AGED CARE ORGANISATIONS' ASSOCIATION (S.A. & N.T.) ("ACOA") SUBMISSION TO

PRODUCTIVITY COMMISSION INQUIRY

INTO NURSING HOME SUBSIDIES

The Aged Care Organisations' Association (S.A. & N.T.) offers the following response to the matters being the focus of the Productivity Commission's "Scope of Inquiry" for Nursing Home subsidy rates, matters raised in the "Issue Paper" and other related comments.

The fundamental challenge that the Commission faces is whether there should be a funding system that is based on equal rates, or one that is based on differential rates (as currently applies). ACOA respectfully suggests that the Commission's assessment of this question needs to be based on objective data that is available to Providers and capable of scrutiny, and ongoing review.

ACOA's response takes account of, and will refer to, the papers being developed by, Aged Care Australia (ACA) in its submission to the Commission. We therefore will not repeat the same data.

1. ACOA'S Rejection of the 7-year coalescence plan

ACOA has consistently argued against the 7-year time frame adopted by the Coalition Government for the achievement of a common level of funding.

It had long been ACOA's belief - now supported by data generated as part of the ACA - commissioned Relative Costing Study (La Trobe University) - that the range of cost variance between s states was much narrower than the range of subsidies being paid (ref ACA submission….).

Indeed, the study demonstrates that, when actual wage costs (measured against common staff profiles) and other non-wage costs (measured against a common basket of inputs) are taken together, South Australia has been significantly disadvantaged by having arguably the highest state operating cost structure but the second lowest rate of subsidy.

2. Observations on the funding system of the past decade, with particular reference to the absence of updating of data and lack of transparent indexation.

Historically, South Australian providers have never accepted the outcomes of the recently superseded system of CAM, SAM, and OCRE, as the structure of these funding processes not only , formalised and legitimised the funding differences between states, but became a contra-incentive to efficient management outcomes.

The objectivity of differential cost models appeared flawed from the very beginning of the CAM system with no apparent rigour or public accountability as to how these differential rates were established. Attempts to identify the basis for these differentials suggests the use of erroneous information or assumptions about wage relativities and staff mix.

The effect of this apparently poor methodology was compounded by the fact that the base starting point had not been reviewed since the inception of CAM in the late 1980s leading up to and including its use as a base in the creation of the RCS high care subsidy levels.

We note so that no other Aged Care Program, such as Hostels, CCPs, Day Therapy Centres, are subject to such differentials.

3. South Australia: Costs/Subsidy Levels

.A broad analysis of S.A's cost position, taking account of the ACA/La Trobe University analysis of wage costs, current CPI data and Workers' Compensation levies, demonstrates a level of costs significantly above the national average - a position clearly incompatible with the state's level of subsidy which is significantly below the national average.

In relation to wage inputs, the La Trobe study demonstrates a relatively narrow range of 4 to 7 points above the index base of the lowest cost state (depending on the assumption adopted relating to low or high salary costs) and concludes that "Queensland is consistently the highest or second highest cost state (followed by) South Australia.

The 1998 consumer Price Index indicates that Adelaide and Brisbane face the highest costs in relation to non-wage nursing home inputs. And South Australia has at - 6.9% - the highest WorkCover levy of any state.

This demonstrable dislocation of any reasonable correlation between the state's costs and subsidy levels indicates that South Australia nursing home residents have had significantly fewer resources available to meet their care needs than has been the case in nearly all other states. This is supported by ACA's own research which indicates that South Australia has the lowest or second lowest ratio of qualified staff to residents of any state (refer ACA submission…..). ACOA would argue, anecdotally, that this is frequently reflected, inter alia, in high rates of turnover, and difficulty of recruitment, of qualified nurses.

4. Efficiency Considerations

4.1 The operating environment:

Historically, performance benchmarks have not been available to the industry. Government has not provided leadership on the necessary systems in this regard, and the wide variety of accounting practices amongst providers has inhibited effective comparisons.

