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Residential Aged Care Funding:
Third Report

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

February 2003

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Contents

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 Ageing
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 aged care before and after the reforms. The report is an update of two previous reports (National Aged Care Alliance, 2001).

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

The analysis is concerned with labour costs as the major influence on the cost of producing services in residential aged care because of its high labour intensity.

The report demonstrates that although there have been substantial increases in total funding for residential aged care subsidies, 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. The level of underfunding over a 5-year period compared with the Commonwealth's current indexation approach was estimated in the range of $226.8 million and $393.5 million from 1996/97 to 2001/02 (or an average of approximately $45.4 million to $78.7 million per annum over 5 years).

For some time, arguments have been put forward that the Commonwealth Own Purpose Outlays (COPO) indexation method is inappropriate for indexing funds for residential aged care. It is argued that the Safety Net Adjustment (SNA) makes assumptions about productivity gain offsets (to wage increases) which do not hold in the residential aged care sector. The result is that the COPO indexation figure underestimates the cost pressures faced by residential aged care providers and hence the funding increases passed on are insufficient.

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 in investigating the impact of indexation. It should also be noted that this analysis only relates to 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 Wage Cost Index (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 aged 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 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 Average Weekly Ordinary Time Earnings (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 that relates payment levels to the dependency levels and care factors that drive costs could be introduced to address these problems.

Introduction

In October 1997, the Coalition government introduced a structural reform package for 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 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 per cent 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 aged 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 aged 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 Ageing. 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.

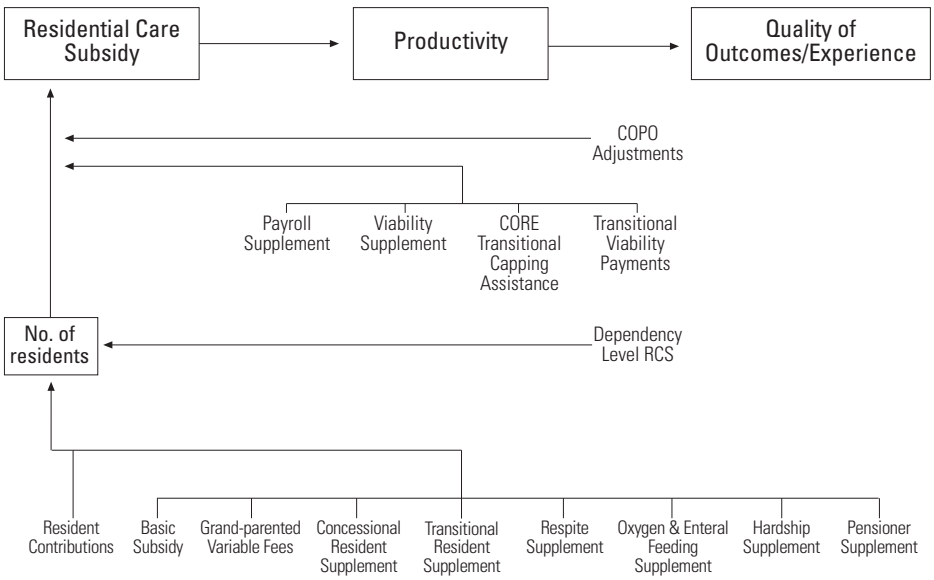
Under the system, responsibility for quality assurance was shifted out of the then Department of Health and Aged Care to a newly established independent Aged Care Standards and Accreditation Agency. Aged care homes must be accredited in order to receive government subsidies.

This paper is 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 adequacy of the residential aged care subsidy provided. 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.

In addition, this paper has not considered whether increased productivity has enabled providers to maintain quality standards. Improvements in productivity that may have been made in other service sectors are difficult in the residential aged care sector because of its high labour intensity. Hence, a gap between labour costs and the residential aged care subsidy places pressure on the ability of the sector to maintain the quality of care provided to residents of aged care facilities.

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 improved, and that the number of residential aged care places as a proportion of the population aged 70 years 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 ageing. 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 2001/2002. 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 Ageing (DHA), 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 aged 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. Given the labour intensive nature of the sector, this paper is concerned with changes in labour rates as the major impact on costs in delivering residential aged care 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 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 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 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 aged 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 the 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 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 (WCI9) which is weighted 75% (of Safety Net Adjustment) for wage costs and 25% (of the Consumer Price Index) 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 are proxied by the Consumer Price Index (CPI).

The WCI9 COPO figures for the relevant years covered in this report are shown in Table 1 below.

Table 1 COPO figures

	1996–1997	1997–1998	1998–1999	1999–2000	2000–2001	2001–2002
COPO (75/25)	1.7%	1.7%	1.4%	1.5%	2.1%	2.3%

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' (p94).

