NATIONAL ASSOCIATION OF NURSING HOMES AND PRIVATE HOSPITALS INC.

Quality Care For A Fair Return

30 September, 1998

Mr Michael Woods
Commissioner of the Productivity Commission
PO Box 80
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BY E-MAIL mwoods@pc.government.au

Dear Mr Woods

SUPPLEMENTARY SUBMISSION
COMMENTS ON THE ISSUES PAPER
PRODUCED BY THE PRODUCTIVITY COMMISSION
ON NURSING HOME SUBSIDY PAYMENTS

As foreshadowed in my letter to you dated 15th September 1998, 1 am enclosing a commentary on the questions raised in the Issues Paper.

This commentary should be read in conjunction with the Submission of the 15th September 1998.

1 look forward to hearing from you in due course.

Yours sincerely

Michael Keats
Chief Executive Officer

Encl.

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SUBMISSION TO THE PRODUCTIVITY COMMISSION

NURSING HOMES SUBSIDIES -

ISSUES PAPER AUGUST 1998 A COMMENTARY

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The Issues Paper produced by the Productivity Commission details background information for the Inquiry, and also raises a significant number of questions.

The purpose of this supplementary paper is to respond to the questions from the Association's perspective.

In many cases, the issues raised are covered in the Association's Submission and will be referred to from time to time.

WAGE AND WAGE RELATED COSTS

Q1: Is the commonly espoused 75%/25% ratio of wage to non-wage costs reasonable?

A: The ratio is a reasonable approximation given different sized facilities, different locations and different configurations of buildings. These various combinations lead to significant variations. Variations of ±10% are not uncommon. Local jurisdictional rulings relating to allowances for climate or remoteness, often are contributing causes.

Q2: In delivering services, what is the scope for substitution between labour inputs and equipment?

A: To reduce manual handling in the occupational health and safety arena the substitution of equipment for labour is being conducted on an experimental basis. This is in part driven by the need for more efficient ways to handle residents who have specific problems, but more importantly by the need for improved occupational health and safety practice by all employers, regardless of their industry classification.

Studies looking at the application of computer technology to resident classification (the "RCS') have the potential to provide for significantly more efficient use of qualified labour in future. The sophistication of computer technology is such that it could well be possible in the near future for less qualified persons than Registered Nurses, to determine the RCS profile for a resident, download the information from the handpiece to the PC and use the information once it is in the main computer to generate resident records for a variety of purposes.

The multiple use of a primary data collection source which tracks a resident from assessment by an Aged Care Assessment Team (ACAT) to ongoing occupancy is theoretically possible once this system is operational. Privacy laws currently prevent the effective use of this technology. Surely it is only a matter of time and a more thorough understanding of the need to be more efficient, which is standing in the way of the widespread use of this technology in management for Nursing Home residents.

It should be noted that Nursing Home care, by definition, is a highly personalised service. The Association believes that it is unlikely there would be significant reductions in labour content in Nursing Home care delivery, without compromising the quality of service.

The possibility for substituting equipment for labour is yet to be fully explored. However, greater capitalisation may not necessarily lead to cost reductions and could lead to a significant decline in the personal nature of service to Nursing Home residents and other aged care clients.

Q3: What proportion of total wages costs are accounted for by the different types of employees?

A: There is a generally accepted care staff industry ratio of 30%/60%10%. This is broadly reflective of the employment pattern in the industry being 30% registered nurses, 60% assistants in nursing and 10% enrolled nurses.

The above is a broad employment pattern of care staff. It relates principally to the former CAM funding model.

This ratio should also be related to the dependency ratio of residents. Across Australia, broadly the resident dependency ratio in Nursing Homes is:-

- Category 1 - 14%
- Category 2 - 42%
- Category 3 - 36%
- Category 4 - 8%

Q4: What is the scope to vary the proportions of different types of employees or to employ people to do more than one job?

A: Union based demarcation is a restrictive position in many situations where employees of different unions see "glass ceilings" for their various roles. Government funding constraints have also had a negative impact on employers wanting to experiment with such models as Enterprise Agreements. Removal of constraints and union co-operation could do much to improve the wage cost efficiency and encourage a more innovative approach to the delivery of care services.

In small remote care facilities, where options are limited, there is considerable multi-skilling of staff. There is also use of external contractors. In some towns, Multipurpose Centres have been established and a multi-disciplinary staff works across acute, sub-acute, aged care as well as community services.

Q5: How significant are labour on costs such as superannuation, payroll tax and workers compensation premiums?

A: The Association’s studies of recent data (May 1998) in four States, show that "on costs" vary in aggregate from approximately 31.19% to 35.51%. The main components of these "on costs" are workers compensation, superannuation and payroll tax.

Q6: How significant are current variations across States and Territories in Award rates for nursing staff and personal carers?

A: There are several unions and a great number of Industrial Tribunals involved in setting the rates of pay for different classifications of staff in all States and Territories.

In all cases the Award rates of pay for the sector are predetermined by decisions which are made in Industrial Tribunals setting conditions and rates of pay for public sector employees. The industry, whether it is the for-profit or the charitable not-for-profit sector goes to Industrial Commissions and Tribunals in full knowledge that the rates that will be determined are predetermined already. The industry is "a follower" when it comes to wages and conditions. It is not possible for Aged Care to separate its nursing or care staff or ancillary staff wages costs from the public sector.

Q7: Are there similar variations in Award rates for other categories of employee and in labour on costs?

A: Yes.

Q8: Are over award payments common in the sector and what are the reasons for them?

A: Nursing Home funding until the most recent Act was controlled by Commonwealth Government prescription. The ratio for staff skills required to deliver care services to residents has developed some rigidities in terms of what can be experimented with in terms of resident needs. With the new arrangements which provide lump sum funding for residents based on their RCS, there is opportunity for employers to employ a different mix of employees. A decline in the number of Registered Nurses employed in the industry has occurred, much to the chagrin of the ANF and other unions representing nursing personnel.

