AGED CARE AUSTRALIA

RESPONSE TO THE POSITION PAPER BY THE PRODUCTIVITY COMMISSION

A GENERAL COMMENTS

The Commission has made a very significant and valued contribution in determining that quality of care must not be a residual balancing item of the residential aged care funding system and in rejecting the coalescence proposal for this reason. This is an important finding which ACA supports.

The Commission clearly states that residential care funding must be sufficient to provide a standard level of quality care to all residents. ACA supports this as the primary policy design principle for residential aged care funding. This will require the development of new concepts and methodologies as well as clearly transparent funding arrangements which are appropriately managed to ensure this policy objective is maintained over time.

The Commission notes that, notwithstanding considerable uncertainties and caveats in the cost data available, the regional variations in the standardised cost of delivering nursing home care are significantly smaller than the current jurisdictional differences in subsidy rates. This inequity resulting in under-funding for high care residents in Queensland and South Australia must be addressed as a matter of priority. Pending the development of new funding arrangements, the basic subsidy rates payable in respect of high care residents in those States should be increased to the national average basic subsidy rates with effect from 1 July 1998. This could be fully funded by restoring the $128 million lost due to the under-compensation of cost increases since 1996. The ACT and WA also receive levels of funding which are below the national average and it would be appropriate for the Commission to consider whether the funding for high level care residents in those jurisdictions should also be increased to the national average basic subsidy rates with effect from 1 July 1998.

ACA sees merit in a movement towards nationally uniform basic subsidy rates to provide a standard level of quality care to all residents. However, this is conditional upon the outcome of an objective and transparent study of the costs of providing the same standard level of quality care to residents in each jurisdiction. The extent of movement towards uniform basic subsidy rates is, as the Commission notes, an empirical issue which should be determined having regard to the average costs of providing the same standard of care in each jurisdiction and the extent of variation in those costs. As the Commission notes the question of uniform and regionally differentiated rates is finely balanced and even a cost disadvantage of a few percentage points may be significant for home viability.

The Commission refers to the tension between current funding and the standard of care implied by accreditation and certification and acknowledges concerns regarding the

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12 November 1998

adequacy of current funding. ACA does not support any re-balancing of the current funding pool (including the use of funds earmarked for future indexation) which would be at the expense of the quality of care provided to residents, or the viability of services. Re-balancing of funding should not be countenanced prior to the completion of the review of the adequacy of funding and the exercise to cost the provision of the same standard of quality care to all residents. For this reason, ACA recommends that the $128 million lost through the under-compensation of nursing home cost increases since 1996 be restored to fund urgent increases for high level care residents and residents in rural and remote facilities.

ACA is pleased that its concerns about the use of the COPO index have been vindicated. The Commission acknowledges the inappropriateness of the COPO index and states that indexing must have specific regard to movements in nursing home costs. However, we are disappointed by the Commission's proposal for the COPO index to continue to be used until such time as the new Productivity Index is available. Given the uncertainty about the availability and suitability of the Productivity Index we recommend that the Commission recommend the use of a more appropriate index than COPO, to be used from 1 July 1999.

The complexity of the residential aged care funding arrangements present significant problems for consumers, providers and others who come into contact with the system. The Commission has been keen to examine ways to promote greater simplicity and administrative efficiency. It would be helpful if the Commission were to consider the scope for increased efficiencies within the payment system, which has created significant ongoing problems since the commencement of the restructure on 1 October 1998.

Given the complexity of the issues and the short time frame available, it is understandable that the Commission has not addressed all the issues requiring resolution. The Commission raises the possibility of simplifying the concessional resident supplement arrangements. However, this must be considered in the context of the broader question of the adequacy of capital funding. Further consideration of this issue in the Commission's final report would be most welcome.

The Commission acknowledges the link between wages for nurses in acute care and aged care. Nurses contribute greatly to the quality of care provided to residents and their wages are a very significant component of care costs. The disparity in the wages paid to nurses in acute and aged care has a significant impact on the recruitment and retention of qualified nursing staff, it is also a major driver of costs in aged care which counteracts any potential productivity gains. The dangers of market failure in this area are real and there is the potential for a serious crisis resulting in declining quality of care. It is essential that the problem of funding disparity between the acute and aged care sectors be managed appropriately. ACA requests the Commission to address these issues in its proposals for new funding arrangements.

The Commission suggests that additional requirements by State and Territory Governments (on top of the national benchmark level of care) should be funded by them

through top-up funding. However, this is unlikely to happen in the absence of bi-lateral agreements with the Commonwealth. It would be helpful if the Commission were to outline a strategy for the Commonwealth to provide leadership in this regard. ACA also suggests that the Commission recommend a review of the workers' compensation industry, particularly in view of the increase in costs due to management and liquidity problems of the schemes in some States.

Finally, the Commission has brought to its analysis of the issues an understanding of the importance of future directions. While short-term problems must be resolved, there is also a need to establish appropriate long-term directions for the future. In this regard, it is appropriate for the Commission to examine and question the applicability of current arrangements in the longer term. While the proposal to reduce the regulation of extra service places is likely to be contentious, it is supported by ACA. In our view, it is not appropriate that we should constrain opportunities for consumers to make choices, provided we ensure that there is universal access to a standard benchmark level of care consistent with accreditation and certification, irrespective of capacity to pay. Consumer expectations are changing and significant improvements must be made to the standard of accommodation in nursing homes. Greater flexibility with regard to extra services will assist in upgrading the standard of accommodation and ultimately this will be of benefit to all residents. However, reduced regulation of extra service places .must not be used as a means of supplementing inadequate funding to provide a standard quality of care to all residents.