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 the component parts of COPO.

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 aged 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	change $ (year on year % change)	1999/2000	change $ (year on year % change)	2000/01	change $ (year on year % change)	2001/02	change $ (year on year % change)
Actual Subsidy Total*	2,698,163,421	3,028,912,197	330,748,776 12.26%	3,337,696,309	308,784,112 10.19%	3,566,025,000	228,328,691 6.84%	3,865,713,000	299,688,000 8.40%	4,048,198,000	182,485,000 4.72
COPO %	1.7	1.7		1.4		1.5		2.1		2.3	
Implied COPO funding		2,744,032,199		3,071,316,968		3,387,761,754		3,640,911,525		3,954,624,399	
Unexplained change (ie. 'real' change after 'inflation')		284,879,998		266,379,341		178,263,246		224,801,475		93,573,601	
% change unexplained by COPO (real change)		10.56		8.79		5.34		6.30		2.42	

**Senate Hansard 11/10/2000 p18374, DHAC annual reports 1996/97, 98/99, 99/00, 2002–2003*
Portfolio Budget Statements – Health & Aged Care Budget Related Paper No. 1.11 Table C3.1, DVA Part C – Agency Budget Statements Table 2.2.1

There are a number of problems with using the SNA to drive funding for residential aged 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 aged care cannot match those productivity gains made in other sectors the relative wage bill changes in residential aged 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 aged care providers.

Residential aged care has high labour intensity, with approximately 78% of total high care costs absorbed in wage costs. Care providers are unable to substitute labour for technology, or significantly improve workforce 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 aged 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 aged 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 the 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 1.4%, whereas using a lower wage (reflecting actual residential aged care salary 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 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 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 organisations. The implication, as further discussed below, is that a different method of indexing for wage changes is needed.

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 aged care subsidy level.

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

1. movements in wage costs faced by the providers of residential care, and
2. movements in non-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. 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 an impact on their viability or the quality of the services provided.

Therefore an index of labour costs which more closely reflects actual wage movements for the residential aged 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 to 2002 and the resulting year on year percentage changes in AWOTE.

Given that the labour force for the residential aged 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	May 2002
Males							
Full time adult ordinary time earnings $	714.60	743.40	775.80	794.60	835.00	858.3	918.00
Year on year % changes		4.03	4.36	2.42	5.08	2.7	6.96
Females							
Full time adult ordinary time earnings $	593.90	621.00	647.30	671.10	697.70	728.4	775.90
Year on year % changes		4.56	4.24	3.68	3.96	4.4	6.52
Persons							
Full time adult ordinary time earnings $	671.60	698.70	728.30	749.00	783.70	810.6	866.80
Year on year % changes		4.04	4.24	2.84	4.63	3.43	6.93

Source: ABS

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 residential aged care services 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 costs increases in the residential aged 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	Mar 2002
Private sector						
Health and community services	100	100.7	104.2	106.5	109.6	113.9
Year on year % change		0.7	3.5	2.2	2.9	3.9
All industries	100	101.2	104.2	107.1	111.4	114.9
Year on year % change		1.2	3.0	2.8	4.0	3.1
Public sector						
Health and community services	100	101.8	106.4	109.7	113.7	117.4
Year on year % change		1.8	4.5	3.1	4.4	3.3
All industries	100	102.2	106.2	109.1	112.6	116.4
Year on year % change		2.2	3.9	2.7	3.2	3.4
Private and public						
Health and community services	100	101.2	105.2	107.9	111.4	115.4
Year on year % change		1.2	4.0	2.6	3.2	3.6
All industries	100	101.2	104.4	107.4	111.7	115.2
Year on year % change		1.2	3.2	2.9	4.0	3.1

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).

Applying alternative indices to estimate changes in funding

Tables 5 and 6 below use the suggested alternative indexation methods detailed above to calculate the implied funding differential 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 5 and 6 in conjunction with the CPI for the calculation of funding figures.

In each of the tables, the top line presents the total residential aged care subsidy for 1996/97 to 2001/02. 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 aged care 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 five-year total is calculated as the difference between that allocated in subsidies and what would have been allocated if the new index rather than the COPO had been used.

