Catholic Health Australia

A Fair Price for Care and Support in Aged Care Homes

October 2010
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### About Catholic Health Australia

21 public hospitals, 54 private hospitals, and 550 aged care facilities are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at [www.cha.org.au](http://www.cha.org.au).

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Introduction

The quality of life experienced by people as they age is a measure of our success as a society.

There are many factors which act in concert to influence an older person’s quality of life. They include the productivity of our economy; the quality and accessibility of our health system; the extent to which people as they age are included in society; giving family carers a fair go; a value system which makes access to aged care services for all in need a priority; our attitude as a community to saving for future needs and our retirement incomes policies; and the design of our cities, housing and transport systems.

Another key factor is paying a fair market price to attract and retain the nurses and personal carers needed to attend to the care needs of the frail aged, and to allow a reasonable return on investment in order to secure the services to support future generations of older Australians.

2. Current pricing arrangements

Under current arrangements, the Commonwealth is the purchaser and price setter for residential aged care, with provision for co-payments from residents assessed as capable of contributing to the cost of their care. However, because the Commonwealth also controls most aspects of the supply of aged care services, there is no market informed basis for setting prices for these services.

The current funding arrangements comprise separate prices for care and hotel-type services (as well as a separate funding stream for accommodation).

Care

The prices for residential care and support (the basic care subsidy) were set historically, and have been adjusted annually in line with a Commonwealth Own Purpose Outlays (COPO) index since 1996. The index used is WCI 9, which is weighted at 75% for wages and 25% for other costs. The index uses the minimum wage decisions by Fair Work Australia to index wages (previously the Safety Net Adjustment) and the Consumer Price index for non-wage costs.

Hotel-type services

The price for hotel-type services (the basic daily fee) is the same for all residents and is set at 84% of the single age pension base rate. It is indexed six-monthly at the same time as the age pension, using the Consumer Price Index (CPI) or the Pensioner and Beneficiary Living Cost Index ( whichever is the greater). The age pension is designed to support only a basic standard of living for older people who live independently and self cater.

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1 The exception appears to be 2010-11 when indexation was set at 1.7%. This would appear to be at odds with the Fair Work Australia decision for the relevant period which did not award an increase in the minimum wage. The Department of Finance and Deregulation will not disclose the WCI 9 index for 2010-11.
Conditional Adjustment Payment

Between 2004-05 and 2008-09, following the Hogan Review\(^2\), an annual payment of 1.75\% of the basic care subsidy (the Conditional Adjustment Payment or CAP) was paid in addition to COPO for care and support. The CAP was intended to provide price increases while encouraging service providers to become more efficient through improved management practices, including giving staff information and opportunities regarding workforce training, making audited accounts publicly available each year and taking part in a periodic workforce census.

Since the 2009-10 Budget, which saw the discontinuation of the annual CAP increase, the indexation of the basic care subsidy has reverted to COPO. \(^3\)

3. The validity of the funding base for care and support

CHA understands that an analysis of staff rosters in 1986 was the last time that consideration was given to a cost of care study to inform the setting of care subsidy levels.

The appropriateness of these levels today has not been systematically re-examined.

When the current 65 point funding scale was introduced in 2008 in conjunction with a new funding tool (the Aged Care Funding Instrument) to replace the former eight point Residential Classification Scale (RCS), it was on the basis that the new scale would achieve a Budget neutral result (aside from a modest top up for the new Behaviour and Complex Health Care Supplements).\(^4\) There was no attempt to use a contemporary cost of care study to set the funding levels.

The former RCS scales, introduced in 1997, brought together long standing separate subsidy scales for nursing homes and hostels. A cost of care was initiated at the time, \(^5\) but it did not become the basis for setting the funding levels. Instead, as was the case for the current funding levels, the RCS was calibrated to achieve a Budget neutral result. The study was not released.

