arrangements introduced on 1 October 1997 have resulted in a significant increase in the contributions expected from nursing home residents towards the cost of their care. Subject to financial eligibility criteria, they are expected to pay:

- accommodation charges (currently $12 a day for a maximum of 5 years) or, in the case of extra services places, accommodation bonds

- contributions towards the cost of care - through the pensioner or standard resident contribution (depending on pensioner status) and for residents with income in excess of the allowable income for a full pension, an income-tested contribution; residents in extra service places also pay an additional extra service amount.

Several case examples (***see Attachment 1) demonstrate the combined impact of taxation, the pension income test, the residential care contribution income test and the extra service amount. They demonstrate that the combined effect of all these arrangements leaves the resident with very little disposable income and offers very limited choice with regard to purchasing quality services. For example, a non-pensioner with $27,000 annual income, after the effects of taxation and the residential care standard contribution and income-tested charge is left with a disposable income of only $5,875 (or around $ 100 a week). This is the only income available to them which can be used by them to influence the quality of residential service they receive (for example, whether or not they share a room with 3 others) and to meet out-of-pocket expenses.

As some residents are now asked to contribute substantially towards the cost of their care (and the proportion is likely to increase in the future), their expectations regarding the quality of care and accommodation they receive are likely to increase and they should have more choice regarding what they pay for. .

However, the new income-tested resident contributions offset the care subsidy payable by the Government; thus they do not provide any additional income to the service provider. Residents who pay more do not derive any additional benefit in terms of the quality or level of service or accommodation they receive, unless they occupy an extra service place.

Extra service places are limited to 12% of all residential care places and are subject to conditions relating to eligibility criteria and fees. For example, a minimum daily fee of $ 10 must be charged, resulting in a minimum extra service amount of $12.50 a day payable by the resident.

Prior to the residential aged care restructure, variable fees were able to be charged by hostels whereby up to 50% of income above the allowable income for a pension could be charged as an additional residential care fee. This income was used to help finance the capital and recurrent costs of hostels and contributed significantly to the substantially better condition of hostels compared to nursing homes. The restructure withdrew the capacity to pay variable fees to new residents admitted after 30 September 1997.

Nursing homes (and hostels) thus have their incomes strictly regulated by Government. They have no capacity to increase income to either offset inescapable cost increases not fully compensated through the indexation of residential care subsidies or to improve the quality of care and/or accommodation they can offer.

This has implications for the choices available to nursing home residents, particularly having regard to the need to upgrade the quality of accommodation to meet improved safety and privacy standards.

The role of resident contributions and income-testing in relation to residential aged care services needs to be reviewed in order to:

- generate income for improvements in the overall quality of accommodation and care services offered to all residents by residential aged care facilities

- enable consumers to exercise greater choice in relation to the quality of residential care services they receive and the quality of accommodation in which they reside

- ensure universal access to quality care and accommodation consistent with accreditation by all residents irrespective of their capacity to pay.

This could be done by:

- reducing or removing the resident contribution income-test as it currently operates and replacing it with more flexible extra service arrangements as outlined below

- increasing the scope for residential care facilities which have achieved 3 year accreditation to offer extra services to residents by reducing the minimum daily extra service fee which must be charged (currently $ 10 a day) and by removing the limit on the number of extra service places which may be approved, subject to requirements that concessional residents ratios are met

- limiting the future approval or renewal of extra service places to residential care facilities which have a current 3 year accreditation

- according priority to approved providers which have achieved 3 year accreditation when considering applications for new residential care places.

Changes to the current residential care income test and extra services arrangements, as proposed above, would help to stimulate further increases in the overall quality of residential care and accommodation which would benefit all residents. The number of residents who could pay for extra services at any stage will be modest. However, limiting the ability to offer and charge for extra services to residential care services which have a 3 year accreditation would ensure that all residents in that facility are receiving quality services. It also provides an incentive and a potential additional income stream for further quality improvements.