The previous system offered little capacity for operators to offer over award payments or any financial incentives. In the charitable non-profit sector there are special circumstances which allow public benevolent institutions to package salaries and reward staff more generously than exists in the for-profit sector. This is a taxation based arrangement, but it does provide for creative opportunities in an over award payment sense.

Given the freeing up of the system in terms of being prescriptive about staff employment, there is an increasing opportunity for employers to be more innovative in their funding approach. Given the number of other changes which are taking place in the industry in the arenas of certification of buildings and accreditation of care delivery, most employers are focussing their scarce resources and attention in achieving these outcomes before venturing into more creative industrial relations arrangements.

Q9: Are over award payments necessary to attract staff to more remote areas?

A: Staff who work in remote areas generally work to award prescription. In some circumstances, the award provides for area/climate allowances. Again, given the former prescriptive regime of funding and its acquittal process, there was little incentive for employers to be creative, or to pay over award payments.

Q10: Does the experience vary across jurisdictions and different types of employees?

A: Yes, the conditions enjoyed by different classes of employees under different awards largely depends on the strength of the bargaining position of the various unions. The previous constraints of funding have tended to minimise payments outside award conditions.

Q11: Are enterprise bargains or certified agreements becoming more common?

A: The experience of the Association is that Enterprise Bargaining or Certified Agreements are unusual. The comments made in question 8 regarding certification and accreditation apply and it will be some time, probably 2002 to 2004 before the industry sees an expansion of more creative employment instruments.

Again it should be remembered that the inflexibility of the previous funding prescription by the Commonwealth made it nearly impossible for trade offs to be negotiated between employers and employees. If there is some deregulation of the funding system as proposed by the Association, then opportunity would exist for employers to enter into creative wage arrangements with employees. Given the pressures of certification and accreditation, it is unlikely that employers will examine this option in the short term.

Q12: Is the small size of many providers an impediment to enterprise bargaining?

A: Size is an additional factor. The comments to the previous question apply. As employers explore the benefits of acting in concert for a variety of activities, for example sharing specialist services such as Diversional Therapy, Occupational Therapy, Podiatry etc, the limitations of size will become less of an issue. Proprietors of small facilities who try to survive alone, will find that business will become increasingly difficult and they will be forced to establish linkages and creative arrangements on a whole range of issues if they are going to survive.

Q13: Have pay rises under enterprise bargains or certified agreements been at least partially matched by cost savings for providers?

A: The Association's has insufficient evidence of such agreements or bargains to make an informed comment.

Q14: Do differences in staffing profiles contribute significantly to differences in wage costs across and within jurisdictions?

A: As indicated, the ratios of registered nurses, assistants in nursing and enrolled nurses are fairly constant across Australia and across Nursing Homes regardless of size. In areas and jurisdictions where funding is constrained more tightly than in others, such as in Queensland, the capacity of facilities to employ Registered Nurses and other highly qualified staff is limited.

Facilities are required by the process of standards monitoring, soon to be accreditation under the new regime, to meet minimum levels of outcome. These constraints forced the employment of a minimum number of skilled personnel in order to meet those outcomes. The greater number of "expensive" staff which have to be employed by prescription under the old regime, the less opportunity existed for creative staffing and more cost effective outcomes.

Proposals for coalescence force employers to look more creatively at a whole range of labour input substitutions ranging from capital opportunities at one end, to multi-skilling of staff at the other end.

Q15: To what extent do differences in staffing profiles result from licensing, regulatory and award requirements as distinct from managerial prerogative?

A: The staffing profile for a facility is determined by resident need. In some cases it is possible for contractors to be engaged, but generally the need to meet outcomes predetermines the staff mix. A high proportion of Category 1 residents in a resident mix, often requires less qualified staff than a high proportion of Category 2 residents. Category 1 residents can often be managed by staff with lesser qualifications, once care and medication regimes are established.

As already commented, the focus by proprietors and providers generally at the moment is towards achieving accreditation of their businesses.

Providers having achieved accreditation will realise the opportunity to creatively substitute capital and multi-skilled labour inputs and will start being much more creative given the needs of their residents.

The opportunity for all facilities to share professional staff in specialist areas will provide for a much greater diversity of services for clients and provide much more flexibility for management.

Q16: Are there other factors leading to jurisdictional differences in wages costs?

A: The remuneration paid to staff in the nursing home sector are directly related to the wages and conditions which are determined in public sector awards in each jurisdiction. The industry does not have the capacity to separate itself from this sector. Traditionally the public sector wage decisions have been more generous than those applying in the not-for-profit and for-profit private sectors.

The impact has been to attract qualified staff away from the sector to the public sector. The exceptions are where staff are dedicated to age care and the wage differential is of secondary importance.

Remoteness and climatic conditions have given rise to award conditions which reflect local situations. State and Territory funding decisions also impact on wages "on costs" for payroll tax, superannuation and to a lesser extent, worker's compensation.

The future capacity of the industry to substitute labour skills without having to employ prescribed employee categories will result in proprietors and providers becoming much more cost efficient.

It is conceivable that small rural providers share qualified staff at all levels. Provided that the care outcomes for all residents in each facility are met, there should be no question of being prescriptive as to who should be employed.

Q17: Are current disparities in wages costs across and within jurisdictions likely to widen, narrow or remain the same? What factors will contribute to this outcome?

A: The wage disparities across and within jurisdictions are likely to continue in much the same vein as at the present. The backdrop is the driving rate of the public sector award decisions already referred to, coupled with the success rate which the various unions negotiate to secure improved benefits for their members.

The freeing up of the prescriptive nature of the system as to how many and what skills should be employed to a situation where the provider must guarantee the resident care outcomes required, will cause the cost of disparities within and across facilities to widen.

Factors which could influence the quantum and rate of change in wages include a diverse array of issues. These range from union amalgamation, to partial deregulation of the industry, to the prospect of the Commonwealth Government determining to address some of the fundamental imbalances in the money made available to the different States and Territories.

Q18: Do non-wage costs vary significantly within or across jurisdictions?

