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AGED CARE alliance

Underfunding Aged Care:
An analysis of the adequacy of care funding in residential aged care

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National Aged Care Alliance Position Paper
Underfunding Aged Care

Introduction

The National Aged Care Alliance (the Alliance) is an alliance representing peak national organisations in aged care including providers, unions, health professionals, and consumer groups working together to determine a more positive future for the residential aged care sector.

This position paper is in response to research commissioned by the Alliance to evaluate the level of Commonwealth funding attached to the care of residents in residential aged care in real terms from the financial year 1996–97 until 1999–2000 (the last year for which complete financial data is available.)

The Alliance commissioned the Australian Institute for Primary Care, La Trobe University to undertake this research.

The report *Underfunding Aged Care* documents a real decline of per capita aged care funding over the last 3 years, from an already questionable base of funding in 1996 (see Report Table 8).

This environment of steadily compounding under-funding of aged care service delivery has been a factor undermining the good intentions underlying the Government's introduction of the new accreditation requirements for residential aged care.

Underfunding Aged Care

The report evaluates Commonwealth care funding available for residential aged care after the introduction of the Government's residential aged care reforms. From 1 October 1997 a new financial system for residential aged care together with a new system of accreditation and certification was introduced.

Industry peak bodies, consumer groups and the Commonwealth Government have debated the adequacy of funds necessary to guarantee that the standards set for residential aged care by the Commonwealth can be met.

The report finds there are constantly rising demands on resources available for care because of marked increases in: resident numbers; the numbers of respite care days used; and resident dependency levels. Funding increases for care have failed to match these rising demands.

Pressures arising from increased care demands are exacerbated by an inappropriate indexation method used by the Commonwealth Government to estimate costs of providing residential aged care.

The Productivity Commission 1999 report *Nursing Home Subsidies* criticised the Government's current system of calculating the government subsidy for residential aged care facilities as being:

> *not linked transparently to the cost of providing a benchmark standard of care… quality care is central to the well-being of nursing home residents, and the standard of care supported should be a conscious and transparent decision.*

Each year the Commonwealth subsidy is adjusted using the Commonwealth Own Purpose Outlays (COPO) index. COPO measures both wage and non-wage costs which have been shown to not adequately reflect the true costs of running aged care services because:

- the wage cost factor assumes productivity gain offsets which do not hold in the residential care sector, and thus compounds over time; and

- the non-wage cost factor excludes items from consideration which have a major impact on the cost of the provision of residential aged care services.

The research indicated that the COPO indexation method is an inappropriate method of indexing funds for residential aged care. The use of the more universal Average Weekly Ordinary Time Earnings or the Wage Cost Index for measuring wage costs, and the Consumer Price Index for measuring non-wage costs would be more realistic, and deliver a more realistic care subsidy. This in turn would lead to more effective, more viable, and higher quality aged care residential facilities.

Overall the providers of residential aged care funding have been squeezed both in terms of the demands for care provision, and from an underestimate of the actual cost pressures they must face.

The study identifies the following understanding of the Government's Aged Care funding changes between 1996–97 and 1999–2000:

- The total increase in funding from 1996–97 to 1999–2000 was $541,989,000 (or 21.02%).

- There was a total *non-indexed* increase of $424,423,000 (a 16.46% increase). It is this increase which, in theory at least, is due to the other changes such as increased resident numbers, increased usage of respite care days, increased levels of dependency and budget portfolio transfers.

- More than half the 16.46% is not additional funds but rather the payment of the pensioner supplement which previously was included as a budget item within the Department of Social Security and paid in the form of rent assistance directly to residents. Prior to 1 October 1997, providers charged nursing home residents 87.5% of the rent assistance, and hostel residents 85%, as a part of their daily fees. Inclusion of the pensioner supplement therefore falsely inflates the aged care budget as it does not represent real additional funding in the post reform era.

- Taking into account the estimated pensioner supplement total, the total increase in funding post reform is reduced to $184.1 million or a 7.2% increase. This $184.1 million increase has to cover the total of all increased demand during the study period.

- There has been a 2.91% increase in resident numbers, an increase of 15.1% in respite care days and an estimated 3% increase in resident dependency between 1996–97 and 1999–2000.

- Contrary to the claims of government, there has been a total underfunding over the 3-year period because of the inappropriate COPO method of indexation. This underfunding is in the range of $61.3 million to $158.6 million.

Conclusion

As a society, Australia needs to support the residential aged care industry to ensure that quality care is available to those who need it. This is dependent on maintaining a viable and sustainable industry.

The looming crisis in aged care funding is due to the fact that the funding systems are not based on nationally agreed and realistic benchmark levels of care as advocated by the Productivity Commission.

The National Aged Care Alliance calls on government to:

- immediately adjust funding of the aged care system to meet the real costs of care;

- introduce a more accurate method of indexing aged care funding;

- establish nationally agreed benchmarks of quality care and quality of life as a basis of funding;

- support research to advance the development of effective indicators to benchmark quality care; and

- provide residential subsidy rates which recognize the increased dependency of residents.

Underfunding Aged Care:

An analysis of the adequacy of care funding
in residential aged care

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

April 2001

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Glossary

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

This report is the product of a commission received by the Australian Institute for Primary Care from the National Aged Care Alliance in which the Alliance sought advice on the quantum of funding available for residential care before and after the residential care aged care reforms which took effect from 1 October 1997.

The analyses presented here are a comparison of funding for the financial year 1996/97 with funding in subsequent years, up to 1999/2000 (the last year for which financial data is currently available).

The key issue the report addresses is the extent to which the total level of subsidy funding provided by the Commonwealth Government has adequately addressed changes in demand for services and in the cost of providing them.