ACA welcomes the opportunity to respond to the Commission's preliminary proposals and is committed to working constructively with the Commission and other stakeholders to achieve positive outcomes which will safeguard and promote the quality of care provided to residents.

B PRELIMINARY PROPOSALS

Preliminary Proposal 1

The coalescence of basic subsidies for high care residents in nursing homes and hostels should not proceed in its current form. Rather, a movement to nationally uniform basic subsidy rates should occur as part of a wider package of changes to address deficiencies in the current arrangements.

ACA **supports** the Commission's proposition that coalescence of basic subsidies for high care residents in nursing homes and hostels should not proceed in its current form.

ACA **strongly agrees** with the Commission's view that it is inappropriate to treat the quality of care as the residual balancing item.

The Commission notes that, notwithstanding considerable uncertainties and caveats in the cost data available, the regional variations in the standardised cost of delivering nursing

home care are significantly smaller than the current jurisdictional differences in subsidy rates. Clearly this inequity resulting in under-funding for high level care residents in Queensland and South Australia must be addressed as a matter of urgency.

ACA **supports** a package of changes to address deficiencies in the current arrangements and **recommends** that the basic subsidies payable in respect of high level care residents in Queensland and South Australia should be increased to the current national average with effect from 1 July 1998. The ACT and WA also receive levels of funding which are below the national average and it would be appropriate for the Commission to consider whether the funding for high level care residents in those jurisdictions should be increased to the national average basic subsidy rates with effect from 1 July 1998.

ACA **sees merit** in a **movement towards** nationally uniform basic subsidy rates to provide a standard level of quality care to all residents. However, as the Commission notes, the extent of any movement towards nationally uniform basic subsidy rates is an empirical issue to be determined by the extent of dispersion of costs. It also notes that:

> the available cost data is inconclusive
> estimates of differences in standardised costs vary considerably and are sensitive to underlying assumptions
> the choice between uniform and regionally differentiated subsidies is finely balanced
> an unfunded cost penalty of even a few percentage points can be significant for home viability. (pp33 & 34)

The actual basic subsidy rates and the extent of movement towards uniform basic subsidy rates should therefore be determined having regard to the average cost of providing the standard benchmark level of care in each jurisdiction and the extent of variance in those costs.

The Commission's proposal seems to imply that a 6% variation in costs would not be sufficient to justify regionally differentiated subsidy rates. However, as the Commission notes, even an unfunded cost penalty of a few percentage points can be significant for home viability. Inadequate funding will compromise the primary policy objective of providing a standard benchmark level of care to all residents, as well contributing to job losses.

ACA **recommends** that the extent of movement towards uniform basic subsidy rates be determined having regard to objective and transparent information on the actual average costs of providing a standard level of quality care to all residents in each jurisdiction.

Preliminary Proposal 2

In combination with resident charges, government funding should be sufficient to support the level of care required to meet the accreditation and certification requirements.

ACA **supports** this proposition which establishes the principle of adequate. funding to meet the (national) requirements of accreditation and certification.

Consultation will need to take place with stakeholders to determine what are the "benchmark levels" of accreditation and certification for funding purposes. (For example, ACA envisages that a satisfactory outcome for each of the four accreditation standards would be the minimum requirement along with a satisfactory certification pass-mark). As the Commission points out, as the benchmark level is raised over time, the adequacy of funding will also need to be maintained.

The Commission acknowledges that State and Territory Governments do impose additional quality requirements on residential aged care services - for example: qualified staffing and building requirements. It suggests that they may have a role in providing top-up funding if they require higher quality than the national benchmark level of care. However, it is disappointing that the Commission offers no firm proposals to address this issue; the likelihood of State and Territory Governments providing top-up funding is remote, particularly in the absence of appropriate bi-lateral agreements with the Commonwealth on this matter. ACA **recommends** that the Productivity Commission develop specific proposals whereby this situation can be managed so that service providers are not caught in the dilemma of having to comply with additional, unfunded requirements by State and Territory Governments. In this regard, ACA **suggests** that the Productivity Commission consider whether it would be appropriate and constitutionally feasible for the Commonwealth to require States and Territories to fluid. any requirements (in addition to those implicit in the standard benchmark level of care) which they place on residential aged care services.

The Commission notes that *"there is a tension between current funding and the standard of care implied by accreditation and certification"* (p 11*)* and refers to the review of the adequacy of capital and recurrent funding in the context of the Two Year Review of the residential aged care restructure. It is of concern to ACA that there is not as yet any firm time-frame or methodology for reviewing the adequacy of funding. Given the strong links between a review of funding adequacy and identifying the cost of providing a benchmark level of care, ACA **recommends** that the Productivity Commission suggest an appropriate methodology for undertaking both tasks so as to provide a basis for further consultation with stakeholders on this issue; and that it recommend that they be completed within 12 months.

Preliminary Proposal 3

a) Basic subsidy rates should be linked to the cost of providing the benchmark level of care in an efficient sized facility using an average input mix. Additional funding support for smaller nursing homes in rural and remote areas should come from a special needs funding pool.

ACA **partly supports** some aspects of this proposal but with significant reservations and provisos.

Benchmark Level of Care

ACA **supports** the principle of providing adequate funding to achieve a standard benchmark level of care across the jurisdictions - ie the same standard of quality care. This is much more appropriate than the current approach which regards quality as a residual balancing item.

