

## **Residential Aged Care Funding: Second Report**

A report by the Australian Institute for Primary Care LaTrobe University  
for the National Aged Care Alliance

October 2001

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## Glossary

AIRC	Australian Industrial Relations Commission
AWOTE	Average Weekly Ordinary Time Earnings
COPO	Commonwealth Own Purpose Outlays
CPI	Consumer Price Index
DHAC	Department of Health and Aged Care
LPI	Labour Price Index
RCS	Resident Classification Scale
SNA	Safety Net Adjustment
TMUI	Treasury Measure of Underlying Inflation
WCI	Wage Cost Index





## Executive Summary

In October 1997, the Coalition Government introduced a structural reform package into the residential aged care sector. The major elements of the package were the unification of nursing home and hostels into one system, greater reliance on resident contributions to fund the sector, and the introduction of a new standards and accreditation system. The changes affected both recurrent and capital funding for residential aged care services.

This report was commissioned by the National Aged Care Alliance to provide advice on the quantum of funding available for residential care before and after the reforms. The report is based on an earlier version of the same material, but it takes into account more recent data and the findings of the Two Year Review of the aged care reforms completed by Professor Len Gray and it includes residential aged care funding for the Department of Veteran's Affairs.

The key issue this report addresses is the extent to which the total level of residential age care subsidy funding provided by the Commonwealth adequately addresses changes in demand for services and the cost of providing them. In particular, the report considers the extent to which:

- residential care funding for services in the period before and after the recent Commonwealth reforms has been adequately adjusted to take account of changes in the costs of producing services
- changes in the total funding for the residential care subsidy kept pace with the increased demands on resources generated by the growth in resident numbers and increasing resident dependency levels.

The report demonstrates that although there have been substantial increases in total funding for residential care subsidy, current indexation arrangements do not adequately adjust for cost increases and data limitations make it difficult to assess the relationship between increasing demand and funding adequacy.

An examination of two alternative indexation methods for capturing increased wage costs (Average Weekly Ordinary Time Earnings and the Wage Cost Index) was undertaken. In addition, for non-wage costs, the use of the Cost Price Index was investigated and compared with current indexing procedures.

The impact of using combinations of these alternative methods on the total level of funding was estimated. The level of underfunding over a 4-year period compared with the Commonwealth's current indexation approach was estimated in the range of \$193.9 million and \$265.8 million from 1996/97 to 2000/01.

For sometime arguments have been put forward that the Commonwealth Own Purpose Outlays (COPO) indexation method is inappropriate for indexing funds for residential care. It is argued that the two parts of the COPO 'cocktail' – the Safety Net Adjustment (SNA) (wage costs) and the Treasury Measure of Underlying Inflation (TMUI) (non-wage costs) – are both arrived at in ways that mean they are unsuitable for the purpose. The SNA makes assumptions about productivity gain offsets (to wage increases) which do not hold in the residential care sector. In addition the TMUI omits items from its 'basket of goods' whose price changes have a major impact on the sector. The result is that the COPO indexation figure underestimates the cost pressures faced by residential care providers and hence the funding increases passed on are insufficient.

The study found that resident numbers, the number of respite care days used and dependency levels have all increased markedly since changes to funding arrangements were made by the Commonwealth in 1997. The increasing level of resident dependency appears to be the greatest pressure on funding for residential aged care. Existing residents are 'ageing in place' and newly admitted residents are from the higher dependency groups.

From 1996/97 to 1999/00 there was a 3.3% increase in the number of residents, a 6.7% increase in the percentage of high care residents, a 15.1% increase in all respite beds and a 40.3% increase in high care respite bed days. Total subsidy funding increased by 32%. Of this change 4.6% was explained by indexation (using COPO). A significant proportion of the increase is also accounted for by the inclusion of funds (previously not included in the total funding figure) covering the Pensioner Supplement. Taking account of these factors, overall there was an 18% rise in funding to cover the 'demand' factor increases referred to above. The increasing level of resident dependency appears to be the greatest pressure on funding for residential aged care as existing residents age in place and newly admitted residents are from the higher dependency groups. However, significant limitations in the data reviewed made it difficult to draw definitive conclusions regarding the extent to which real funding increases have kept pace with greater demand for services.

It is important to note that the current Commonwealth funding arrangements lack transparency. As a result a number of assumptions had to be made about the treatment of various factors that affected changes to funding levels both in relation to changes in demand and in investigating the impact of indexation. It should also be noted that this analysis only relates to the Commonwealth funding. Other sources, such as resident contributions also affect the overall funds available to aged care providers.

Three options could be considered to address the issues identified in this report. The design of the funding system could be left as it is, but a one off adjustment could be made to the payment levels to compensate for underfunding due to indexation. Alternatively a more appropriate index to adjust for changes to the cost of provision could be introduced. Finally a costing model that relates payment levels to the dependency levels and care factors that drive costs could be introduced.

The option of a one off adjustment has the advantage that it would restore funding for changes in the cost of provision with minimal disruption for a relatively modest cost to the overall system. However, it has the disadvantage that the underlying cause of the problem will not be addressed and funding levels will again be eroded over time.

Alternatively, the option of developing an appropriate index to replace the COPO is open to further investigation. In this report the WCI produced much lower indexation estimates. This index adjusts for quality factors affecting wage costs and thus may be said to be a more accurate measure of 'pure' wage inflation. However, whether this is actually the case depends on whether wage costs as measured by the WCI specific to public sector health and community services are an accurate reflection of the wage cost movements in the residential care sector. This is an empirical question and further work is required to examine whether or not the assumptions made in calculating the public sector health and community services WCI hold specifically for the residential care sector. This is the only way of truly arriving at a reliable view on the veracity of using the WCI as opposed to use of AWOTE.

It should be noted that a possibly more valid alternative to the WCI is currently under development – the Labour Price Index (LPI), (formerly referred to as the Labour Cost Index). This index will measure changes in the price paid for labour services inclusive of wages and salaries as measured by the WCI *and* non-wage items such as paid leave, employer funded superannuation, payroll tax, workers' compensation, fringe benefits and fringe benefits tax. The LPI will produce movements covering the broader concept of the price of labour

services. However, the ABS expect that collection of the LPI data set will commence from the September quarter 2001, with publication from 2003. Until then the WCI may remain the most valid alternative to the SNA method of dealing with wage cost increases faced by the sector.

While the development of an appropriate index to adjust for changes in the cost of provision has a number of advantages, it will not adequately compensate for changes in the nature of the model of care required. These may occur as a result of the interaction of regulatory demands (eg accreditation) and the changing mix of resident dependency. A costing model which relates payment levels to the dependency levels and care factors that drive costs could be introduced to address these problems.

The current RCS cost gradient was derived from a study undertaken in 1996/97 by Coopers and Lybrand (Cuthbertson et al 1998). The Coopers and Lybrand study 'established that an additive approach that included a number of care need areas (compared to a categorical casemix model) was the most appropriate for classification in a residential care setting' (ibid p.6). A sliding scale of subsidy rates for each RCS level will not ensure quality care and viability of care provision by organisations if it is not based on the true costs of care faced by providers.

Consistent with the findings of the Productivity Commission (1999) a regular, comprehensive study of the cost of providing residential age care across settings and resident characteristics could be introduced as the basis for adjusting residential aged care funding. In this respect, the assumptions made by Coopers and Lybrand in reaching their conclusions regarding the inappropriateness of a casemix model need to be re-examined. It is only by relating actual resident care requirements (and hence care costs) at the various RCS levels, that a true estimate of the additional funds required by changing dependency levels will be reached. A 'full-cost' model of the costs associated with increasing dependency would probably require a detailed prospective cost study which sought to determine the relationship between rising dependency levels of individual residents and also the impact of changing resident dependency ratios in care units.

## Introduction

In October 1997, the Coalition Government introduced a structural reform package into the residential aged care sector. The major elements of the package were the unification of nursing home and hostels into one system, greater reliance on resident contributions to fund the sector, and the introduction of a new standards and accreditation system. The changes affected both recurrent and capital funding for residential aged care services.

Prior to the introduction of the 1997 reform package, nursing homes and hostels operated under different legislation and, of particular significance to the present discussion, under different funding arrangements. The Commonwealth provided a higher proportion of the funding for nursing home care than for hostel care. Conversely, hostel residents, who were historically less dependent than nursing home residents, were generally required to make a greater financial contribution towards their own care.

