australian nursing federation

Senate Finance and Public Administration Committee

Inquiry into residential and community aged care in Australia

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Introduction

The Australian Nursing Federation (ANF) was established in 1924. The ANF is the national union for nurses, midwives and assistants in nursing, with Branches in each State and Territory of Australia.

The ANF is also the largest professional organisation in Australia, with a membership of over 170,000 nurses, employed in a wide range of enterprises in urban, rural and remote locations in both the public and private sectors. The ANF's core business is the industrial and professional representation of our membership.

The ANF participates in the development of policy in nursing, nursing regulation, health, community services, veteran's affairs, education and training, occupational health and safety, industrial relations, immigration and law reform.

Nursing and midwifery are regulated professions. By law, before nurses may practice, they must be registered, enrolled, endorsed or authorised by their state or territory nursing and midwifery regulatory authority (NMRA). The titles of 'registered nurse', 'enrolled nurse', 'midwife' and 'nurse practitioner' are protected by legislation, and these titles may only be used when permitted by the state or territory NMRA.

Another group of health care worker, assistants in nursing (AINs) or unlicensed carers, also delivers aspects of nursing care and are an integral part of the nursing workforce. Assistants in nursing do not yet have a consistent minimum standard of educational preparation and are not regulated or licensed by the NMRA.

Aged Care and Nursing

The ANF is concerned with issues relating to the aged care workforce, including the number of care staff available, the qualifications of the care staff and the employment standards for nurses and unlicensed carers. Many factors have increased the intensity of nursing care in aged care at a time when registered and enrolled nursing numbers have diminished. Much of the nursing care is being provided by unlicensed carers, who may not have the qualifications or skills commensurate with the care needs of the resident profile.

Residential aged care is meeting the care needs of an increasingly more dependent group of people. By far, the majority of residents at 30 June 2007 were assessed as high-care (70%). By way of contrast, 58% of residents were classified as high-care in 1998. In addition, 62% of permanent residents who were admitted during 2006–07 were high-care.[1]

The age profile of the resident population continues to increase. Over half (54%) of the 156,549 residents at 30 June 2007 were aged 85 years or older, and over one-quarter (27%) were aged 90 years and over. Overall, only 4% of residents were less than 65 years of age.[1]

At the same time as there are growing numbers of residents and their dependency is also increasing the numbers of registered and enrolled nurses employed in aged care has fallen from 38,633 in 1995 to 34,031 in 2005 a decline of 4,602.[2] Over the same time the number of residential aged care places has increased from 134,810 in 1995 to 161,765 an increase of 26,955.[1]

The decline in the number of registered nurses was highlighted in the AIHW Nursing Labour Force 2001 based on 1999 figures.[3] It reported that the substantial skill loss resulting from the loss of registered nurses from this sector and the increase in dependency levels places further pressure on the residential aged care sector.

During this same period, the supply of Community Aged Care Packages, aimed at providing the equivalent of low care residential support to people living in their homes, has expanded significantly and now represents around 16%[4] of all aged care services. This pattern is in keeping with established bi-partisan government policy, which aims to provide a greater proportion of aged services to people in their homes.

The combination of high care resident needs and an under skilled, undermanned workforce are, in the ANF's opinion, the cause of most of the quality of care problems arising in aged care facilities. The obligation placed on the provider in the Accreditation Standards (Schedule 2 of the Quality of Care Principles 1997) requires that[5]:

There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives.

Yet the Aged Care Standards and Accreditation Agency reported in August this year[6]:

…it was found that a significant proportion (of non – compliant homes) did not maintain appropriate numbers and types of staff, with many of them not being able to ensure that staff skills and qualifications were the right fit for the work required and to reflect their residents' needs.

A strong causal link was found between homes that were non-compliant with Human resource management (1.6) and deficiencies in other service systems, in particular Clinical care (2.4), Specialised nursing care needs (2.5), Medication management (2.7), Behaviourial management (3.7) and Information systems (1.8).

