CONSISTENCY AND ADJUSTMENT OF FUNDING FOR NURSING AND PERSONAL CARE IN RESIDENTIAL AGED CARE FACILITIES

a submission to the Productivity Commission
prepared by the Australian Nursing Federation (SA Branch)

CONTENTS

1 Introduction

Current arrangements for funding, of residential aged care differentiate not only on the basis of relative need (as measured by the Resident Classification Scale) but also on the basis of location by state.

The new funding arrangements presently in place continue to treat all states and territories differently although there is an express intention to equalise (or coalesce) the rates over the next 7 years (by 2004/05). The basic residential care subsidy for permanent residents varies in each case for residents in high care classifications.

The current rates as set out in the Commission's discussion paper are:

Category	NSW	Vic	Q1d	SA	WA	Tas	ACT	NT
1	104	109	90	97	100	110	100	106
2	94	98	81	88	91	100	91	97
3	81	84	70	76	78	86	78	82
4	57	60	-41)	54	55	62	56	58

It can be seen that subsidies for Category 1 residents have a span of some $20.00, for Category 2 residents the span is $19.00, Category 3 is $ 16.00 and for Category 4 the span is $13.00. The differential between Category 1 and 4 residents varies between the states.

There is no specific link between the rates of subsidy and the relative cost of providing the level of service need by clients within the various categories. The lack of logic inherent in the previous CAM funding arrangements has been carried over in to the new system. The absence of an agreed or accepted resident care assessment related to staffing for care purposes means that the costs under assessment do not necessarily reflect the care needs of the residents.

However, unlike CAM the new subsidy levels are not specifically linked to movements in salary levels within the industry or more broadly. This is creating immense difficulties for employers in the industry who claim they are unable to meet reasonable wage expectations of employees due to the reduced levels of funding provided and competing demands for resources ie resident care, capital requirements and staff wages and conditions.

Nursing Home costs

The Commission has invited comment regarding

- "the extent of the differences in costs across and within States and territories and the reasons for these differences; and
- the impact on services provision costs in any particular location of factors such as the size of a facility, its ownership and integration with other facilities"

page 10 discussion paper

Whilst the extent of our direct knowledge is limited in relation to these matters we offer the following comments:

- the costs of labour for nurses and other workers in SA is essentially constant as there have been only a handful of extensive agreements affecting workers in aged care, all of them in integrated facilities;

- the variation between rates of pay for nurses in aged care across Australian bears no relationship to the ranking of those states in the order of funding. Tasmania and NSW (first and fourth highest funded) and SA (second lowest funded) have the highest base rates applying to nurses.

- Size does matter. Smaller homes have minimum staffing requirements to ensure resident and staff safety of 2 NPC staff at all times. This base level of cost is not adequately funded in all cases.

- Ownership affects taxation costs to the provider. FBT exemption has been used by some parts of the industry as a competitive advantage over those non-exempt providers.

- Integration (typically in SA with Public Hospitals although a few private hospital links do exist) serves to reduce infrastructure costs needed for a provider eg shared DON, CEO, payroll etc.

2 Historical. review

When the previous funding arrangements for the industry were introduced in 1986/87, the level of CAM payments was devised by the Department having considered factors including:

- the then current award applicable to each state;
- the wage rates of nursing and other direct care staff;
- the conditions of employment patterns, ie Full time, Part time and casual mix of staff;
- the skills mix as reflected in the industry survey of 1986 ie the proportion of Registered and Enrolled nurses, Assistants in nursing and other care workers;
- applicable nursing work force career structure.

These factors varied between the states and territories at the time of data collection in 1986.

Many of the circumstances considered at the time have changed substantially over that period yet have not led to reconsideration of the relative funding provided to each state/territory.

For example, between 1986 and 1995 nurses wage relativities were affected by:

- the application of equal pay;
- the implementation of new career structures in all states/territories;
- the implementation of professional rates of pay for Registered nurses by 199 1;
- the development and implementation of national career structure and associated rates of pay for Enrolled nurses in 1994/95.

Relative wage disparities which underpinned the development of CAM were eradicated without a corresponding shift in the relative funding allocation.

Other factors which also brought change to the relative costs between states include:

- the development and implementation of nationally consistent salary related conditions of employment for nurses in 1991;
- changes in the composition of the workforce from the time of the data collection eg the drop in the proportion of the workforce employed as casuals in South Australia;
- the introduction of traineeships in some states (Vic and NSW).

