Submission to the Productivity Commission

This paper is in response to the *Nursing Home Subsidies - Position Paper* prepared by the Productivity Commission and released on Friday, October 23, 1998.

This document should be considered in conjunction with TriCare's previous submissions of September 14, 1998 and October 9, 1998 respectively.

The Nursing Home Subsidies - Position Paper of October 23, 1998 has made several preliminary recommendations which are ***generally*** supported by TriCare. The paper has also raised a number of issues relevant to funding and comparative state costs.

We intend to deal with these issues briefly and individually but we are, of course, happy to speak to them at greater length during the public hearings scheduled for Monday, November 16, 1998.

We will firstly address the matters detailed in the "Preliminary Proposals" section upon which the Commission has invited parties to provide specific comment. These are as follows:

- **Whether there are more efficient alternatives to varying payments to homes each time a new resident replaces a previous resident with a different RCS classification;**

The current method of linking funding to resident frailty, as assessed by the Resident Classification Scale, is intended to ensure nursing and personal care staffing levels are sufficient for nursing and personal care needs. It is acknowledged that this is a necessary mechanism given the substantial variations in care requirements in any resident population.

Unfortunately, as noted in our first submission, funding levels for other components of resident care, which are affected by frailty levels did **not** change.

One of the more difficult aspects of nursing home administration, is managing staff levels within the parameters of care monies given the ***significant*** variations in funding which result from resident population changes. These variations occur primarily because new admissions are rarely of the same category as the residents they replace. For instance, if a 90 bed nursing home lost five high category residents in a month (not an implausible scenario) and replaced them with five lower category residents, the effect on funding is significant. As would be expected, Industrial Awards and State Industrial legislation do not provide for easy facilitation of staff movements to occur with anywhere near the frequency of funding changes.

It is therefore difficult to maintain appropriate staffing levels given the direct correlation with funding which is subject to rapid change. An unfortunate consequence is the high degree of casualisation and uncertain employment conditions inherent in the sector, In such an environment, it is harder to attract and retain highly trained, motivated staff and to introduce workplace change aimed at *continuous quality improvement.*

The situation is further compounded by the fact that a number of residents in nursing homes have been re-categorised as low-care (therefore funded at a much lower level) by the new Resident Classification Scale - this could not have occurred under the RCI. It has also been reported (and is certainly TriCare's experience) that waiting lists have declined dramatically. Occupancy at most TriCare homes has been adversely affected since the advent of the October 97 reforms.

Perhaps a system could be considered whereby funding was provided to individual facilities annually, based on a projected resident mix taking into consideration previous RCS levels. Obviously, this would be monitored by proprietors and the Commonwealth, and upper and lower tolerance levels would need to be established outside of which adjustments would be made to future payments,

We would recommend strongly against the reintroduction of acquittal of such monies as this would nullify the savings in administrative staff time and resources. This system would encourage the creation of more permanent staffing arrangements and minimise the necessity to utilise casuals.

Under such a scheme a dear incentive exists for proprietors to endeavour to admit high care residents at increasingly higher categories as this is the only way that funding could increase.

We also believe that it is unreasonable that high care residents can "default" to low care upon re-assessment following ACAT admission. This again is a factor that is beyond providers.' control.

- **Whether the current two-tier concessional resident supplement is appropriate, and on the implications of any changes in the structure of the supplement for the assisted resident and transitional supplements;**

The two-tier concessional residents supplement is not ideal particularly since the abolition of accommodation bonds for high-care facilities. The system can lead to substantial differences in funding for reasons beyond the control of a provider. Further, since the abandonment of accommodation bonds, the system has no justification in terms of equity of access.

The system was introduced to provide an incentive for proprietors to admit a higher percentage of concessional residents than the minimum requirement. Such an incentive **would** be justified if non-concessional residents could be asked to pay an uncapped accommodation bond. As this is no longer the case and bonds have been replaced by accommodation charges, there is less incentive for providers to be selective in admissions because the financial benefits derived from concessional and non-concessional residents are almost the same.

The illustration the Commission has used demonstrates clearly the negative aspects of such a system. This scenario is actually occurring at some TriCare facilities.

We would recommend a flat rate for all concessional residents.