There is a concern therefore that the current subsidy levels are simply a recalibration within a pre determined historically based Commonwealth Budget estimate of aged care outlays. As such, the new funding levels cannot be expected to reflect the impact on the cost of care of significant changes that have occurred. These changes include changes in care practices and

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\(^2\) Review of Pricing Arrangements in Residential aged Care (WP Hogan April 2004)
\(^3\) There was a one off increase in the basic daily fee for hotel services in 2009-10 Budget, a partial flow on of the one off $10.09 per week increase in the single age care pension base rate. The increase in the single age pension was intended to provide a basic acceptable living standard for pensioners living independently, and did not take into account the cost of providing care and support in aged care homes or changes in the cost of providing hotel services in aged care homes.
\(^4\) $96m over four years
\(^5\) A cost of care study was referred to by the Department of Health and Ageing in evidence to the 2009 Budget Estimates
procedures, community expectations, accreditation and space and privacy standards, additional regulatory and compliance reporting requirements and, most importantly, changes in labour markets which have tightened significantly since the funding base was established in the mid 80s, and the growing demand for (and shortage of) health care workers.  

A trend analysis based on survey data collected by Stewart Brown Business Solutions, which shows significant differences in outcomes for homes with similar resident profiles (Figure 1), has led them to the conclusion that the funding provided is not effectively matched to the cost of providing the services.  

It is also noteworthy that the National Health and Hospitals Reform Commission recommended that ‘the level of care subsidies should be periodically reviewed to ensure they are adequate to meeting the care needs of very frail people in residential aged care. Ensuring adequate care subsidies is also essential if aged care facilities are to provide sufficient appropriately trained professionals, including nurses, to meet the complex health needs of residents’.  

4. Adequacy of the indexation arrangements

As well as the validity of the funding base, there are serious concerns about the adequacy of the current indexation arrangements to sustain high quality aged care services.

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6 Unlike the Department of Health and Ageing, aged care providers have not received additional funding to cover the administrative overheads of the new regulatory and compliance reporting requirements.

7 Submission to the Productivity Commission Inquiry Caring for Older Australians (Stewart Brown Business Solutions July 2010)

8 Stewart Brown categorizes homes by income bands, with Bands 1 and 2 and Bands 3 to 5 including high care and low care homes respectively.

9 A Healthier Future for All Australians (National Health and Hospitals Reform Commission June 2009)
In the period prior to the adoption of COPO, care funding was indexed each quarter in line with movements in nursing award wages. As noted above, the COPO WCI 9 index is linked to Fair Work Australia’s minimum wage decisions. As such, it does not, and cannot, take into account changes in industry-specific costs.

As illustrated in Figure 2 below, the index has not kept pace with wage pressures, as evidenced by the large gap between Average Weekly Ordinary Time Earnings (AWOTE) and WCI 9 and the Labour Price Index (LPI) for health and community services and WCI 9. WCI 9 has not even kept pace with general price increases, as indicated by the gap between the CPI and WCI 9.

**FIGURE 2**

![Graph showing wage pressure comparison between AWOTE, LPI (H&CS), CPI, and WCI_9](source: Department of Finance and Deregulation, ABS 6302.0, 6345.0, 6401.0, Access Economics)

The gap would have been greater for 2010-11 because Fair Work Australia did not grant an increase in the minimum wage for the relevant period. It appears, however, that the 1.7% in the basic care subsidy for 2010-11 involved a departure from the COPO WCI 9 formula.  

The premise which justifies this outcome is the assumption that virtually all wage increases are productivity based, and that the aged care sector has the same ongoing capacity as all other sectors to achieve productivity gains from labour substitution and changes in work practices.

The blanket application of this assumption to the age care sector is problematic because personal care and attention is inherently labour intensive and time spent with residents, including social inclusion activities, is an important aspect of the quality of services. Hence productivity gains that may be possible in other sectors of the economy are difficult to achieve on a sustained basis in labour intensive personal and direct care sectors such as aged care. Moreover, the flexibility of aged care providers to adopt more efficient work practices is

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10 See footnote 1
constrained by legislated scopes of practices in nursing, and the risk adverse climate generated by the severe compliance and sanction regimes that apply in age care.