These changes show that by 1994/95 the nursing workforce had established national consistency in pay levels (at benchmark levels of the respective career structures) and salary related conditions (such as overtime and shift penalties). This led to a significant change in the relative cost structures under CAM across the states which went largely unrecognised in terms of the Standard Hourly Rate calculation set as a consequence of the 1986/7 data.

It should be noted that staff costs are common within each of the states as a consequence of the application of Awards and the almost total absence of enterprise agreements.

3 Basis for funding

The Australian Nursing Federation continues to believe that funding subsidies should be based on meeting the assessed nursing and other care needs of residents.

This is not the current position since a limited (and inadequate) amount of money is provided as a budget measure and the Resident Classification Scale is then used to categorise the relative needs of residents in competing for the available dollars. This system is open to manipulation by:

- alteration of the RCS or the definitions for scoring particular responses; alterations of the range of points for each category so as to 're-categorise' residents;
- varying the amount of money to be distributed by the funding system;
- interstate disparity regarding departmental validation of the RCS.

The ANF believes that the objective classification of residents needs should drive the provision of resources which would vary according to any fluctuation in need.

One of the most significant issues facing the industry is the absence of accepted care based standards which can be used to drive both resource allocation and staffing of facilities. As a consequence we have been consigned to use a system based on relative rather than actual care needs which often bears no resemblance to the actual care delivered to the resident.

This system does not assure residents of aged care facilities that they will receive either the volume of care or the skill level of intervention required in their case. The increases frailty of residents particularly those with high care needs must be recognised and resourced by an increase in both the volume and skills mix of the staff providing care. The situation in the aged care sector contrasts with the acute health care sector where casemix based staffing standards are used to determine both staffing and budgetary allocations.

4 Change in resident needs

The increasing dependency, frailty and complexity of the elderly who enter residential aged care is reflected in the Annual Report of the Department of Health and Family Services 1996/97.

According to the Department of Health and Family Services 'the average dependency level of new residents in nursing homes and hostels has been rising steadily'. By June 1997 the proportion of residents entering nursing homes in Categories 1 to 3 had grown to just under 90% from a level of around 75% in 1993.

Hostels have experienced similar trends with high and intermediate care needs growing from under 20% of new residents in 1992 to over 35% in 1996. The Department has produced figures showing a nearly 7% growth in dependency for hostels in 1996 alone nearly 1.5% greater increase than was expected for the period.

Length of stay continues to drop. More than 50% of people admitted to a nursing home (now known as a high care facility) stay for less than 12 months. Nearly one third of hostel residents stay for that same period.

A combination of a need for greater levels of care along with increased throughput has placed increasing strain on the capacity of nurses to meet the needs of residents.

There has been a 14% growth in funding for residential aged care between 1991 to 1997. However, nursing homes received only 5.5% increases over that whole period with most of the increases directed to new hostel services.

There is no evidence in SA of improved skills mix or staffing levels in nursing or personal care staff to meet this increased dependency. Indeed if anything we believe that staffing levels have deteriorated as have skills mix in some facilities.

Given the increased costs over the 6 year period experienced by the sector, higher resident care needs and increased throughput it is clear that funding levels across the nation have experienced a real reduction in value.

Continuing with the current system of providing a single subsidy payment does not provide appropriate targeting of funds to achieve quality, type and level of care outcomes needed or provided to residents. The move to 3 yearly accreditation lengthens the period of any possible accountability rather than the new system increasing the potential for accountability for the use of funds.

5 Equity in Commonwealth funding distribution

The per capita (of persons aged over 70 years) expenditure by the Commonwealth for residential services varies, significantly from a low of $1,359 in the ACT to $2,296 in the NT. If we exclude the territories from consideration the rates for the states range from $1,569 in Queensland to $1,923 in NSW. This constitutes a 22% variation in the amount paid per capita between the states for residential services.

These disparities continue in HACC funding with a variation (between the states) of a low of 746 hours (per month per 1,000 people aged 70 or more) in South Australia to a high of 1,202 hours in Victoria. This constitutes a 61% variation in funded hours of HACC services between the states.

Source *Report on Government Services Vol. 2, Steering Committee for the Review of Commonwealth/State Service Provision. 1998*

6 The need for greater consistency

The Commonwealth announced moves toward the coalescence of funding over the next 7 years as part of the reform strategy for the industry.

However, there is no commitment to develop a new national subsidy at the levels paid to the state/territory presently receiving the highest rate. Indeed the concern is that the national rate will decrease the high. state subsidies while the bottom states 'catch up' meaning that the lowest common denominator will apply to residential aged care funding for the future.