Table 5 AWOTE female 75% + CPI 25%

	1996/97	1997/98	1998/99	1999/2000	2000/2001	2001/2002
Actual subsidy total	2,698,163,421	3,028,912,197	3,337,696,309	3,566,025,000	3,865,713,000	4,048,198,000
Implied funding based solely on COPO change		2,744,032,199	3,071,316,968	3,387,761,754	3,640,911,525	3,954,624,399
Unexplained change $		284,879,998	266,379,341	178,263,246	224,801,475	93,573,601
% change unexplained by COPO		10.56	8.79	5.34	6.3	2.42
AWOTE female 75% + CPI 25%						
AWOTE adult females % change	4.56	4.24	3.68	3.96	4.40	6.52
75% AWOTE adult females % change	3.42	3.18	2.76	2.97	3.30	4.89
CPI %	0.33	0.67	1.07	3.19	6.02	2.84
CPI 25%	0.08	0.17	0.27	0.80	1.51	0.71
Total index (75% AWOTE + 25% CPI)	3.50	3.35	3.03	3.77	4.81	5.60
Implied indexed subsidy figure $		2,788,454,474	3,120,645,682	3,463,434,670	3,737,396,599	4,082,226,622
Implied new total based on *topline* $		3,073,334,472	3,387,025,023	3,641,697,917	3,962,198,074	4,175,800,223
Difference actual (COPO) index total and AWOTE/CPI total		44,422,275	49,328,714	75,672,917	96,485,074	127,602,223
Total *underfund* over 5 years:	**393,511,203**					

Table 6 WCI public sector 75% + CPI 25%

	1996/97	1997/98	1998/99	1999/2000	2000/01	2001/02
Actual subsidy total	2,698,163,421	3,028,912,197	3,337,696,309	3,566,025,000	3,865,713,000	4,048,198,000
Implied funding based solely on COPO change		2,744,032,199	3,071,316,968	3,387,761,754	3,640,911,525	3,954,624,399
Unexplained change $		284,879,998	266,379,341	178,263,246	224,801,475	321,262,601
% change unexplained by COPO		10.56	8.79	5.34	6.30	2.42
WCI (75% + CPI 25%)						
WCI health & community services % change		1.80	4.52	3.10	3.65	3.25
75% WCI		1.35	3.39	2.33	2.73	2.44
CPI %	0.33	0.67	1.07	3.19	6.02	2.84
25% CPI	0.08	0.17	0.27	0.80	1.51	0.71
Total index implied %		1.52	3.66	3.12	4.24	3.15
Implied indexed subsidy figure $		2,739,078,084	3,139,697,480	3,441,944,172	3,717,234,368	3,987,508,017
Implied new total based on *topline* $		3,023,958,082	3,406,076,821	3,620,207,419	3,942,035,843	4,081,081,618
Difference actual COPO total and WCI/CPI total		-4,954,115	68,380,512	54,182,419	76,322,843	32,883,618
Total underfund over 5 years.	**$226,815,276**					

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 7. From 1996/97 to 2001/02 the difference between COPO and the AWOTE/CPI and the WCI/CPI indices was $393.5 million and $226.8 million respectively.

Table 7 Summary of the difference between COPO and alternative indices

Wage Index	Non-Wage Index	Implied Funding Difference (vs COPO) 1996/97–2001/02
AWOTE female 75% (5 yrs)	CPI 25%	$393,511,203
WCI public sector health & community services 75% (5 yrs)	CPI 25%	$226,815,276

Table 8 clearly demonstrates the way in which use of the COPO index has disadvantaged the residential aged care sector when compared with the use of alternative indexation methods. The use of the AWOTE has the largest differential impact, by 2001/02 exceeding COPO by approximately 13% since 1996/97. If the WCI had been used the 'excess' over COPO would be approximately 5% over the same period. 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 8 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	2001/02 yearly % change	Additive % change since 96/97
COPO	1.7	1.7	1.4	1.5	2.1	2.3	10.7
AWOTE female 75% + CPI 25%	3.51	3.34	3.03	3.77	4.81	5.6	24.05
WCI 75% + CPI 25%		1.8	3.66	3.12	4.24	3.15	15.69

Given the importance of labour costs for residential aged 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 aged 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 aged 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 aged care sector. This is equivalent to investigating the extent to which productivity gains can be made in the sector.

Conclusion

This report addressed the extent to which changes to funding provided through the Commonwealth residential aged care subsidy has adequately addressed increased costs for providing care. The report demonstrates that although there have been substantial increases in total funding for residential aged care subsidies, current indexation arrangements do not adequately adjust for cost increases.

For some time now arguments have been put forward that the COPO method used for the indexation of residential aged care subsidy funding is inappropriate. The main reason being that the indexation of wage costs in the COPO – the SNA (wage costs) – makes assumptions about productivity gain offsets (to wage increases) that do not hold in the residential aged care 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. 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 5-year period lies in the range of $226.8 million and $393.5 million from 1996/97 to 2001/02 (or an average of approximately $45.4 million to $78.7 million per annum over 5 years). 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.

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 is not 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 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 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 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. 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. accredititation) and the changing mix of resident dependency. A costing model that relates payment levels to the dependency levels and care factors that drive costs could be introduced to address these problems.

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