The Commonwealth government funded nursing homes through three payment components:

1. *The Care Aggregated Module (CAM)* – paid to provide nursing and personal care for each resident according to their dependency level. Calculated on the basis of a five tier Resident Classification Instrument (RCI).
2. *The Standard Aggregated Module (SAM)* – paid at a flat rate for each resident to provide infrastructure or hotel costs.
3. *Other Cost Reimbursed Expenditure (OCRE)* – covered other costs such as payroll tax and workers' compensation premiums.

Commonwealth funding for hostels consisted of a single payment based on resident classification according to the Personal Care Assessment Instrument (PCAI).

Nursing home residents paid daily fees set at 87.5% of the age pension plus rent assistance. They did not pay any entry fees. Capital investment for nursing homes was generally seen as the responsibility of providers, although some Commonwealth assistance was available through a limited capital grants scheme. Residents in hostels, on the other hand, paid variable daily fees based

on the hostel's assessment of their capacity to pay, with the minimum contribution being 85% of the combined pension and rent assistance. Hostel residents also paid negotiated capital entry contributions, known as bonds, which providers could use for capital development. This was augmented by a substantial Commonwealth program of capital grants.

Under the previous residential care arrangements, separate schemes were operated by the Commonwealth Government to monitor Outcome Standards for nursing homes and hostels.

The structural foundation of the 1997 reform package was the unification of nursing homes and hostels into one residential aged care system, with individual homes potentially able to offer the full continuum of care. It was argued that this would overcome distortions which had arisen in the previous system because of the increasing dependency of the hostel population, with hostels increasingly caring for people who would once have entered nursing homes, but not being provided with the necessary financial resources.

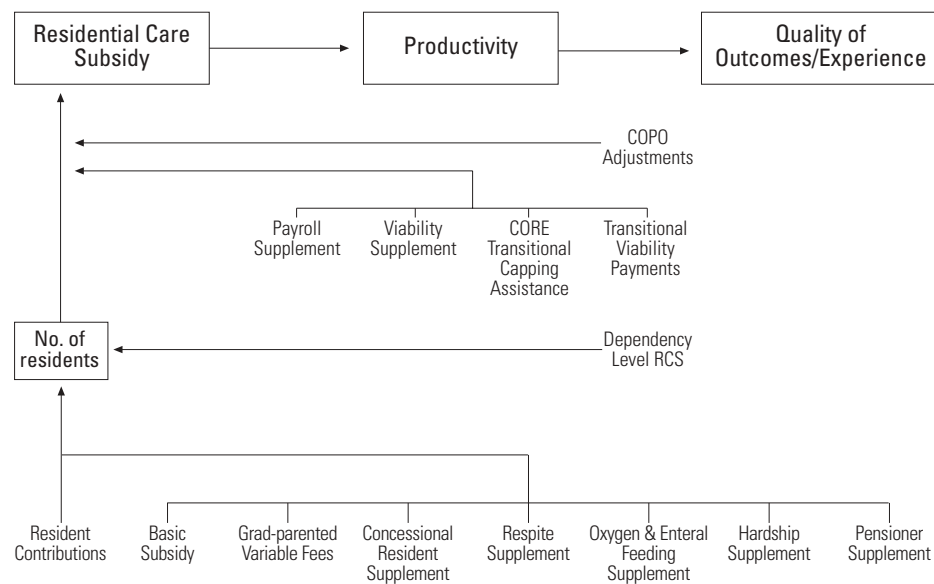
The 1997 reforms also included the introduction of an integrated funding system, based in general terms on the previous hostel funding arrangements. A single funding tool, the Resident Classification Scale (RCS) was introduced. The new system also expanded the principle of resident contributions for both capital and recurrent costs (based on capacity to pay) to the entire residential care sector. Under the new scheme, all residents pay a basic daily care fee called the standard resident contribution. For most people, this is set at 85% of the basic single age pension, although certain residents may be asked to pay at a higher rate. As well, residents who are part-pensioners or non-pensioners may be asked to pay additional income-tested fees, depending on an income assessment process involving Centrelink, the Departments of Veterans' Affairs and the Department of Health and Aged Care. Subsidies paid to providers are reduced by the amount of the income-tested fee. In addition, all residential aged care homes are now able to seek capital contributions from residents who can afford to make one.

Under the system, responsibility for quality assurance was shifted out of the Department of Health and Aged Care to a newly established independent Aged Care Standards and Accreditation Agency. Aged care homes must be accredited in order to receive government subsidies.

This paper is primarily concerned with the extent to which the total residential care subsidy funding provided by the Commonwealth Government has adequately addressed changes in demand for services and the cost of providing them. These relationships are outlined in Figure 1.

As the figure indicates, the quality of outcomes and experiences of residential aged care is determined by the extent to which labour and capital inputs are used productively to provide services and the residential care subsidy which is provided for this purpose. It should be noted that the extent of capital funding adequacy also affects this relationship, but this has not been a subject of analysis in this paper.

**Figure 1** Recurrent funding relationships



The adequacy of recurrent funding is affected by the demand for places in residential aged care adjusted for client dependency and other characteristics and changes to input costs associated primarily with labour and consumables.

The Commonwealth makes a number of payments and supplements to aged care providers, to adjust for differences in input costs across agencies and over time. These include:

- *COPO Adjustments* – Commonwealth funding is indexed to the Commonwealth Own Purpose Outlays (COPO) index, which is based on a combination of the Consumer Price Index (CPI) and the Safety Net Adjustment (SNA).
- *Payroll Tax Supplement* – paid to recognise the cost of payroll tax that is faced differentially by providers from different industry sectors.
- *Viability Supplement* – paid in recognition of the additional costs faced by rural and remote aged care homes, and by homes catering for special need groups.

- *OCRE Transitional Capping Assistance* – paid for four years to homes whose OCRE costs were significantly greater than average in 1996–67.
- *Transitional Viability Payments* – gradually reducing payments to former nursing homes that had received special payments under the pre-1997 funding arrangements but which were not eligible for the new viability supplement.

The Commonwealth also makes adjustments to recurrent payments for client characteristics based on dependency levels and other care needs, such as oxygen and enteral feeding requirements, incentive payments, to encourage agencies to provide services to particular classes of residents, such as people on low incomes, transition and grand-parenting payments, and adjustments to subsidy levels for user contributions.

Adequate funding for residential aged care would ensure that the quality of client outcomes and experiences, adjusted for dependency levels, are maintained or improve and that the number of residential aged care places as a proportion of the population aged 70 or over, was maintained or increased. In the absence of dependency adjusted quality indicators for experience and outcomes, estimates may be made of the extent to which changes in Commonwealth funding levels have kept pace with changes in the cost of providing residential aged care services, changes in client characteristics and dependency levels and increased demand associated with population aging. Any such calculation will need to take into account the fact that one of the stated intentions of the 1997 reforms was to increase the proportion of funding for residential aged care provided by the residents themselves, and hence to decrease the proportion provided by the Commonwealth. In the case of recurrent funding, this was to be achieved primarily through introducing income-tested fees additional to the standard resident contribution, and reducing the Commonwealth subsidy for residents paying these fees by an equivalent amount.

The analyses presented in this paper attempt to compare funding for the financial year 1996/97 with funding in subsequent years, up to 1999/2000. In other words, the paper takes a 'before-and-after' approach. The analyses draw on data taken from number of government sources, the main ones being Commonwealth Budget Portfolio papers, Department of Health and Aged Care (DHAC), Australian Bureau of Statistics (ABS) documents and their website facilities, the Australian Institute for Health and Welfare (AIHW), and the Two Year Review of Aged Care Reforms undertaken by Professor Len Gray for the Government. The source of each item of data is identified in the text when it is dealt with.



## Cost of Service Provision

This section addresses the extent to which residential care funding services in the period before and after the recent Commonwealth reforms has been adequately adjusted to take account of changes in the costs of producing services. As Figure 1 indicates a number of supplementary payments are made to adjust for differences in input costs. However, the Commonwealth Own Purpose Outlays (COPO) index is the major factor that impacts on the level of the subsidy for changes in costs. This paper addresses two key questions in this respect:

1. What are the best available proxies for cost increases in the residential care sector?
2. How has the chosen indexation method, COPO, affected the total level and the 'buying power' of the subsidy?

As will be shown below, the debate and decision as to what are the best proxies for cost increases in this sector and hence which indexation method should be employed has a great impact on the total level of funding provided. The current method of indexation is the use of the Commonwealth Own Purpose Outlays – referred to as COPO. The purpose of indexation is to maintain the real value of funding such that outputs produced by residential care outlays are constant in terms of both quality and quantity. For an index to be suitable it must therefore accurately reflect the cost pressures faced by the sector. Over the last few years it has been suggested that the COPO index has produced increases in funding levels which are not adequate to maintain the standards of care desired by the Commonwealth Government (see below for more comment from Productivity Commission).