What is meant by the "benchmark level of care" and how it will be costed and funded are critical issues which must be addressed in consultation with stakeholders. It will also be important to clarify how the "benchmark level of care" will interface with the accreditation and certification systems.

As a starting point for this process, it would be helpful if the Commission were to expand on its concept of a "benchmark level of care" and suggest an appropriate methodology for identifying the cost of providing the benchmark level of care.

Varying interpretations have been placed on the Commission's proposal. ACA understands "benchmark level of care" to be a notion of constant quality of care which is defined in terms of care outcomes for residents and a suitable mix of inputs to achieve those outcomes.

We envisage the development of the "benchmark level of care" and the associated cost of providing it would involve a process along the following lines:

a) a panel of experts and stakeholders makes recommendations to the Minister regarding the parameters of the standard benchmark level of care (constant quality of care) and an appropriate methodology for a survey to determine the average cost of providing the standard benchmark level of care

b) identify a representative sample of services providing the standard benchmark level of care (while this will interface with the accreditation system, this exercise can proceed prior to accreditation)

c) identify the average input mix used by this representative sample of services providing the "standard benchmark level care"; this would include staff mix and the

mix of goods and services for the respective resident classifications (as current inputs reflect current funding arrangements, it may be more appropriate to consider identifying a "suitable" input mix that is applied uniformly in all jurisdictions)

d) undertake an actual costing exercise to establish the average cost of providing the suitable input mix to achieve the standard benchmark level of care; this would need to be done for each jurisdiction, as well as for rural and remote areas; this -costing exercise would need to ensure that the costs measured are for **constant quality**

e) at that point it would be possible to identify the degree of variation in the average cost of delivering the standard benchmark level of quality care among the jurisdictions in order to determine whether uniform basic subsidy rates or regionally differentiated rates are appropriate; the level of the special needs supplement (eg rural and remote services) would also be determined

f) in the event the degree of variation in average costs is sufficient to justify regionally differentiated basic subsidy rates, it is imperative that the basis for the different rates is clearly transparent so that they can be appropriately managed over time in order to achieve the primary policy principle: sufficient funding to provide the same standard of quality care for all residents. This is particularly important given the lack of transparency in the current regionally differentiated rates and the funding inequities that have resulted.

In using a "suitable input mix" to establish the average costs of providing the "benchmark level of care" it is imperative that these inputs do not become prescriptive. Services should have the flexibility to determine the input mix which best meets the needs of their residents in order to provide the same standard of quality care (the benchmark level of care). Accountability for delivering the benchmark level of care would be through the accreditation system.

ACA **recommends** that the Productivity Commission provide more information about the proposed approach and the methodology it would recommend. The merit of the proposed approach will ultimately depend on the definition of what constitutes the - "benchmark level of care", the details and methodology used and how well they are managed over time to achieve the primary policy objective. It is important that there is agreement and transparency in these areas.

"Efficient-Sized Facility"

ACA does **not support** the proposal that the cost of providing the standard benchmark level of care should be based on an *"efficient-sized facility"*. Such an approach would automatically disadvantage facilities which are smaller than what is deemed to be an "efficient-sized" facility, thereby making it impossible for them to provide the standard quality of care to residents in that facility and compromising equity. The implications for residents would be significant as over 60% of facilities currently have 50 places or less.

In its paper, the Commission refers to suggestions by a number of participants that 60 beds now constitute minimum efficient scale. While this may be an important consideration in allocating new residential aged care places, it is not a fair basis for funding existing places which were established under Government policies which favoured small home-like environments. In the interests of safeguarding the well-being of residents in existing facilities, funding must be sufficient to provide the benchmark level of care to all residents.

Research should be undertaken to determine what is an "efficient-sized" facility for future planning purposes and the allocation of new places (bearing in mind that an efficient-sized facility may not be feasible in all cases because of the need to ensure equity of access in small population areas). The benchmarking project currently being undertaken by ACA may assist in this regard. It is important that efficiency is not the only criterion and that the impact of facility-size on the quality of care and life-style of residents is also considered.

ACA **recommends** that the basic subsidy rates be based on a study of the cost of providing the benchmark level of care among a representative sample of facilities, irrespective of their size. Given the intention to provide additional funding support for facilities in rural and remote areas, it would be appropriate to exclude facilities in rural and remote areas from the study of costs to determine the basic subsidy rates for all other facilities. A similar costing exercise will need to be undertaken to determine the cost of providing the benchmark level of care to residents in facilities which warrant special needs funding.

Additional Funding Support for Small Rural and Remote Facilities

ACA **supports** the Commission's proposal for additional funding for nursing homes in rural and remote areas and **recommends** that this also apply to hostels (low level care places).

It would be appropriate for there to be a clear definition of rural and remote areas. The proposal refers specifically to "small" facilities but the size is not defined. In view of the additional costs associated with the distance of rural and remote facilities from metropolitan/urban areas and the greater role they play in their communities, the special needs supplement should not be limited to "small" facilities.

b) The industry cost should reflect nursing wage rates and conditions applicable in the aged care sector rather than in the acute care sector.

While the Commission acknowledges a link between wages for nurses in acute care and aged care, it appears to hold the view that these are two distinct markets. In practice this is not the case. The level of dependency of residents in residential aged care facilities has increased significantly over the past 5 years in line with the changing role of residential aged care facilities. They are now providing care for residents with complex care needs,

including post-acute and palliative care. In addition, nurses in aged care carry significant responsibilities as there are no doctors on duty.

Appropriate indexation arrangements are essential to enable the industry to recruit and retain appropriately qualified staff. This matter is discussed more fully in relation to proposal 4.