A: Yes, land and building costs in New South Wales are significantly greater than in all other States. The greatest contrast is between New South Wales and Tasmania.

Distance is a significant problem. Where inputs such as food have to be transported over long distances it is a cost differential. Heating and cooling costs appear to be fairly equally balanced between the north and south of the continent.

The development of the so called SAM component of nursing home funding in 1987 was an attempt by the Commonwealth to coalesce, non wages costs into a single figure payment.

Ever since its establishment, the so-called SAM funding component has been contentious and always understated the real costs of service provision.

The increased costs of technological advances in banking at one extreme and the increased costs of continence aids at the other, showed that the former SAM component was deficient by up to $9.00 per day. Various Departmental inquiries over the life of SAM showed how inadequate it was. The end of CAM SAM/OCRE funding and the payment of a single lump sum without strings, has done something to free up the system in terms of the allocation of money, but it certainly has not increased the real quantum of money available to providers to meet operational costs.

Q19: Do such variations mainly relate to land and building costs or are variations in non-wage recurrent costs also significant?

A: It is certainly true that land and building costs vary widely across the States of Australia. Again NSW and Tasmania provide the classic example.

Some of the non-wage recurrent costs in States such as New South Wales are higher as a result of legislation. For example the NEW Environment Protection legislation provides directions for the disposal of medical sharps, medical wastes, the retention of surface water and appropriate disposal of sewage.

There is a wide spectrum of non wage recurrent costs which are faced by providers which are generally more expensive in the more closely populated States. This is only one of many pieces of legislation which impact on non wage recurrent costs.

Over a period of time it is likely that all States and Territories will move towards greater controls and as these are imposed, there will be cost implications which must be met by providers.

Q20: How much control do providers have over their non-wages costs?

A: In respect to statutory charges, providers have little control. State/Territory and Local Government detail specifications for everything from the incline rate of ramps, the type of materials for handrails, fire regulations, provision for off street parking, ambulance bay specifications and a myriad of other matters. Each of these are costs which providers must meet. The rate of change of these requirements will continue to accelerate and every change brings with it attendant costs.

Other statutory charges such as payroll tax and superannuation are prescribed by law. Workers Compensation premiums can be effected by good practice, however one accident can cause a proprietor a huge increase in costs which impacts on worker's compensation premiums for the ensuing three year period.

With respect to non wages costs of a non statutory nature, providers can have some impact on these through such processes as group buying and negotiated volume and term contracts with preferred suppliers. These issues have already been canvassed to some extent in a response to question 18.

Q21: What impact will the new accreditation certification requirements have on future costs?

A: It is uncertain at this stage what the total cost burden of certification and accreditation will be. The espoused position of the Aged Care Standards Agency, that accreditation is a goal which can never be reached in the full sense of the word, the costs of accreditation are an ongoing commitment of staff and resources to the achievement of this objective.

Breaking the question down into two parts - Certification which relates to building standards and building requirements will probably be taken into account by amendments to the Building Code of Australia which will lead to a more uniform approach towards building specification requirements. It should be noted that every site and every set of circumstances will have particular circumstances which are unique. The broad provisions relating to fire safety and egress will be constant for all facilities.

Technology is evolving at a rapid rate. In so far as buildings are concerned this process of revolution in building technology will continue to improve. As improvements are developed, authorities will apply the changes to the Building Codes and community expectations will be that these improvements translate into new buildings.

This will mean that larger floor areas per resident will be the norm. This will lead in turn to higher operational costs for cleaning, lighting, heating and cooling. The greater number of single wards will also mean a higher level of staffing, which will require more time merely to provide appropriate monitoring and surveillance of residents to ensure their safety.

When it comes to the accreditation process, the requirement to consult all the stakeholders about each of the forty four standards, is an ongoing process. Many proprietors and providers are yet to come to grips with the implications of accreditation being a continuous process. Providers have had years of being belted into submission by meeting specific outcomes at a specific period of time. To now move to a situation where the process is an ongoing one, with the initiative for review largely moving to the stakeholders collectively, provides a challenge which few providers can yet fully comprehend.

Accreditation also has direct cost implications for provider's budgets.

The Agency has, due to the political situation, been unable to announce to providers and the industry at large what the licensing fee for accreditation will be.

Rumours in the industry are rife. Estimates range from a low figure of $4,000 to $5,000 for an average facility to as high as $20,000 for a three year licence for a hundred bed facility.

Information in the field would seem to indicate that the fee will be in two parts, with the first part being similar to the "flag fall" when hiring a taxi. The second part would be a per bed fee which relates to the number of beds in the facility concerned.

The $20,000 fee that has been rumoured for a hundred bed facility, would be possibly made up of $2,000 "flag fall", plus $60 per bed per year for the three year term, making three years of $6,000 and a total of $20,000 in all.

The Association holds the view that if facilities which are able to achieve the three year accreditation status are allowed access to a de-regulated market, then the cost of accreditation will be recoupable as a result of the incentive initiatives which are available.

If incentive is not available, then the industry faces a very bleak situation in terms of capacity and willingness to deliver improved conditions on an ongoing basis with no financial reward.

Governments may find, to their disappointment, that proprietors and providers are more interested in handing in their licences under such circumstances, rather than trying to meet impossible financial and poor commercial situations.

THE MERITS OF ALTERNATIVE FUNDING METHODOLOGIES

Q22: Are subsidy arrangements recognised differences in costs across jurisdictions an effective way of promoting equitable access to quality residential age care services?

A: The short answer to this is yes. However, the subsidy arrangement should recognise the differential cost of wages, wages on-costs and other inputs which are determined by State jurisdictions which are independent of Commonwealth arrangements or Commonwealth policies.

In some States such as Queensland and South Australia historical precedents have led to the current situation resulted in a distortion in funding. This distortion should be corrected independently of any other initiatives which are taken, whether this be in the field of a partial deregulation or a coalescence of funding.

Q23: Would this rationale also extend to differentiating subsidies within States and Territories as well as between them?