Below we critically examine the current indexation arrangements and present some alternative indexation approaches, showing the potential impact on funding levels compared to those produced under COPO.

### **Commonwealth Own Purpose Outlays index (COPO)**

The current indexation formula for residential care subsidy funding is the COPO or Commonwealth Own Purpose Outlays index introduced by the Labor

Government in the 1995 Federal Budget to commence from 1 July 1996. The particular COPO index used is Wage Cost Index 9 (WCI9) which is weighted 75% (of Safety Net Adjustment) for wage costs and 25% (of Treasury Measure of Underlying Inflation) for non wage costs. WCI9 uses the Safety Net Adjustment (SNA) for indexing wage costs. The SNA is used as a proxy for non-productivity wage growth, in other words it reflects 'true' wage inflation by 'stripping out' wage increases that have been funded by improved productivity. Changes in non-wage costs were proxied by the Treasury Measure of Underlying Inflation (TMUI), which was used until July 1999, ie it was last used to index funding for the financial year 1999/00. The TMUI has now been replaced by the Cost Price Index (CPI), which is discussed below.

**Table 1** COPO figures

	1996–1997	1997–1998	1998–1999	1999–2000	2000–2001
COPO (75/25)	1.70%	1.70%	1.4%	1.50%	2.1%

*Source: Personal communication, Department of Finance and Administration*

Table 2 on the next page sets out the implied changes in residential aged care funding accounted for by COPO indexation over this period.

The 1999 Productivity Commission report on nursing home subsidies concluded that the current COPO indexation regime was not based on movements in industry specific costs. It went on to say that:

'With other sources of income for providers largely tied, inadequate increases in subsidies... will, in one way or another, compromise the delivery of quality care' (p.94).

In other words the Productivity Commission believed that COPO driven increases in funding would lead to an 'underfunding' situation. In order to understand how this conclusion may be reached it is necessary to examine each of the component parts of COPO – that is, the SNA and the TMUI.

#### **The Safety Net Adjustment (SNA) (wage costs)**

The SNA is determined by the Australian Industrial Relations Commission (AIRC) as a flat dollar value (wage increase) for lower paid workers who have been unable to achieve wage increases through enterprise bargaining (ie through productivity gains). The SNA component of the COPO index expressed as a percentage of average weekly earnings is used to adjust residential care subsidies for wage movements.

**Table 2** Changes in funding and COPO calculations (revised)

	1996/97	1997/98	change \$ (year on year % change)	1998/99 <sup>^</sup>	change \$ (year on year % change)	1999/2000	change \$ (year on year % change)	2000/01	change
Actual Subsidy Total*	2,698,163,421	3,028,912,197	330,748,776 12.3%	3,337,696,309	308,784,112 10.2%	3,566,025,000	228,328,691 6.8%	3,865,713,000	299,688,000 8.4%
COPO %	1.7	1.7		1.4		1.5		2.1	
Implied COPO funding		2,744,032,199		3,071,316,968		3,387,761,754		3,640,911,525	
Unexplained change (ie. 'real' change after 'inflation')		284,879,998		266,379,341		178,263,246		224,801,475	
% change unexplained by COPO (real change)		10.56		8.79		5.34		6.30	

\*DHAC Annual Reports, Senate Hansard 11/10/2000, p.18374, portfolio budget statements

There are a number of problems with using the SNA to drive funding for residential care. By using the SNA (weighted as 75% in COPO) it is intended that COPO should only reflect those wage increases that are not offset by productivity gains. The corollary of this is that if residential care cannot match those productivity gains made in other sectors the relative wage bill changes in residential care will not be covered by COPO driven increases. Wage increases from other sectors (for example the acute care sector) then have the potential to flow through into the wage costs faced by residential care providers.

Residential care has high labour intensity, with approximately 78% of total nursing home costs absorbed in wage costs. Care providers are unable to substitute labour for technology, or significantly improve work force practices to improve productivity. Consequently, they cannot match the productivity gains made in the acute care sector where technology and workforce reform have significantly reduced length of stay and thereby unit costs.

Over time, as wage rates in related sectors flow through to aged care, unit costs for the delivery of care rise. Where funding levels are capped, and productivity offsets cannot be found, costs are likely to be reduced either through lowering staff to resident ratios, employing less expensive (less skilled) labour or reducing non-labour costs with potential consequences for the quality of the services that are delivered. This effect is sometimes referred to as the Baumol effect. Baumol (1967) described the impact of unbalanced productivity growth on unit labour costs as being a particular problem for government outlays in the service sector which is labour intensive and hence has costs which increase over time as described above. Governments then face the dilemma of reducing the quantity or quality of care or of increasing taxes (or user charges) to address rising unit costs.

Residential care facilities in Australia are subject to quality standards by the Commonwealth government and the pressure to maintain these care standards lowers the possibility of making the type of efficiency gains implied by SNA. Residential care may be able to make efficiency gains (productivity improvements) through creating larger units (gaining economies of scale) and through substituting the use of high-cost nursing staff with increased use of more generic (lower paid) staff, but this may also have an impact on the quality of care provided.

The increases in funding flowing from the use of SNA may also be inadequate as they are based on average weekly earnings for all persons (sectors), which are greater than average earnings in the residential care sector. The impact of this, taking a hypothetical example, is that a \$10 SNA based on average weekly earnings of \$750 gives an index of 1.4%, whereas using a lower wage

(reflecting actual residential care pay levels) of \$600 gives an index of 1.66%. In other words this approach to indexing wage costs produces a gap between the increased wage costs faced by the sector and the funding increases received. Another criticism of the use of SNA is that adjustments are irregular and that there is a time-lag between a general movement (increase) in wages and the 'handing down' of safety-net increases by the AIRC.

The consequence of the above factors is that funding increases to the residential care sector based on SNA leads to a significant erosion of the buying power of the funds obtained. This situation may lead to pressures on quality of care and/or the viability of care organizations. The implication, as further discussed below, is that a different method of indexing for wage changes is needed.

#### **Treasury Measure of Underlying Inflation (TMUI) (non-wage costs)**

As explained above, the TMUI is used to index the non-wage costs of residential care providers. This index differs from the Consumer Price Index (CPI) in that it excludes items from the CPI basket of goods that are:

- (i) influenced by government policy (eg publicly provided goods and services, mortgage interest charges)
- (ii) subject to price volatility (eg petrol prices)
- (iii) affected by seasonal factors (eg holiday travel and clothing).

The impact of this arrangement is to remove a number of items from the TMUI that are of particular relevance to the residential care sector, these being:

- fresh fruit and vegetables
- meat and seafood
- mortgage interest charges
- household fuel and light
- pharmaceuticals.

The implication of excluding these items is that if they are subject to sudden (or prolonged) increases then the funding for residential care will be too low. This may again force providers to trim quality standards or to become unviable.

It should be noted that the TMUI was last published in the June quarter 1999 issue of the CPI. It was thus (last) used in the 1999/00 indexation process and has since been replaced by the CPI itself.

## **Alternative indexation approaches**

The problems resulting from the use of COPO lead to a consideration of a number of alternative indexation approaches that could be used to adjust the total residential care subsidy level.

These alternative indexation arrangements can be built up from indices which (more) accurately reflect:

1. movements in wage costs faced by the providers of residential care
2. movements in non-wage costs.

As detailed above, the major flaw in using the SNA indexation approach is that it assumes that residential care providers can match the productivity gains made in other sectors. Residential aged care is characterised by prescribed outcome standards, high labour intensity in the provision of care, limited potential for technology based productivity offsets, limited options for work practice productivity offsets and significant flow on pressures for wage movements from related sectors. Residential aged care providers are unlikely to achieve significant productivity gains to allow them to absorb general wage movements above the SNA without impact on their viability or the quality of the services provided.

Therefore an index of labour cost which more closely reflects actual wage movements for the residential care sector should be used. There are two such indices published by the ABS which fit this criterion – the Average Weekly Ordinary Time Earnings Index (AWOTE) and the Wage Cost Index (WCI).

Below we examine the 'behaviour' of these indices over the relevant time periods and then examine the impact that the use of these alternative wage indices would have had on total funding.

### **Average Weekly Ordinary Time Earnings Index (AWOTE)**

The AWOTE is a non-industry specific measure of wage changes across the economy. It presents measures of earnings for males, females, and for all persons, separately. Table 3 below shows the actual index figures from 1996–2000 and the resulting year on year percentage changes in AWOTE.