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.

Although there are significant limitations in the data reviewed which make it difficult to draw definitive conclusions, the findings indicate that Commonwealth funding for residential aged care has not kept pace with these increases in demand since changes to funding arrangements were introduced in 1997.

An examination of two alternative indexation methods for capturing increased wage costs (Average Weekly Ordinary Time Earnings and the Wage Cost Index) was also 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 3-year period compared with the Commonwealth's current indexation approach was estimated in the range of $61.3 million to $158.6 million (or an average of approximately $20 million to $53 million per annum over 3 years).

If, as appears likely, Commonwealth contributions are not keeping pace with changes to the cost of service provision and increased demand, over time, there will be consequent effects on either: the viability of service providers; the quality of the services which are provided; and/or increased requirements for contributions from other sources such as residents.

The analysis conducted in this report needs to be seen in the context of the funding changes for residential aged care introduced by the Commonwealth Government in October 1997 along with a system of accreditation and certification for care providers.

Subsequently there has been much debate between industry peak bodies and the Commonwealth Government over the level of total funds necessary to guarantee that the standards set for residential aged care by the Commonwealth can be met.

There has also been a report by the Productivity Commission, which found that the subsidies were deficient in that the subsidy rates are not linked transparently to the cost of providing a benchmark level of care. (Productivity Commission report 1999)

Residential care finds itself in a situation of consistently rising demand on resources with funding increases struggling to match these rising demands. Increasing resident dependency is a key issue and has major implications in terms of the resources necessary to provide the required quality of care.

Between 1996/97 and 1999/00 total subsidy funding increased by 21%. 4.56% of this change was explained by indexation (using COPO). The *non-COPO* (ie non-indexation) related increase in funding since 1996/97 (up to 1999/00) was 16.5%. Much of this increase is accounted for by the inclusion of funds (previously not included in the total funding figure) covering the Pensioner Supplement. Of the $541.9 million funding increase since 1996/97, $240.2 million is accounted for by (new) money for the Pensioner Supplement. This leaves a 7.2% rise to cover the *demand* factor increases referred to above.

In addition to pressures arising from increased demands there are also potential problems arising from the use of COPO as an indexation method. For some time arguments have been put forward that the COPO indexation method is inappropriate for indexing funds for residential care. It is argued that the two parts of the COPO *cocktail* – the SNA (wage costs) and the 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.

Notwithstanding the findings of this report, 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. It is therefore strongly recommended that further research investigates:

1. The actual impact on care costs of increasing dependency levels – erroneous assumptions regarding the impact of increasing dependency costs will render the provision of high quality care impossible and may lead to providers of care becoming non-sustainable. The National Aged Care Alliance should also consider seeking to have questions tabled in Parliament relating to the method that is currently used to produce the gradient of costs (subsidies) for higher levels of dependency.

2. The empirical basis of using Average Weekly Ordinary Time Earnings or the Wage Cost Index as alternative ways of capturing the impact of rising wage-costs should be investigated. It is possible that the assumptions built into the WCI do not hold specifically for the residential care sector. This work is the only way of arriving at a reliable view on the veracity of using the Average Weekly Ordinary Time Earnings as opposed to use of the Wage Cost Index.

Methodology

The analyses presented here represent a comparison of funding for the financial year 1996/97 with funding in subsequent years, up to 1999/2000. In other words the analysis here takes a *before-and-after approach*. The analyses draw on data taken from a 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, and the Australian Institute for Health and Welfare (AIHW). The source of each item of data is identified in the text when specific to the analysis.

The two key questions stated above are dealt with in turn. The first question relates to the total funding increase experienced over the period of interest and the *demand* factors that are operating on that budget. AIPC has calculated the *extra* amount of funding made available and compare this with the demands made upon those resources. Secondly, we examine the impact of COPO on funding levels, suggest some alternative indexation methods and compare the total funding levels implied with those actually seen under the COPO arrangements.

There are many technical issues relating to the various measures and data items used in the analysis and these are discussed in the relevant places in the following text.

Key Issue 1
Demand Factors *Driving* Total (Required) Subsidy Funding Levels

This section addresses changes in demand and funding levels for residential aged care services in the period before and after the recent Commonwealth reforms. The key question here is:

How has total funding increased in the post-reform period and has it kept pace with the increased demands on resources generated by the growth in resident numbers and increasing resident dependency levels?

The key factors in assessing the issue of whether the increases in total funding are adequate are those which can be labelled as *demand factors*. These are the total numbers of residents in the system, the number of respite days being used, and the way in which resident dependency levels are changing over time.

Current funding arrangements address variable demand by adjusting residential care subsidies according to the assessed care needs of residents. The issue of resident dependency is an important one in terms of resource usage and hence funding. 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) and would allocate funds accordingly, ie higher dependency attracts higher levels of funding irrespective of care location. The RCS consists of 8 care levels – with RCS1 representing the highest dependency level and RCS8 the lowest. Residents in categories RCS1 to RCS4 are classified as *high care* residents whilst residents in categories RCS5 to RCS8 are classified as *low care* residents. Residents classified as RCS 1 to 7 receive funding for their care, whilst RCS 8 attracts no government funding.

Each resident is initially classified by an Aged Care Assessment Team (as high or low level care) and then further classified by the care provider on the basis of a 21 part questionnaire assessing clinical needs, ability to do various tasks, etc.

The fact that RCS8 residents are 'unfunded' as a result of the reforms – needs to be taken into account if calculating expenditure per resident. Table 5 below shows that 3.1% of residents were in this category in June 2000, a fall of 0.7% on the previous years total.