A: The short answer is yes. This is particularly the case for the larger States where distances and geography are such that special circumstances exist which have been recognised by way of loadings or climate payments. These special loadings should continue to be appropriately funded where providers are disadvantaged by remoteness or geography vis à vis the rest of the community.

Q24: Other rationales for such subsidy arrangements

A: Given that the costs of wages and wages on-costs drive the cost of care delivery and that the costs of services are determined by local conditions within States and Territories, then the cost of care delivery like any other service must reflect the cost of the inputs for its delivery.

The Association is prepared to accept a uniform payment which is not a 100% reimbursement of actual costs on the proviso that incentive based deregulation at the top end is permitted.

Q25: Would the objective of equitable access be better served by taking into account differences in total costs rather than primarily differences in wages costs for nursing and personal care staff?

A: Yes. Given that the cost of care is a function of costs relating to wages, wages on costs, transport, availability of services and a myriad of other items, then the total cost of care of a prescribed nature and level requires aggregation of all costs in order to achieve the outcome.

The Association would argue, as it has in its principal Submission, that incentive based deregulation for organisations that have achieved three year accreditation should provide entrepreneurial opportunities for organisations to be creative and responsive to total care needs. The more opportunity there is for innovation in care delivery the greater the chances are of new ways of care delivery being developed and the cost of such care to be more competitively priced.

The Association holds the view that the industry is still to come to grips with the funding offered by the Commonwealth and to flex its muscles in terms of creative approaches to care delivery. Whilst the Commonwealth Government may have freed the funding formula, the union certainly have not taken such a flexible approach and many still wish to hold to rigid formulas which are no longer relevant.

The industry would also like to be guaranteed that the changes brought about by certification and accreditation and the abandonment of CAM SAM funding are to be a permanent feature of Nursing Home fee payments by the Commonwealth Government.

If this is the case, then the industry would feel much more encouraged to be more innovative and experimental in its approach to care delivery. If however, every three years a change in Government is going to bring about a change in circumstances and conditions in which the industry operates, then there is no incentive whatsoever for the industry to be creative and invest heavily in alternative approaches.

Q26: Alternatively should State based subsidies only reflect cost differences beyond the control of providers?

A: This question again begs that the funding regime for Nursing Homes is going to remain in a deregulated market situation where the provider has discretion over the quantum of payments which are used for personal care and other costs in providing care to residents.

The Association would argue that the industry needs to have these reassurances before it can effect a total cultural change into its approach to service delivery. Experience with Commonwealth Government involvement in Nursing Home care provision over the last twenty five years, does not give confidence to providers that creativity in terms of service provision will be rewarded.

Indeed, history shows that providers who want to be innovative, usually end up being penalised as a result of validations, standards monitoring and other draconian measures which are designed to satisfy acquittal and accounting procedures, but not necessarily reflect the quality and care and dedication of care provision.

The Association would also argue as a very minimum that payments made by the Commonwealth to providers in various States and Territories, should meet the real costs of statutory charges which are imposed, as well as a reasonable measure of actual costs. Then and only then is access to deregulated activity on an incentive basis provided.

Q27: Does a State based regime necessarily promote equitable access to services over time?

A: No, given the answer to the previous question, an approach which is to generate innovation and improvement on an ongoing basis is far better.

Q28: Should indexation arrangements take account of changing cost relativities between and within jurisdictions?

A: Yes, the Association has detailed an approach to indexation in its major Submission which is reflective of the various components of cost. This approach is a realistic one. The Association reaffirms its position that such indexation should be accompanied by a partial deregulation which provides the incentive to take providers beyond a mere reimbursement formula to one which stimulates interaction and linkages with other service providers at both the community and acute care ends of the care spectrum and stimulates better quality and continuous improvement outside traditional residential care.

Q29: Does a State based regime tend to lock in the quality relativities across jurisdictions that prevailed at commencement?

A: Yes. The answers given to the previous two or three questions should be revisited in answer to this question.

Q30: Should a differentiated subsidy regime also take into account the differences across Government, charitable and private providers in liability for sales tax, fringe benefits tax, payroll tax and the like?

A: There are significant advantages currently enjoyed by both State Governments and the charitable not-for-profit sector. Within the charitable not-for-profit sector there are further distinctions. Organisations which have the further distinction of being public benevolent institutions enjoy tax concessions which are greater than those that are not, even though they may enjoy some exemption from sales tax.

There have been arguments mounted that the for-profit sector enjoys deduction of business expenses before striking its bottom line and that the net effect of tax concessions to the charitable sector is marginal. The Association would prefer to see a much more open accountability of payments made and the differential benefits paid on both sides taken into account. This is quite apart from cross jurisdictional issues which have already been canvassed.

Q31: Are there other ways of addressing tax related cost differences?

A: One, proposition is for the Commonwealth Government to rank all Nursing Homes and age care facilities as equals in terms of taxation treatment. This would mean that any concessions granted to one sector, eg sales tax exemption, would apply equally to all other sectors.

There is a tension between the charitable not-for-profit organisations that do not distribute profits and those operated by entrepreneurs that do. The charitable not-for-profit sector argues that all surpluses below the bottom line are ploughed back into improved services to the clients. This may result in excessive staffing levels in comparative terms. Financial statistics of the two sectors show that the for-profit sector can achieve positive results in terms of resident care, after depreciation with the current funding regime. There would appear to be a case for the charitable sector to answer, that it is inefficient in care delivery.

Q32: Has the state based subsidy regime reduced incentives for cost effective service delivery?

A: Where State based subsidies are for direct reimbursement for statutory costs and charges, there is no possibility of incentive reductions being made because the statutory charges are non negotiable.

If award conditions are added to the equation and the industry is deprived of access to enterprise bargaining because of Commonwealth funding constraints, then there is little for providers to negotiate. Again, if we restate the proposition that there are guarantees to providers that creativity in terms of utilisation of resources is not going to be penalised or subject every three years to a possible change in how it operates, then there will be a much greater willingness to examine creative approaches to the total resourcing of aged care services.