4.1.1 Controlled Income:

Efficiency outcomes in South Australia aged care appear based on 'cost' containment as Aged Care Providers have little flexibility to combine efficiency outcomes with income generation strategies in new markets, etc. Income is totally controlled by Government in all facets:

- Subsidy levels
- Number of "Approved Places"
- Validation of assessment
- "Income Test restrictions
- Standard daily fees
- Accommodation charge stipulations

4.1.2 Labour Intensiveness

The labour-intensive nature of the aged care sector also brings with it limited opportunities for Cost reduction which need to be considered in the context of greater general expectations of standards of care as are evident in the new standards associated with the accreditation process.

Our only efficiency options, therefore, relate to management of costs and occupancy levels. Economies of scale also may offer opportunity for some further efficiencies but the associated capital costs are frequently prohibitive; larger-scale facilities are generally not an option in regional/isolated areas.

Efficiency and productivity gains from reduced staffing levels are very difficult to achieve because the history of staffing levels is that they have been geared to minimum - and in South Australia's case, inappropriately depressed - levels. It is our experience that staff offer unpaid time to perform their duties, and that they work in demanding people environments that often not only involves the needs of the residents but also their families,

4.2 Impact of Technology

The introduction of technology has not offered efficiencies to reduce workload and staffing costs. At best they have served to try and keep abreast of the greater service demands being placed on the sector in terms of:

1. Contractual information
2. Accounts
3. Mortality information
4. Quality reporting and monitoring
5. Other legislative obligations
6. Record keeping

Technology in a service area emphasising "hands on care" has to meet the test of a cost benefit. We need to closely monitor technology and the dangers of higher priced services with no income return. A focus on technology outcomes for staff, e.g. lifters, has not reduced staff hours; lifters still require two or three staff members in attendance, and they aim to reduce incidence of injury rather than staff costs as such. A focus on computer operation has limited application in a strong "hands on" environment. Some argue for innovation such as 'care plans' on computers. These innovations need to be balanced with maintaining staff's active involvement with residents. We do not wish to project a 'luddite' view that no efficiency gains are possible, but where we have made progress in these areas it does not appear to have generated an efficiency that creates more flexible use of available resources.

4.3 Other emerging efficiency issues / challenges

In the immediate future the sector will be faced with other changes that will pose Efficiency challenges. These changes will involve key cost increases within a limited Income me environment. These include:

- management of a GST
- changes to Fringe Benefit Taxes and Exemptions
- accreditation costs (preparation and participation), etc,
- increased focus on safety standards with associated cost offsets
- increased administration of the Aged Care Reforms
- greater turnover of residents due to the increased frailty of those cared for in
- residential environments
- cost of compliance with management obligatory compliance, e.g. ABS surveys,
- affirmative action surveys

4.4 Enterprise bargaining

Enterprise bargaining as the main method of wage movements, creates some challenges to our sector. We believe there are very limited opportunities to convert an efficiency to an income generating source that covers wage increases. More than 50% of our workforce have obtained an automatic flow-on from 'safety net' decisions, indicating the low level of pay in this sector in South Australia.

4.5 "Ageing in Place"

"Ageing in place" undoubtedly achieves improved outcomes for residents. From an economic perspective it has the potential to generate some efficiencies through reduced turnover of residents within individual facilities, but will also produce potentially higher costs - especially where qualified staff are required to care for a given number of high care residents dispersed over a larger site area.

In smaller facilities, the impact of a significant number of low care places in a primarily high care environment will impose an imbalance between subsidy income and (high cost) qualified nursing requirements which may become critical.

4.6 Aged Care Assessment Teams

Aged Care Assessment Teams could also be considered in terms of 'efficiencies'. We believe the Commission should give some closer scrutiny to the role of Aged Care Assessment Teams (ACAT) and to what degree they offer 'value added'. Again, there is a shortage of information on their effectiveness. We can give anecdotal comments of some 'non-urgent' applicants waiting four or five months just to be assessed for accommodation (in one particular region). Where is the accountability measure for these Teams? What explains different response outcomes? Are they offering a better assessment outcome than medical practitioners the average case?

ACATs have an implied 'gatekeeper' role but from a provider perspective the most significant force impacting on admission is the rigour of the RCS validation process. This ultimately, be necessity, assists providers to understand who is an appropriate resident in aged care.