There is a maximum charge (income) set by government for each RCS Level and this is payable by Commonwealth Government residential care subsidies and, where eligible under the income test, user contributions. Under current arrangements these rates vary from state to state but at this time the payment levels for categories 1 to 4 (high care residents) 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).

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

Table 1 Residential places – 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
Note: these are permanent places and exclude community aged care packages

Resident places available. The number of places available grew by 1.62% between June 1997 and June 2000. It should be noted that there is a downward drift in the number of high care places relative to an upward movement in the number of low care places. This factor contributes to the number of high care residents in low care facilities classified as high care, under the new ageing in place policy permitted as a result of the reforms. This observation concurs with the RCS Review Committee's findings that hostels would benefit more from the reforms than nursing homes – see below for more discussion of RCS and ageing in place. There are also increasing demands for 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%.

Table 2 Average resident numbers and occupancy levels

	Average numbers of residents (total)*	% occupancy^
June 1997	131,677	94.7
June 1998	132,862	95.1
June 1999	134,536	95.8
June 2000	135,504	95.9
Increase in resident numbers 1997–2000 based on occupancy		3,827
% increase in resident numbers based on occupancy 1997–2000		2.91%

*Source: *Answers to a question tabled by Senator Evans, February 2000 from DHAC
except for year 2000 resident figures which are estimated using trend in average occupancy rates
1997–1999 (ie annual average growth in resident numbers = 0.72%)
Occupancy = average numbers of residents/total number of places (Table 1)*

Average number of residents. It can be seen that there is a rising trend in the average numbers of residents in the system. The overall growth in resident numbers between June 1997 and June 2000 was 2.91% – an overall increase of 3,827 residents in the system[1].

Respite care days. Table 3 shows that there has also recently been a sharp increase in the number of respite care days used. There was an overall increase of 15.14% in days provided from 1997–1999 (data not available for 2000) with a very marked increase of 13.81% between 1997 and 1998. The reasons for this are unclear and may warrant further investigation.

Table 3 Respite care days used

Calendar year	High care	Low care	Total	Year on year increase	% change	% change 1997–99
1997	277,791	579,420	857,211			
1998	384,241	591,385	975,626	118,415	13.81	
1999	389,688	597,289	986,977	11,351	1.16	15.14

Source: AIHW

It is noticeable that there is a trend in terms of the % of high care days as a proportion of total days used – these being 32% of total respite days in 1997 and rising to 39.5% in 1999. The number of high care days increased by 28% against a general increase of 15% for all respite care days. The actual reason

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[1] It should be noted that the average number of residents for June 2000 was estimated as this figure was not available in the series of figures used (ie those supplied by DHAC in answer to Senator Evans in February 2000). The figure for June 2000 is based on an average growth of 0.72% per annum 1997–1999.

for the increase in the number of high care days is undocumented. It may, however, be speculated that this may be due to demographic factors with more elderly individuals *ageing at home* and subsequently reaching increased dependency levels.

It is again concluded that there are growing demands on resources arising from the usage of respite care days. The differential pattern of growth between low care and high care days also results in increased resource requirements. This raises the issue as to how funding arrangements may need to change to deal with this increased demand.

Resident dependency

The nature of the client population means that the levels of resident dependency will increase over time for each (surviving) resident and overall the average level of dependency among the client population will increase. Cuthbertson et al refer to this as *classification creep* (1998:14) which should be more accurately referred to as the *increasing dependency of current residents*. The impact of this is to increase average payments made, as the average dependency level increases. 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 that increasing dependency levels *drove* 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 the remnant of the increases after taking into account COPO 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). It should be noted that 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). This figure does not appear to be justified by Cuthbertson et al or underpinned by any obvious evidence (or at least this evidence is not presented in the RCS report). See Table 9 below for more discussion of this issue.

Changing levels of dependency

As mentioned above there is a tendency for the numbers of new residents classified as requiring high care by ACATs within the RCS to rise. Apart from *classification creep* as defined above, there are other reasons behind this change. It may be hypothesised that as demand for places in residential care outstrips availability then individuals gaining access to such care are likely to be in higher RCS categories. This phenomenon raises the average level of dependency of the current population of residents. This is demonstrated in Tables 4 and 5.

Table 4 RCS category of residents who were admitted for the first time in the year

RCS	1998/99	1999/00	% change	Year on year increase	% change
RCS 1	3,897	10.11%	4,073	11.11%	1.00%
RCS 2	8,899	23.08%	8,579	23.40%	0.31%
RCS 3	7,417	19.24%	6,778	18.49%	-0.75%
RCS 4	2,030	5.27%	1,966	5.36%	0.10%
RCS 5	3,754	9.74%	3,593	9.80%	0.06%
RCS 6	4,453	11.55%	4,273	11.65%	0.10%
RCS 7	7,029	18.23%	6,520	17.78%	-0.45%
RCS 8	1,071	2.78%	883	2.41%	-0.37%
Totals	38,550		36,665		

Source: DHAC

Table 4 shows a combined increase of 1.31% in the two highest dependency levels for new residents 1998/99 to 1999/00. Although overall the proportion of new residents in RCS-1 to 4 increased only marginally over the two years being compared with 57.7% of new residents classified as RCS-1 to 4 in 1998/99 compared to a figure of 58.4% in 1999/00.