The Australian Nursing Federation (SA Branch) believes that any new coalesced rate must be capable of supplying levels of care and support to residents in keeping with their assessed needs.

7 Adjustment to subsidy levels under CAM

Under the previous funding arrangements, CAM (which funded nursing and personal care hours) was subject to indexation by award movements.

This meant that employers were able to seek adjustment to CAM in the event that increases were granted to Award rates of pay and were therefore insulated from the increased costs. The funding (the Commonwealth) had some protection under this process since all funds provided under CAM were required to be spent on the provision of care and unexpected funds returned to the Commonwealth under the acquittal process.

With the move to a decentralised enterprise bargaining wage system (foreshadowed in the Gregory Review 1993/94), the nature of indexation for care funding would have had to be reviewed.

8 The new arrangements

The current subsidies per resident day replace funding previously made under CAM, SAM (for other staff, costs and profit) and OCRE (which met the costs of such staff related matters as payroll tax, workers compensation etc). It is no longer possible to identify the money provided by the Commonwealth specifically for care of residents, nor is it possible for the Commonwealth to ensure that the money is spent in the manner intended.

With different workers compensations systems and costs, payroll tax differentials, FBT and other variances which could have been taken account of under OCRE, the ANF (SA Branch) believes that the abolition of discrete funding for these areas has the potential to create divergences in funding requirements across the states.

We also note that the nature of these payments are subject to variation by State Governments. This is yet another reason for continuing with reimbursement of costs rather than total grants which would then have to be changed to reflect any shift in charges and costs.

This arises as a result of the abolition of the requirement for acquittal which provided the Commonwealth with a device to ensure that employers were accountable for the way in which money intended to purchase care was spent

The Australian Nursing Federation (SA Branch) argues that the Commonwealth should restore a requirement for nursing and personal care funding to be separately identifiable ***and*** tied to the actual levels of care provided by the aged care facility. This could be done simply and, of itself, would not attract additional costs to the Commonwealth.

Alternative funding arrangements

The discussion paper advances alternative arrangements at page 15. One of these proposals is a subsidy scheme based on reimbursing a given percentage of costs.

Such a scheme in our view leaves open the potential for providers to opt for lower costs and lower quality options with others spending more to achieve higher quality outcomes for residents. Unless such an approach was narrowly constrained (for example as was the case under CAM which set tolerance levels) the potential for intra-state inequities is increased significantly.

ANF (SA Branch) opposes in principle any proposal to move towards funding a basic level of care with optional pay as you access additional services. Such a system would lead to the creation of a welfare based service for the poor and a Rolls Royce version for the well-to-do.

Workcover (Workers compensation) costs are significant for Aged care providers. Nurses working in this sector have one of the highest injury rates and, as a consequence highest claims rates, for all industries. Nurses suffer personal and professional damage as a consequence of their injury.

As a consequence of the high injury rates Workcover has been working towards the achievement of improved performance by the industry requiring the acquisition of equipment to assist or eliminate manual handling for example. This important area of activity requires discrete funding if it is not to be placed in competition with capital works developments or care provision to residents. The previous OCRE structure provided for such a vehicle.

The obvious benefits of reducing the appalling rate of injury to staff include the retention of skilled staff at a time when it is increasingly difficult to recruit into the sector. It is recommended that any funding model should designate a proportion of funds to be used for equipment and training associated with improving OHS performance.

9 Nursing labourforce, and salary levels

As a consequence of historical funding differences the nursing workforce varies substantially across the country both in terms of the number of staff/resident and skill levels employed. Whilst acute care health services have increased the proportion of Registered and Enrolled nurses in the workforce as a consequence of changes in the nature of care and client needs the same cannot be said for the aged care sector.

Most employers argue that this is a decision based on the levels of funding provided rather than any developed staffing mix position. Given reductions in budgets reported by many aged care facilities we can anticipate continuing pressure to reduce rather than improve skills mix.

We recognise that this issue is one of the matters under consideration by the ***Aged Care Nursing Labourforce Committee*** at present and we look forward to the outcomes of their deliberations.

Since the 1991 national wage adjustment (the last time that nurses across the country enjoyed comparable rates of pay) nurses in the aged care sector in most states/territories have been dependent on safety net increases alone. If the Commonwealth's submissions in the Living Wage Case are accepted by the AIRC they will not have access to even the safety net for the year ahead.

As a consequence nurses working in the aged care sector in..