Given that the labour force for the residential care sector is predominantly female in nature, it is suggested that the most relevant index would be that of female earnings. This 'variant' is used below in the calculations of funding figures.

**Table 3** Average Weekly Ordinary Time Earnings Index

Average weekly earnings of employees, Australia	May 1996	May 1997	May 1998	May 1999	May 2000	Feb 2001
<b>Males</b>						
Full time adult ordinary time earnings \$	714.60	743.40	775.80	794.60	835.00	858.3
Year on year % changes		4.03	4.36	2.42	5.08	2.7
<b>Females</b>						
Full time adult ordinary time earnings \$	593.90	621.00	647.30	671.10	697.70	728.4
Year on year % changes		4.56	4.24	3.68	3.96	4.4
<b>Persons</b>						
Full time adult ordinary time earnings \$	671.60	698.70	728.30	749.00	783.70	810.6
Year on year % changes		4.04	4.24	2.84	4.63	3.43
<i>Source: ABS</i>						

**Wage Cost Index (WCI)**

The WCI does not include 'non-wage labour costs' and, as with the AWOTE, it does not adjust for productivity changes resulting from capital investment, technological change, entrepreneurial activity and organisational restructuring.

The ABS conducts a number of sample surveys of businesses providing measures of changes in wages and salaries over time, including the AWOTE figures referred to above. This is designed to provide reliable estimates of average weekly earnings and the quarterly change in that average. However, the AWOTE can be affected by a number of factors such as compositional shifts in the labour market and changes in the hours worked by employees.

The WCI was developed as a quarterly measure of changes over time in wage and salary rates of pay for employee jobs in such a way as *not* to reflect changes in the composition of the labour force, the numbers of jobs, hours worked or changes in characteristics of employees. Thus, unlike the quarterly Average Weekly Earnings series, the WCI does not measure changes in average (per employee) wage payments. The WCI is a Laspeyres price index measuring changes over time in wage and salary rates of pay for employee jobs, unaffected by changes in the quality and quantity of work performed. As such it may be regarded as a better indication of 'true wage inflation' and as will be seen below the WCI produces a lower wage indexation figure than the AWOTE figures.

A previous discussion paper prepared by La Trobe University (1998) on the implications of using the COPO for aged care residential services recommended the use of the public sector Health and Community Services

WCI (75%) *with* the TMUI in order to maintain the quality/value of the outputs produced by the sector. The public sector measure index was suggested as it is wage increases (for nursing staff) in the public sector that by and large drive wage costs increases in the residential care sector.

**Table 4** Wage Cost Index – total hourly rates of pay excluding bonuses, sector by industry average annual index numbers for year ended June quarter

	Jun 1997	Jun 1998	Jun 1999	Jun 2000	Mar 2001
<b>Private sector</b>					
Health and community services	100	100.7	104.2	106.5	109.6
Year on year % change		0.7	3.5	2.2	2.9
All industries	100	101.2	104.2	107.1	111.4
Year on year % change		1.2	3.0	2.8	4.0
<b>Public sector</b>					
Health and community services	100	101.8	106.4	109.7	113.7
Year on year % change		1.8	4.5	3.1	4.4
All industries	100	102.2	106.2	109.1	112.6
Year on year % change		2.2	3.9	2.7	3.2
<b>Private and public</b>					
Health and community services	100	101.2	105.2	107.9	111.4
Year on year % change		1.2	4.0	2.6	3.2
All industries	100	101.2	104.4	107.4	111.7
Year on year % change		1.2	3.2	2.9	4.0

#### **Other alternatives for indexing wage costs**

The Labour Price Index (LPI), formerly referred to as the Labour Cost Index (LCI), has been put forward on several occasions as possibly a 'better' alternative to the WCI. The LPI will measure changes in the price paid for labour services inclusive of wages and salaries as measured by the WCI *and* non-wage items such as paid leave, employer funded superannuation, payroll tax, workers' compensation, fringe benefits and fringe benefits tax. When developed, the LPI will produce movements covering the broader concept of the price of labour services. The ABS expect that collection of the LPI will commence from the September quarter 2001, with publication from 2003.

#### **The Consumer Price Index (CPI)**

The simple alternative to the TMUI is to use the CPI (25%) in an unadjusted form as this index includes the items listed above as being excluded from the TMUI. It is thus hypothesised that the CPI would more accurately reflect the price changes faced by providers of residential care and would therefore not disadvantage them in the way in which TMUI does.



The 1998 La Trobe University report made a comparison of the CPI and the TMUI over 38 quarters between March 1990 and June 1998. This showed that the TMUI yielded a higher index 55% of the time and an equivalent index to the CPI 22% of the time. This, however, does not inform us as to the impact of using the CPI compared to using COPO, which used TMUI.

The movements in the CPI for the relevant period are shown in Table 5.

**Table 5** Movements in the Consumer Price Index

	1996/97	1997/98	1998/99	1999/2000	2000/2001
CPI	0.33%	0.67%	1.07%	3.19%	6.02%

*Source: ABS*

### Applying alternative indices to estimate changes in funding

Tables 6–9 on the following pages use the suggested alternative indexation methods detailed above to calculate the funding differential implied when using them compared to the funding changes experienced under the COPO arrangements.

As outlined above, the fact that the labour force for the residential care sector is predominantly female in composition suggests that the most relevant index would be that of female earnings. This 'variant' is used in Tables 6 and 7 in conjunction with the CPI and the TMUI for the calculation of funding figures.

In each of the tables, the top line presents the total residential care subsidy for 1996/97 to 2000/01. The adjustment to the previous year's subsidy implied by the COPO index is calculated. The difference between the COPO adjusted subsidy for the previous year and the actual allocation for the current year is then calculated as the unexplained change (ie change associated with factors other than the COPO such as increased residential places or increased dependency). The unexplained change is expressed as a percentage of the previous year subsidy. The components of the alternative index (eg AWOTE/CPI) are then listed and a composite index calculated. The implied subsidy for the new index is calculated by applying the index to the previous year's subsidy level. The amount expressed as unexplained change is then added to produce the subsidy level that would have resulted if the new index had been used. The difference between subsidy level based on the proposed index and the top line (actual) subsidy level based on the COPO is calculated and presented for each year. Finally a three year total is calculated as the difference between what was allocated in subsidies and what would have been allocated if the new index rather than the COPO had been used.

**Table 6** AWOTE female 75% + CPI 25%

	1996/97	1997/98	1998/99	1999/2000	2000/2001
<b>Actual subsidy total</b>	2,698,163,421	3,028,912,197	3,337,696,309	3,566,025,000	3,865,713,000
Implied funding based solely on COPO change		2,744,032,199	3,071,316,968	3,387,761,754	3,640,911,525
Unexplained change \$		284,879,998	266,379,341	178,263,246	224,801,475
% change unexplained by COPO		11	9	5	6
<b>AWOTE female 75% + CPI 25%</b>					
AWOTE adult females % change	4.56	4.24	3.68	3.96	4.40
75% AWOTE adult females % change	3.42	3.18	2.76	2.97	3.30
CPI %	0.33	0.67	1.07	3.19	6.02
CPI 25%	0.08	0.17	0.27	0.80	1.51
Total index (75% AWOTE + 25% CPI)	3.51	3.34	3.03	3.77	4.81
Implied indexed subsidy figure \$		2,788,355,411	3,120,573,246	3,463,525,834	3,737,396,599
Implied new total based on <i>topline</i> \$		3,073,235,409	3,386,952,587	3,641,789,080	3,962,198,074
Difference actual (COPO) index total and AWOTE/CPI total		44,323,212	49,256,278	75,764,080	96,485,074
<b>Total underfund over 4 years:</b>	<b>265,828,644</b>				

**Table 7** AWOTE female 75% + TMUI 25%

	1996/97	1997/98	1998/99	1999/2000	2000/01
<b>Actual subsidy total</b>	2,698,163,421	3,028,912,197	3,337,696,309	3,566,025,000	3,865,713,000
Implied COPO funding		2,744,032,199	3,071,316,968	3,387,761,754	3,640,911,525
Unexplained change		284,879,998	266,379,341	178,263,246	224,801,475
% change unexplained by COPO		11	9	5	6
<b>AWOTE (female 75% + TMUI 25%)</b>					
AWOTE adult females % change	4.56	4.24	3.68	3.96	4.40
75% AWOTE adult females % change	3.42	3.18	2.76	2.97	3.30
25%TMUI	0.84	0.54	0.38	0.43	
Total index implied %	4.25	3.71	3.14	3.40	
Implied indexed subsidy figure \$		2,798,166,221	3,123,947,604	3,451,269,147	
Implied new total based on <i>topline</i> \$		3,083,046,219	3,390,326,946	3,629,532,394	
Difference actual COPO total and AWOTE/TMUI total		54,134,022	52,630,637	63,507,394	
<b>Total difference over 3 years:</b>	<b>170,272,052</b>				

Note that the TMUI was not available after 1999/2000, therefore total is over 3 years.

