Table of Contents

Nursing Home Subsidies

Response to the Productivity Commission Position Paper on Nursing Home Subsidies

Introduction

Following the release of the Commission's Position Paper the ACHCA has submitted a submission to the Inquiry Public Hearing held in Melbourne on Wednesday 18 November 1998. The following is the text of the opening statement made by ACHCA representatives:

From the outset it is important to state that the Catholic aged care sector accounts for over 500 services nationally. This includes up to 17000 nursing home and hostel beds. In addition to residential aged care these services encompass community and home care for the aged. Catholic aged care services are not restricted to metropolitan areas, but are located throughout rural areas and in country townships.

The Federal Governments Aged Care Structural Reforms need to be seen in the context of the wider community debate concerning aged care, health care and community care. Although residential aged care services are provided in both the for-profit and Church and charitable sectors, Catholic health care Is totally committed to the concept of non-profit service provision. Our providers do not warmly embrace measures which commodify aged care services, as if they are merely another product for purchase on the open market. We contend that our services are more akin to social goods and integral to the social fabric of the community. Fundamentally, the ethos of Catholic aged care does not sit comfortably with the for-profit modus operandi.

Based on a survey of our sector 55 percent of Catholic aged care facilities provide over 50 percent of their accommodation to financially disadvantaged people. Approximately 15 percent of Catholic facilities cater almost exclusively for financially disadvantaged people. This ethos and tradition is fundamental to the providers of Catholic aged care.

As a country we have developed a residential aged care system where the elderly are entitled to quality essential care and support particularly in their last years.

This access is based on clinical need. This entitlement is inextricably connected to our concept of community our appreciation of social responsibility and our respect for the dignity of all members of the community regardless of age, background or circumstance.

This entitlement system is an obvious extension of those accrued under Medicare for medical/nursing care. Nursing home-type patients are under no obligation to pay entry fees or income tested charges if they are accommodated in public hospitals.

To date, the Government still maintains a commitment to universal health coverage, however it is increasingly adopting a user pays approach to the sick and frail members of our community who are in the last weeks or months of life.

Altering universal access to nursing home care will make the co-ordination and linkage between residential aged care and the acute and community care sectors more challenging.

The adequacy of funding for residential aged care and the provision of resources for capital refurbishment of the sector are key issues that still require resolution.

ACHCA welcomes the Productivity Commission's preliminary proposal that the coalescence of basic subsidies for high care residents in nursing homes and hostels should not proceed in its current form. We also agree with the proposal that in combination with resident charges, government funding should be sufficient to support the level of care required to meet the accreditation and certification requirements.

Whilst basic subsidy rates should be linked to the cost of providing a benchmark level of care using an appropriate input mix, we do not agree that this should be based on an 'efficient size facility' whatever that means.

Additional funding support for smaller nursing homes in rural and remote areas should be an automatic subsidy right and should not come from a special needs funding pool. Funding pools have a habit of contracting over time or being done away with by subsequent governments. An example of this was the contracting of the capital funding pool by the former Labor and current governments.

We contend that funding for services in rural and remote areas should be a priority and we agree with the Commission's proposal

that the Commonwealth government should develop and cost new special needs funding arrangements in consultation with providers, resident groups and state and territory governments.

We also agree with the proposal that increases in basic subsidies should be based on annual increases in the cost of the standardised input bundle necessary to deliver the benchmark level of care, however we cannot agree that this should be subject to a productivity discount.

We also agree that there should be periodic reviews of the industry's cost base and of the adequacy of the subsidies in the light of changes in care requirements.

The Commission's proposal that there should be no requirement for providers to acquit subsidy payments under the proposed regime certainly accords with the current practice in operation since 1 October 1997 which has removed the over-regulated acquittal system under the previous nursing home subsidy regime.

The Commission however did not comment on the fact that providers currently have to issue an annual signed statement regarding their prudential arrangements with respect to accommodation bonds but do not have to provide any form of annual statement setting out that subsidies received have been spent in accordance with the requirements under the Act.

The Commission also proposes that the regulation of extra service provision should be reduced and that the controls on what constitutes an extra service, where in a facility extra service places are provided, and the price charged for such services should be abolished.