Table 5 RCS levels for *all* residents

Dependency category	June 1999	June 2000	% change
RCS 1	12.0%	14.3%	2.3%
RCS 2	25.1%	25.6%	0.5%
RCS 3	16.9%	16.5%	-0.5%
RCS 4	3.8%	4.6%	0.8%
Total high care	57.9%	61.0%	3.1%
RCS 5	10.5%	8.8%	-1.8%
RCS 6	10.2%	10.2%	0.1%
RCS 7	17.7%	16.9%	-0.7%
RCS 8	3.8%	3.1%	-0.7%
Total low care	42.1%	39.0%	-3.1%

Source: DHAC

Table 5 considering all residents, shows as forecast by the notion of classification creep, an even larger increase in the two highest dependency levels – a combined increase of 2.8% between the years being considered.

As the RCS was introduced at the time of the reforms it is not possible to make direct comparisons with previous dependency data. However the AIHW has presented data showing trends over 6 years (1994–1999) for the changes in high care residents as shown in Table 6.

Table 6 Percentage 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

Source: AIHW Residential age care facilities in Australia 1998–99: a statistical overview, p.6

It can be clearly seen that from 1997 there has been a substantial rise in the total numbers of residents classified as high care.

Table 7 Summary of changing *demand* factors

Resident number factors			
Increase in resident numbers 1997–2000	2.91%		
Increase in use of all respite bed days 1997–1999	15.14%		
% change in *high care* respite days	28.0%		
Dependency factors by RCS	1999	2000	% change
Total high care residents	57.9%	61.0%	3.10%
Residents in RCS1 category	12.0%	14.3%	2.3%

The implications of changing demand factors for funding

Table 7 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 8.

Table 8 Funding changes and *demand* factor changes 1996/97–1999/2000

	1996/97$	1999/2000$	96/97–99/00 change
Total subsidy funding	2,578,199,000	3,120,188,000	$541,989,000 (% change 21.02)
Total COPO change over period 96/97–99/00			4.5%
Compound COPO rate 96/97–99/00			4.56%
Implied figure using compound COPO		2,695,765,000	% change
Increase in funding not explained by COPO		424,423,000	
% change in funding not explained by COPO		16.46%	2.3%
Resident number changes			
Increase in resident numbers 1997–2000		2.91%	
Increase in all respite bed days 1997–1999		15.14%	
% change in high care respite days		28%	
Dependency factors	1999	2000	% change
Total high care residents	57.9%	61.0%	3.10%
Residents in RCS1 category	12.0%	14.3%	2.3%

Source: Total subsidy funding figures 1995/96 DHAC, February 2000 in answer to a question tabled in the Senate (by Senator Evans) 1996/97 and Portfolio Budget Statements 2000–2001. (Note: for a comparison of the funding levels for the period 1995/96–1999/2000 see Appendix B.)

Table 8 shows the total increase in funding that has occurred since the reforms were introduced in 1997. Each year the total sum is increased using the Commonwealth Own Purpose Outlays (COPO) index (see below for full details) and the total % change due to COPO is shown (note the issue of indexation and what is the *appropriate* indexation method is dealt with in detail later in this report).

The total increase in funding from 1996/97 to 1999/00 was $541,989,000 (or 21.02%). Of this 4.56% (or $2,695,765,000) is due to COPO adjustments. This leaves a total *non-indexed* increase of $424,423,000 (a 16.46% increase). It is this increase which, in theory at least, is due to the other changes shown in Table 8, ie increased resident numbers, increased usage of respite care days, and increased levels of dependency.

There is, however, a further item that needs to be taken into account when examining the total amount of increased funding available – the *pensioner supplement*, which from October 1 1997 replaced rent assistance. 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 $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.

Taking into account the estimated pensioner supplement total, the total increase in funding post reform is reduced to $184.1 million or a 7.2% increase. This $184.1 million increase has to cover the increased demands outlined above. The report on the RCS by Cuthbertson et al states that '…classification creep is reflected in DHAC budgeting procedures which in past years have presumed a need for a 1 per cent per annum increase in funding needs for continuing residents' (p.14). It should be noted that this was not verifiable with the Commonwealth Government. This statement implies a 3% post reform increase in funding is needed to account for increasing dependency levels.

Taking all the above factors into account leaves a 4.2% increase in funding since 1996/97 to cover the extra activity from additional residents and increased usage of respite care. Given that there has been a 2.91% increase in resident numbers (and assuming that this implies a 2.91% increase in funding is required) this leaves an increase in funding of 1.3% to cover an increase of 15.1% in respite care days.

The question as to whether the total increase in funding made available has increased in real terms or not since the introduction of the reforms depends crucially on two aspects of funding. Firstly, whether the figure of a 1% increase in funding stated by DHAC as being necessary to cover the increasing dependency of current residents is really sufficient. There appears to be no stated empirical basis to this assertion and some work relating to this should be undertaken.

The second question relates to the resources necessary to provide an extra 15% of respite care days since 1997 with an increase of 28% in the number of *high care* respite days. Table 3 shows that a total increase in funding (as calculated in Table 9) of $33 516 587 (1.3%) is left to cover the costs of the extra respite days used. This calculation assumes that only a 1% increase in funding is required to address increasing dependency levels of current

residents. It is our contention that this is unlikely given the overall increase in the proportion of high care residents shown in Table 7.

Our tentative conclusion is that the funding increases given since the reforms introduced in 1997 are unlikely to have been large enough to be classed as *real increase* when one takes into account all the factors outlined above and shown in Table 9. If the increase in funding required to meet the increasing residency dependency levels is actually 2% (not 1% as stated by DHAC), this only leaves an increase in funding of 1.2% over 3 years to meet a 2.9% increase in resident numbers and a 15% rise in respite care days used.