**Table 8** WCI public sector 75% + CPI 25%

	1996/97	1997/98	1998/99	1999/2000	2000/01
<b>Actual subsidy total</b>	2,698,163,421	3,028,912,197	3,337,696,309	3,566,025,000	3,865,713,000
Implied funding based solely on COPO change		2,744,032,199	3,071,316,968	3,387,761,754	3,640,911,525
Unexplained change \$		284,879,998	266,379,341	178,263,246	224,801,475
% change unexplained by COPO		11	9	5	6
<b>WCI (75% + CPI 25%)</b>					
WCI health & community services % change		1.80	4.52	3.10	3.65
75% WCI		1.35	3.39	2.33	2.73
CPI %	0.33	0.67	1.07	3.19	6.02
25% CPI	0.08	0.17	0.27	0.80	1.51
Total index implied %		1.52	3.66	3.12	4.24
Implied indexed subsidy figure \$		2,739,078,084	3,139,697,480	3,441,944,172	3,717,234,368
Implied new total based on <i>topline</i> \$		3,023,958,082	3,406,076,821	3,620,207,419	3,942,035,843
Difference actual COPO total and WCI/CPI total		-4,954,115	68,380,512	54,182,419	76,322,843
<b>Total difference over 4 years:</b>	<b>\$193,931,658</b>				

**Table 9** WCI Public sector health and community services 75% + TMUI 25%

	1996/97	1997/98	1998/99	1999/2000	2000/01
<b>Actual Subsidy Total</b>	2,698,163,421	3,028,912,197	3,337,696,309.00	3,566,025,000	3,865,713,000
Implied funding based solely on COPO change		2,744,032,199	3,071,316,968	3,387,761,754	3,640,911,525
Unexplained change \$		284,879,998	266,379,341	178,263,246	224,801,475
% change unexplained by COPO		11	9	5	6
<b>WCI (75% + CPI 25%)</b>					
WCI health and community services public sector %		1.80	4.52	3.10	
75% WCI		1.35	3.39	2.33	
25% TMUI	0.83	0.53	0.38	0.43	
Total index implied %		1.88	3.77	2.76	
Implied indexed subsidy figure \$		2,748,888,893	3,143,071,838	3,429,687,486	
Implied new total based on <i>topline</i> \$		3,033,768,891	3,409,451,179	3,607,950,732	
Difference actual (COPO) index total and AWOTE/CPI total		4,856,694	71,754,870	41,925,732	
<b>Total difference over 3 years:</b>	<b>\$118,537,296</b>				

## A summary of the impact of the alternatives to COPO

The impact of using the various indices on actual funding levels can be seen below in Table 10. From 1996/97 to 2000/01 the difference between COPO and the AWOTE/CPI and the WCI/CPI indices was \$266 million and \$194 million respectively.

**Table 10** Summary of the difference between COPO and alternative indices

Wage Index	Non-Wage Index	Implied Funding Difference (vs COPO) 1996/97–1999/00
AWOTE female 75% (4 yrs)	CPI 25%	\$265,828,644
AWOTE female 75% (3 yrs)	TMUI 25%	\$170,272,052
WCI public sector health & community services 75% (4 yrs)	CPI 25%	\$193,931,658
WCI public sector health & community services 75% (3 yrs)	TMUI 25%	\$118,537,296

Table 11 clearly demonstrates the way in which use of the COPO index has disadvantaged the residential care sector when compared with the use of alternative indexation methods. The use of the AWOTE has the largest differential impact, exceeding COPO by approximately 5% (regardless of whether TMUI or CPI is used). If the WCI had been used the 'excess' over COPO would be only approximately 2%. As detailed above the WCI measures changes over time in wage and salary rates of pay for employee jobs, adjusted for changes in the quality and quantity of work performed. As such it may be regarded as a better indication of 'true wage inflation' and produces a lower wage indexation figure than the AWOTE figures.

**Table 11** Comparing total COPO changes since 1996/97 with alternative indexation approaches

Indices	1996/97 yearly % change	1997/98 yearly % change	1998/99 yearly % change	1999/2000 yearly % change	2000/01 yearly % change	Additive % change since 96/97
COPO	1.7	1.7	1.4	1.5	2.1	6.7
AWOTE female 75% + CPI 25%	3.51	3.34	3.03	3.77	4.81	14.95
AWOTE female 75% + TMUI 25%	4.25	3.71	3.14	3.4		
WCI 75% + TMUI 25%		0.54	3.61	2.68		
WCI 75% + CPI 25%		1.8	3.66	3.12	4.24	12.82

**Table 12** A comparison of the rates of annual change in 25% TMUI vs 25% CPI

Index	1996/97 yearly % change	1997/98 yearly % change	1998/99 yearly % change	1999/2000 yearly % change
TMUI 25%	0.83	0.53	0.38	0.43
CPI 25%	0.1	0.2	0.3	0.6

Table 12 shows that since 1996/97 the change in the CPI has only exceeded the change in the TMUI in one year – 1999/00 when 25% CPI was 0.6% vs. a change of 0.43% for TMUI 25%. This is not to say, as was pointed out above, that over a larger time period the use of CPI would have implied a larger total % change in funding than the use of TMUI. This debate for the future, however, becomes somewhat academic as the calculation of the TMUI (as also pointed out above) has been discontinued since the June 1999 quarter of the CPI was published (as confirmed by the ABS).

However, given the importance of labour costs for residential care, the selection of an appropriate labour cost index is more significant than the measure of non labour inflation selected. The decision of whether to use the AWOTE (female) or the WCI (public sector health and community services) as the most accurate reflection of the wage cost rises incurred by residential care providers is an empirical one. Neither index adjusts for productivity gains and as such are both likely to be suitable as it has been extensively argued that the residential care sector is unlikely to match the productivity gains achieved in other less labour intensive sectors.

The key difference between the two indices is that the WCI measures changes over time in wage and salary rates of pay for employee jobs, adjusted for changes in the quality and quantity of work performed. On theoretical grounds the WCI may be seen as superior to the AWOTE as it is a more accurate indication of actual 'non-quality' wage inflation. Although the 1998 La Trobe report recommended the use of the Health and Community Services WCI (75%), this situation needs further (empirical) investigation and a definite conclusion cannot be reached within the ambit of this report. It is suggested that empirical work be undertaken to investigate the way in which quality adjustments implied in the WCI are met in the residential care sector. This is equivalent to investigating the extent to which productivity gains can be made in the sector.



## 'Demand' Factors

This section addresses the relationship between changes in demand and funding levels for residential aged care services in the period before and after the recent Commonwealth reforms. As indicated in figure 1 the level of the total residential care subsidy is a function of the number of residents, the basic subsidy and primary supplement payments made for each resident, the dependency level of the resident and the deductions made for resident contributions. Of these, the two main factors that affect demand are changes in resident numbers and their dependency levels. The key question addressed in this section is therefore:

To what extent have changes in the total funding for the residential care subsidy kept pace with the increased demands on resources generated by the growth in resident numbers and increasing resident dependency levels?

Current funding arrangements address variable demand by adjusting residential care subsidies according to the assessed care needs of residents. The level of resident dependency is measured using the Resident Classification Scale (RCS). The RCS was introduced in October 1997 as a single classification instrument that reflected the relative care needs of residents irrespective of care setting (ie nursing homes or hostels). The RCS allocates funds so that higher dependency attracts higher levels of funding irrespective of care location. The RCS has eight levels – with RCS1 representing the highest dependency level and RCS8 the lowest. Residents in categories RCS1 to RCS4 are classed as 'high care' residents and residents in categories RCS5 to RCS8 are classed as 'low care' residents. Each resident is initially classified by an Aged Care Assessment Team as either high or low level care and then given an RCS classification by the care provider on the basis of a 21 part questionnaire assessing clinical needs, ability to do various tasks and so forth.

There is a maximum charge (income) set by the Commonwealth for each RCS level and this is payable by user contributions and, where eligible under the income test, Commonwealth residential care subsidies. Under current

arrangements these subsidy rates vary from state to state for categories 1–4 (high care residents), but are nationally uniform for residents in RCS categories 5 to 7<sup>^</sup>. Under the reforms, RCS level 8 residents are unfunded.