ACHCA considers this will have unintended consequences in terms of access and equity. As a technique for injecting additional income for capital regeneration, it will force those hostels with all single bedroom en-suites to convert to either an all extra service facility or offering no extra service places.

The proposal will produce visible inequities in the provision of hotel services. Some residents in the same dining room being offered a la carte silver service and alcohol with meals whilst the non extra service residents will be treated as second class citizens.

The Productivity Commission's position paper discusses allowing people to pay for a higher standard of care and that

providing equity of care does not necessarily mean there should be one quality standard for all.

This language suggests that the standard and quality of nursing and personal care provided to residents would vary according to their capacity to pay.

ACHCA considers that a fundamental principle of access to aged care should be that the same standard and quality of care is provided to all regardless of capacity to pay.

The expansion of the user pays principle should only apply to the additional hotel services and accommodation style and should not apply to short stay nursing home residents.

ACHCA is disappointed that the Commission did not highlight that $66M of concessional supplement monies was removed from the care subsidy pool. The intention of this supplement was as a capital income replacement in lieu of the loss of the accommodation bond or accommodation charge from financially disadvantaged residents.

ACHCA considers it fundamental that providers separately identify capital income for capital regeneration purposes from recurrent subsidy and daily resident fees for the purposes of daily care.

A merging of these two elements will lead to the sector subsidising care from capital income and failing to adequately regenerate their capital stock.

ACHCA welcomes this opportunity to contribute to the Productivity Commission's deliberations.

In the Position Paper the Commission argues that equity of access to quality aged care must be the main criterion for assessing alternative subsidy regimes. The need to encourage efficient and responsive service provision, to avoid unnecessary administrative costs and to promote transparency, are also relevant considerations.

The Position Paper goes on to state that available government funds should be used to support a uniform quality of care across Australia and if the underlying costs of provision varies significantly across regions, this will require higher subsides for services in high cost locations.

The Commission Position Paper sets thirteen preliminary proposals and also invites specific comments on:

- 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

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

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

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

- the merits of, and scope to combine the resident daily fee in the accommodation charge;

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

- an appropriate timeframe for implementation of the full proposals, the interrelationships with the residential aged care review, and whether new arrangements should be phased in or simply introduced after a grace period.

ACHCA has responded to these in its submission to the Public Hearing.

Assessment Criteria

ACHCA supports the guiding principles and criteria for evaluating funding approaches as set out in Aged Care Australia's submission and outlined in the Commission's Position Paper (box 2.2 page 8).

ACHCA does not agree with the statement **'providing equity of care does not necessary mean there should be one quality standard for all. Thus, for example, it does not rule out allowing people to pay for a higher standard of care'.** (page 9)

ACHCA considers that whilst it may be appropriate for residents with the capacity to pay for a higher level of 'hotel' services are given that choice, the standard and quality of care provided should be the same for all residents regardless of the standard and quality of accommodation and hotel services and location.

The Paper goes on to state that **'providing equitable financial access does not imply that all residents should be equally subsidised irrespective of their ability to pay. Indeed, targeting available funding to those least able to pay for themselves is more equitable than distributing funding equally among all residents. The recent introduction of income tested care fees recognises this principle'**. (page 9)

Income testing care fees operates across all residents in categories one to seven but not in category eight as a subsidy is not available for this care category.

Income testing imposes a means testing regime on care subsidies even when some residents are in a highly dependent and frail stage in the last weeks or months of life.

The care level provided is basically health care similar to that provided in an acute setting. Hospital care is decreasingly that of acute episode followed by convalescent care. The trend is to that of acute episode followed by discharge with convalescent care being delivered in a step down facility or at home.

With the changing demographic profile of the population, increasingly older people will require post acute convalescent rehabilitation prior to either returning to their normal home or transferring to longer term residential care or short term palliative care.

The blurring of distinction between high care short stay nursing home care and that of step down convalescent rehabilitation will require a fundamental shift in government funding philosophy. The complexity of care now provided in residential aged care has resulted from changes in acute care discharge policies and the increasing average age of entry coupled with dependency.

The principles of Medicare and access to health services should also apply where the health service is provided in residential aged care ie short stay high care nursing home residents.