4.7 Efficiency dividend - incentive?

Acknowledgement of the various challenges identified in 41.1, 4.1.2 and 4.13 above raises the difficult question of "is there potential for an efficiency dividend in aged care operations". It is quite clear that there continues to be significant pressures on aged care providers to create efficiencies merely to absorb the cost imposts of various standards that have been increased in the community and this is a challenge that aged care providers are struggling to maintain. The challenge for funders is to create sufficient flexibility within the aged care administration to allow for some efficiencies that can help absorb such additional costs associated with higher services thus attempt to limit the call on the government to provide for higher funding for these higher standards that are being demanded by the community. Reductions in transaction costs, and in the extensive costs of documentation to support funding, would translate to increased care funds.

5. Equity

5.1 Equitable Access to Service

Access to service is theoretically controlled by means of the aged services planning formula adopted in each state, i.e. 100 per 1,000 people aged over 70 years (though the service is not limited to those aged 70 years plus, an outcome which can impact on the assumed outcomes of the policy). At this stage both previous and existing Governments appear to be falling behind this ratio. This will affect access.

The other key issue of residential access relates to the degree to which providers will assess the viability of establishing new residential facilities within the new Aged are Act, using the Accommodation Charges and Bonds, and not having access to capital grants. There exists uncertainty about the viability of these funding streams which will impact on confidence and in turn, affects assessment of new facilities' viability and access.

5.2 Equity of resource availability

Equity, of course, implies not only access to services, but to services of a common (minimum) standard; such a standard requires the application of similar levels of man and other inputs regardless of location and it is self-evident that the cost of those inputs will vary between capital city, regional and isolated areas; fund costs, equipment maintenance, training and incentives for qualified staff are significant factors faced by South Australian regional providers. We are, however, conscious that taken as a whole the total basket of costs varies by a relatively narrow margin across all locations (refer ACA Submission ....), and would therefore support a , common national subsidy rather than seek to develop a subsidy system which attempts to reflect (relatively minor) cost variations.

5.2.1 Competing for professional staff

Working in aged care historically has not been seen as an attractive career option for professional nurses, particularly younger professional nurses.

The national environment of a shortage of professional nurses has the nursing home sector competing with the acute sector for staff. The wage pressures in South Australia are as follows:

1. NSW acute sector creates benchmark for parity claims.

2 South Australian acute sector creates responses with award changes and more recently enterprise bargain outcomes.

3. Aged Care, being a relatively small sector, is challenged to maintain parity with the acute sector.

   Recently South Australian public hospitals offered nurses 10.2% over three years, the first instalment of this was 3.3%. Providers have received an indexation in the RCS of 1.4%. Where do we find the difference in these rates?

   There are real issues in salary forces both between and within states both for acute care and aged care sectors.

5.2.2 Differential Costs

We are aware that ACA's submission to the Commission will be offering a paper on differential costs. It is our view that South Australia is a relatively high cost region with a relatively low income base from the RCS subsidy system.

We acknowledge the dangers of a system that automatically gives financial backing to higher cost regional outcomes, irrespective of their impact on quality. Surely all states would have the same outcomes and seek the same funding levels, if the arguments for these differences were plausible.

5.2.3 Social Equity

We would bring to the Commission's attention the sensitivity associated with models that imply double standards for the 'wealthy' and 'disadvantaged'. Discussion needs to emphasise that common Accreditation outcomes are the basis for all options considered.

5.2.4 Capital

'Capital' is another area that may relate to differential costs, Again, there is little data indicating the cost of capital. ACOA providers build in a competitive tendering environment and it costs in the order of $80,000 per place to provide a single room facility with ensuite and accompanying communal areas. Yet we are told some providers achieve lower cost outcomes interstate; does this reflect a minimalist response, a response with shorter life spans, or higher maintenance demands, or lower quality outcomes (shared rooms, less bathrooms, etc) or simply better management?