…in homes where workloads are unrealistic, or where staff are unqualified, poorly trained or poorly deployed, then process malfunctions will occur across a wide range of expected outcomes. Employment of staff without appropriate skills may exacerbate any staff shortages as this may lead to inefficiencies in time and effort and place greater work related stresses on staff.

Increasing numbers of residents with higher and more complex care needs have added to the workloads of nursing care staff in residential care settings. Indeed, the staff ratio has exhibited little change despite the proportion of residents classified as requiring 'high care' increasing. As a result, a 2003 survey reported that over two-thirds of direct care employees in residential facilities felt they were not able to spend enough time with each resident and were too rushed to do a good job.[7]

The provision of quality care requires adequate staffing levels with an appropriate skill mix. Over a quarter of aged care nurses responding to a Queensland survey stated that they did not believe that there were enough qualified staff to meet client needs.[8] Another more recent study of aged care nurses in NSW found that:

… just under three quarters of respondents did not support a model of care whereby registered nurses fulfil the role of care facilitator/planner only with all direct care tasks, including medication administration, delegated to unlicensed workers.[9]

In the aged care sectors the work of registered and enrolled nurses is progressively being substituted by unlicensed carers, which now represent the bulk of the workforce providing aged care services.

A recent Australian study found skill mix was a significant predictor of patient outcomes. Reinforcing the findings of other international studies, a skill mix with a higher proportion of registered nurses produced statistically significant decreased rates of negative patient outcomes such as decubitus ulcers; gastrointestinal bleeding; sepsis; shock; physiologic/metabolic derangement; pulmonary failure; and failure to rescue.

The study found one extra registered nurse per day would reduce the incidence of decubitus ulcers by 20 per 1000 patients, of pneumonia by 16 per 1000 patients, and of sepsis by 8 per 1000 patients. Patients are also less likely to fall and suffer injury as registered nursing hours increase.[10]

The reduction in the number of nurses and the subsequent changes to skills mix is leading to a lower level of safety and quality of care and putting these vulnerable residents at risk.[6]

The aged care accreditation data on failed standards reveals this has led to a decline in quality of care with residents exposed to serious risk from neglect, poor infection control, malnutrition and dehydration, and assault.[11]

The community's increasing alarm with this situation can be seen not only in the regular media reports but also from the following figures: in just six months last year, the federal government's Office of Aged Care Quality and Compliance received nearly 4,000 complaints (more than triple the number of complaints lodged in the previous twelve month period) about the treatment of people that potentially breached the *Aged Care Act 1997*. This included 418 reportable assaults.[11]

Aged Care Services

Arrangements for the provision of aged care services are complex and varied with all tiers of government involved either as regulators, providers of care services or as both.

As the table below shows in 2007 the main providers of residential aged care services were religious organisations (29%), private for profit providers (27%), community based providers (17.5%) and charitable organisations (15%). In addition the federal government, state and territory governments and local governments also provided over 11% of the total number of aged care services.

Table 2.4 Ownership of residential aged care facilities [12]
As at 30 June 2007

	Number of facilities	Percent
Private not-for-profit	1762	61.4
Religious	827	28.8
Community-based	504	17.5
Charitable	431	15.0
Private for-profit	773	26.9
Government	337	11.7
State/Territory	262	9.1
Local	75	2.6
Total	**2872**	**100.0**