As indicated by Access Economics, ‘rather than making explicit allowance for productivity gains, it would appear that WCI 9 has been constructed primarily to be a slow growing index. The consequence is that, over time, WCI 9 indexation does not adequately compensate for cost increases in the sectors where wage rates are above the minimum wage and where there is little scope for substantial productivity gains.’

The provision of the CAP on top of the basic subsidy rates between 2004-05 and 2008-09 meant that increases in the basic subsidy rates for residential aged care over this period slightly outpaced CPI growth. However, even with the inclusion of the CAP, increases over this period were between 0.7% and 0.9% less than PLI (health and community services), a sector within which residential aged care competes for skilled staff.

Since the annual CAP increase was discontinued in 2009-10, subsidy levels have again fallen well below economy wide wage and price indices (Figure 2).

5. Consequences of the current funding arrangements

A consequence of the current funding arrangements is that many providers have been experiencing a steady decline in their net trading results, with the most pronounced decline being since about 2004. The trend is captured in Figure 3 below prepared by Stewart Brown Business Solutions which tracks net trading results over time.

![Figure 3](image)

**FIGURE 3**

Net Trading Results Over Time

Dollars per occupied bed day

Bands 1 & 2 Result  Bands 3 to 5 Result

Australia and Uniting Care NSW & ACT  August 2008

12 Submission to the Productivity Commission Inquiry Caring for Older Australians (Stewart Brown Business Solutions  July 2010)
A similar trend of deteriorating results over the last three survey years (2006-09) has been identified in the Bentleys Aged Care Surveys. These show that the net profit margins of providers surveyed has decreased from 9.95% to 4.5%, average EBITDA’s have declined by 17% to $11.46 per resident per day and the overall percentage return on assets (ROI) has declined from 2.95% to 1.99%.\(^\text{13}\)

The pressure on results is expected to continue in 2010-11 as COPO is set at only 1.7%, whereas the CPI index for the year through to June 2010 was almost double (3.1%), and wages increases in the sector have generally been in the range of between 3% and 4% in order to meet labour market prices.

The wages gap between the health and age care sectors, which ranges between 10% and 20%, depending on the State/Territory and employee category, is making staff attraction and retention increasingly difficult and is placing upward pressure on wage rates in aged care. A survey in 2007 of the aged care workforce by the National Institute of Labour Studies found that the difficulties aged care homes had in recruiting nurses had increased since the first survey in 2003, and that the length of time to fill vacancies indicated real difficulties in filling nurse positions.\(^\text{14}\)

The pressures on trading results have coincided with a significant restructuring of the workforce in the residential aged care sector.

The most recent data available shows that over the four year period 2003-07, there has been a significant decline in equivalent full time registered nurses, enrolled nurses and allied health staff in residential care (-14%), substituted for by a 17.7% increase in personal care workers. There has been some up skilling of the personal carer workforce to offset the loss of more skilled staff, with 13% having Certificate 4 in 2007 compared with 8% in 2003. However, the percentage of personal carers with Certificate 3 in aged care, viewed as the base qualification for personal carers, remained relatively unchanged at about 65%.\(^\text{15}\)

Over the same four year period, the number of licensed residential aged care places increased by 12.5%.

The Department of Health and Ageing considers that the labour substitution and the increase in the number of residents together contributed a productivity gain of 1.7% per annum over the period, represented by a decline of 2% in the weighted mix of labour inputs and a rise of 5% in the weighted mix of outputs.\(^\text{16}\)

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\(^{13}\) Bentleys Aged Care Survey 2009  
\(^{14}\) Who Cares for Older Australians: A Picture of the Residential and Community- Based Aged Care Workforce  (National Institute of Labour Studies, Flinders University, October 2008)  
\(^{15}\) Who Cares for Older Australians: A Picture of the Residential and Community-Based Aged Care Workforce  (National Institute of Labour Studies, Flinders University 2007)  
\(^{16}\) Supplementary Submission to the Senate Finance and Public Administration Committee Inquiry into Residential and Community Aged Care in Australia  (Department of Health and Ageing, April 2009)
CHA has concerns, however, that the decline in nursing and allied health staff may, to a significant degree, be the result of cost cutting due to funding pressures, rather than best practice enhancements. It should be noted that this dilution in the skill base of the aged care workforce is occurring at the same time as the acuity of residents is rising, including increasing numbers of residents living with dementia and presenting with complex behavioural and nursing care needs.