Though a significant topic in its own right, our view is that the 'capital' costs should not be reflected in RCS levels, and is not, therefore, a focus of the Commission in this inquiry. This issue extends to other funding streams, e.g. Concessional rates, the level of accommodation charges and accommodation bonds. In part, these account for regional differences with the higher costs, which are assumed to relate to land costs in some areas being reflected in higher bond levels (higher personal home sales). Flexibility in the level of 'accommodation charge' may lead to some further consideration of regional differences in costs that reflect higher land costs and higher incomes from sale of houses etc.

An option to increase the "Bond" level would involve adjusting the eligibility cut off point for the "Pensioner Supplement" which is currently $92,000. We would argue that given "Rent Assistance" and "Pension Supplement", are not exactly the same in the future, then the 'cut off' point applied to 'pensioner supplements' should be higher, thus encouraging greater Bond contributions being set by Providers.

Modelling suggests that the loss of 'Pensioner Supplement' e.g. around $5 per day, is equivalent to $1,825 a year, or a facility earning 4% on $45,000. Hence the loss of a Pensioner Supplement, assuming it is not borne by the resident, requires an extra bond of $45,000 or a bond level of $137,000. We therefore, argue that there are benefits to the sector, with minimal cost, if any, to Government, of increasing the "Pensioner Supplement" limit to $120,000, or so, thus protecting the supplement for residents and increasing the bond levels and confidence in Providers establishing new facilities.

6. Options for distribution of the funding pool

6.1 Equal Rate Models

An option that reflects the underlying assumption of the Coalition Government's seven year coalescence policy is that all states should have equal rates.

There are a number of different ways of achieving this outcome.

6.1.1 Coalescence to an average rate

Thus adopting the existing Coalition policy. However, this has a number of problems with it, as discussed in the first few pages of this paper. There are also problems faced by higher paid states, with difficulties in moving backwards to a lower cost base.

6.1.2 Coalescence to the higher rates - e.g. Victoria or Tasmania

In a cost-neutral environment this is also difficult as it involves a form of funding that acknowledges the need to increase lower paid states. Aged Care Queensland has mooted a model whereby indexation funding is used to increase lower paid states, thus higher paid states are kept at the existing funding levels. Lower paid states receive an accelerated indexation level until they reach the stipulated rate.

6.1.3 Equal share of the pool of funds in each state

The draft RCS Review highlighted the different outcomes in each state in relation to the proportion of residents in level 1, 2, 3 and 4. NSW and Victoria had significantly higher proportion of residents at levels 1 and 2, Western Australia and South Australia had significantly low proportions of residents in these levels.

It is a reasonable assumption, with the significant numbers of elderly being assessed in each state, that it was unlikely that 'skewing' such as has been evident in RCS 1 and 2 levels would be expected. We had assumed with a 'normal population curve' distribution the percentage of the RCS population in each state appearing in each level of the RCS to be in close proximity.

Why is this an issue? Because as there is a set pool of aged care funds the distribution of these funds in nursing homes (where the greater majority of funds are directed) will be related to:

(1) Whether the subsidy rate for each level is the same.
(2) Whether the same distribution of each state population is reflected in each RCS level.

The draft RCS Review identifies a concern we have regarding the compounding effect of the higher RCS subsidy level in Victoria and NSW and at the same time the significantly higher proportion of residents in these two states being assessed as needing the two highest subsidy levels, i.e. RCS 1 and 2.

Therefore, another funding option based on 'equal' rates would, for example have:

(1) Equal subsidy rates across Australia.
(2) Equal distributions of the RCS population in each state within each RCS level.

There is therefore the option to consider block funding states, on this equal share basis, (using the level of elderly in the population age 80 plus) and thus allowing each state to be accountable for the variations it particularly focuses on to resolve different cost issues within the state.

6.2. Differential Rate Models

The difficulty with a differential rate identified in the previous RCI or CAM system an now RCS, has been the:

(1) Lack of rigorous and transparent data
(2) Lack of review.

Thus, in South Australia, we believe that there is little if any, objective criteria that explains existing differentials between the states. This lack of transparency has caused emotive rather than objective arguments and a lack of appreciation of the key issues.