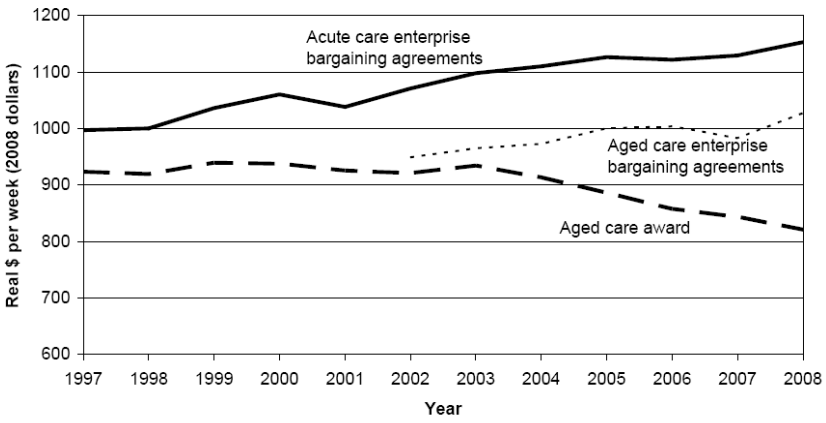
Wages and Bargaining

A significant wages gap has developed between aged care nurses and nurses working in other sectors. Providers have consistently argued the funding mechanisms in aged care have hampered their ability to provide wages that are commensurate with the acute sector. Since the demise of the CAM SAM funding, however, care costs have been absorbed into overall expenditure and accountability for government funds has been, in our view, completely inadequate.

The introduction of WorkChoices radically altered the role of awards and introduced new legislative objects that altered the function of awards and the role of the Australian Industrial Relations Commission (AIRC) in relation to them. It significantly limited the extent to which awards could act as a comprehensive safety net of minimum working conditions by removing any reference to fairness and requiring that awards provide only 'a safety net of minimum entitlements'.

For nurses, particularly those employed in the aged care sectors who have been unable to reach an agreement with their employer the impact of the decline in the awards has been significant. As the table below demonstrates the Productivity Commission has concluded that real weekly award wage rates (as adjusted by the GDP deflator) for a nurse (level 1 Year 8) employed in the aged care sector, are less in 2008 than they were in 1997.

Figure 6.2 Comparison of registered nurse remuneration[13a]



[a] Median national Registered Nurse (Level 1, year 8) wage in January of each year, adjusted using the GDP deflator. *Data sources:* ABS (*Australian National Accounts: National Income, Expenditure and Product, March 2008*, Cat. no. 5206.0); ANF (Melbourne, pers. comm. 21 May 2007 and 16 June 2008).

The structural labour cost advantages that aged care employers enjoy is something they wish to now embed through the Award Modernisation process in a new modern aged care industry award. They can confidently hold this view because there is nothing in the policies of the federal government that suggests that in future they will have to bargain with their employees.

A new modern aged care industry award will provide comfort to aged care employers that they can continue to decline to engage with their employees in bargaining.

The ANF is submitting to the AIRC that an occupational award should be the industrial instrument that covers nursing staff in aged care. Bargaining mechanisms must be strengthened and stringent

accountability requirements be placed on the providers to show that funding is expended on care in such a manner that provides for commensurate wages and conditions.

The NSW Industrial Relations Commission in 2005 awarded a significant pay increase to nursing staff in aged care of 23%[14] which brought the wages very close to parity with the public sector. This was despite the employers arguing incapacity to pay. The 'evidence' surrounding the incapacity to pay was disregarded by the commission who stated:

…we consider that nothing the employers have put regarding their capacity to pay would prevent an increase in wages for nurses in the aged care industry that achieves fair and reasonable pay rates that properly reflect the work value of nurses.

To our knowledge the pay increases did not result in a comprehensive collapse of the sector in NSW causing nursing homes to close as was the dire prediction of the providers.

While the content of federal safety net awards covering nursing staff in both the acute and aged care sectors remains broadly comparable, enterprise bargaining outcomes have led to significant differences in remuneration levels. The difference is primarily due to the inability to secure comparable enterprise agreements outcomes to those in the acute sectors.

Employers have argued that enterprise bargaining is unsuited to the sector due to the lack of funding and the strict controls on the employers ability to raise revenue. The aged care industry is primarily funded by the commonwealth and such funding does not recognise agreement outcomes. The constraints of the funding arrangements and the employer's slavish reliance on such arrangements to decline to participate in meaningful bargaining with their employees have been subject to comment by the Australian Industrial Relations Commission.

It should also be noted that since 2002 there has been a range of funding initiatives by the commonwealth government directed at enhancing the capacity of aged care employers to offer competitive wages. These initiatives include $211 million over four years in the 2002-03 budget and a further $877.8 million in 2004. Unfortunately these additional amounts were not tied to wages and much of the money was used for other purposes. The parlous state of bargaining in the sector has led to an inability of employers to fully compete in the labour market and they have struggled to recruit and retain nurses and other health professionals. Establishing a new modern industry aged care award would be the antithesis to the promotion of enterprise bargaining. It would entrench a different and inferior set of employment conditions for aged care employees exacerbating the ability to recruit and retain staff and ultimately the viability of the sector.