The Association reaffirms its previous comments that partially deregulated incentive based funding is the best approach and one which would lead to innovation and creative solutions.

Until the industry is freed of the shackles that currently bind it, we do not know what horizontal and vertical linkages and innovations are possible and the potential benefits which could accrue to clients who have for years been compartmentalised by Government policy and by provider care provision.

For example the industry has been firmly constrained from mixing younger residents with older residents. It has been firmly constrained from mixing people with disability from people with aged care needs. It has been firmly constrained from mixing residential and non-residential care services.

The reality is that in the real world these groups intermix. If these barriers are now to be removed, then the opportunities for providers to move across all these sectors, plus integrating acute and sub-acute services with residential services and at home services, then there will be greater efficiencies and more natural outcomes.

Q33: If so, is this a function of the former subsidy or the previous acquittal system which required nursing home operators to return some unspent funding to the Commonwealth?

A: The Association regards a return to a system of "bean counting aged care services" as an anathema. If the industry is to have a better performance in the marketplace, then the industry must be allowed to flourish and create outcomes which provide services which consumers want. Services that are cost effective. Services that are flexible and capable of working across the whole spectrum.

In short, the process must not only become market oriented, it must also become consumer oriented and the funding regime must reflect the needs of providers to meet these outcomes.

Q34: Have constraints on the overall level of Commonwealth support offset any such disincentives for efficient provision?

A: The short answer is yes. The constraints have prevented a proper efficient industry from developing which is marketplace sensitive.

The level of Commonwealth support to the industry has been investigated on a number of previous occasions by the Department and internal inquiries as well.

The Association would argue that there is evidence that the previous level of constraints on funding and its restrictive compartmentalised nature supported both financial and labour practices which were a disincentive to the industry and care provision.

Under regimes such as CAM/SAM/OCRE funding, standards monitoring and acquittal, there were no opportunities for reinvestment in the industry. The whole process was geared towards completion of paperwork in meeting set predetermined policy targets, rather than focussing on incentives for improvement and on the needs of individual clients.

Q35: Has the State based subsidy regime had other efficiency impacts?

A: The previous funding formula of CAM/SAM/OCRE plus State prescriptions had the effect of forcing providers to tread a balance between dependency levels, staffing levels and funding.

In Victoria for example where the number of Registered Nurses to be employed is part of a State formula, proprietors had their flexibility in management constrained. In such cases efficiency could not be achieved as full-time Registered Nurse hours precluded appropriate use of total resources.

As the former funding process developed, proprietors new that a particular mix of residents optimised their financial return. This often led to the quixotic situation where it was cheaper to have an empty bed, rather than to have an inappropriate classification of resident coming in and thus upsetting the balance of funding and therefore resources available to the organisation for care delivery.

Under such circumstances, individual facilities developed profiles of profitability and comparable profiles of dependency and matched these as far as possible.

Under the new funding regime, it is possible for proprietors and providers to be far more creative in their approach with classifications of staff employed and the duties of those staff, except in those States where prescription is still a feature.

It has already been mentioned the industry is still grappling with certification and accreditation as prerequisites for ongoing Commonwealth funding. Provider focus on staffing, particularly creative staffing has not yet been fully developed and will not be until the certification and accreditation process is worked through.

The new RCS instrument is a further factor which is challenging providers.

Q36: How well correlated are current subsidy rates to jurisdictional wage costs?

A: Effective from 1 st October 1997 the fee income which was payable to providers no longer related to identified costs but to the amount of money which the Commonwealth Government had budgeted as being necessary for the care of residents, based on the historical precedent.

As far as the industry is able to ascertain, the payments made by the Commonwealth Government do not relate to actual costs. They are simply estimates of the previous unsatisfactory arrangements, indexed by methods which are equally unsatisfactory.

The Association would argue on a number of levels. Firstly, that the fee paid by the Commonwealth is appropriately indexed as per the Submission. Secondly, the base of the indexation be reviewed. Thirdly that partial deregulation of the industry is allowed and providers who had achieved three year accreditation would have the right to charge residents able to pay room supplements.

Q37: Could changes to the indexation formulas produce a better match in the future?

A: As discussed in the Association's paper, the formula for reimbursement of the Commonwealth fee must be indexed as closely as possible to the real costs entailed. As has been explained, the public sector awards are the drivers for nursing and related wages costs which form the vast bulk of costs incurred by providers in delivering quality care.

Q38: Will access to more flexible labour market arrangements and possibly greater reliance on enterprise based wage deals make it more difficult to link subsidy rates to wage costs in the future?

A: The Association believes that once the industry and providers have overcome the historical precedent of CAM/SAM/OCRE funding, overcome the challenges of certification and accreditation and the new RCS instrument, then creative approaches can and will be taken towards employment of labour of a range of skills.

In so far as linking subsidy rates to wages cost in the future, this will become a more difficult exercise. Given that the Commonwealth Government needs a viable, effective and vibrant nursing home industry, the relevance of the question is questionable.

What the industry needs is freedom from the shackles of industrial prescription as well as the shackles of prescriptive funding. It needs the opportunity to be creative, flexible and provide quality care across the whole aged care sector. As has been reiterated on numerous occasions, we have moved from policy based funding to client based funding. It is going to take time both for employers and employees as well as other stakeholders to adjust to this new situation.

Q39: Do such considerations suggest that the information requirements and administrative costs of the State based subsidy regime will increase in the future?

A: There is no doubt that providers in the industry will be required to provide more information to an increasing array of authorities to justify fee payments that are received.

Of great concern to industry is that information requirements and administrative costs are increasing at an alarming rate. Not all that many years ago, on-costs relating to administration and various employee benefits were estimated between 14-15% of total wages costs. This figure is now conservatively placed towards 26% and rising.

Take the example of the new sophisticated Worker's Compensation requirements in the New South Wales. The requirements on the provider of care who is to partner with the Doctor, the employee, the rehabilitation co-ordinator and the insurance company to ensure the fastest possible rehabilitation of the worker or to return to work is in place. The amount of staff time involved in counselling, advising and assisting every worker's compensation claim, is a significant cost to the business.