## Total numbers of resident places, total number of residents in the system, and respite care days used

**Table 13** Number of operational nursing home and hostel places\*

	Nursing Homes	Hostels	Totals
June 1996	74,380	62,471	136,851
June 1997	74,216	64,771	138,987
June 1998	74,724	65,000	139,724
June 1999	74,536	65,965	140,501
June 2000	73,916	67,321	141,237
Increase in place numbers 1997–2000			2,250
% increase in place numbers 1997–2000			1.62

\*Source: Productivity Commission Table – supplied by DHAC

### Resident places available

Table 13 indicates that the number of residential care places available grew by 1.62% between June 1997 and June 2000. There has been a proportional decline in the number of places available in high care facilities (formerly nursing homes) and a proportional increase in the number of places available in low care facilities (formerly hostels). This is consistent with long term government policy, which has seen the balance in the provision of residential care places shift markedly between high care and low care facilities. However, it should be noted that the new ‘ageing in place’ policy allows low care facilities to retain residents who move into the high care categories. This has blurred the meaning of high care and low care places since nearly a fifth of high care residents now live in low care facilities.

There are increasing demands for residential care places as the proportion of the population aged 70+ continues to increase. The numbers of persons aged 70 and over increased from 1,510,871 in 1996 to 1,643,929 in 1999, an increase of 8.8%. Government policy has been to contain this demand by providing community based care for older people who would once have needed to enter residential care. Thus, the provision of residential care has been

<sup>^</sup> Payment levels for RCS categories 1–4 are subject to a process of ‘coalescence’, whereby jurisdictional (ie state and territory) differences in funding levels are to be phased out beginning in 1998 (see Appendix A for more details).



progressively reduced from 99.5 places per 1000 people aged 70+ in 1985 to 95.0 places in 2000. Moreover, this latter number includes 10.7 Community Aged Care Packages per 1000 70+, under a new program introduced in 1992 to directly substitute residential care places with high level community care places (Gray, 2001).

The number of residential aged care places does not necessarily equate with the number of residents in residential aged care services. Allocated places can take some time to become operational and not all operational places are always fully utilised. Table 14 presents the average numbers of residents and occupancy levels. While there is a rising trend in the numbers of residents in the system, there are fewer residents than there are places. The overall growth in resident numbers between 1997 and 2000 was 3.28% – an overall increase of 4,314.

**Table 14** Average resident numbers and occupancy levels

	Numbers of residents*	% occupancy <sup>^</sup>
June 1997	131,677	94.7
June 1998	132,862	95.1
June 1999	134,536	95.8
June 2000	135,991	96.3
Increase in resident numbers 1997–2000 based on occupancy		4,314
% increase in resident numbers based on occupancy 1997–2000		3.28

*Sources: \*1997–1999: answers provided by DHAC to parliamentary question by Senator Evans February 2000. Year 2000 resident figures: Australian Institute of Health and Welfare (2001) Residential Aged Care in Australia 1999–00: a statistical overview*

<sup>^</sup> occupancy = average numbers of residents/total number of places (Table 13)

### Respite care

Table 15 shows that there was an overall increase of 15.14% in respite bed days provided from 1997–1999 (equivalent data not available for 2000) with a very marked increase of 13.81% between 1997 and 1998. It should be noted that respite care residents are included in the overall resident numbers. In effect, increased use of respite days is offset by reductions in the use of permanent residential care places. However, respite care usage should also be considered separately because of the additional administrative and direct care costs involved in providing respite care. Compensation for these costs is provided through the Respite Supplement which is included in the total residential care subsidy allocated by the Commonwealth.

**Table 15** Respite care bed days used

Calendar year	High care	Low care	Total	Year on year increase	% change	Bed days used expressed as places
1997	277,791	579,420	857,211			2,348.52
1998	384,241	591,385	975,626	118,415	13.81	2,672.95
1999	389,688	597,289	986,977	11,351	1.16	2,704.05

*Source: Gray, 2001*

The percentage of high care days as a proportion of total days used has increased from 32% of total respite days in 1997 to 39.5% in 1999. The number of high care days increased by 40.3% against a general increase of 15% for all respite care days. The reason for this differential increase is unknown. It is possible that changes in subsidy arrangements for respite residents introduced with the aged care reforms were more attractive to high care than low care facilities.<sup>^</sup>

However, it should be noted that while the proportion of allocated respite bed days used has increased since 1997 from 55.22% to 62.70%, it is still well below the total allocation. This does not appear to be the result of lack of demand. In consultations with consumers carried out for the Two Year Review of the Aged Care Reforms, consumers consistently reported that in their perception 'respite care was very difficult to access in emergency situations, if at all' and that 'places were not available at times when consumers sought to book them'.

For their part, providers in the Two Year Review of the Aged Care Reforms, put the view that administration of respite places was problematic for several reasons, including 'the need to retain very high occupancy rates to ensure financial viability' and their belief that 'the greater care needs (and thus costs of care) for respite care recipients, related to expectations of carers and the settling in period, are not fully recognised in the funding arrangements'. There is thus considerable circumstantial evidence that the Respite Supplement is not sufficient to meet the costs of administration and care associated with respite residents.

<sup>^</sup> The Respite Care Subsidy is paid at a single rate of RCS3 for high care approvals and RCS6 for low care approvals. In addition, a Respite Care Supplement and a Pensioner Supplement are paid, which are aimed at offsetting the higher administration and care costs of respite care.

## Resident dependency

The nature of the client population in residential aged care means that the levels of resident dependency will increase over time for each (surviving) resident and that overall the average level of dependency among the client population will increase. The Review of the Resident Classification Scale referred to this phenomenon as 'classification creep' (Cuthbertson, et al, 1998). It can be more accurately described as the 'increasing dependency of current residents'.

In addition, the dependency level of new residents has been increasing: the major reason for this trend is probably the success of programs designed to prevent or defer entry to residential care by providing higher levels of care in the community. The overall impact is to increase average payments made, as the average dependency level increases.

The extent to which changes to total residential care subsidy funding are affected by increased average dependency levels is unclear but appear to be substantial. Figures supplied by the Department of Health and Aged Care (DHAC) in February 2000 in answer to a question tabled in the Senate by Senator Evans show increasing dependency levels as 'driving' funding increases by 5.5% in 1996/97, by 9.4% in 1997/98 and by 7.3% in 1998/99.

These figures appear to be both greater than and in addition to increases accounted for by COPO indexation and increasing resident numbers. There is no mention of the impact of including funding covered by the Pensioner Supplement after 1996/97 (see below for more comment on this issue and also Appendix A).

As noted by Cuthbertson et al (1998), prior to the reforms, Department of Health and Aged Care (DHAC) funding appears to have presumed a need for a 1% per annum increase in funding for continuing residents as they become more dependent (on care).

Table 16 on the next page shows that from 1997, there has been a substantial rise in the total proportion of residents classified as high care. Tables 17 and 18 provide more detailed information about this trend in terms of changes in specific RCS categories.

**Table 16** Percentage of total residents classified as high care

Year	% total of all residents classified as high care
1994	58.4
1995	57.0
1996	55.9
1997	55.1
1998	57.8
1999	60.8
2000	61.8

*Source: AIHW Residential age care facilities in Australia 1998–1999 & 1999–2000*

Table 16 shows an increase of nearly 4% in the proportion of newly admitted residents classified as ‘high care’ between the first half of 1998 and 1999/2000. The largest increase, of 5.4%, was in residents classified as RCS1, the most highly dependent category, with the proportions of newly admitted residents classified as RCS3 and 4 actually falling over the period. The fall in the proportion of ‘low care’ residents was largely accounted for by a drop of 2.9% in people being admitted at the RCS level 7 – nearly at the bottom of the ‘low care’ grouping. (The number of RCS level 8 admissions also fell, but because this category of admissions was so low even in 1998, there was no capacity for a further large fall).

It is, however, important to note that most of the shift in the balance of admissions from ‘high level’ to ‘low level’ took place between 1998 and 1998/99. There was virtually no change between 1998/99 and 1999/00, which suggests that the system change associated with the reforms may account for much of the initial change in RCS admission levels, and that the ongoing trend towards greater dependency among newly admitted residents may be relatively slow and gradual.

Table 17, which shows the RCS categories of all permanent residents for the period 1998 to 2000, demonstrates a similar trend towards greater dependency in the overall balance between ‘high care’ and low care’ residents. In this case, though, the growth in the proportion of RCS1 category residents is stronger, demonstrating the importance of the ‘classification creep’ phenomenon in driving cost increases as the existing resident population becomes more dependent.