The Commission suggests that productivity-based wage rises may counteract the trend towards a narrowing of the jurisdictional differences in wage costs. ACA agrees with this view and also contends that it is likely to further increase the disparity in nursing wage rates between the acute health and aged care sectors. A member has undertaken a comparison of the Tri-Care Enterprise Agreement (outlined in the Position Paper) with a recent Enterprise Agreement in the acute sector in South Australia. This shows a marked difference in the capacity to provide productivity increases between the two sectors - as the acute sector starts from a higher base in terms of wages and conditions, it has a greater capacity to negotiate productivity increases.

Given the importance of the aged care workforce in determining the quality of care provided to residents, there is a need for a more strategic approach to workforce planning and development issues. This could build on the work carried out by Pearson et al in 1990 and the subsequent work done by the Committee chaired by Mary Murnane but without any service provider involvement.

ACA **recommends** that the Productivity Commission consider and suggest appropriate strategies, in addition to appropriate indexation arrangements, to address these issues and to promote effective workforce planning in aged care so as to ensure quality of care is maintained in the future.

Preliminary Proposal 4

a) Increases in basic subsidies under the new regime should be based on annual increases in the cost of the standardised input bundle necessary to deliver the benchmark level of care, less a productivity discount. When it becomes available, the ABS productivity index for the nursing home sector should be used to determine the discount

ACA **supports-in principle** this proposal subject to further discussion regarding the methodology and the following provisos:

- the basis for annual increases in the basic and supplementary subsidies should be fully transparent and available to all stake holders on a timely basis

- there is agreement by ACA and other stakeholders regarding the appropriateness of the standardised input bundle

- annual re-pricing of the standardised input bundle is done using an appropriate representative survey method to identify increases in the costs of the various inputs in order to determine the actual increase in the price of the standardised input bundle and to monitor whether dispersion in costs is such as to warrant regionally differentiated rates

- the "productivity discount" is determined by actual empirical evidence of productivity gains achieved by residential aged care services and applies only to the labour related component of the basic subsidy rates. ACA would **oppose** any arbitrary "discount factor" or expected productivity gain, given the very limited opportunities for productivity gains in residential aged care, particularly in view of new unfunded cost imposts and the decline in funding due to the RCS for 39% of nursing homes

- all supplements to the basic subsidy must also be indexed annually and on a transparent basis in line with actual movements in cost.

ACA **recommends** that the Commission outline an appropriate methodology for annual re-pricing in its final report which can then be considered in detail by stakeholders.

ACA does **not support** the Commission's proposition for the continuation of the current COPO index arrangements until such time as the new ABS productivity index for the nursing home sector is available (not before mid 2000, at the earliest). As the Commission notes:

> *"the current COPO indexing arrangements are deficient in that the index is premised on the view that virtually all wage increases are productivity based."(p36)*
>
> *"...if equitable access to quality care is to be maintained over time, indexing must have some specific regard to movements in nursing home costs." (p36)*
>
> *"...inadequate increases in subsidies will in one way or another compromise access to quality care." (p46).*

ACA has sought further advice from the ABS regarding its proposed productivity index. We have been advised that the development of a productivity index is primarily to provide output rather than input measures in the national accounts. As such, the proposed application is quite different from a productivity index which could be used to discount wage increases. The former requires a degree of accuracy at a macro level, the latter needs to be very accurate at a micro level. Work has commenced on developing output measures in the acute health sector (using casemix) but has not yet begun for nursing homes. Furthermore, the focus is on measuring outputs (eg the number of residents weighted by a measure of dependency such as the RCS) not inputs. To develop a true productivity index for discounting wage increases would require an examination of changes in inputs as well as outputs. The ABS has indicated that work on the productivity index is experimental, that there is no certainty that it will proceed and that it is unlikely

that an appropriate productivity index would be available for the purpose of discounting wage increases in the nursing home sector by mid 2000.

ACA **opposes** the continued use of the COPO index even on an interim basis and **recommends** the use of the Wage Cost Index for Health and Community Services as outlined in its earlier submission, or if that is considered to be too young, Average Weekly Ordinary Time Earnings.

$128 million has already been lost through under-compensation of nursing home cost increases since 1996. ACA **recommends** that this funding be restored and more appropriate indexation arrangements be introduced with effect from 1 July 1999.

b) There should also be periodic reviews of the industry's cost base and of the adequacy of subsidies in the light of changes in care requirements.

ACA **supports** this proposal. Regular reviews of costs and funding adequacy are essential given the changing role of residential aged care services, the accreditation requirement of continuous improvement and increasing consumer expectations. The current funding inadequacies have arisen because of insufficient transparency in the funding arrangements, the locking-in of historic cost differences and a failure to review funding arrangements on a periodic basis to ensure that they continue to align with policy objectives.

ACA **recommends** that the benchmark level of care funded by the Government is clearly defined so that it is transparent and so that changes in relation to expected standards and the role of the industry can be clearly discerned for funding purposes.

ACA **recommends** that the Commission indicate in its final report an appropriate timeframe and methodology for periodic reviews of the adequacy of residential aged care funding to meet changing care expectations. In this regard, it may also be appropriate to consider key factors which should trigger a review (such as increasing dependency of residents as measured by the distribution of RCS classifications).

Preliminary Proposal 5

The pensioner, oxygen, enteral feeding, respite, and hardship supplements should be retained in their current form in the new subsidy regime.

ACA **supports** this proposal.

Preliminary Proposal 6

The Commonwealth should take steps to ensure that the payroll tax supplement is only payable to facilities that are registered to pay payroll tax on their primary payroll.