As a rule of thumb, each Worker's Compensation claim in dollar terms costs ten times the amount to the provider.

Accreditation is another area where increasing amounts of overhead time must be spent with the stakeholders in order to satisfy the accreditation process.

The Association believes that the application of computer technology in a range of areas does hold the prospect of once only data entry which can in turn be used to generate a whole series of documents and information required to satisfy State and Commonwealth acquittal processes. The possible downside of this innovation is the inability of many small providers to invest in the resources required to achieve use of this technology.

As has already been canvassed on a number of issues, there are opportunities for providers to link together to pool activities of all kinds.

The investment in computer technology is very low in the industry at the present time. This is particularly so in rural and remote areas. There are many facilities that do not even have basic communication facilities such as facsimile. The number of facilities who have e-mail and similar technology is very low.

The ongoing information requirements of providers by all stakeholders is going to be such that unless the very latest in technology is used, then the organisations will simply not survive as independent entities.

It is recommended that a further Inquiry be conducted into the industry, as to the existing levels of technology application and how these levels might be increased and the resources required to achieve this can be funded.

The way things are heading, it would seem that any group that is unable to use a base of one thousand beds or greater, will be unable to be cost effective and to meet the expectations of all stakeholders. The one thousand bed figure is a guesstimate, given the advances in technology the on-cost resources which are not productive in terms of hands on care. Anything less would seem to be sub-optimum in terms of stakeholder and client outcomes.

Q40: Are there other administrative considerations impinging on the use of State based subsidies or cost based subsidies more generally?

A: Where cases have to be made for receiving subsidy there is an increasing demand for justification for payment of the subsidy by the proprietors. The more authorities that have to be satisfied, the greater the need for generating reports and providing data.

There is already a situation in many facilities, where as much time is spent on paperwork as is spent on care delivery. Not only is this a gross misuse of expensive resources but it is done to satisfy audit requirements rather than to meet client care outcomes.

Whilst the above comment is not directly related to the use of State based subsidies, it is relevant where an accountability process is required.

PROPOSED NATIONAL SUBSIDIES

Q41: What impacts would coalescence to national average subsidy rates have on access to and quality of residential aged care services across Australia?

A: In facilities in those States and Territories which are coalescing downwards, there will be pressure to reduce staff to balance budgets. Such an approach will have an adverse effect on care unless the constraints on care provision by providers are completely flexible and new classifications of employees can be engaged who are not constrained by union prescription, rather oriented towards the holistic care of the client.

Even if that freedom in the marketplace were granted and were to happen immediately, the financial pressure could well result in adverse impacts on clients.

As the Association has documented in its major Submission, States and Territories that are coalescing upwards will have pressure placed on them by the union movement for increased wages for employees.

For the concept of coalescence to be workable at all levels, there needs to be structural adjustment to the payments made by the Commonwealth for the States of Queensland and South Australia. It has already been demonstrated that coalescence embracing a mixture of jurisdictional outcomes is not a sensible approach to funding aged care facilities of itself.

Coalescence, if it is going to be successful, needs to be in the context of significant other changes including partial incentive deregulation of the market.

Q42: Would there be significant differences and impact between regions within States or Territories?

A: As has been indicated in the Association's major Submission, the jurisdictional divisions created by the States and Territories are a less than satisfactory instrument on which to base payments, but they do recognise some of the differences which apply across Australia.

Regional differences due to distance, climate or other factors are generally accounted for in the current inadequate funding mechanisms.

A new policy for reimbursement of nursing home subsidies which is less sensitive than the existing one would lead to significant financial disequilibrium. and may cause a number of facilities to close.

The Commonwealth Government's control of the aged care industry has been such that it is arguably the most controlled industry in the country. The long term outcome of certification and accreditation, coupled with deregulation of the labour market and also a stepping back of some of the State Government Authorities, provide the opportunity to deliver better, more cost effective care to clients.

One of the issues which the industry has been arguing with the Commonwealth and State Authorities over many years is the inability of "authority" to listen to reality and understand that remote areas, climatically adversely effected areas, particular communities such as the Aboriginals and Torres Straight Islanders do require market specific funding assistance rather than a meek acceptance of an Australia wide funding formula on the basis that one size fits all.

Q43: What impact would coalescence have on the wages and conditions of employees in nursing homes and hostels?

A: Where an employer has less money to employ the workforce, there has to be worker shedding in order to balance the budget and remain in business.

Any application of coalescence which is insensitive to this situation will fall in terms of delivering better care outcomes.

In those States where coalescence is downwards, the effect on labour will be disastrous from a morale point of view and would cause immediate shedding and a flight of quality labour from the Nursing Home industry to other parts of the health sector.

As indicated, the wage disparity between the public sector funding and private non-profit and profit sectors for aged care has created a situation of industry having to put up with people who are either totally dedicated or who are unable to secure a position in the public sector.

Q44: What impact would it have on the market value of bed licences?

A: The value of "bed licences" is a poorly understood concept. Such licences have acquired a value in that they are transferable within prescribed areas. Also under certain circumstances bed licences can be transferred from over-bedded areas to under-bedded areas.

The "value" of a bed licence relates to the commercial decision of a provider to acquire licences in order to aggregate beds and make economic units. The value of the licence is very much related to supply and demand. As has been indicated, the need for providers to become big investors in technology and to aggregate their purchasing and operational size into significant units is going to involve an increasing number of transactions of bed licences within the industry.

Given the desire to restructure the industry, the Commonwealth should be encouraging such a process and realise that a bed licence is part of the total investment required by a provider to develop a cost effective and viable market operation.

Q45: Would the proposed introduction of nationally uniform subsidies improve the incentive for cost effect provision, and if so, how?

A: The Association believes that the diversity of factors which are overlooked by a uniform subsidy payment, provide subsidies which are unrelated to industry costs and therefore would create dislocations and closures. As already indicated, in certain States the problems are fundamental and these need addressing independently of any uniform payment by a coalescence or any other mechanism.