ACOA does not support differential rate outcomes as it would seem the system used in CAM has contributed more to inefficiencies, e.g. higher staffing ratios in Victoria, higher pay claims in NSW, not reflected nor subsidised in low paid states.

6.21 Child Care Model

We understand the child care model implies an option of a 'standard notional cost' across Australia. There is the standard $115 notional rate per approved place with no acknowledgement of cost differentials between states. Access to an approved place based on an income test with a maximum Government contribution of 83% of the notional rate ($115) for income of $500 or less per week down to nil (Government) contribution for income of $1,264 per week.

The existing child care model involves

- Standard Government subsidy - standard across Australia
- Varying facility budgets and costs which reflect a 'variable' fee above the standard Government subsidy,

The 'variable fee' concept is not significantly different in nature to that which was operating in 'hostels' and which the industry argued for but which the Government did not use. The difference in child care is that it involves a two-level differential; firstly the application of an income test on subsidy, secondly the application of a variable fee depending on the budget outcome of a particular facility.

Such a model in aged care would appear unrealistic, a key reason being that the arguments recently seen in nursing homes over fees (therefore politically unlikely) make this seem a more complicated system than the existing system in aged care and thus more difficult for providers and residents to fully understand.

We have limited experience of this model, relative to the existing aged care model. It is our view that the move towards the child care model would involve a significant change in aged care funding and hence be unlikely to be implemented for many years, if at all, given the recent political experience of implementing the existing aged care reforms

A concern with this model as described in the issues paper is how different states and regions are reviewed for the 'quality of service provided as well as in the costs of input' and how these are objectively reflected in a funding index. It raises the potential of the re-introduction of a 'validation' process which has recently ceased due to its administrative workload demands (being on top of demands arising out of the GST system applied to our sector).

6.2.2 Minimum Car Model

Theoretically this was the model previously adopted by hostels and their use of variable fees, which we believe worked very well,

Issues with this model relate to the degree to which the government will also regulate to ensure higher outcomes for higher fees, rather than allow the 'purchaser' to make their own choices in the market.

The concept of a 'minimum care model' is also argued to be in place now. There is a very strong reinforcement within the Accreditation system that existing standards are minimum and that 'continuous improvement' is a key requirement to build on these standards. Apart from the sense of Mission to encourage quality in the service, the additional existing incentive to continuously build on these minimal standards is the standing Accreditation requirement,

6.3 Reduction in transaction / documentation costs

Alternatives considered by the Commission need to give specific weighting to the impact on the administration and documentation requirements that are associated with a funding model.

It is ACOA's view that the Government has comprehensively failed in its stated intention to simplify the system and reduce administrative demands (and therefore costs) upon providers.

It has been frequently raised with ACOA by its members that the current aged care reforms have significantly increased administrative demands which have caused cost increases associated with managing the current aged care system. This is with an acknowledgement of further administrative increases that are expected in areas yet to be fully implemented such as accreditation and tax reform. In essence the more bureaucratic and administratively demanding these aged care systems are the more that limited financial resources are focused away from the direct care of the elderly.

ACOA suggests that a key objective of the Productivity Commission's role should be not only to direct its focus to productivity outcomes emanating from the system of funding which allows Providers to undertake their business, but just as importantly in such a regulated service environment, to undertake a critical analysis of the level of regulation and administrative demands placed on the system by the Government.

6.4 Exceptional Funding Needs

The existing funding system has already established and acknowledged that there is a need for the funding system to give additional support in some limited but essential areas of disadvantage. These are acknowledged through the viability supplements and hardship allowance subsidy streams in the existing process. It is ACOA's view that such distinctions should remain and be considered differently to the unjustified differentials that have been applied to state RCS subsidy levels. It is essential where such supplements are provided that they are based on objective and transparent criteria and would therefore be equitably applied across the nation.

7. Productivity Commission Recommendations. Sensitivity to impact on Public and Providers

Given the widespread public concern and difficulty of understanding over the 1997/98 aged care reform process and the considerable human and administrative costs experienced by providers, ACOA would argue that the Commission should focus on a realignment of the existing RCS based approach, taking account of the cost data provided by ACA and facilitating the early achievement of a common national subsidy,