SUBMISSION TO THE PRODUCTIVITY COMMISSION

NURSING HOMES SUBSIDIES INQUIRY

The South Australian Government makes the following points for the Commission's consideration in its Inquiry into Nursing Homes Subsidies.

Reference of the Nursing Home subsidies issue to the Commission

The reference of the subsidies issue to the Commission is of concern in that the Commonwealth has previously acknowledged the need for uniform rates across Australia. The referral to the Productivity Commission opens up the possibility of maintenance of non-equal rates.

Current interstate discrepancies

There exists a significant discrepancy in Commonwealth subsidy rates between the States and Territories. SA receives the lowest subsidy rate behind all States and territories, except for Queensland. SA also receives the lowest (after Queensland) rates of payroll tax supplementation and respite care bed rates.

If the bed rate fees are considered over a year for the average nursing home size of 40 beds, the difference in funding is significant. A 40 bed nursing home in Victoria at $39,602 per bed per year will receive $1,584,100 in bed fees. A similar size home in SA will receive $35,434 per bed per year for a total of $1,417,368.

This is a difference of $166,732 per annum or the equivalent of 3 level 1 nursing staff'

Coalescence time lag

The staggered move towards addressing the subsidy discrepancy over a seven year period will continue to disadvantage SA. For example, the 2% adjustment from 1 July 1998 only represents $0.26 per day against the $13 per day difference in rates between SA and Tasmania.

This inequity is further compounded by NSW and Victoria having a higher proportion of RCS1 and 2 residents and thus receiving a larger share of Commonwealth subsidy.

Demographic differentials between States

In SA, the percentage of the population in all older age cohorts is higher than for the Australian population, demonstrated below:

	65 years +	70 years +	80 years +
Australia	12.02	8.27	2.67
South Australia	13.82	9.70	3.20

ABS projections indicate that in SA, between 1996 - 2006, the age cohort of 65 - 74 years will grow by +0.4%, while the cohort of 75 - 84 years and over will grow by 28.7% and the age cohort from 85 years and over will grow by 57.3%.

This increase in the older age cohorts from 75 years and above will occur over much of the period of seven years coalescence. The majority of aged care residents are aged more than 80 years of age. Figures show that the average age of high care residents is just over 80 years of age. If places were distributed on age usage rather than the 70+ formula, South Australia would have a further 150 places approximately.

SA would strongly argue that both coalescence and bed numbers ought to be adjusted an the basis of national equity and that it is more appropriate to base any funding formula on the number of people aged 80+ thus better reflecting the usage pattern of nursing homes.

Administration and Standards

Aged Care Reforms have placed additional administrative requirements on the proprietors of aged care facilities, especially with the introduction of accommodation charges for high care facilities (nursing homes) not previously charged and the introduction of assets assessment.

In South Australia both ANHECA and ACOA have raised issues with the SA Minister for the Ageing concerning the additional administrative impact of meeting Commonwealth Standards, income testing in particular.

The previous funding allocation provided an incentive for States to incur higher wages for nursing home staff; the proposed coalescence removes that incentive and provides a significant efficiency gain.

That distribution also allowed State policies to affect funding levels. For example, some States (eg Victoria) have State mandated qualification and staffing ratios which were directly reflected in the funding provided. SA does not accept that State policy should have such an effect - in the interest of efficiency, the funding allocation should be policy-neutral. The existence of Commonwealth Standards provides sufficient assurance that the standard of policy care is of an acceptable level in each State

With the more rigorous implementation of the National Standards the expectation that SA adheres to them becomes more difficult, given the lower classifications of staff and the possible use of the capital funding pool to upgrade the many interstate facilities that are currently "non-certified". The industry also argues that with a higher turnover of residents over the last 5-10 years, the effects of the coalescence funding discrepancies are compounded.

Some States (eg Victoria) have state mandated qualification and staffing ratios which may mean that the Productivity Commission will look at maintaining the status quo (eg acknowledging Victoria's employment of higher level staff whilst maintaining that SA should suffice with the non-enrolled staff, yet expecting SA to keep to the National Standards). It is even possible that states such as Victoria, that currently have lower standards than those kept in SA, may be funded to improve their standards.

Awards

The historical bias in the current remuneration structure supposedly reflected the higher rates of employment awards, particularly in the south eastern states. The recent increases in nursing awards in SA would now obviate this need for discrimination. In addition the alternative approach taken in SA in its higher use of paramedical and other support staff has meant that operational costs have been unrealistically contained within the present funding model. Consumer groups have raised issues about whether this may lead to a lower quality of care being achieved in SA.

There is concern that individual State imposts may not be adequately accounted for in the productivity Commission deliberations, such as the recent increase of 0.3% in the WorkCover levy and the 9.9% wage increase negotiated for nursing staff with the SA Health Commission.

Community Care

The current focus on the retention of older people in the community through the use of Community Aged Care Packages and Nursing Home Packages ought to be more vigorously pursued, however incentives to utilise these models of care is constrained by the funding levels of the Packages. The ceiling of the Packages (equating to that of a Resident Classification System (RCS) level 3 subsidy rate in nursing homes) does not cater for the many people (who could be eligible for an RCS payment level 1 or 2 if they were in a home) who can still be maintained in the community.