- Victoria
- Queensland
- Northern Territory
- Western Australia
- ACT

are now receiving salary levels which are broadly 10% or more less than nurses working in public and private hospitals. This wage disparity (currently 10%) will increase to levels of 15 to 20% over the next 3 years.

Nurses in NSW, South Australia and Tasmania obtained increases for the aged care sector in 1996 through Aware variations under the old funding system but employers are faced with similar problems in terms of funding future increases in rates of pay.

As a consequence we are faced with aged care facilities attempting to recruit and retain skilled and experienced nurses in competition with other sectors of nurse employment who are offering substantially higher rates of pay.

The overall nursing workforce is now in short supply across most ~s and territories with a slight worsening of this situation likely over the next year or two.

There is a very real potential for a serious decline in the capacity of the Residential Aged Care industry to meet the increasing needs of clients with complex nursing needs when

they are confronted with a reduced capacity to recruit and retain appropriately qualified and skilled staff.

Wages and wage related costs

The ANF (SA Branch) rejects any proposal that allows for the substitution of equipment for equipment or other capital inputs. There is no scope for the further lowering of costs associated with NPC labour. Skill mix is poor and staffing levels minimal and therefore extremely rigid as a consequence of the current arrangements.

The Registered nurse proportion of skills mix is appalling in SA and the small numbers of RN's are, as a consequence. constantly engaged in the dispensing of drugs and documentation. There is little opportunity in many cases to deliver direct care to residents and this is left to other NPC staff who may not receive the appropriate levels of supervision.

Salary levels for nurses in the aged care sector vary by approximately 10% nationally. The variance between aged care nurses and their acute care counterparts is in some cases up to approximately 15% and could grow further by 2000 if no action is taken to address this problem in the funding base. The is a growing problem with attraction and retention of Registered nurses in the aged care sector in SA and this is likely to become worse if the differential opens up in the next 2 years. The shortage of Registered nurses in SA is likely to magnify the effects of any salary differential.

It should be noted that the use of overaward payments is almost non-existent in this sector as a consequence of the paid rates history of Award regulation. Similarly there has been a failure to reach enterprise agreements. Any variations in actual costs within states are therefore likely to be as a consequence of staffing decisions or requirements.

It is of great concern to the ANF (SA Branch) that the current wage disparity will either grow or lead to nurses taking industrial action to obtain fairer market rates. If these rates are achieved then employers may he forced to cut levels of care in the event that funds are not made available from the Commonwealth. This situation is clearly untenable.

10 Special circumstances of the sector which relate to nurses wages and funding

Employers and unions alike recognise the particular circumstances of nurse employment in the aged care sector. In their 1996 submission to the Department regarding CAM indexation these were identified as:

"That control (by government) includes

- *the size and geographic spread of the* industry;
- *the size and location of individual facilities;*
- *the type and number of residents;*
- *the* nature *of the services to be provided;*
- *the financial inputs to the industry through government funding and resident contribution;*
- *the standards of care to be provided"*

Whilst the detail concerning the mechanism for controls way have altered as a consequence of the reform package the controls are largely still in place.

The combination of these circumstances make 'productivity' bargaining an alien proposition since any improvements in effectiveness are likely to lead to either:

- a greater need to cope with increased workloads created by the increased needs of residents; and/or
- improved quality of care to residents (in keeping with the continuous quality improvement objective in the accreditation principles),

which do not create cost savings which can fund salary increases for staff.

11 Recommendations

The Australian Nursing Federation recommends the adoption of policies which:

1. Provide funding levels which meet the assessed needs for care of the aged who are receiving residential aged care wherever that care is provided.

2. Adopt a base subsidy rate for nursing and personal care immediately based on parity with nurses wages in the acute (public sector) in each state.

3. Introduce a funding allocation model which ties funds provided to meet the nursing and personal care needs of residents to the actual delivery of care.

4. Ensure that the current departmental validation process is expanded to audit the use of nursing and personal care funds.

5. Allow for the adjustment of nursing and personal care funding to meet increased wages costs experience by employers. This, could be achieved by the adoption of an indexation system based on Average Weekly Ordinary Time Earnings (AWOTE) or in keeping with the rate of growth in wages as a consequence of enterprise agreements for nurses in the public health sector within each state.

   Such funding would only be available to employers after they had concluded Agreements/Award variations which had been approved by the relevant authority. Compliance is ensured through the expanded validation processes

6. That providers of residential aged care services be required to display in the facility and provide to residents and relatives the ratio of qualified nurses to residents employed in that facility.