ACHCA agrees with the funding methodology criteria as set out on page nine of the Position Paper.

Implications for Funding Methodology

The Commission argues that providing higher subsidies to all smaller operators, irrespective of location, could reduce incentives for providers in the cities and the larger towns to expand or amalgamate to provide quality care at lower cost.

The demise of smaller facilities and their absorption into ever increasingly larger campuses of care will lead to a reduction in access for communities.

Operators of smaller facilities do not necessarily equate with the description 'inefficient management or work practices'.

ACHCA agrees that subsidy arrangements should not indefinitely underwrite cost differences that reflect inefficient management or work practices, but the cost differences between small operators and large operators must be recognised otherwise the community will lose the benefit of decentralised and localised availability of residential aged care.

To argue that a higher standard of care has to be funded from higher resident charges and/or savings made by providers is a position that should be vigorously opposed by providers, consumers and the community. Standards of care should be universal in terms of quality and should not be dependent on the person's capacity to pay. For the frail aged, good quality care is a right and not a commodity to be bought and sold.

State and territory governments should have a role in providing top up funding where they require the employment of more staff than provided for in the benchmark level of care or where higher building standards are imposed.

ACHCA welcomes the Commission's acceptance that some allowance needs to be made for significant regional differences in costs faced by nursing home providers in providing a benchmark standard of care. We also welcome the Commission's view that coalescence cannot be accepted as an equity principle in its own right. (page 12)

Nursing Home Costs and Their Determinants

The Position Paper identifies that apart from the cost differences arising from variations of efficiencies of providers, the following factors can influence the cost of delivering nursing home care; (pages 15 and 16)

- resident mix
- quality of care
- home size
- service integration
- ownership
- location

The Commission argues in its Position Paper that it is preferable to make any funding allowance for smallness and remoteness separately from the basic subsidy regime. (page 17)

ACHCA would agree with this conclusion providing that any such funding allowance adequately recognises the fundamental cost differences and adjusts these cost differences by appropriate indexation measures and changes in dependency levels.

It must also be recognised that a rural district may not be classified as 'rural and remote' yet be at a cost disadvantage from metropolitan and large urban areas. The differences in resident mix and building configuration may not be readily adjusted.

In looking at wage trends and productivity, the Commission has concluded that the differences in wages in the aged care sector have been narrowing in recent years and could continue to narrow over time. (pages 28 and 29)

With future trends and wage costs, the Commission considers a relevant factor is the likely extent of productivity based wage increases. ACHCA considers that the scope for significant productivity improvements in the residential aged care sector is minimal.

The question that must be asked is can improvements in productivity lead to lower costs? The example of Tricare's experience, as outlined in the Position Paper, indicates that, through enterprise based negotiations an increase in salaries was funded out of changes in workplace conditions of employment.

There appears to be no reduction in salary cost through the enterprise agreement however over the long term there may be the potential for some small savings.

The funding methodology should not assume that a so called productivity growth measure on overall funding needs will lead to anything more than a marginal saving in cost.

Relationship between Standardised Cost and Current Subsidies

It is a pity that the Commission was unable to undertake its own cost data analysis and has had to therefore rely on cost data provided in submissions.

The Commission concludes that there are considerable uncertainties and caveats in the cost data supplied, however apart from very remote areas, regional variations in the standardised cost of delivering nursing home care are significantly smaller than the current jurisdictional differences in subsidy rates. These differences also appear to be narrowing over time. (page 32)

ACHCA considers that the current state subsidy levels do not reflect the cost differences between the jurisdictions.

Coalescence

Based on the cost data provided, the Commission has concluded (page 34) that in broad terms the current cost situation can be summarised as follows:

- The standardised cost comparisons show jurisdictional variations in labour costs of up to 12 percent. However, the broader set of comparisons by Aged Care Australia suggests a much smaller variation of up to four to six percent.

- While there may be some differences in wage costs within jurisdictions, there was no evidence provided to suggest that these are generally significant in total cost terms.

- Non wage recurrent costs vary across regions, but are a relatively small part of the overall cost to providing care.

- Land and building costs vary significantly across Australia.