**Table 17** RCS category of permanent residents on admission

RCS	Jan- June 1998		1998/99		1999/00		% change
1	1,490	7.5	5,122	12.2	5,513	12.9	+5.4
2	4,936	24.7	11,040	26.3	11,388	26.6	+1.9
3	4,271	21.4	8,406	20.0	8,125	19.0	-2.4
4	1,168	5.8	2,050	4.9	2,117	4.9	-0.9
<b>Total high care</b>	<b>11,865</b>	<b>59.4</b>	<b>26,618</b>	<b>63.4</b>	<b>27,143</b>	<b>63.3</b>	<b>+3.9</b>
5	1,737	8.7	3,565	8.5	3,700	8.6	-0.1
6	2,024	10.1	4,199	10.0	4,363	10.2	+0.1
7	3,783	18.9	6,755	16.1	6,840	16.0	-2.9
8	562	2.8	914	2.2	827	1.9	-0.9
<b>Total low care</b>	<b>8,106</b>	<b>40.5</b>	<b>15,433</b>	<b>36.8</b>	<b>15,730</b>	<b>36.7</b>	<b>-3.8</b>

*Source: AIHW, Residential aged care facilities in Australia, 1998; 1998-99; & 1999-2000*

As with the newly admitted residents, the increase in RCS1 category residents was greater between 1998 and 1999 than it was between 1999 and 2000, suggesting some system effect related to the reforms. However, there was a greater increase in dependency for all residents between 1999 and 2000 than there was for newly admitted residents, suggesting that increased dependency of existing residents is a more important factor in driving cost increases than the increasingly dependent profile of incoming residents.

**Table 18** RCS levels for ALL permanent residents

RCS	30 June 1998		30 June 1999		30 June 2000		% change
1	1,490	7.5	5,122	12.2	5,513	12.9	+5.4
2	32,279	24.9	33,279	25.9	33,835	26.0	+1.1
3	26,250	20.3	22,995	17.9	21,781	16.7	-3.6
4	7,398	5.7	5,875	4.6	6,081	4.7	-1.0
<b>Total high care</b>	<b>74,795</b>	<b>57.8</b>	<b>78,120</b>	<b>60.8</b>	<b>80,483</b>	<b>61.8</b>	<b>+4.0</b>
5	9,910	7.7	11,072	8.6	11,538	8.9	+1.2
6	12,576	9.7	13,036	10.1	13,399	10.3	+0.6
7	26,287	20.3	22,383	17.4	21,869	16.8	-3.5
8	5,835	4.5	3,944	3.1	3,027	2.3	-2.2
<b>Total low care</b>	<b>54,608</b>	<b>42.2</b>	<b>50,435</b>	<b>39.2</b>	<b>49,833</b>	<b>38.3</b>	<b>-3.9</b>
<b>Total</b>	<b>129,403</b>	<b>100.0</b>	<b>128,555</b>	<b>100.0</b>	<b>130,316</b>	<b>100.0</b>	

*Source: AIHW, Residential aged care facilities in Australia, 1998; 1998-99; & 1999-2000*

**Table 19** Summary of changing *demand* factors

Factors	1997	1998	1999	2000	% change
<b>Resident number factors</b>					
Resident numbers	131,677			135,991	+3.28%
<b>Respite usage factors</b>					
Respite bed day utilisation	857,211		986,977		+15.14%
High care respite days	277,791		389,688		+40.3%
<b>Resident dependency factors</b>					
Total high care residents	55.1%			61.8%	+6.7%
Residents in RCS1 category		6.9%		14.4%	+7.5%

### The implications of changing demand factors for funding

Table 19 above summarises the way in which resident numbers and resident dependency levels have changed since the reforms were implemented in 1997. In order to judge the potential impact of these changes on the residential care system it is necessary to examine the changes in funding that have occurred over the same period. These changes alongside changes in demand factors are detailed in Table 20.

From 1996/97 to 1999/00 there was a total increase in residential care funding of \$867million or 32% (see Table 2). Of this it is estimated that \$138 million is due to COPO adjustments. A further \$242 million is accounted for by the inclusion of payments for the pensioner supplement which replaced rent assistance from 1 October 1997. This is paid direct to residential care providers, and was initially set at \$5.30 per day (subject to indexation) This supplement was set at \$5.56 per day from 1 July 2000, or an annual supplement of \$2029.40. This payment by DHAC replaced Rent Assistance paid by the Department of Social Security, thus the total subsidy may be seen as falsely inflated by including this (ie it does not represent real additional funding in the post reform era). According to answers provided by DHAC, 89.2% of residents in 1999/00 received the pensioner supplement. Using this estimate of 'take up', the annual cost (included in the total subsidy) would be \$242,632,200 (121,304 of 135,991 residents x \$2000.2 annually). This calculation is based on 'down adjusting' the July 2000 payment figure of \$5.56 to the level for 1999 (ie by 1.4% COPO) to \$5.48, equivalent to an annual payment of \$2000.2.

This leaves an increase of \$487 million or 18% which, in theory at least, is due to the other changes such as increased resident numbers, increased usage of respite care days, and increased levels of dependency. These data are summarised in Table 20.

**Table 20** Summary of the increases in funding and the adjustments necessary to find if a real increase in funding has occurred

Estimated funding available to meet increased demand	\$487m
% increase in funding from 1996/97	18%
Demand factors	
Increased resident numbers	3.28%
Increased percentage of high care residents (dependency)	6.7%
Increase in all respite bed days 1997–1999	15.14%
Increase high care respite days	40.3%

It is difficult to accurately assess the extent to which available funding is adequate to meet increased demand from 1996/97 to 1999/2000 without access to more precise utilisation and funding data. According to Gray, in his Two Year Review of the Aged Care Reforms, the Commonwealth claims a real increase of 7% above indexation, increased resident numbers, increases in dependency and the introduction of the pensioner supplement resulted in \$200m more in 1999/2000 than would have been the case under the previous system. However, Gray does not present detailed information to support this proposition. In part the claimed increase appears to be confounded by funding increases associated with changes to the measurement of dependency by the new RCS. Cuthbertson et al (1998) estimated the impact of the change at \$73 million in a full year. Additionally, although arguably a capital funding measure, the Commonwealth has introduced the Concessional Resident Supplement for residents who are not required to pay the accommodation charge (see Appendix A). There have also been changes to subsidy levels across jurisdictions to address relativities. These factors have also added significantly to the residential care subsidy. Finally it should also be noted that the new system has changed the system of resident contributions with the intention of increasing resident contribution to total funding.





## Conclusion

This report addressed the extent to which changes to funding provided through the Commonwealth residential care subsidy have adequately addressed increased costs for providing care and increased demand. The report demonstrates that although there have been substantial increases in total funding for residential care subsidy, current indexation arrangements do not adequately adjust for cost increases and data limitations make it difficult to assess the relationship between increasing demand and funding adequacy.

For sometime now arguments have been put forward that the COPO method used for the indexation of residential care subsidy funding is inappropriate. The main reason for this line of argument being that the two parts of the COPO 'cocktail' – the SNA (wage costs) and the TMUI (non-wage costs) – are each arrived at in ways that mean they are not suitable for the purpose. In brief the SNA makes assumptions about productivity gain offsets (to wage increases) which do not hold in the residential care sector. On the other hand the TMUI omits items from its 'basket of goods' whose price changes have a major impact on the sector. As a result the COPO indexation figure is insufficient to match the (actual) rising costs faced by the sector.

Two alternative and more appropriate indexation methods for capturing increased wage costs were examined – firstly the use of movements in Average Weekly Ordinary Time Earnings (AWOTE) and secondly the use of the Wage Cost Index (WCI) specific to public sector health and community services. For the non-wage costs the use of the Cost Price Index was investigated. The impact of using combinations of these alternative methods on the total level of funding was estimated. The difference between the COPO measure and more appropriate indices over a 4-year period lies in the range of \$193.9 million and \$265.8 million from 1996/97 to 2000/01. In the longer run this difference has the potential to increase pressure on the quality of care provided as providers find it increasingly difficult to attract and maintain staffing levels and skills. Alternatively, as viability declines, providers may choose to leave the industry or it may become difficult to attract new entrants.

With respect to the relationship between funding and demand, it is clear that over time, residential care has been characterised by consistently rising

demands (on resources). Resident numbers, the numbers of respite care days used, and resident dependency levels have all increased markedly since the reforms were introduced. However, it is difficult to determine the extent to which real increases in funding over this period have kept pace with increased demand. The new funding arrangements have introduced a number of anomalies and the relationship between funding levels and demand or care need now lacks transparency.