It has also been shown that State based statutory costs are independent of the Commonwealth's funding arrangements and even given that the range of such costs is approximately 5%, the quantum of that 5% is of such a magnitude as to have a negative impact on care provision.

This position is exacerbated by the years of under funding through the former CAM SAM/OCRE process, the lack of return on investment for providers would be totally inadequate for capital funding regime opportunities which have presented themselves in the past. It is not possible to look at the introduction of nationally uniform subsidies without doing so in the context of what has happened in the past.

As indicated, the future is equally challenging with certification and accreditation being prerequisites to ongoing funding. The industry needs far more sensitive understanding by the Commonwealth Government before a decision is made.

Q46: Would there be other efficiency benefits or savings in administrative costs

A: The Association believes that the costs detailed in future administration are set to continually rise as the accountability requirements to all stakeholders including statutory authorities increases.

The Association believes that many of the small providers will find themselves caught in impossible financial situations and forced either to close their doors or to look at staff mixes and levels which are not based on care needs but which are based on survival. The Association believes that this situation will lead to providers being unable to meet their accreditation processes and consequently they will be forced to merge, reconstruct, form consortia, or leave the industry.

A major issue which has not been addressed in the Inquiry, is the level of investment and reinvestment in the aged care industry. It is all very well to look at published statistics about the quantum of money which has been invested in the past, but this does not take into account the combined effect of requirements from such a diverse array of stakeholders, including statutory authorities, the increasing expectations of stakeholders and the lack of resources over the years for providers to invest in new technology and communications equipment.

Q47: Would coalescence simply speed up or slow down expected structural changes in the residential age care sector or would it substantially alter the shape of the sector in years to come?

A: The Association believes that appropriate modelling of funding and care needs, needs to be undertaken. This would involve an understanding of the total capital funding requirements of the industry, including investment in technology and communication.

On the recurrent cost side, there needs to be substantial freeing up of labour that can be employed and the skills mix required of that labour.

The industry has taken some initiatives in terms of labour training. The Association would advocate the development of entirely new skilled staff which is outside the constraints of Registered Nurse training and demarcation issues of non-care staff training as well.

The industry needs a new hybrid type employee who is capable of meeting statutory requirements. For example, capable of medication delivery, but at the same time freed from the nexus of award payments and public sector awards.

Here the industry needs the encouragement of the Government and the positive support of the union movement to develop an innovative program which leads to a new classification of employee which is quarantined from history.

The Association would lend its expertise and industry knowledge to assist in the development of such courses, the graduates of which would be technology literate, legally and morally aware of their total responsibilities and capable of working across the spectrum of care delivery from its highest to lowest levels.

ALTERNATIVE FUNDING ARRANGEMENTS

Q48 Are there alternatives to the current and proposed subsidy regimes which would promote more equitable access to nursing home services, a greater range of choice for residents and/or more efficient service provisions?

A: As discussed in the Association's Submission to the Commission, the Association proposes an incentive driven partial deregulation which would enable providers who had achieved three year accreditation to charge a premium on single ward accommodation at two levels.

The first level would be single ward accommodation with shared facilities. The second would be single accommodation with private facilities.

The suggested maximum premium which could be charged by providers (subject to indexation) is $6 per day for a single room with shared facilities and $12 per day for a single room with private facilities.

As a trade off, the proprietor would accept say a 15% reduction in the quantum of Commonwealth fee payment but still retain 85% of the pension paid by the resident.

All the above is on the assumption that the Commonwealth is prepared to accept proper indexation of its contribution based on the formula detailed in the main Submission.

The proposal has the advantage of commanding an affordable .contribution from residents able to pay

The outcome is the delivery of a capital cash flow stream to the industry which proprietors can use to upgrade facilities and provide better care.

There are few providers if any, who at this stage have been prepared to invest in hotel suites as part of a residential aged care complex for use by relatives and family on a fee for service basis.

There are no innovations at this stage to create resort type accommodation with Nursing Home accommodation and to construct facilities accordingly.

Many times the Commonwealth has said it wants industry to be innovative, but the funding constraints have always precluded a real innovative approach because of blinkered vision by bureaucrats and inspectors who in the past have been driven by policy frameworks rather than client outcomes.

If the Commonwealth Government and the State Governments want the industry to produce aged care services and facilities which are indicative of the total needs of the Australian community, then a resort type approach is one of many options which are available.

One of the positive outcomes of the existing situation is that proprietors have learnt to not only to meet Commonwealth targets for looking after concessional residents, but to exceed them.

With a freeing up of the resources, both labour and capital that are required, future developments in aged care should be innovative and create a situation where Nursing Homes are regarded very positively by the community.

Q49 Would a pure percentage based subsidy be sensible? Would there be a need for some maximum dollar caps to avoid taxpayers subsidising unnecessary embellishments to services? With residents meeting a percentage of total costs would there be a greater incentive for providers to levy a services cost effectively? Under a percentage based scheme would some additional special needs funding be required to keep services affordable in very high cost locations?

A: Given the Association's proposals to date, we believe that the model would meet all of the criteria and, at the same time, meet the stated objectives by the Commonwealth of meeting the needs of concessional residents as well as the marketplace.

To have an industry that is positive in community and marketplace expectations, all of the factors must be right. This includes:-

- Capital investment;
- Freeing up the labour market and developing new types of skilled labour; and
- Involving Commonwealth contributions which are appropriately indexed.

As the Association has indicated, the fee payment of a percentage of costs is acceptable. This is provided the fee is linked to incentive based deregulation and provided the set percentages of concessional residents are met. Provided that those residents who can afford to pay are making a contribution, then services which are developed will be in line with marketplace needs. The Commonwealth should have no fear that taxpayers are subsidising unnecessary embellishments to services.

Q50: Would paying subsidies direct to residents rather than Nursing Homes increase the pressure on providers to deliver the right service at the right price, or would it simply involve an additional administrative cost with little or no offsetting efficiency gain?