Ultimately the extent to which funding increases have actually matched costs associated with increased demand remains an empirical question. In particular it would be interesting to know the extent to which increasing RCS levels of current residents results in increased costs for care provision. The fact that there are increasing numbers and proportions of high care residents may lead to exponential increases in costs rather than linear ones. This may happen as there may be a *costs-step* as more facilities and higher numbers of staff are required by high care resident numbers reaching a certain level.

Table 9 Summary of the increases in funding and the adjustments necessary to find if a real increase in funding has occurred.

Total subsidy funding change 1996/97–1999/00	**$541,989,000**
% Total Subsidy Funding change 1996/97–1999/00	21.02
Compound COPO rate over period	4.56%
Implied figure using compound COPO	$2,695,765,000
Increase in funding not explained by COPO	$424,423,000
% change in funding not explained by COPO	16.5%
Increase in funding accounted for by pensioner supplement funding included in total	$240,276,237
(% increase on 1996/97 funding)	-9.3%
% increase in funding available for increased numbers and dependency levels	7.2%
Increase in funding over period implied by c*lassification creep* as defined by DHAC	3%
% change in funding left for increased numbers of residents and respite days	4.2%
Resident number changes	
Increase in resident numbers 1997–2000	2.91%
Increase in all respite bed days 1997–1999	15.14%
% change in high care respite days	28%

Key Issue 2
Indexation

This section addresses the extent to which residential care funding has been adequately adjusted to take account of changes in the costs of producing services. In this aspect of the debate around the total level of funding provided for the residential care sector there are two key questions:

1. What are the best available proxies for cost increases in the residential aged 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 given. 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. 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). For an index to be suitable it must therefore accurately reflect the cost pressures faced by the sector.

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 aged 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 (WCI-9) which is weighted 75% (of Safety Net Adjustment) for wage costs and 25% (of Treasury Measure of Underlying Inflation) for non wage costs. WCI-9 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 – see below for more details of the Cost Price Index.

The WCI-9 COPO figures for the relevant years covered in this report are shown in Table 10.

Table 10 COPO figures

	1996–1997	1997–1998	1998–1999	1999–2000
COPO (75/25)	1.80%	1.70%	1.40%	1.40%

Source: Answers to Senator Evans for 1999/2000

As was discussed earlier in this report COPO produces a certain % increase in funding and there are also increases in funding associated with increased resident numbers and increased dependency levels as measured by the RCS. In this section we are only concerned with the percentage changes in funding that are associated with inflationary pressures (as proxied by WCI-9). The main line of enquiry being – did COPO deliver funding increases in line with the 'true' cost pressures faced by the sector?

The merits of the various aspects of COPO are examined below.

A Critique of COPO

The Productivity Commission report (1999) identified that the current COPO indexation regime is not based on movements in industry specific costs. They stated 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 component part of COPO, ie the SNA and TMUI.

Changes in funding under COPO indexation 1996/97 to 1999/2000

Table 11 Changes in funding and COPO calculations

	1996/97	1997/98	change $ (year on year % change)	1998/99^	change $ (year on year % change)	1999/2000**	change $ (year on year % change)
Actual Subsidy Total*	2,578,199,000	2,863,726,000	285,527,000 (-11.07)	2,846,404,000	17,322,000 (-0.60)	3,120,188,000	273,784,000 (9.62)
COPO %	1.8	1.7		1.4		1.4	
Implied COPO funding		2,622,028,000		2903818		2,886,253,000	
Unexplained change (ie *real* change after *inflation*)		241,698,000		-57,414,000		233,934,000	
% change unexplained by COPO (real change)		9.37		-2.00		8.22	

Source: personal communication DHAC to Aged and Community Services Australia, June 1999
** *Taken from Portfolio Budget Statements 2000/01*
^ *It should be noted that the funding figures supplied by DHAC show a decrease in total subsidy funding from 97/98 to 98/99. This may reflect the impact of the introduction of the resident income test (see details in Appendix A point 3).*

The Safety Net Adjustment (SNA – wage costs)

The SNA is determined by the Industrial Relations Commission (IRC) 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 for the COPO is a proportion of the Average Weekly Ordinary Time Earnings index (produced by the ABS) for all adults in Australia.

There are a number of problems with using the SNA to drive funding for residential care.

By using the SNA (weighted as 75% of COPO) it is intended that COPO should only reflect those wage increases that were not offset by productivity gains. The corollary of this is that if residential aged care cannot match those productivity gains made elsewhere the relative wage bill changes in residential aged care will not be covered by COPO driven increases. The situation is then one of wage increases from other sectors (for example the acute care sector) flowing through into the wage costs faced by residential aged care providers. Residential aged care has high labour intensity, with, wage costs being approximately 78% of total nursing home costs. Care providers are thus unable to substitute labour for technology, and hence cannot match the productivity gains made in the acute care sector where technology has replaced labour (with length of stay being reduced thus lowering unit costs).

This means that the total wage bill for residential care will increase over time as the amount of labour inputs are not reduced and each unit of labour costs more. This subsequently impacts on government finance as more cash will be needed to maintain levels and standards of service provision. 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 are labour intensive and hence have costs which increase over time as described above. Governments then face the dilemma of the quantity or quality of care or of increasing taxes (or user charges).

In reality residential aged care facilities are subject to quality standards set by the Commonwealth Government and maintaining these care standards lowers the possibility of making the type of efficiency gains implied by the SNA. Residential aged care may be able to make efficiency gains (productivity improvements) through larger units, ie 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 have an impact on the quality of care provided.

Residential care may be able to make efficiency gains (productivity improvements) through larger units, ie 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 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 aged 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 1.3%, whereas using a lower wage (reflecting actual residential aged 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 the SNA is that adjustments are irregular and there is a time-lag between a general movement (increase) in wages and the *handing down* of safety-net increases by the IRC.