ACHCA considers that these elements are significant enough to warrant a funding structure that reflects even relatively minor cost differences.

The profitability of the nursing home sector is so finely balanced, facilities within identified regional cost areas should not be financially disadvantaged.

The Commission concludes that while greater uptake of enterprise bargaining could lead to some increase in wage differentials, such increases would be offset by productivity improvements. ACHCA cannot agree with this conclusion and questions the basis for its authority. (page 34)

The current variations in wage rates may be a reflection of the current differences in subsidy rates. A move to nationally uniform basic subsidies would most certainly accelerate the trend reduction in wage differentials. This raises the question as to the appropriateness of a revised subsidy regime to implement wage parity across jurisdictions. Should the subsidy arrangements lead wage increases or be a reflection of changes in wage costs? Is there wage parity across jurisdictions in other comparable sectors of the economy?

The Commission concludes (page 37) in **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 subsidy arrangements.**

ACHCA agrees that coalescence should not proceed in its current form. The question as to whether there should be nationally uniform basic subsidy rates would depend on how variations in cost structures between and within jurisdictions are addressed.

An Alternative Uniform Regime

The Position Paper suggests that a basic subsidy regime would not make provision for the higher unit costs of small facilities. Where higher funding for small services is warranted, it would come through a special needs pool. (page 39)

ACHCA does not support the use of a special needs pool as a process for providing for higher unit costs of small facilities. Such a pool would have a finite amount of money and would be subject to erosion over time or removal by a subsequent government.

ACHCA supports **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**. (page 41)

The Commission considers that the cost base of the basic subsidy regime should not make allowances for the proportionately higher costs incurred by small homes. The basic subsidy should be based on an 'efficient size facility' which has been suggested in the position paper as being 60 beds. (page 42)

If the subsidy regime were to be based on this figure which is higher than the average size facility the result would be the demise of facilities of up to 55 bed size.

The Position Paper supports the continuing rationalisation in the sector where between 1992 and 1997 the number of facilities with less than 25 beds fell by more than 40 percent.

Continuing rationalisation will only limit access for people to residential care in their own communities. It would also conflict with the objectives of the Aged Care Act 1997 with respect to access, responsiveness to individual needs and the provision of respite for families.

The Position Paper also suggests that the ongoing additional support for small facilities in rural and remote areas be handled through the special needs funding pool. ACHCA does not support funding for these facilities through a special needs funding pool. The funding should be an additional supplement.

If the Commission believes that subsidies should be based on the 'average' cost of providing the benchmark level of care, why not base this on an average size facility rather than an 'efficient sized facility'?

Efficiency of size of a nursing home as a concept for determining funding levels would disregard the factors governing size and would unfairly treat those homes for whom it would be impractical to reach the 'efficient size' level.

ACHCA therefore does not support **Preliminary Proposal 3 with its current wording: 'basic subsidy rates should be linked to the cost of providing the benchmark level of care in an efficient size 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. The industry cost base should reflect nursing wage rates and conditions applicable in the aged care sector rather than in the acute sector'.** (pages 43, 44**)**

The success of this proposed arrangement will depend crucially upon the detail of the method used to define a 'benchmark level of care', 'an efficient sized facility' and 'an average input mix'.

The Commission invites comment on 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.

In the longer term there may be more efficient alternatives but these would need to be developed in conjunction with how the residential aged care sector is to be better linked to the acute and community care sectors in order to achieve a seamless continuity of care for people with growing dependency and complex care needs.

Additionally, as residential aged care services increasingly differentiate between short stay high dependency clients as opposed to those longer stay residents that 'age in place,' the funding system will need to change to better reflect the short stay high dependency linkage with the acute sector.

ACHCA is disappointed that the Commission made no comment about the removal of $66M from the RCS funding pool for the concessional resident supplement.

The concessional resident supplement is intended to be a capital income item to replace the accommodation bond or the accommodation charge for financially dependent residents. As such the original money earmarked for this supplement shouldn't have been removed from the care funding pool when the RCS subsidy levels were developed.

Preliminary Proposal 4: 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 the productivity discount. When it becomes available, the ABS Productivity Index for the nursing home sector should be used to determine the discount.