ACA does **not support** this proposal if it means that the payroll tax supplement would not be payable in respect of contracted. staff and out-sourced services.

It is not uncommon for the not-for-profit sector to use agency staff when they have difficulty in recruiting permanent qualified nurses and in order to ensure qualified staff are available to replace permanent staff on sick or other leave. Some not-for-profit facilities also outsource the provision of laundry, food, cleaning and maintenance services.

Payroll tax is payable on contracted staff and out-sourced services and this is reflected in the price paid for their services. It is therefore appropriate that the payroll tax supplement should be payable in respect of out-sourced services and contracted staff by not-for-profit organisations, in order to ensure parity of treatment with the private sector.

ACA **recommends** that the payroll tax supplement be payable in respect of out-sourced services and contract staff employed by the not-for-profit sector as the cost of payroll tax is reflected in the price paid for their services.

However, ACA **accepts** that the payroll tax supplement should only be paid in relation to payroll tax expenditure incurred. This will require changes to the current arrangements which lack the necessary flexibility for this to occur.

Preliminary Proposal 7

Commonwealth contributions towards workers compensation costs should continue to be provided through the basic subsidy regime.

Workers' compensation levies are a significant cost factor within the industry and there are significant variations in the flat rate costs among the jurisdictions.

Of particular concern is the extent to which these costs have risen over the past few years and the limited ability of the industry to control these costs. In some jurisdictions costs have been increased to address management and/or liquidity problems of the schemes.

ACA believes that it would be appropriate for there to be an industry-wide review of Workers' Compensation Schemes by the Productivity Commission and **recommends** that the Productivity Commission highlight the need for a national review of that industry in its final report.

ACA does **not support** the inclusion of workers' compensation costs in the basic subsidy rates, as they contribute significantly to variations in costs among the jurisdictions. In this regard, the Commission's recommendations with regards to payroll tax supplement and workers' compensation costs are inconsistent.

ACA **recommends** that workers' compensation costs be funded through constrained cost-reimbursement within pre-determined funding caps, as applied under the CAM/SAM funding arrangements. This approach balances the need to provide incentives for efficiency with the need to recognise legitimate variations in costs which are beyond control of service providers.

ACA **recommends** that the funding provided for workers' compensation costs be transparently identified in the funding arrangements.

Preliminary Proposal 8

Government-run homes and those transferred to the non-government sector should receive the same level of basic subsidy as their private and charitable counterparts.

ACA **partly supports** this proposal but considers that other financial arrangements which have been entered into must first be taken into account.

It would be appropriate to establish to what extent the financial agreements regarding the transfer of beds from State Governments to the private sector have included inducements (such as capital grants) and/or have taken into account the adjusted subsidy reduction. This exercise should be completed before determining whether the same level of basic subsidy should be payable, in order to avoid the possibility of over-funding in some situations.

The estimated cost of this proposal is $33.2 million a year.

ACA **recommends** that the financial arrangements applying to the privatisation of nursing home places be examined further before committing to this increased expenditure and that it be funded with new money.

Preliminary Proposal 9

There should be a rebalancing of Commonwealth support for residential aged care towards special needs funding for services in rural and remote areas. To this end, the Commonwealth should develop and cost new special needs funding arrangements in consultation with providers, resident groups and State and Territory Governments.

ACA **supports** the need for increased funding for services in rural and remote areas and the delivery of this via a special needs funding supplement in addition to the basic subsidy.

ACA **supports** the Commission's view that this is a matter of funding equity and that it must be accorded a very high priority (ACA considers its priority is on a par with increasing funding to those jurisdictions which are currently under-funded).'

ACA **supports** the development of eligibility criteria for special needs funding and a methodology for costing the special needs supplement (and funding pool) by the Commonwealth in consultation with stakeholders. Guidelines regarding the definition of rural and remote areas would be of assistance and the locality index used by the Commonwealth to adjust capital funding grants may be of assistance in this regard.

ACA **recommends** that consideration also be given to the provision of special needs funding for services in urban/metropolitan areas which are meeting the needs of special needs groups (eg Aboriginal and Torres Strait Islanders, NESB groups, homeless elderly) and face higher costs because of their special needs focus.

As stated earlier, ACA does **not support** re-balancing of the current funding pool in order to provide more adequate funding for residents in rural and remote areas or the use of the productivity index for this purpose. There is already concern about funding adequacy due to: the under-indexation of cost increases; RCS changes (resulting in funding reductions for 39% of nursing homes); and new un-funded requirements, such as accreditation. A re-balancing of the funding pool would result in a further decline in funding adequacy (and hence quality of care) for residents not in rural or remote areas.

ACA **recommends** that new funding be allocated to the special needs funding pool (from the restoration of the $128 million lost due to the under-indexation of cost increases due to the COPO index) and that the methodology for this be developed in consultation with stakeholders.

Preliminary Proposal 10

There should be no requirement for providers to acquit subsidy payments under the proposed regime.

ACA **supports** this proposal.

Preliminary Proposal 11

Subsidies should continue to be paid to providers rather than to residents.

ACA **supports** this proposal.

Preliminary Proposal 12

Regulation of extra services provision should be reduced:

- ***the controls on what constitutes an extra service; where in a facility extra services are provided; and the price charged for such services should be abolished;***
- ***the current reduction in the basic subsidy for residents receiving extra service should be abolished - this defacto income-tested charge should be incorporated in a budget neutral way into an income test applying to the basic subsidy***
- ***the Commonwealth Government should give consideration to replacing the current quota on extra service places with a monitoring system aimed at identifying any cases where extra service provision is reducing access to basic care. It should also look at the scope to simplify concessional resident ratios.***

ACA **supports** the reduction of controls on extra service places as this will enable the following objectives to be met:

- residents and their families are able to exercise more choice regarding the standard of accommodation provided;

- the overall standard of accommodation provided in nursing homes is improved, thereby benefiting all residents over time.