A: The Association holds the view that subsidy holders should continue to be Nursing Home providers rather than residents.

The average length of stay of high care residents is continuing to decline as pressure on facilities is to take people with the greatest need.

The demand for residential accommodation by the frail aged has led to low vacancy rates in most facilities and little opportunity for potential residents to shop around. There would seem to be little advantage in paying subsidies to residents who in turn pay it to a residential provider.

However, if the resident could buy comparable services in their own homes, with a tapered subsidy payment, the opportunity exists for the industry to evolve a whole new approach to residential care delivery, which includes care at home.

Without financial modelling, it is not possible to say whether this is a feasible approach. There are also issues of service delivery in remote areas and the needs of particular communities, such as Aboriginals and Torres Straight Islanders.

Given the existing processes of assessment and the options of home care services, it would seem that when residential care is required, a specialised facility is the most effective cost option. Under these circumstances, there seems little point in residents holding the subsidy.

What would help is the subsidy:-

(a) being tapered; and
(b) being transferable from within a registered facility to a person at home or vice versa on a flexible basis.

Again, we are looking at the situation where the payment made by the Commonwealth should assist the client to buy the services they require, not the Government policy being acquitted to the satisfaction of bureaucracy.

Q51: How important is resolution of the funding methodology issue for providers and their residents? Will its significance increase or diminish over time?

A: The adequacy and appropriateness of funding for aged care is of fundamental importance to reassure the industry that the future will be market driven.

Since the involvement of the Commonwealth Government in 1963, the industry has been subject to ongoing changes in control and funding. The significance of the Productivity Commission Inquiry cannot be underestimated. It is perhaps the greatest opportunity the industry has ever had to demonstrate that it needs a positive environment to flourish and to fulfil its obligations to frail, aged Australians.

The Association believes that the freeing up of the process to encourage a wide spectrum of services, innovation is required. The abandoning of CAM/SAM/OCRE funding as an acquittal process is only the beginning.

The new funding mechanism should reward providers who not only achieve accreditation, but who go beyond the lines of Government specification and develop new linkages and services which cross the acute, sub-acute, residential and home care service and provide holistic care for frail, aged Australians.

The issue of funding methodology should be seen as a total opportunity for aged care in whatever setting it is delivered.

Q52: Would it continue to be appropriate to separate funding for residential care from funding for other forms of Aged Care? What sort of funding methodologies would help to facilitate the integration of support for residential and community based care?

A: The short answer is no. The reply to question 51 above gives some indication of where the Association believes funding should be applied. Funding should look at the needs of the client, not programs and policies.

It is fair to say that there are huge educational, funding and logistical processes to be addressed.

Traditionally, providers of residential aged care have remained separate and aloof from home and community care and community aged care packages.

The Association believes the blurring of the boundaries is an important part of the changes which need to occur. This approach has the need for accreditation to be extended to non-residential care services and the rigid compartmentalising of funding and operation of services to be abandoned.

It is only in the last ten years that a number of residential aged care providers in the for-profit sector have ventured into the area of hostel care provision.

A number of those who have put their toe in the water have discovered that frail aged hostels are a constructive and profitable option to expand their business activities. There is no reason to believe that in the future residential aged care providers, given access to the non-residential care market, with appropriate freedom to operate, become effective players as well.

IMPLEMENTATION ISSUES

Q53: Over what period of time should any proposed alternative funding arrangements be introduced?

A: The Association's proposal assumes that there will be some understanding by the Commonwealth Government of the need initially for ongoing funding and resource provisions to occur so that the existing system can continue to function.

The implementation and accreditation processes are going to cause restructuring of the industry and major concerns for consumers and providers alike. The Association also believes that stance and position of the traditional players in the industry has been so rigid, so predictable, that it has been impossible for outcomes to be achieved which are anything other then predictable in themselves.

The time that the above process is going to take can not be readily quantified, but what needs to happen is for the Productivity Commission to recommend the creation of opportunities for a fresh approach to be taken.

Q54: Would any proposed changes to the funding regime require change to the supporting bureaucratic structures and/or regulations, and if so what would this entail?

A: As already outlined, the Association is taking a fresh creative approach to the provision of aged care services whether they are residential or not. The blending of programs and need to be client driven rather than policy driven, needs to be a new philosophical paradigm.

As with the change from the separate Nursing Home and Hostel programs to a residential aged care facility program, this process now needs to be extended to non-residential care services at the one end and acute care services at the other end. It needs to provide a total envelope of care.

Programs should be people driven, not policy driven. Industry policy and policy deliberating structures should include a broad range of stakeholders . The charter of such groups needs to be holistic and also needs to acknowledge reality, not the artificial constraints imposed by either Government, providers, unions, consumers or other players.

The Aged Care Standards Agency should expand its role to include acute and non-residential care services. Quality Assessors should span the range of aged care services. Funding should attach to providers, but clients should feel and safe in the knowledge that the subsidy which attaches to their care needs is flexible and changes as their needs changes.

Profiles of care needs of individuals from basic home care needs to intensive residential care should be developed.

Acute care episodes and the diversity of needs of clients along the way from HACC to palliative care should be addressed and the funding regimes and care provisions adjusted accordingly.

A fresh approach to total aged care services should be developed which is client driven, not program driven.

The changes to supporting bureaucratic structures and/or regulations detailed by these thoughts are significant.

The industry is not asking for an open cheque book from the Commonwealth. What the industry is asking for is understanding and an awareness that artificial barriers imposed by any interest group along the way mitigate against appropriate care provision.

Q55: What sort of accountability requirements should apply to providers?

A: All stakeholders are accountable. When it comes to providers, all providers have accountability to a multitude of stakeholders. Each provider should be required to produce an annual report and this report should be available in the public domain for all to examine.

This accountability should apply equally to consumer groups, to the union movement and to Government.

Each should have the honesty and the integrity to provide reports which acknowledge both the successes and failures of the system and be prepared to work together to develop care service delivery which is the best we can do for frail aged Australians.