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. (page 48)

ACHCA could not support this preliminary proposal until further information is known about the productivity measure, its construction and its financial impact on the sector. There may, however, be justification for a productivity discount on the SAM element of a funding model, but not on the nursing and personal care portion.

Preliminary Proposal 5: The pensioner, oxygen, enteral feeding, respite, and hardship supplements should be retained in their current form in the new subsidy regime. (page 49)

ACHCA supports this proposal.

The Commission considers that the current two tiered system of funding concessional residents leads to funding inequities associated with the 40 percent tier (page 49).As the large majority of aged care residents qualify as concessional, there seems no further purpose in continuing with the two tier. ACHCA recommends that the concessional resident supplement for all concessional residents be set at the amount of the supplement applying at the 40 percent tier.

The Commission invites comments on the impact of input taxes, other than payroll tax, on private providers costs and whether these should be recognised in the subsidy arrangements.

The Commission has not considered the changes to input taxes that will flow from the tax reforms and introduction of a goods and services tax.

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 payrolls. (page 53)

If facilities that are registered to pay payroll tax on their primary payrolls are also enabled to receive a supplement for the payroll tax component of contract labour, these facilities would have an income advantage over charitable sector facilities.

Preliminary Proposal 7: Commonwealth contributions towards workers compensation costs should continue to be provided through the basic subsidy regime. (page 54)

ACHCA supports this proposal providing that the differences in workers compensation costs between jurisdictions are taken into consideration in setting jurisdictional variations and also in the adjustment of subsidy levels through indexation. ACHCA also considers that some allowance must be made for facilities, particularly small ones, that experience claims resulting in significant premiums increases. A capping arrangement on premium cost should apply.

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 components. (page 55)

ACHCA supports this proposal, it could, however, lead to a funding windfall for those operators who purchased state government beds at a discounted price or who operate under a state government funding top up contract.

The Commission argues that the special needs pool could also incorporate capital support to help small-scale services comply with accreditation and certification requirements. ACHCA agrees that support for capital upgrades should come in the form of a grant rather than as an adjustment to the basic subsidy.

However ACHCA does not agree with the Commission's intention that such supplementation be a one off of capital costs of achieving accreditation and certification and that these should only be available when services in a region as a whole would not otherwise be viable.

ACHCA considers that the viability of the ongoing day to day operation of the service is separate from the capital needs of these facilities and their capacity to generate capital income.

ACHCA considers that the Government should have an ongoing capital grants program of sufficient size to meet the needs of the sector.

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 Government should develop and cost new special needs funding arrangements in consultation with providers, resident groups and state and territory governments. (page 59)

ACHCA supports this proposal providing it is not intended to use the same size funding pool altered by a reorganisation of funding priorities.

On the question as to whether subsidies should be acquitted the Commission considers that a return to the acquittal system would hamper the development of enterprise bargaining now beginning to emerge in some sections of the industry. (page 61)

ACHCA considers that it is possible to have an acquittal system that would not hamper the development of enterprise bargaining. We recommend that providers should provide an audited statement that the subsidies and grants have been spent in accordance with the purposes intended. We agree that a return to acquitting subsidies against expenditures should not take place.

Preliminary Proposal 10: There should be no requirement for providers to acquit subsidy payments under the proposed regime. (page 61)

ACHCA does not agree with this proposal however would not support an acquittal of subsidies against expenditures.

Preliminary Proposal 11: subsidies should continue to be paid to providers rather than to residents. (page 62)

ACHCA supports this proposal.

Income and Asset Tested Resident Charges

The Position Paper mentions that a number of submissions drew parallels with the Medicare system, which provides free or heavily subsidised medical and public hospital treatment irrespective of a persons means. (page 64)

It is disappointing that the Position Paper did not explore further the parallel between the very frail and sick entering nursing home care for short stay palliative care and the Medicare system with respect to public hospital treatment.

The Commission seeks further comment on whether, in moving to a new subsidy regime, another round of changes to income and asset tested charges should be contemplated.

ACHCA considers that in view of the inequity between short stay high care nursing home residents and those entering the acute sector under the Medicare system that it is appropriate for adjustments to be made to the income and asset tested resident charges to appropriately align them.