Continuous improvement is expected to drive the accreditation system and to deliver quality improvements over time. This will benefit all residents, especially as the residential care funding system must guarantee universal access to quality services consistent with accreditation to all residents, irrespective of their financial position.

Funding Methodologies to Promote the Integration of Support for Residential and Community Care

The Productivity Commission asks whether there are particular funding methodologies which would promote the integration of support for residential and community care.

A primary objective of funding policy in aged care must be to enhance the care and accommodation options available to older people to ensure that wherever possible they receive the care they need in the place they would most prefer to receive it.

This does not necessarily require common funding approaches or integrated management. However, it would be desirable to facilitate greater flexibility and transparency with regard to funding arrangements so that the choices and options become more apparent to both consumers and providers.

Work has begun on the development of a classification system for community care recipients. It is likely that this will be different from the Resident Classification Scale because of the need to take into account a range of environmental factors in community care (such as the availability of carers, the standard of accommodation, proximity to services etc). Thus integration of funding instruments and arrangements is unlikely.

The application of common principles and greater clarity regarding the components of funding may facilitate greater synergy between residential and community care services and improved flexibility and choice. For example: common principles such as: funding linked to assessed care needs and accreditation; access to quality care services based on need not capacity to pay. Clarity regarding the components of funding would involve separately identifying the care component from the hotel component.

[1] Pearson, Alan et a, Optimal Skills Mix for Desired Resident Outcomes in Non-Government Nursing Homes, AGPS, October 1990

[2] ibid, p 3

Case Examples Showing the Effects of Taxation, Pension Income Test. Residential Care Income: Tested Contribution. Extra Service Fee.

Single Non Pensioner	**Per year**	
Age Pension Income Test:		
Annual Income (All sources)	$27,000.00	
Less Allowable Income	$2,600.00	
Income Subject to Pension Reduction	$24,400.00	
Pension Reduction Based on Income Test	$12,200.00	
Maximum Age Pension Payable	$9,219.60	
Less Pension Reduction (at 50%)	$12,200.00	
Pension Payable Under Income Test	**($2,980.40)**	No pension payable
Income Tax Payable:		
Gross Taxable Income	$27,000.00	
Tax Payable	$5,202.00	**$5,202.00**
Residential Care Income-Tested Fee:		
Annual Income (All sources)	$27,000.00	
Less Allowable Income	$2,600.00	
Income Subject to Income-tested Fee	$24.400.00	
Income Tested Fee(at 25%) Payable	$6.100.00	**$6,100.00**
Daily Equivalent (Less than Maximum of up to $37.65)	$16.71	
Resident Pensioner Contribution to Care	$9,822.15	**$9,822.15**
Total Paid on Tax and Standard Residential Care Fees		**$21,124.15**
Disposable Income		**$5,875.85**
EXTRA SERVICE RESIDENTIAL CARE		
Extra Service Amount (minimum allowed ie $12.50 per day)	$4,562.50	**$4,562.50**
		$1,313.35

Case Examples Showing the Effects of Taxation. Pension Income Test, Residential Care Income-Tested Contribution, Extra Service Fee.

Single Non Pensioner	**Per year**	
Age Pension Income Test:		
Annual Income (All sources)	$37,000.00	
Less Allowable Income	$2,600.00	
Income Subject to Pension Reduction	$34,400.00	
Pension Reduction Based on Income Test	$17,200.00	
Maximum Age Pension Payable	$9,219.60	
Less Pension Reduction (at 50%)	$17,200.00	
Pension Payable Under Income Test	**($7,980.40)**	No pension payable
Income Tax Payable:		
Gross Taxable Income	$37,000.00	
Tax Payable	$8,602.00	**$8,602.00**
Residential Care Income-Tested Fee:		
Annual Income (All sources)	$37,000.00	
Less Allowable Income	$2,600.00	
Income Subject to Income-tested Fee	$34.400.00	
Income Tested Fee(at 25%) Payable	$8.600.00	**$8,600.00**
Daily Equivalent (Less than Maximum of up to $37.65)	$23.56	
Resident Pensioner Contribution to Care	$9,822.15	**$9,822.15**
Total Paid on Tax and Standard Residential Care Fees		**$27,024.15**
Disposable Income		**$9,975.85**
EXTRA SERVICE RESIDENTIAL CARE		
Extra Service Amount (minimum allowed ie $12.50 per day)	$4,562.50	**$4,562.50**
		$5,413.35

Appendix 8

Summary of Recommendations

Recommendation 1.