Three options could be considered to address the issues identified in this report. The design of the funding system could be left as it is, but a one off adjustment could be made to the payment levels to compensate for underfunding due to indexation. Alternatively a more appropriate index to adjust for changes to the cost of provision could be introduced. Finally a costing model that relates payment levels to the dependency levels and care factors that drive costs could be introduced.

The option of a one off adjustment has the advantage that it would restore funding for changes in the cost of provision with minimal disruption for a relatively modest cost to the overall system. However, it has the disadvantage that the underlying cause of the problem will not be addressed and funding levels will again be eroded over time.

Alternatively, the option of developing an appropriate index to replace the COPO is open to further investigation. Here the WCI produced much lower indexation estimates. This index adjusts for quality factors affecting wage costs and thus may be said to be a more accurate measure of 'pure' wage inflation. As AWOTE is not an index in the true sense of the term (instead it is a simple reporting method of changes in average wage levels, unadjusted in any way), it would seem that the use of the WCI is more appropriate. However, whether this is actually the case depends on whether wage costs as measured by the WCI specific to public sector health and community services are an accurate reflection of the wage cost movements in the residential care sector. As the WCI used is specific to the public sector health and community services sector it would seem plausible that it *is* an appropriate measure. This is an empirical question and it is strongly recommended that further work is undertaken to examine whether or not the assumptions made in calculating the public sector health and community services WCI hold specifically for the residential care sector. This is the only way of truly arriving at a reliable view on the veracity of using the WCI as opposed to use of AWOTE.

It should be noted that a possibly more valid alternative to the WCI is currently under development – the Labour Price Index (LPI), (formerly referred to as the Labour Cost Index). This index will measure changes in the price paid for labour

services inclusive of wages and salaries as measured by the WCI *and* non-wage items such as paid leave, employer funded superannuation, payroll tax, workers' compensation, fringe benefits and fringe benefits tax. The LPI will produce movements covering the broader concept of the price of labour services. However, the ABS expect that collection of the LPI data set will commence from the September quarter 2001, with publication from 2003. Until then the WCI may remain the most valid alternative to the SNA method of dealing with wage cost increases faced by the sector.

While the development of an appropriate index to adjust for changes in the cost of provision has a number of advantages, it will not adequately compensate for changes in the nature of the model of care required. These may occur as a result of the interaction of regulatory demands (eg accreditation) and the changing mix of resident dependency. A costing model which relates payment levels to the dependency levels and care factors that drive costs could be introduced to address these problems.

The current cost gradients for the RCS are the results of a study undertaken in 1996/97 by Coopers and Lybrand (Cuthbertson et al 1998). The Coopers and Lybrand study 'established that an additive approach that included a number of care need areas (compared to a categorical casemix model) was the most appropriate for classification in a residential care setting' (ibid p.6). A sliding scale of subsidy rates for each RCS level will not ensure quality care and viability of care provision by organisations if it is not based on the true costs of care faced by providers.

Consistent with the findings of the Productivity Commission a regular, comprehensive study of the cost providing residential age care across settings and resident characteristics could be introduced as the basis for adjusting residential aged care funding. In this respect, the assumptions made by Coopers and Lybrand in reaching their conclusions regarding the inappropriateness of a casemix model need to be reexamined. It is only by relating actual resident care requirements (and hence care costs) at the various RCS levels, that a true estimate of the additional funds required by changing dependency levels will be reached. A 'full-cost' model of the costs associated with increasing dependency would probably require a detailed prospective cost study which sought to determine the relationship between rising dependency levels of individual residents and also the impact of changing resident dependency ratios in care units.



## Appendix A

### Other factors and issues impacting on residential care subsidies

#### 1. The replacement of residential care allowance (rent assistance) with the Pensioner Supplement (demand driven)

Prior to October 1997 pensioners resident in nursing homes or hostels received a residential care allowance (in addition to their pension). From 1 October 1997 the rent assistance allowance has been replaced by a 'pensioner supplement' which is paid direct to providers, this was initially set at \$5.30 per day (subject to indexation).

This supplement was set at \$5.56 per day from 1 July 2000, or an annual supplement of \$2029.40.

This payment by DHAC replaced Rent Assistance paid by the Dept of Social Security, thus the total subsidy may be seen as falsely inflated by including this (ie it does not represent real additional funding in the post reform era). The total sums budgeted for in 1996/97 budget statement are shown below.

Rent Assistance Totals

Year	Amount \$ millions (annual % change)
1997/98	128
1998/99	129.4 (1.09)
1999/2000	131.1 (0.54)

*Source: 1996/97 budget statement*

According to answers provided by DHAC 89.2% of residents receive the pensioner supplement, using this estimate of take up, the annual cost (included in the total subsidy) would be \$240,276,237 (120,006 of 134,536 residents x \$2000.2 annually).

This calculation being based on 'down adjusting' the July 2000 payment figure of \$5.56 to the level for 1999 (ie by 1.4% COPO) to \$5.48, equivalent to an annual payment of \$2000.2.

## **2. Concessional Resident Supplement (demand driven)**

A concessional resident is a resident who is not required to pay the full accommodation charge (nursing homes) or accommodation bond (hostels). Entitlement is established by individuals having assets below a certain benchmark (DHAC does this in association with Centrelink data sources).

This payment varies according to the percentage of concessional residents in a nursing home or hostel. For those where concessional residents make up 40% or more of total resident numbers the daily concessional supplement for 2000/01 is \$12.60 (indexed by use of COPO), where there are less than 40% of residents of concessional status the daily concessional supplement is \$7.35.

Available data (from the Aged Care Working Group) shows that in February 1999 44.3% of new residents were 'concessional'.

The total amount of concessional funding in total subsidy level reported in budget papers was not verifiable. To do this data showing exact take-up numbers would be needed or some total given in answer to questions to DHAC. However, if 44.3% of all residents in 1999 qualified for the higher daily supplement of \$12.60, the total annual cost (in the 2000/01 budget) would be \$274,097,861 (ie  $\$4599 \times 134\,536 \times 0.443$ ), or based on the lower figure of \$7.35, the annual total cost would be \$159,890,419 (ie  $\$2682.75 \times 134536 \times 0.443$ ).

As this element of funding is a new provision (post reform) there are no comparable data pre-reform to compare any pre and post-reform increases with.

## **3. Resident Income Test**

Introduced from 1 March 1998 for new residents. Full pensioners to pay 85% of their pension (basic pensioner fee = \$21.10), others to pay an extra income-tested charge of up to \$36.90 per day (to be indexed) or the full cost of their care if this is lower. For 1999/2000 the basic pensioner daily care fee was \$22.58 and for others the maximum (income-tested charge) was \$39.53 per day or the full cost of their care if this is lower.

The income generated by the Resident Income Test is basically treated as an 'expenditure offset' by the Commonwealth government. The Budget Portfolio Statement for 1996/97 shows expected reductions in residential care subsidies (estimate savings) resulting from the introduction of the Resident Income Test. These were calculated as being \$72.2 million, \$85.1 million, and \$95.8 million for the years 1997/98, 1998/99, and 1999/00 respectively. The total estimated

savings to the government totaled \$253.1 million with an offset of \$9.7 million in 1996/97 resulting from the costs of aligning nursing home and hostel payment cycles, giving net savings of \$243.4 million since 1996/97.

#### **4. Coalescence Procedure**

Prior to 1 October 1997 nursing home payment varied across states and territories whilst those for hostels did not. Under the (proposed) coalescence arrangements the jurisdictional differences in basic subsidy rates for high care residents (RCS1–RCS4) were to be phased out over a 7-year period. The initial plan was to adjust payments by 2% in 1998, followed by adjustments of 4, 8, 14, 24, and 24% respectively. The effect thus being that by 2004/05 all subsidy payments for RCS1–RCS4 would be equal across all jurisdictions.

However this process was suspended after two 'rounds' of adjustment had occurred and was the subject of a Productivity Commission report (1999). Subsequent to this report the Commonwealth government have now instituted a process whereby subsidy rates for Queensland, South Australia, WA, and ACT will reach the 'current' national average by July 2002, NSW and Northern Territory by July 2004, and Victoria and Tasmania by July 2006. In total the government are scheduled to provide an additional \$148 million over 6 years to 2005–2006.

As this issue is not one which is of relevance to the main issue of the adequacy of total subsidy payments in relation to the numbers of residents etc and the indexation level applied to them, it was not be considered further in the main analysis above.





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