The consequence of the above factors is that funding increases to the residential aged care sector based on the 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 Treasury Measure of Underlying Inflation (TMUI) is used to index the non-wage costs of residential aged 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;

- loan interest charges;

- fuel and light; and

- pharmaceuticals.

The implication of excluding these items is that if they are subject to sudden (or prolonged) increases then the funding for residential aged 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 been replaced by the CPI itself.

Alternative indexation approaches

The problems alleged to stem from the use of COPO as detailed above, lead to a consideration of a number of alternative indexation approaches that could be used to adjust the total residential aged care subsidy level.

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

(i) movements in wage costs faced by the providers of residential care; and

(ii) movements in non-wage costs.

Suggestions for indices which (accurately) reflect the movements in wage costs

As detailed above, the major flaw in using the SNA indexation approach is that it assumes that residential aged care providers can match the productivity gains made in other sectors. This was also argued above to be a false premise, there being good reasons why such productivity gains are unlikely to apply to residential aged care organisations.

This being the case it is suggested that an index of labour cost which does not take into account economy wide productivity gains 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 on total funding.

Table 12 Average Weekly Ordinary Time Earnings Index

Average weekly earnings of employees, Australia	May 1996	May 1997	May 1998	May 1999	May 2000
Males					
Full time adult ordinary time earnings $	714.60	743.40	775.80	794.60	835.00
Year on year % changes		4.03	4.36	2.42	5.08
Females					
Full time adult ordinary time earnings $	593.90	621.00	647.30	671.10	697.70
Year on year % changes		4.56	4.24	3.68	3.96
Persons					
Full time adult ordinary time earnings $	671.60	698.70	728.30	749.00	783.70
Year on year % changes		4.04	4.24	2.84	4.63

Source: ABS

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. The above table shows the actual index figures from 1996 to 2000 and the resulting year on year % 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.

Wage Cost Index

The WCI does not include *non-wage labour costs* and, as in 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 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 in Table 16 the WCI produces a lower wage indexation figure than the AWOTE figures.

The La Trobe report (in 1998) recommended the use of the public sector Health and Community Services WCI (75%) with the Treasury Measure of Underlying Inflation (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 cost increases in the residential aged care sector.

Table 13 Wage Cost Index – total hourly rates of pay excluding bonuses, sector by industry average annual index numbers for year ended June quarter

	June 1997	June 1998	June 1999	June 2000
Private sector				
Health and community services	100	100.7	104.2	106.5
Year on year % change		0.7	3.5	2.2
All industries	100	101.2	104.2	107.1
Year on year % change		1.2	3.0	2.8
Public sector				
Health and community services	100	101.8	106.4	109.7
Year on year % change		1.8	4.5	3.1
All industries	100.0	102.2	106.2	109.1
Year on year % change		2.2	3.9	2.7
Private and public				
Health and community services	100	101.2	105.2	107.9
Year on year % change		1.2	4.0	2.6
All industries	100	101.2	104.4	107.4
Year on year % change		1.2	3.2	2.9

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 (ABS Information Paper 6346, June 2000).

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 aged care and would therefore not disadvantage them in the way in which the TMUI does. The key question being what impact would this have had on funding if it had been used?

The La Trobe University report (1998) 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. This empirical question is investigated below in Tables 12 and 14. The movements in the CPI for the relevant period covered in this report are shown in Table 14.

Table 14 Movements in the Consumer Price Index

	1996/97	1997/98	1998/99	1999/2000
CPI	0.3%	0.66%	1.06%	2.31%

Source: ABS

Applying alternative indices to estimate changes in funding

Tables 15 to 18 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 aged 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 12 and 13 in conjunction with the CPI and the TMUI for the calculation of funding figures.

Table 15 AWOTE female 75% + CPI 25%

	1996/97	1997/98	1998/99	1999/2000
Actual subsidy total	2,578,199,000	2,863,726,000	2,846,404,000	3,120,188,000
COPO % (wage and non-wage)	1.8	1.7	1.4	1.4
Implied funding based solely on COPO change		2,622,028,000	2,903,818,000	2,886,253,000
Unexplained change $		241,698,000	-57,414,000.00	233,935,000
% change unexplained by COPO		9.37	-2.00	8.22
AWOTE female 75% + CPI 25%				
AWOTE adult females % change	4.56	4.24	3.68	3.96
75% AWOTE adult females % change	3.42	3.18	2.76	2.97
CPI %	0.3	0.7	1.1	2.3
CPI 25%	0.1	0.2	0.3	0.6
Total index (75% AWOTE + 25% CPI)	3.50	3.35	3.03	3.55
Implied indexed subsidy figure $		2,664,439,757	2,950,353,712	2,947,380,182
Implied new total based on *topline* $		2,906,137,757	2,892,939,712	3,181,315,182
Difference actual (COPO) index total and AWOTE/CPI total	42,411,757		46,535,712	61,127,182
Total *underfund* over 3 years	150,074,650			

Table 16 AWOTE female 75% + TMUI 25%

	1996/97	1997/98	1998/99	1999/2000**
Actual subsidy total	2,578,199,000	2,863,726,000	2,846,404,000	3,120,188,000
COPO %	1.8	1.7	1.4	1.4
Implied COPO funding		2,622,028,000	2,903,818,000	2,886,253,000
Unexplained change		241,698,000	-57,414,000	233,935,000
% change unexplained by COPO		9.37	-2.00	8.22
AWOTE (female 75% + TMUI 25%)				
AWOTE adult females % change	4.56	4.24	3.68	3.96
75% AWOTE adult females % change	3.42	3.18	2.76	2.97
25%TMUI	0.83	0.53	0.38	0.43
Total index implied %	4.25	3.71	3.14	3.4
Implied indexed subsidy figure $		2,673,850,183	2,953,646,996	2,943,181,736
Implied new total based on *topline* $		2,915,548,183	2,896,232,996	3,177,116,736
difference actual COPO total and AWOTE/TMUI total		51,822,183	49,828,996	56,928,736
Total *underfund* over 3 years	$158,579,915			