ACA recommends that the Productivity Commission be guided in making its recommendations by the key principles of access, quality and viability.

Recommendation 2

ACA recommends that the Productivity Commission put forward recommendations relating to the funding of nursing homes which are consistent with the desired outcomes identified by ACA.

Recommendation 3

ACA recommends that the Productivity Commission take into account in making its recommendations the substantial reduction in the number of small facilities and the decline in accessibility of nursing homes (particularly in rural areas).

Recommendation 4

ACA recommends that research be carried out to identify the reasons for significant differences among the jurisdictions with regard to the assessed levels of dependency of residents in order to highlight any implications for service provision and care practices.

Recommendation 5

ACA recommends that the Productivity Commission take into account the fact that supply controls on nursing home places since 1986 have resulted in reduced expenditure of $1 billion a year; and that under-compensation of cost increases has resulted in a real reduction in nursing home funding of about $128 million since 1996.

Recommendation 6

ACA recommends that the Productivity Commission take into account the significant challenges and uncertainties presented by the residential aged care restructure and, in particular, the fact that 39% of nursing homes are expected to receive reductions in recurrent care funding at a time when they are facing new unfunded cost imposts in relation to accreditation.

Recommendation 7

ACA recommends that the Productivity Commission note the efforts by the industry to further enhance its strategic planning and management capability.

Recommendation 8

ACA recommends that the Productivity Commission take into account in framing its recommendations: the need for more aged care services to address current and future needs; the importance of providing a continuum of care which is responsive to a diverse needs and aspirations of older people; the desirability of "unpackaging" the housing and care components in order to promote greater program flexibility, increased innovation in service provision and more adequate provision of housing options for older people who are homeless or living in insecure accommodation.

Recommendation 9

ACA recommends that the Productivity Commission takes into account the dynamic nature of varying relativities in award rates among the jurisdictions (within awards and over time) in considering appropriate nursing home funding arrangements.

Recommendation 10

ACA recommends that the Productivity Commission note that the care needs of residents, facility size, management philosophy and the affordability of nurses appear to be as important as minimum regulations and award conditions in determining staff mix in nursing homes.

Recommendation 11

ACA recommends that the Productivity Commission note the objectives, limitations and findings of the study of relative labour costs conducted for ACA by La Trobe University; this indicates that the range of funding relativities among the States and Territories for high level care residents is currently much larger (22%) than indicated by the study of relative labour costs (5% to 7%).

Recommendation 12

ACA recommends that the Productivity Commission note that nursing homes have virtually no control over the price of qualified nursing staff, that the more generous public sector award rates are likely to drive further price increases for qualified nurses in nursing homes; and that unless funding arrangements permit greater parity, current recruitment, retention and morale problems will deteriorate.

Recommendation 13

ACA recommends that the Productivity Commission note that the scope for productivity gains in nursing homes through enterprise bargaining and the substitution of labour inputs with equipment is extremely limited.

Recommendation 14

ACA recommends that the Productivity Commission note that the non-labour operating costs of nursing homes vary within and between jurisdictions and appear to be due to a range of factors including: facility size; ownership type; location; management and accounting practices.

Recommendation 15

ACA recommends that the capital and recurrent funding streams for nursing homes be separately identified in order to promote transparency, stewardship and accountability.

Recommendation 16

ACA recommends that there be greater flexibility so that accommodation charges paid by financially eligible residents requiring high level care can be more closely linked with their capacity to pay and to variations in the cost of land and building.