It is recommended that a nursing occupational award covers all health sectors including aged care. Bargaining mechanisms need to be strengthened and stringent accountability requirements be placed on the providers to show that funding is expended on care in such a manner that provides for commensurate wages and conditions.

It is the view of the ANF that quality service provision is not being met due to understaffing and an inappropriate skills mix. It is difficult to ascertain the level to which the current funding levels are impacting on the providers' ability to pay competitive wages but from the desire to instigate an industry award it can be surmised there is no will or intent to improve the current situation. It is also

difficult to ascertain the capacity to pay, as the wage differential between acute and aged care varies considerably from state to state, from between 9% and 25%[15]. One has to ask if one provider can pay wages high enough to come within 10% differential then why can't the others? Where is the evidence of incapacity to pay? where is the accountability?

It is recommended that:

- care costs including wages be quarantined as separate funding and individually accounted for; and
- staffing standards be developed and placed in the accreditation standards providing a framework for both minimum numbers and skill mix based on hours of nursing care and that this could be achieved through the basic ACFI calculations.

How appropriate is the current indexation formula in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services.

The introduction of the conditional adjustment payment (CAP) was recommended by Warren P Hogan to overcome in the short term what he viewed as the inadequacies of the current indexed payment system. It is fair to say that it would be difficult for the sector to now do without the funding provided by the CAP and the ANF would not support withdrawing that money from the sector. The ANF supported a letter to the Minister for Ageing by the National Aged Care Alliance regarding the CAP review. That letter asserted that the COPO index is inadequate as a funding measure and does not reflect the true movement of costs in the sector. The Hogan report concurs with this view.[16]

It is recommended that a review of the indexation mechanisms that determine the overall funding for aged care, both in residential and community settings be undertaken.

The ANF recognises the complexity of issues facing the industry including capital costs, rural and regional cost factors, and the effects of economies of scale. However we also warn against the call for deregulation. Whilst we would support a review of the bed allocation process, deregulating the sector in favour of 'true competition' is not the answer. It will further divide the sector on a 'have and have nots' basis that will create a two tiered system of aged care provision. Aged care is an important part of the health care sector. As the population lives longer health care needs of the elderly reflect the chronicity of disease and the available evidence suggests that more acute care episodes develop as chronic conditions exacerbate. It is a prime attribute of Australian society that we value equity of access to health and aged care and the sector cannot be allowed to become an even 'poorer cousin'.

A robust and efficient private sector can still be part and parcel of an equitable and just aged care system providing choice, but not at the disadvantage of those who choose or are unable to choose that option. Deregulation is not a viable option to improve efficiencies in the sector.

Any further financial assistance however, be it through the continuation of the CAP or through improving the indexation mechanisms beyond the COPO, must be tied to improving wages for aged

care workers. There needs to be a transparent and accountable mechanism that ensures providers will pay competitive wages with any extra money offered by the government. The ANF has offered and continues to offer resources to work with industry and government to establish what that mechanism might look like and how it could be implemented over time.

New standards in building regulations have created a situation which may well be viewed as better for residents in terms of privacy and creating a home environment. But the requirements, such as provision of single rooms actually make all aspects of nursing care more resource intensive; particularly for high care residents who require more intense observation and more complex and frequent nursing interventions.

The Aged Care Accreditation Agency recently reported that homes that could not provide adequate supervision of their residents were not managing their risks and were unable to provide a good level of care.[6]

At a time when residential aged care facilities are being described by industry representatives as 'mini hospitals', facilities are larger and residents less directly observable, employers are reducing staff numbers and diluting the skill mix. As well as a requirement for minimum staffing levels and skill mix of nursing staff, it would be beneficial to review accommodation requirements allowing for more hospital style accommodation for high care, bed rest residents, allowing for safer observation and more economical use of resources.