It is not appropriate to constrain the choice of older people because of their varying capacities to pay. This does not happen for any other age group or in any other sector (including acute care).

There are other more appropriate strategies than constraining consumer choice for safeguarding universal access to quality care by all residents. These include:

- determining an appropriate standard benchmark level of care for all residents

- ensuring that this is adequately funded

- removing inappropriate regulation of extra service places (such as requiring that a minimum fee be charged) as this has the effect of further constraining choices for people with modest means - concessional residents should also be able to access extra services if they wish

- monitoring to ensure that the de-regulation of extra services does not reduce access to the standard benchmark level of care or create undesirable side-effects.

ACA **recommends** that the term "standard care" be used instead of the term "basic care" used by the Commission, as all residents must have access to the standard benchmark level of care, irrespective of their capacity to pay.

With regard to possible inclusion of the extra service subsidy reduction in the income test applying to the basic subsidy, ACA agrees that this is feasible but **recommends** that further consultation be undertaken with stakeholders, particularly with consumers and their representatives, on this issue.

ACA does **not support** the freeing up of extra service places in order to provide income to address inadequate funding to provide the same standard of quality care (the benchmark level) to all residents.

Preliminary Proposal 13

Subject to any recommendation from the Residential Aged Care Review for an increase in total Commonwealth funding for residential aged care, funds earmarked for indexing current subsidies should be redirected to increasing basic rates for the current low subsidy States.

ACA **agrees** that urgent action is required to address the inadequate funding of the care needs of residents in Queensland and South Australia and of residents in facilities in rural and remote and areas.

ACA **recommends** that the $128 million lost since 1996 through under-compensation of price increases using the COPO index be restored to the nursing home funding pool and that these funds be used to increase the basic rates in those jurisdictions which are currently under-funded and for the special needs funding pool.

ACA does **not support** the use of funds earmarked for the future indexing of current subsidies in order to increase the basic rates of current low subsidy States, as this will involve an erosion of the real value of funding in other jurisdictions where there are also concerns about funding adequacy. Such action would compromise the quality of care and viability of services and **should not be countenanced prior to the completion of the review of the adequacy of funding and the exercise to cost the provision of the standard level of quality care for all residents.**

B ADDITIONAL MATTERS FOR COMMENT

1. **Are there more efficient alternatives to varying payments to homes each time a new resident replaces a previous resident with a different RCS classification?**

The Commission asks whether an alternative, such as determining subsidies on the basis of RCS profiles at the beginning of each quarter or year, would be appropriate.

While this would provide greater certainty of income for the applicable period, the level of income would depend on the RCS profile of residents at a particular point in time. Providers would face the risk of lower levels of subsidy (than would occur under the

current system) if for some reason their RCS profile at the relevant time was lower than usual; similarly, some facilities would gain for the opposite reason.

However, this would not obviate the need to make commensurate adjustments to staffing to offset any reduction in income. Changes in income are likely to be more dramatic when based on the total resident profile than due to new admissions as they arise.

Furthermore, it would not be as equitable as the current arrangements - a facility's income would depend on the resident mix at a particular point in time rather than on an ongoing basis; and any advantages would be eliminated when retrospective adjustments were made.

Such an arrangement may also involve additional administration (completing current RCS profiles of residents at a given point in time) and it would be less transparent than the current arrangements where the subsidy for each resident is clearly visible. Also, it does not interface well with income-testing and its relationship to subsidy payments.

ACA **recommends** that the current arrangement of paying the correct subsidy in relation to the RCS profile of each resident continue.

2. **Is the current two-tier concessional resident supplement appropriate and what are the implications of any changes in the supplement for the resident and transitional supplements?**

This issue cannot be properly considered without clarifying the purpose of these supplements.

ACA, along with the rest of the industry, believes that these supplements are for capital funding purposes. We hold this view for the following reasons:

- The concessional and assisted resident supplements were negotiated during the Senate debate on the Aged Care Bill 1997 and were designed to recognise the inability of some residents to pay accommodation bonds or charges. The eligibility criteria for these supplements set down in the Aged Care Act 1997 reflect this context in their references to home-ownership, asset values and the amount of any accommodation bond paid.

- Section 57-2(n) of the Aged Care Act 1997 specifies that income derived from accommodation bonds and the retention amount must be used in the following ways:

    i) *to meet capital works costs relating to residential care*
    ii) *to retire debt relating to residential care; or*
    iii) *where no capital expenditure is reasonably necessary to comply with matters specified in the certification principles for the purposes of 38-3(3)*

and meeting accreditation requirements - to improve the quality and range of aged care services.

However, this view is not shared by Departmental officers who indicated in the context of the RCS Review that the concessional supplement was not intended for capital purposes but in order to facilitate access to residential care by concessional residents. In that context it was counted as a contribution to the recurrent costs of providing care.

It is highly desirable that there be clarity and consistency in regard to the purpose of these supplements. This will be important in reviewing the adequacy of capital and recurrent funding in the context of the two year review of the residential aged care restructure.