- **The impact of input taxes, other than payroll tax, on private providers' costs and whether these should be recognised in the subsidy arrangements;**

This issue has been contentious since the existence of different capital funding systems for the Church and Charitable and private sectors. There is no doubt that Church and Charitable organisations enjoy a commercial advantage due to their sales and fringe benefits tax free

status and this advantage can translate to better standards of equipment. Within the TriCare nursing home division approximately $500,000 per annum in sales tax and FBT is incurred for purchases related to resident care and accommodation - laundry chemicals, building material, furniture and fittings, linen., kitchen equipment etc.

It is our belief that as standards of care and accommodation relate directly to funding levels and similar expectations are applied to both sectors then the same taxation exemptions should also apply.

- **Whether there are strong arguments against moving to a cost reimbursement system for payroll tax payments;**

TriCare supports a fully cost reimbursed system for payroll tax for those providers who incur it. A simpler suggestion may be to make private sector providers payroll tax exempt as Church and Charitable organisations already are. Obviously, some recompense would have to be made to State Governments for the income lost as a result.

- **Whether, in moving to a new subsidy regime, another round of changes to income and asset tested resident charges should be contemplated;**

Inevitably, from a purely economic imperative, there will be changes to income and asset tested resident charges in the future. It has always been TriCare's view that a strategic plan, with full participation by all stakeholders, should be created to move the industry away from reliance on tax payers subsidies in favour of user-pays. Coupled with less prescriptive regulation in favour of tougher sanctions, this is the only mechanism which will improve standards, expand resident choice and create a more quality focussed industry.

Our concern is for the way these changes are announced and implemented. Administrators at TriCare centres report an incredible amount of confusion and hostility from residents and relatives with regard to the income and asset testing mechanisms. In addition, problems arise when residents who pay additional fees due to their higher income, display a belief that they should receive extra services as a result.

- **The merits of, and scope to, combine the Resident daily fee and the accommodation charge;**

We believe this proposal does have merit, but would repeat the concerns raised in the previous question with regard to the manner in which such a policy is implemented and ""sold" to the wider community.

- **The likely effects of the Commission's preliminary subsidy proposals;**

As previously noted, TriCare generally supports the proposals as such, but believes further detail is required prior to providing additional input. It should be acknowledged, that the Commonwealth will no doubt oppose some of the proposals on the basis that they may involve an increased financial commitment from government.

This being the case, the development of proposals relating to resident charges and any further move toward user pays, should occur with the involvement and participation of the Commonwealth, consumer and provider groups. Ideally such discussions need to be non-political in nature due to the capacity (as evidenced recently) for older people to be unduly frightened and exploited.

- **An appropriate time frame for implementation of the full proposals, the inter-relationships with the Residential Aged Care Review, and whether the new arrangements should be phased-in or simply introduced after a grace period.**

The appropriate time frame for the implementation of any change will depend on the nature of the change. Such a time frame should be cognisant of the substantial resources required to educate the community about the necessity for change and the impact it will have. It would be unfortunate if the implementation of changes was successively delayed as with the previous reforms.

With regard to the Residential Aged Care Review, it should be said that the industry ***generally*** is **not** supportive of the process as it currently stands. TriCare's experience is that the review is not **genuinely** consultative nor independent and that the real views of the industry are not being sought. We would regard the review as a separate exercise from the Productivity Commission's investigation.

Whether the new arrangements should be phased in or simply introduced after a suitable grace period is dependent again, upon the nature of the changes. As is evident in nearly all submissions put to the Commission, Queensland is significantly disadvantaged in the funding and cost comparison and this should be addressed **immediately.**

Changes to income and asset, testing and other proposals should probably be phased in over a period of time not exceeding 12 months from the date of announcement. The should be sufficient to enable consultation, discussion, community education and allow proprietors to adjust their systems accordingly.

We would now like to address some other issues arising from. the body of the report and make comment on matters pertaining to our original submission.

(1) Workers Compensation

In preparing our original submission we deliberately chose to leave aside the difference between workers compensation **costs**. We did acknowledge the difference in funding in as much as we used ***total*** funding (which includes a component for workers compensation) amounts per category in our comparison. The following factors however must be considered;

- Workers compensation costs can be largely Influenced by individual proprietors depending upon workplace policies and procedures. Costs relate to facilities or organisations rather than regions.

- We would submit that there is a ***greater*** capacity to control workers compensation costs than nursing and personal care costs,

(2) Volunteers

Reference is made in the report to the use of volunteers - presumably in the government and charitable sectors. There is virtually no involvement by volunteers in the TriCare workforce.