Recommendation 17

ACA recommends that the Productivity Commission note in considering the future funding arrangements for nursing home that there is a significant and long-standing capital shortfall which will not be adequately addressed through accommodation charges; and that ACA has outlined policy recommendations to address this in its 1998 Federal Budget Submission.

Recommendation 18

ACA recommends that the Wage Cost Index (Health and Community Services, Public Sector) be used to index the labour component of residential aged care subsidies; that where differential rates of change in AWOTE among the jurisdictions are entrenched over time, the relevant State/Territory measure of this index be used; and that consideration be given to using the Labour Cost Index (Health and Community Service, Public Sector) once it becomes available.

Recommendation 19

ACA recommends that the TMUI continue to be used to index the non-labour component of residential aged care subsidies.

Recommendation 20

ACA recommends that there be a one-off adjustment to the pool of funding for high level care residents in 1999/00 of $128 million in order to restore the funding lost through under-compensation due to the use of the COPO index.

Recommendation 21

ACA recommends that additional funding for small-sized residential aged care facilities be provided through the viability supplement; and that the Productivity Commission recommend that the adequacy of the viability supplement, taking into account the phasing out of the 24-Hour Top Up Funding, be reviewed as a matter of priority.

Recommendation 22

ACA recommends that the Productivity Commission note that a wide range of factors contribute to quality care; that all these factors are included in the accreditation standards; and that accreditation provides a much better basis for assessing quality care than using a proxy such as staff mix.

Recommendation 23

ACA recommends that the Productivity Commission note that the accreditation system will play an important role in enhancing consumer choice and in improving the quality of care.

Recommendation 24

ACA recommends that the Productivity Commission ensure that any new funding arrangements for high level care residents provide universal access to quality care consistent with the standards for accreditation, irrespective of their location or financial situation.

Recommendation 25

ACA recommends that the Productivity Commission note that the two year review of the residential aged care restructure will examine the adequacy of funding to deliver quality care to the standards for accreditation.

Recommendation 26

ACA recommends that the allocation of residential aged care funding should continue to be based on the assessed relative care needs of residents.

Recommendation 27

ACA recommends that the Productivity Commission apply the criteria for evaluating various funding approaches outlined by ACA.

Recommendation 28

ACA recommends that the Productivity Commission note that Aged Care Australia intends to produce a discussion paper regarding funding methodologies for residential aged care services by the end of October.

Recommendation 29

ACA recommends that the Productivity Commission note that ACA does not support percentage based subsidy arrangements or paying subsidies directly to residents.

Recommendation 30

ACA recommends that the role of resident contributions and income testing be reviewed in order to generate income for quality improvements in residential aged care and to enable consumers to exercise greater choice in relation to the standard of care and accommodation they receive.

Recommendation 31

Aged Care Australia recommends that high level care residents in those States and Territories which are relatively under-funding be funded at the national average rate for each applicable high care level with effect from 1 July 1999.

Recommendation 32

Aged Care Australia recommends that the review of the adequacy of residential care funding (to be undertaken in the context of the two year review of the restructure) be completed prior to any decisions being taken with regard to funding reductions for any high level care residents.

Recommendation 33

Aged Care Australia recommends that the quantum of a national rate for each high level care classification under the RCS be determined in the context of the review of the adequacy of residential care funding, to be undertaken as part of the two year review of the restructure.

Recommendation 34

Aged Care Australia recommends that the $128 million under-funding which has occurred since 1996 due to the under-indexation of high level care subsidies be restored with effect from 1 July 1999; and that it be used, in the first instance to meet the following priorities: 1) to fund the increase in high level care subsidies to the national average for residents in those States and Territories which are currently relatively under-funded; 2) to provide more adequate assistance to small-sized facilities through the viability supplement.

Recommendation 35

Aged Care Australia recommends that transition management assistance be provided to facilities providing high level care in the event that there are future funding reductions based on the study of funding adequacy; and that this include management advice and program flexibility.