It is also appropriate to have transparency with regard to capital and recurrent funding for the following reasons:

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

- to facilitate a much closer relationship between recurrent funding and care outcomes for residents - this will be important to enable the cost of providing the same standard of quality care (the benchmark level) to be priced independently of the cost of providing quality accommodation consistent with certification

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

ACA **recommends** that funding for capital and recurrent pm-poses be separately and transparently identified and that the purpose of the concessional resident, assisted resident and transitional supplements be clearly identified.

The following comments are based on the view that these supplements are for capital funding purposes.

a) ***Transitional Supplement***

The transitional supplement rate is substantially less than the lower rate of concessional resident supplement. It is paid in respect of all pre 1 October 1997 residents as their eligibility for a concessional resident supplement after 1 October 1997 could not be assessed.

The level of the transitional supplement disadvantages those low level care facilities which prior to the restructure catered predominantly for financially disadvantaged residents and therefore received very few or no accommodation bonds. Facilities in this position are those which cater predominantly for the elderly homeless, Aboriginal or

Torres Strait Islanders, and/or residents from rural and remote areas. The arrangements also disadvantage facilities with longer than average lengths of stay. Wintringham hostels in Victoria which cater to the elderly homeless have been particularly disadvantaged by the transitional supplement arrangements.

The transitional supplement is also inequitable for high level care facilities (nursing homes) which were unable to charge pre 1 October 1997 residents any contribution towards capital costs and do not have the capacity to augment the transitional supplement because the maximum accommodation charge is set by the Government (unlike accommodation bonds for low level care).

ACA **recommends** that the transitional supplement be replaced by the concessional resident supplement with effect from 1 July 1999. It is appropriate to have a sunset date for transitional arrangements and to limit the disadvantage to those facilities with residents with longer than average lengths of stay.

b) The Level of the Concessional Resident Supplement

Before considering the appropriateness of the two-tier structure, it is necessary to consider whether the amount of the concessional supplement is appropriate.

The concessional supplement should provide an income stream which, when combined with income streams achieved through accommodation bonds and/or accommodation charges, is sufficient to meet the capital funding needs of the industry in relation to the upgrading, replacement and building of new beds (in line with the population planning ratios).

In the 1994 review of nursing home funding, Professor Gregory considered various options for raising sufficient capital funding to meet the backlog of upgrading and to maintain and replace nursing home beds. He noted:

> *Assuming that by rebuilding, a home is able to attract residents able to pay* ***an average additional $12.15 a day instead of the $4.34*** *received by an average home, then it could be rebuilt, upgraded and replaced after 40 years. If the proprietor deferred taking any return until the home was paid* off, *he or she would start to receive a return on equity after 7 years and the eventual return on equity would be 8%, ignoring the effect* of *tax.* (Gregory Report Stage 2, page 27, our emphasis)

However, in his explanation of the modelling, Gregory noted that it over-estimated viability for the charitable sector and that the return on equity would therefore be much lower (page 97). In addition, Gregory's modelling is based on average nursing home building and land costs of $56,500 per bed which is very conservative (particularly in view of the new certification requirements) and it does not include the extra capital funding needs associated with certification.

Using the Gregory report as a minimum benchmark, the maximum concessional resident supplement of $12.17 will not be adequate on its own to generate sufficient funding to meet the capital funding needs of nursing homes. As the Government has legislated a maximum accommodation charge of $12 a day, high level care facilities have no means of augmenting the inadequate concessional resident supplement through contributions by non-concessional residents.

ACA **recommends that** the Productivity Commission acknowledge in its final report the capital funding problems facing nursing homes; the role of the concessional, assisted and transitional resident supplements in providing income streams for capital funding purposes; and the need to ensure that these are set at appropriate levels so that, in combination with accommodation bonds and accommodation charges, they are able to meet the capital funding needs of the industry.

c) The Concessional Resident Supplement - should there be two tiers?

The original rationale for a second tier was to provide greater compensation to those facilities which have a significant proportion of concessional residents and therefore do not have the capacity to achieve the same levels of capital funding via accommodation bonds or charges.

This rationale was weakened for high-level care facilities when the provision to charge (variable) accommodation bonds was replaced by the maximum $12 per day accommodation charge, thereby capping the effective capital income stream which facilities could achieve. For high-level care facilities there is no longer any justification in having the lower concessional resident supplement of $7. 10 per day as it disadvantages those facilities which, for whatever reason, are unable to achieve 40% or more concessional residents.

For low-level care facilities which are able to charge accommodation bonds, it is debatable whether the 40% threshold is set an appropriate level, particularly given that this is close to the current average number of concessional residents per facility. It is important to ensure that facilities which cater predominantly for concessional residents are not disadvantaged; the 40% threshold is too low as an indicator of those facilities - it should be closer to 75% or 80%.

It would be more equitable to have either a sliding scale for the concessional resident supplement whereby the higher rate is paid only for residents above the threshold level. It may also be appropriate to consider more than one threshold. However, as the Department has not yet been able to pay the two-tier concessional resident supplement (all facilities have been paid at the $12 a day rate, with retrospective adjustments to be made over the coming months) it may not be practical to implement a more sophisticated system.

An alternative approach may be to have two standard concessional resident supplement rates -for high level care and low level care residents respectively. The level of the

concessional resident supplements would need to be set having regard to the capital funding needs of the industry and the accommodation bond and accommodation charge arrangements which apply. As there is greater flexibility to generate income for capital purposes under the accommodation bond arrangements, there may be some scope for the concessional resident supplement to be set at a lower rate for concessional residents in low level care than in high level care, where the accommodation charge provides no such flexibility. Alternatively, the maximum cap on accommodation charges could be removed.