Table 17 WCI public sector 75% + CPI 25%

	1996/97	1997/98	1998/99	1999/2000
Actual subsidy total	2,578,199,000	2,863,726,000	2,846,404,000	3,120,188,000
COPO %	1.8	1.7	1.4	1.4
Implied COPO funding		2,622,028,000	2,903,818,000	2,886,253,000
Unexplained change		241,698,000	-57,414,000	233,935,000
% change unexplained by COPO		9.37	-2.00	8.22
WCI (75% + CPI 25%)				
WCI health and community services % change		0.018	4.3	3
75% WCI		0.01	3.23	2.25
CPI %	0.3	0.7	1.1	2.3
25% CPI	0.1	0.2	0.3	0.6
Total index implied %		0.2	3.5	2.8
Implied indexed subsidy figure $		2,583,355,398	2,963,956,410	2,926,103,312
Implied new total based on *topline* $		2,825,053,398	2,906,542,410	3,160,038,312
Difference actual COPO total and WCI/CPI total		-38,672,602	60,138,410	39,850,312
Total *underfund* over 3 years	61,316,120			

Table 18 WCI public sector health and community services 75% + TMUI 25%

	1996/97	1997/98	1998/99	1999/2000**
Actual subsidy total	2,578,199,000	2,863,726,000	2,846,404,000	3,120,188,000
COPO %	1.8	1.7	1.4	1.4
Implied COPO funding		2,622,028,000	2,903,818,000	2,886,253,000
Unexplained change		241,698,000	-57,414,000	233,935,000
% change unexplained by COPO		9.37	-2.0	8.22
WCI (75% + TMUI 25%)				
WCI health and community services % change		0.018	4.3	3
75% WCI		0.01	3.23	2.25
25%TMUI	0.83	0.53	0.38	0.43
Total index implied %		0.54	3.61	2.68
Implied indexed subsidy figure $		2,592,121,274	2,967,106,508	2,922,687,627
Difference actual COPO total and WCI/TMUI		-29,906,725	63,288,509	36,434,627
Total *underfund* over 3 years	$69,816,410			

A summary of the impact of the alternatives to COPO

Table 19 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	Additive % change since 96/97
COPO	1.8	1.7	1.4	1.4	4.5
AWOTE female 75% + CPI 25%	3.50	3.35	3.03	3.55	9.9
AWOTE female 75% + TMUI 25%	4.25	3.71	3.14	3.4	10.2
WCI 75% + TMUI 25%		0.54	3.61	2.68	6.8
WCI 75% + CPI 25%		0.2	3.5	2.8	6.5

Table 19 clearly demonstrates the way in which use of the COPO index has disadvantaged the residential aged care sector when compared with the scenario if alternative indexation methods had been used. 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 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.

The impact of using the various indices on actual funding levels can be seen in Table 20. The table shows that the underfunding implied by using the alternative indexation methods to the COPO 25% TMUI and SNA 75% ranges between $61.3 million and $158.6 million. In line with the figures shown in Table 16 the use of AWOTE female earnings has the largest implied impact on total funding levels.

Table 20 A Summary of the COPO *underfunding* examining the impact of alternative indices

Wage Index	Non-Wage Index	Implied Funding Difference (vs COPO) 1996/97–1999/00
AWOTE female 75%	CPI 25%	$150,074,650
AWOTE female 75%	TMUI 25%	$158,579,915
WCI public sector health and community services 75%	CPI 25%	$61,316,120
WCI public sector health and community services 75%	TMUI 25%	$69,816,410

One noticeable implication is that the use of 25% TMUI over that of using 25% CPI did not appear to disadvantage the residential aged care sector. In each of the scenarios in Table 17 the implied funding figure is lower when the CPI is used as opposed to TMUI. Table 18 compares the rates of annual change in 25% TMUI vs 25% CPI.

Table 21 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 21 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 above) has been discontinued since the June 1999 quarter of the CPI was published (as confirmed by the ABS).

The *choice* regarding whether the AWOTE (female) or the WCI (public sector health and community services) indices should be used as the most accurate reflection of the wage cost rises felt by residential aged care providers is an empirical one. Both indices do not adjust for productivity gains and as such are both likely to be suitable as it has been extensively argued that the residential aged care sector cannot achieve the productivity gains which other less labour intensive sectors can benefit from. The key difference between the two indices is that the WCI measures changes over time in wage and salary rates 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 approach as it is a more accurate indication of actual *non-quality* wage inflation. Whilst the La Trobe report (1998) 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 aged care sector. This being equivalent to investigating the extent to which productivity gains can be made in the sector.

Discussion and Overview
of Key Issues

Demand factors and funding changes

In brief terms the situation which residential aged care finds itself in is one of consistently rising demand on resources with funding increases struggling to match those rising demands. Taken together the data presented in Tables 7 and 8 show that resident numbers, the numbers of respite care days used, and resident dependency levels have all increased markedly since the reforms were introduced. Table 9 shows that the *non-COPO* (ie non-indexation) related increases in funding since 1996/97 (up to 1999/00) was 16.5%. This increase is largely explained by the inclusion of funds (previously not included in the total funding figure) covering the pensioner supplement. Of the $541.9 million funding increases since 1996/97, $240.2 million is accounted for by (new) money for the pensioner supplement. This leaves a 7.2% rise to cover the *demand* factor increases shown in Tables 7 and 8.