Whilst we should not make too much of this factor, it must be noted that if volunteers are undertaking duties normally carried out by unskilled staff - diversional therapy, gardening, personal care etc then there exists an additional cost variation between the sectors which should be taken into consideration.

If the figures quoted in the report are to be relied upon - 14,000 volunteers across Australia working an average of 11 hours per month - then, using a total gross cost of $15.00 per hour (the volunteers are presumably unskilled), an additional $27 million per annum of care and support available to the not-for-profit sector.

(3) Value of Bed Licences

Page 45 of the report contains the following passage;

"Moreover, the substantial prices paid for bed licences do not sit comfortably with the view that there is a funding crisis in the sector. As the Department of Health and Family Services argued:

> **Recent planning rounds indicate record levels of interest from prospective providers in entering the sector or expanding the size of their existing services. The market value of places - a good indicator of confidence - has also increased since the reforms.**
> (Sub. 52, p. 22)"

As this is an argument often heard with regard to the nursing home industry, we would like to comment briefly upon it.

To the best of our knowledge, no credible independent study or review of the nursing home industry has ever indicated that the sector is highly profitable. Indeed the Department's own research leading up to the SAM. review of 1991 concluded that an increase in funding should be made at that time, due obviously to a deficiency in funding, to cover the costs of delivering minimum standards.

Similarly the latest such study of which we are aware - that from Bentleys MRI Chartered Accountants (copy attached) indicates that the average per resident per day surplus for the private sector **not including** building depreciation, interest or rent was $7-42. These figures were based on 1996/97 data.

The cost of building a new nursing centre these days is expensive; approximately $80,000 per bed - source: Australian Association of Gerontology Inc. "Centre for Ageing Studies". The most recent nursing centre TriCare built - Kawana Waters 1995 - cost $67,000 per bed. It should be noted that these figures apply to standard **not** extra services facilities.

Anecdotally, bed licences are selling for $25,000. TriCare has no actual experience of sales at this price so we have no hard data to rely on. However for the purposes of this discussion, we propose to use a bed licence value of $25,000.

Using this information, it is a fairly straightforward exercise to estimate an indicative return on investment.

Assumptions
* 50 bed nursing home
* Bed licences purchased for $25,000 each
* Building costs (standard nursing home) - $70,000 per bed
* Operating surplus of $15.00 per day

NB. It should be noted that we have *conservatively* estimated the cost of construction and *doubled* the daily surplus from the Bentleys survey.

TOTAL CAPITAL COST;
50 X $95,000 = $4,750,000

ANNUAL EARNINGS BEFORE INTEREST:
$15.00 X 50 X 365 = $273,750

Using an interest rate of 10%, an investor would need 50% of the up-front capital cost just to break even.

In any discussion of bed licence values we believe the following factors should be considered:

(A) Hostel and Extra-Service facilities
Extra Service facilities may charge accommodation bonds and/or higher fees. Accordingly, there is a capacity to recover some or all of the capital cost via an accommodation bond and generate more healthy surpluses. Similarly hostels can charge bonds to defray a portion of their costs. It is understandable that investors in either of these facilities may well pay greater prices for licences than other providers

(B) Church and Charitable-organisations
Church and Charitable organisations may not seek to make a surplus but rather to break-even or run at a loss. They also have, via more favourable tax and borrowing regimes, a capacity to pay an amount in excess of that which private operators would pay. The purchase therefore would not be justified on purely commercial grounds.

(C) Bed Licences-as part of a Nursing Homes Sale

Our submission on this matter to date has worked on the assumption that licences are being purchased ***individually*** by an investor intending to construct a new facility. If the purchase of licences however is only one component of the purchase, then it is the entire purchase amount which needs to be critically examined. For instance, an investor who paid $25,000 per bed licence and $30,000 per bed for the building, land and infrastructure is looking at a far more attractive proposition than an investor who intends to build a new facility.

In summary, we believe there is no commercial justification for paying $25,000 for individual bed licences if a new facility which meets all of the expected standards is to be constructed.

If such prices are being paid it may be based on a premise (not reasonably founded in our view) of increased or improved funding in the future.

Generally, however, we do **not** accept anecdotal information relating to bed licences without an independent review or study of nursing home profitability, has any relevance to this argument.

We welcome again the opportunity to assist the Commission in its deliberations and are happy to provide any further information the Commission may require.

Jim Toohey'
Chief Executive Officer