The Commission has asked ACHCA to identify the cost elements and their quantification in meeting the needs of short stay high care residents. Since the ACHCA appearance at the Public Hearing in Melbourne, ACHCA has sought information from its members as to the proportion of residents that are high care short stay and the cost items incurred.

Short stay high care

According to the Australian Institute of Health and Welfare, "Nursing Homes in Australia 1996-97: A statistical overview", 26% of permanent nursing home residents stay less than 3 months, 36% less than 6 months, 42% less than 9 months and 47% less than 12 months. Eighty two percent of these separations were as a result of death, 8% returned to the community, 3% went to hospital, 3% to a hostel, 3% to another nursing home, whilst 1% are unknown. (page 79)

Nursing home length of stay experience is very variable in the sector and depends on the location, size and resident profile of the individual facility.

Up to 33% of residents stay less than 3 months, up to 12% stay between 3 and 6 months, up to 18% stay between 6 and 9 months, whilst up to 8% stay between 9 and 12 months.

The cost elements involved with short stay high care residents are essentially the same as for long stay. These can be grouped under the headings of:

- Pre-admission
- Admission
- Assessment
- Staff training and familiarisation
- Family counselling and post discharge.

It is estimated that the cost of each admission is at least $1,200. Whilst this cost exists for every resident admitted, short stay results in a greater frequency with which the cost is incurred.

The existing funding pool and consequent subsidy levels have been derived from the CAM/SAM/OCRE funding formula which was based on 19984-85 cost data. Length of stay and frequency of new admissions was radically different at that time. The current funding does not adequately recognise the higher cost of an increasingly shorter stay resident profile.

ACHCA re-states its position that short stay high care residents should not have to pay an entry fee or income tested charge.

There is also the issue that low care residents now have the choice of paying the accommodation bond either as a lump sum or as a periodic payment. The periodic payment is very similar to the accommodation charge for high care residents. Unfortunately high care residents are not given the same choice, the only option for them, regardless of their needs, is to pay the daily accommodation charge of up to $12 a day as a daily fee.

Many high care residents would prefer to convert this payment into either a lump sum or an annual payment.

The elimination of the bond for high care residents has created an incentive for providers to preferentially seek out and admit concessional residents. To date there is no hard evidence to support any contention that non concessional residents are experiencing access difficulties.

Those non concessional residents with substantial sums of money resulting from the sale of the family home are leading providers into offering increasingly more creative ways of overcoming the loss of the bond.

The Commission also raises the question as to whether it is appropriate to continue to separate asset tested accommodation charges and income tested daily fees. (page 65)

The accommodation charge is intended to be an income stream for capital works. It is appropriate that it continue to be identified separately to resident daily fees.

As these are both daily fees they are paid together by residents when meeting their regular invoice payment commitments.

Extra Service Arrangements

The Commission argues (page 69) that there is merit in a less prescriptive safeguard mechanism as part of a general reduction in the controls of extra service places. In the Position Paper it is stated that a preferable approach would be to leave it to nursing home proprietors to determine the number of extra service places they wish to provide with the Department of Health and Aged Care monitoring those places and waiting lists for basic care.

The Commission, in arguing for this deregulation, is overlooking the structure of the aged care sector and how such deregulation would operate unfairly for consumers.

For example, hostels that currently have all their rooms as single bedrooms with en-suites would either have to make all of their rooms extra service places or none of them. The nursing home down the road with only a few single bedrooms with en-suites would be able to declare those as extra service places.

It would also be impractical within the same dining room to provide extra quality services to the extra service place residents whilst the remaining residents sharing the same dining room are offered lesser quality eg a la carte menu or no a]a care menu, wine with meal or no wine with meal, linen table cloth and silver service or no linen table cloth and silver service.

Preliminary Proposal 12: Regulation of extra service provision should be reduced:

- **The controls on what constitutes an extra service; where in a facility extra service places are provided; and the price charge for such services should be abolished;**

- **The current reduction in the basic subsidy for residents receiving extra services 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; and**

- **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 the concessional resident ratios.** (page 70)

ACHCA does not agree with the first dot point or the last dot point. We believe that until the 12 percent of extra service places is achieved there should be no change in the planning controls on extra service places.