It would appear that perhaps the major challenge faced by the residential aged care sector is that of increasing resident dependency levels. These pressures are twofold, firstly existing residents are *ageing in place* and newly admitted residents are from the higher dependency groups as shown in Table 4. The amount of funding left after taking into account rising dependency levels depends on the assumptions one makes regarding what increase in funding is required to cover them. The DHAC assume that a 1% rise is needed to tackle what they call *classification creep*, ie increasing dependency of current residents. This does not therefore appear to allow for the increasing numbers of new residents classified as *high care*.

There appears to be little evidence base to the 1% assumption and it is strongly recommended that empirical work be undertaken to assess the true impact of rising dependency levels. 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. The current *cost gradients* for RCS levels 1 to 4 are the results of a

study undertaken in 1996/97 by Coopers and Lybrand (Cuthbertson et al 1998). This costing study was done in 60 facilities and built on the methodology used earlier (by Professor Hindle of the University of NSW). 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. The Australian Institute for Primary Care therefore suggest that a fundamental re-examination of the level of funds required to match the required standards of care should be undertaken. The assumptions made by Coopers and Lybrand in reaching their conclusions regarding the inappropriateness of a casemix model need to be examined before any further costing work is commenced. 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. The hypothesis here being that as a higher proportion of residents in units reach RCS level 1 there may a step in the cost function (as opposed to a linear increase in costs).

Indexation factors and funding changes

For some time now arguments have been put forward that the COPO indexation 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 aged care sector, whilst the TMUI omits items from its 'basket of goods' whose price changes have a major impact on the sector.

The result of these two *faults* is that the COPO indexation figure used is too low and the funding increases passed on are insufficient to match the (actual) rising costs faced by the sector. Hence the key question here is what are the most appropriate means of accurately capturing the cost increases faced by the sector. Two alternative indexation methods for capturing increased wage costs were examined – firstly the use of movements in Average Weekly Ordinary Time Earnings (which is not actually an index) 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 (which as noted above has now replaced the use of TMUI). The impact of using combinations of these alternative methods on the total level of funding was estimated. As shown in Table 20 the calculated level of underfunding over a 3-year period lies in the range of $61.3 million to $158.6 million (or an average of approximately $20 million to $53 million per annum over 3 years).

The long-run impact of this underfunding is potentially one where there are increasing pressures on the quality of care provided due to inadequate funding for the maintenance of staffing levels, etc. There will also be an impact in terms of individual care providers becoming non-viable and producing a situation where units close and the available amount of residential aged care provision dwindles.

Using the WCI produced much lower underfund estimates as 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 aged 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 accurate reflection. This, however, is an empirical question and it is strongly recommended that empirical work is undertaken which would examine whether or not the assumptions made in calculating the public sector health and community services WCI hold specifically for the residential aged 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.

If, as appears likely, Commonwealth contributions are not keeping pace with changes to the cost of service provision and increased demand over time, there will be consequent effects on either the viability of service providers, the quality of the services which are provided or increased requirements for contributions from other sources such as residents.

Finally, 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 the consideration of indexation strategies. It should also be noted that this analysis only relates to the adequacy of Commonwealth funding. Other sources of funding such as resident contributions also affect the overall funds available to aged care providers. It is therefore strongly recommended that further research is undertaken relating to:

1. The actual impact on care costs of increasing dependency levels – erroneous assumptions regarding the impact of increasing dependency costs will render the provision of high quality care impossible and may lead to providers of care becoming non-sustainable. The National Aged Care Alliance should also consider seeking to have questions tabled in Parliament relating to the method that is currently used to produce the gradient of costs (subsidies) for higher levels of dependency.

2. The empirical basis of using Average Weekly Ordinary Time Earnings or the Wage Cost Index as alternative ways of capturing the impact of rising wage-costs should be investigated. It is possible that the assumptions built into the WCI do not hold specifically for the residential aged care sector. This work is the only way of arriving at a reliable view on the veracity of using the Average Weekly Ordinary Time Earnings as opposed to use of the Wage Cost Index.

Appendix A
Other factors and issues impacting on residential aged 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 October 1 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).

From 1 July 2000, this supplement was set at $5.56 per day, or an annual supplement of $2029.40.

This payment by the Department of Health and Aged Care (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). 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)

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 DHAC 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 x 134,536 x 0.443), or based on the lower figure of $7.35, the annual total cost would be $159,890,419 (ie $2682.75 x 134,536 x 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.

3. Resident Income Test

The Resident Income Test was introduced from 1 March 1998 for new residents. Full pensioners pay 85% of their pension (basic pensioner fee = $21.10). Others 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 aged 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 payments 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, 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 is 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 has not been considered further in the main analysis above.

Appendix B
Changes in funding 1995/96–1999/00

Changes in funding 1995/96–1999/00

	1995/96$	1999/2000$	95/96–99/00 change $	95/96–99/00 % change
Total Subsidy Funding	2,463,300,000	3,120,188,000	656,888,000	26.7
Total COPO % change over period 95/96–99/00			6.3%	0.6
Increase in funding not explained by COPO		501,700,100		
% change in funding not explained by COPO		20.4		

Source of total subsidy funding figures: 1995/96 total ($2,463,300,000) from DHAC February 2000 in answer to a question tabled in the Senate by Senator Evans – 1999/00 total from Commonwealth Portfolio Budget Statements 2000–2001

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