The traditional 30-40 bed nursing home may well become unviable and consolidation by larger providers is gathering pace. Although the concept that aged care is a good real estate investment rather than a health care service seems to drive much of the for-profit large scale investors.

With aging in place, however, there are very few exclusively low care facilities and costs of care may well have risen. There is also no doubt that regional variations exist in the cost of service delivery and that for some providers capital expenditure requirements may have increased the price of delivering services.

It is recommended that:

- there is a transparent and accountable mechanism that ensures providers will pay competitive wages with any extra money provided by the government;
- capital costs and regional variances be incorporated into any review of funding indexation; and
- a review of accommodation requirements for high care residents incorporate the consideration of safe observation by nursing staff.

The success or otherwise of the new funding instrument (ACFI) is still in contention as it is too early to assess the long term outcomes as only the first 33,000 appraisals have been assessed.

The recently released Grant Thornton Report[17] argues that margins in high care are as low as 1.1% and up to 40% of providers are unviable and the recent collective decision by some providers to not tender for beds has brought the viability of the sector into the spotlight. The government contends

that the sector is viable. It is difficult to ascertain the truth without a true benchmark of care costs, which is analysed against income.

It is recommended that a benchmark of care costs that can be analysed against income and allow for transparent acquittal of public funds be developed.

With the need to have access to bonds to supplement operations most high care providers would prefer to take low care residents and are calling for the abolishment of the high/low distinction to allow them to take bonds from all residents. The ANF does not support bonds in high care as there is ultimately no choice for residents entering high care. But with the current profile of the sector with 70% of residents entering at high care level, the industry needs to find an alternative to bonds which have traditionally funded capital costs.

It is the belief of the ANF that most aged care services, either for profit or not for profit are viable if they have established infrastructure. In fact large not for profit networks aim to provide 7%-11% return to their investors. It is reasonable to argue though that those who don't may well require further financial assistance. The current lack of accountability of funding has left the industry open to dubious profit making activities and recent occurrences of improper use of bonds and government funding has drawn criticism and calls for better scrutiny and regulation of these funds.

It is almost impossible to ascertain the true financial status of aged care facilities from the ANF's perspective. Many aged care providers constantly report being in dire financial difficulty, unable to pay decent wages and provide decent working conditions, but as workers' representatives we have no detail or evidence to show it is the case.

Certainly we have seen some facilities close due to financial situations, but it is difficult to ascertain exactly how the finances of these facilities have been managed. Indeed in recent incidences of this nature it appears that there may have been some questionable activities at a management level leading to the stripping of assets that eventually forced closure. As a result our members have lost entitlements to the value of hundreds of thousands of dollars in superannuation savings, long service leave entitlements and wages. Residents and their families are placed in terrible situations creating anxiety and uncertainty about their futures and in some cases the security of their bonds. Moreover the impacts on highly skilled and qualified nursing staff when this situation arises often results in experienced nurses leaving the sector for more secure and financial rewarding jobs in the public or acute private health sectors or leaving the profession entirely. Unqualified workers then need to seek alternative employment with another provider, if indeed that is possible, as in rural or remote areas there may be no alternative employment option available.

It is recommended that providers be scrutinised as fit and proper persons and there be a requirement that the company that provides services is also the company who employs staff and manages the facility.

Conclusion

The ANF is concerned that the aged care sector is being hived off and out of the health care industry and is becoming an industry focused on investment returns from infrastructure and real estate rather than the provision of safe and secure care for our most vulnerable Australians. The sector is predominantly there to provide health care. With 70% of residents entering facilities at high care levels it is obvious that health care provision is the paramount need. If a person were able, he or she would remain in their home, it is only when they require care or care required is beyond the scope of community care do they enter a facility. Aged care is about quality care through high levels of best practice health provision, high standards of operational accountability, and an open and transparent process for allocation of beds and funds.

The financial viability of the sector is one that is shrouded in dubious accounting methods, and inadequate accountability mechanisms. But there is, we believe, some scope to investigate the real costs of care against government funding. Once this is done, a true picture can be revealed about the sector's financial situation and standards can be set accordingly – minimum staffing levels, appropriate skills mix and quality care.

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