CHA notes in this regard that while the percentage of accredited homes remains high (98%), there has been a disturbing increase in the number of reported consumer contacts with the Complaints Investigation Scheme (11% in 2008-09, compared with a 3.2% increase in the number of people receiving aged care). This increase has occurred despite a significant stepping up of regulatory activity, including an increase in the number of announced and unannounced visits to homes by regulatory authorities, mandatory police checks for staff, key personnel checks and mandatory reporting of missing persons and suspected abuse. 17

The Department of Health and Ageing in oral evidence to a recent Senate Inquiry acknowledged ‘that there must be a limit to the extent of such labour substitution that can occur in the industry so that it is possible that growth in labour productivity will begin to mitigate at some time in the future.’ 18 We would agree with this assessment, all the more so because of the legislated restrictions on scopes of practice.

6. Conclusion

The current funding arrangements for residential aged care are not based on any contemporary independent studies of the cost of providing quality care and support in a residential setting, and COPO indexation does not reflect movements in industry-specific costs.

The sector’s operating costs will continue to rise as a result of growing demand for and complexity of aged care needs, changing community expectations, labour force pressures and the limits to the potential for labour substitution. The cost of increasing complexity will be compensated to some extent by movements towards higher subsidy rates, but the strong demand for care, rising skill level requirements and broader labour market pressures, especially in the health care sector, will continue the strong growth in wages for nurses and personal care attendants.

In the circumstances, reverting to WCI 9, and its compounding effect, will have dire consequences for the future of age care services. A long term and transparent basis for setting fair prices is urgently needed to replace WCI 9 indexation and the ad hoc arrangements that have applied in recent years.

The pressures on the costs of care facing the aged care sector seem to have been recognized by the Government in the Terms of Reference set for the Productivity Commission’s public inquiry into aged care. The Terms of Reference require the Commission to develop sustainable

17 Report on the Operation of the Aged Care Act 2007-08 and 2008-09 (Department of Health and Ageing)
18 Department of Health and Ageing evidence to Senate Standing Committee on Finance and Public administration inquiry into Residential and Community Aged Care in Australia April 2009
regulatory and funding options which reflect the cost of care and provide sufficient revenue to meet quality standards, provide an appropriately skilled and adequately remunerated workforce and earn a return that will attract the investment needed to meet future demand.

It is critical that the Productivity Commission inquiry and the Government’s election commitment to make aged care reform a second term priority will result in the development and implementation of long term funding arrangements to sustain viable and high quality residential aged care services.

It is also critical that measures are taken in the short term (the 2011-12 Budget) to address the immediate funding pressures on the sector pending the implementation of long term reform. In its submission to the Productivity Commission inquiry, CHA has advocated for:

- a more open market for the supply of aged care services and greater consumer choice;
- prices to be determined by an independent authority based on periodic reviews of the cost of care provided in a more open market, complemented by indexation which tracks movements in the cost of care between the periodic reviews. The Independent Hospital Pricing Authority is a precedent for such an approach; and
- restoration of the 1.75% annual Conditional Adjustment Payment increase pending the formulation of longer term and transparent price setting arrangements.

7. Recommendations

That the Commonwealth Government:

a) legislate for an independent authority to undertake periodic reviews of the cost of care and to determine prices and indexation which will provide sufficient revenue to meet quality standards, provide an appropriately skilled and adequately remunerated workforce and earn a return that will attract the investment needed to meet future demand; and

b) restore the annual increase of 1.75% under the Conditional Adjustment Payment (on top of COPO) pending the implementation of the structures and processes to independently determine prices for the provision of aged care.

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19 Initial Submission to the Productivity Commission Inquiry Caring for Older Australians (Catholic Health Australia April 2010)
20 Supplementary Submission to the Productivity Commission Inquiry Caring for Older Australians (Catholic Health Australia July 2010)