It would also be desirable for eligible prospective high-level care residents to be able to choose whether they pay an accommodation bond or an accommodation charge.

It would still be appropriate to ensure that services provide access to concessional residents. The use of mandatory concessional resident ratios achieves this.

ACA **agrees** that the current two-tier concessional resident supplement poses problems and **recommends** that the structure of the concessional resident supplement be reviewed by the Department in consultation with stakeholders.

d) The Assisted Resident Supplement

ACA **recommends** that the assisted resident supplement be included in the review of the concessional resident supplement.

3. **Should the impact of input taxes, other than payroll tax, on private providers' costs be recognised in the subsidy arrangements?**

As this is a matter primarily for the private providers of residential aged care services, ACA makes no comment on this issue.

In the event that input taxes are recognised in the subsidy arrangements, this should be by way of a separate supplement in order to promote transparency and to facilitate adjustments when taxation changes occur.

4. **Are there strong arguments against moving to a cost-reimbursement system for payroll tax payments?**

ACA **supports** this proposal. Cost-reimbursement would provide more accurate compensation for payroll tax costs than the current inflexible system which is not well suited to the use of contract staff by the not-for-profit sector.

5. **In moving to a new subsidy regime, should another round of changes to income and asset tested resident charges be contemplated?**

The Commission incorrectly notes that concessional and assisted residents comprise a large majority of new entrants to facilities; however, the Commission was probably intending to refer to the proportion of residents who are full pensioners, as it suggests that the proportion of income from income-tested fees is likely to remain modest over the next few years.

It is unlikely that there would be political support for further changes to the income and asset-tested resident charges at this stage. However, there is a need to promote informed public debate on the role of income-testing and user contributions and other approaches to financing in the context of developing a National Strategy for an Ageing Australia. The focus of those discussions would be on medium and long term directions rather than on short term changes.

Discussions should focus on developing a comprehensive and integrated approach to financing which deals with the age pension, superannuation, the long-term financing of aged care, and the role of income-testing and user contributions. Focusing on only one of these areas runs the risk of having competing policies which are poorly integrated and which send the wrong messages and incentives to people who should be planning now for their future old age. This is also an area where a bi-partisan approach is highly desirable in order to provide greater certainty conducive to long-term planning.

6. **What is the scope for and the merits of combining the resident daily fee and the accommodation charge?**

There have been very serious and protracted problems with the payment system for residential care subsidies since 1 October 1997 which have created an enormous workload for service providers.

The payment system is still not working efficiently. In addition, frequent reviews of pension entitlement mean that there are frequent adjustments to the income-tested user contribution and the resulting residential care subsidy payable, creating confusion for residents and ongoing work for service providers. For example, a resident in South Australia recently received 3 letters of adjustment on one day involving some 14 separate adjustments by the service provider and the resident being required to back pay significant amounts.

In view of this situation, combining the resident daily fee and the accommodation charge would simply exacerbate the problem rather than improve efficiency.

The payments system is a source of considerable inefficiency and frustration and should be simplified. There is a high degree of churning which could be eliminated if the income-tested user contribution were paid along with the standard residential care

contribution (85% of pension) and the pensioner supplement directly to the service provider. Currently, the resident pays the income-tested contribution directly to the service provider with the result that every time there is an adjustment to the income-tested amount the resident and the service provider must make the appropriate adjustments.

ACA does **not support** combining the., resident daily fee and the accommodation charge due to the inefficiency of the payment system.

ACA **recommends** that the Productivity Commission consider ways in which the payment system could be simplified and efficiency improved.

7. **What are the likely effects of the Commission's preliminary subsidy proposals?**

It is difficult to assess the likely effects of the Commission's preliminary subsidy proposals given the lack of specific detail. ACA and other stakeholders must be consulted in determining the detail of future arrangements.

This submission has highlighted a number of concerns regarding the proposals which could undermine the equity objective of providing sufficient funding so that the standard benchmark level of care is able to be provided to residents in all jurisdictions, irrespective of their capacity to pay.

8. **What would be an appropriate timeframe for implementation of the full proposals; what should be the inter-relationship with the Residential Aged Care Review; should new arrangements be phased-in or simply introduced after a grace period?**

Time taken to develop new arrangements must not result in further delays in providing increased funding to meet the care needs of residents in high level care facilities in Queensland and South Australia and of residents in residential aged care facilities in rural and remote areas.

ACA has already recommended that the $128 million lost due to under-compensation of cost increases through the COPO index be restored and used to increase the funding provided for residents in Queensland and South Australia with effect from 1 July 1998 and for residents in residential aged care facilities in rural and remote areas.

With regard to the time-frame for the implementation of the full proposals, ACA suggests that there is scope for the review of funding adequacy (to be conducted as part of the two year review of the restructure) and the work to be done in defining the standard benchmark level of care and then the subsequent pricing of the standardised input bundle to be done as a single exercise. It would be appropriate for this work to commence

immediately so that is completed within the next 12 months. This would allow the implementation of the new arrangements to commence from 1 July 2000.

With regard to the question as to whether the new arrangements should be phased in or introduced fully after a period of grace, ACA considers that the implementation arrangements are best resolved once the review of funding adequacy and-the development of the new funding methodology have been completed. Until the details are known, it is not possible to assess the potential impact on services and this should be the key consideration in determining an appropriate implementation strategy.

ACA **recommends** that the new funding arrangements for residential age care should commence from 1 July 2000; and that the phasing of the implementation of changes be determined in the light of the outcomes of the review of funding adequacy and the pricing of the national standard benchmark level of care.