There may be scope for a change in the subsidy reduction process and defacto income tested charge.

Implementation

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 currently low subsidy states. (page 74)

ACHCA supports an increase in the basic rates for the low subsidy states, but is concerned that a simplistic redirection of funds earmarked for indexation would deprive the higher subsidy states of appropriate increases to meet cost increases. Why should Tasmania, Victoria, Northern Territory and New South Wales have to forego funding to meet cost increases?

The current funding regime is the result of the federal government's development of the former CAM/SAM/OCRE scheme and the translation of it into the RCS basic subsidy amounts.

The inherent constructional flaws, the failure on the part of the federal government to implement the $1.56 increase in SAM identified in the 1991 SAM Review and the removal of the $66M from the care subsidy pool earmarked for the Concessional Resident Supplement, places the responsibility for correction fairly and squarely with government. Providers and their residents should not be called on to wear the cost.

ACHCA does not support this proposal.

Conclusion

ACHCA considers that the Commission should undertake its own analysis and not rely on the analysis contained in the various submissions. Any analysis should not rely only on aggregate resident data, but should correlate resident data with facility profiles such as size, location and ownership type.

Issues such as what constitutes a 'benchmark level of care' and ,an efficient size facility' and 'an average input mix' clearly require substantial work and in the absence of this work it is difficult for the sector to be able to fully support some of the proposals outlined in the position paper.

There is also a need for a list of key quality indicators that can be measured and for an identification as to the measurement process. The accreditation process is unlikely to be able to provide a benchmark on quality as the rating process is predicated on establishing, for each standard outcome, whether a major health and/or safety risk and/or major concern about residents' well-being has been identified.

Providing a facility is able to satisfy this question in the negative, it will score a 'satisfactory' or 'commendable' on each outcome and 'commendable' or 'satisfactory' on each standard. A three year accreditation will be the result.

As outlined in proposal number nine regarding special needs funding for services in rural and remote areas, it is clear that the viability supplement is inadequate however the Productivity Commission has not identified the amount needed to meet the needs of the sector.

Flexibility around the resident fee for small homes could be an option, but not in financially deprived locations.

The disparity of nurses wages between acute and non-acute sectors has been identified but there was inadequate exploration of the factors that could lead to maintenance of a disparity. Even if there are work value differences, residential aged care has to compete with the acute sector for registered nurses.

The size, design, location and physical nature of nursing homes today are a direct consequence of federal government policies over the last 30 years. In many cases the facilities with low bed numbers are a direct product of the government's prevailing policy of 'small is beautiful' and 'homelike environment'.

The now out of fashion multi bed wards were frequently foisted on providers, sometimes against their wishes, by department officers and their notion of economic design.

In delivering its final recommendations, ACHCA would urge the Commission to avoid leading the sector into the same economic environment that has resulted in the supremacy of the regional supermarkets and the demise of the multiple numbers of suburban convenience stores.

The final subsidy regime should enable the sector to be viable for nursing homes that are small as well as large. Rationalisation into increasingly larger campuses of care will result in reduced access and will not improve the personal care of residents. Small facilities are able to provide a more personal care experience for its residents.

The subsidy regime should have a construction that is transparent. It should enable the diversity of the sector to be maintained, be adequate to provide for the care needs of residents, ensure a quality level is achievable, provide incentives for resident rehabilitation, provide for depreciation, return on investment and an appropriate surplus.

Basing funding on a grouping of resident dependencies at a fixed daily amount may provide more certainty of funding and provide an incentive for rehabilitation, but could result in an emphasis on lower levels of dependency in each grouping.

Some nursing homes are experiencing financial pressures when admitting residents assessed by ACAT's as high care but are funded at low care levels as a result of the RCS appraisal. ACHCA requests that the Commission seek data from the Department of Health and Aged Care on the incidence of incorrect ACAT assessment.

A solution would be for the default level of funding for high care residents to be set at RCS 4.

In view of the size of the residential aged care sector and its contribution to the total health and aged care system, ACHCA considers that the Productivity Commission should continue to be involved in consideration of future changes in the financing of the sector.

Richard Gray

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