Sundale

A Lifestyle of Dignity and Security

Submission to the Productivity Commission

"Nursing Home Subsidies"

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The deliberations of the Productivity Commission will cover a wide variety of integrated but separate issues. As a precursor to our submission we would like to highlight the view that the inquiry must deliver:

- ✓ ***Funding Adequacy:***
  Funding must be sufficient to provide quality care outcomes, and take into consideration the ability of providers to control costs and income. This principle applies to both recurrent and capital funding.

- ✓ ***Funding Equity:***
  We must recognise that different services have varying inescapable costs to provide the same level of care for residents. Funding must be flexible enough to be maintained in real terms as cost relativity changes.

- ✓ ***Universal Access:***
  Access must be based on care need, ensuring the delivery of high quality care, (consistent with accreditation requirements) to all residents - whatever their capacity to pay or geographical location.

- ✓ ***Incentives for Quality & Efficiency:***
  Improvement should be encouraged through the funding mechanism, not discouraged as it is currently. Rehabilitation of residents to lower levels of care should be recognised and rewarded for the important contribution it makes, and not be punished through a totally rigid funding regime.

- ✓ ***Administrative Efficiency:***
  The system must minimise transaction costs, streamline processes, make use of electronic media technology, and fund the implementation of the requirements of the Aged Care Act 1997.

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INTRODUCTION

The Terms of Reference of this inquiry have been clearly set out to address the "form" of Nursing Home subsidies, and not the "quantum". It is understood that the Federal Government, or more particularly the Treasurer and Minister, regard the priority as being how to distribute a finite amount of funds with the most beneficial return to the community.

The inquiry focuses on differences in subsidies between states. It is important however that organisations operating within the confines of a specific state should have input into this inquiry. The ability of such organisations to input however will be principally restricted to their own operational experience.

There is a basic fundamental issue -

"Senior Australians have an inalienable right to access quality care services when they most need them on a basis of equity and justice, not on the basis of their geographical location".

It is a travesty of justice that Queenslanders are considered to be worth up to $7,442 per annum less than Australian citizens in other states. Such blatant discrimination would not be tolerated in any other part of our society, but it seems to be regarded as appropriate by our Federal Government, regardless of which political party is in power.

Sundale is a community-based organisation, celebrating 25 years of Nursing Home service to the community on 17th September this year. Our operational profile is

Nursing Home	115 beds
5 Hostels	237 beds (approx. 26 high care)
Day Therapy Centre	
3 Retirement Villages	350 residents approximately.

We are located currently at Nambour in the Sunshine Coast hinterland, and therefore could be considered in the category of rural/remote, although we are only 90 kms from Brisbane.

For many years we have subsidised the operations of our Nursing Home by way of returns on investments in other activities, such as our Retirement Villages and Hostel earnings through term deposit interest. We now have the situation where these returns have diminished through interest rate reductions, and additionally we need to reinvest in our villages through capital works, and likewise upgrade our hostels. During the fiscal period 1997/8 we took the decision that each entity needed to stand alone financially, and as a result made some major structural changes to facilitate this, along with reductions in hours available to our work teams.

As this submission shows, the financial position has deteriorated, although action taken is starting to reverse the trend. Our people are getting fatigued (they continue to provide extra attention to residents in their own time), sick leave has increased to stubbornly higher levels, workers' compensation claims are reducing but only through significant input of time and resources, and it is true that our residents are not getting the personal attention they deserve and not unreasonably, had come to expect.

We are facing assaults from several fronts from Government -

- **A real reduction in funding rates** - our facility has always been predominantly category 1 and 2 residents. The funds for these were reduced significantly under the new Aged care Act 1997. The majority of our high category residents need care due to frailty, not behaviour demands.

- **Building Certification** - the Building Code of Australia is being used as a measure of the quality of our building infrastructure. Issues of such enormous relevance include toilet and bathroom ratios, which reflect absolutely no benefit to the quality neither of care nor indeed with the operational requirements of our facility.

- **Accreditation** - it would appear that Government is unaware of the enormous task that accreditation presents to an organisation - especially one which is a "stand alone" operation, and by necessity develops its own systems.

- **Administration** - the Government has taken several months to bed down the new system and their own computer systems. We have had to not only transit from one system to another, but in the process have had to check every entry, line by line, and educate members of the DH&FS, Centrelink, and DVA on the new system as we went. Administrative workloads have indeed increased as a result of the legislative restructure.

- **Local Government** does not acknowledge the charitable status of organisations unless they are religious in nature. Local government charges and taxes therefore remain high, although there are some limited concessions offered.

- The previous **Queensland Government** thankfully saw fit to remove duplication of coverage of facilities, although there remain some controls under the Poisons Act for medication administration (which is appropriate). It is hoped that the current Queensland Government will not turn the clock back.

We have two simple messages for consideration by the Government -

1. *Discriminatory treatment of Queenslanders will not be tolerated any longer, and action must be taken now to adequately fund Queensland Nursing Homes to provide the quality of care that our residents and Government expect.*

2. *Since the Government no longer wishes to fund capital projects, they should completely remove themselves from any role except for establishment of required standards, and let the market determine success or failure. There should be no artificial barrier to care through a bed allocation system since if there is no need, operations will simply not survive.* ***Put simply - set the ground rules then get out of the way!***

If the Government is not prepared to be a part of the solution - then they must accept that they are a part of the problem!

SUBMISSION SUMMARY

As a stand-alone facility in regional Queensland, our submission focuses on the operational performance of our own 115 bed Nursing Home. Our analysis spans a 4-year period from 1994/95 to 1997/98. We believe to take a more historical perspective would make the data statistically irrelevant. Our submission therefore will focus on specific areas.

EQUITY AND JUSTICE FOR SENIOR AUSTRALIANS

In Australian society we are used to national regimes of taxation, welfare support, and infrastructure provision generated through our system of Federal Government. It is not unreasonable therefore that there are expectations from senior Australians that Government support should align to their care needs and not be dictated by their geographical location.

The basis of the current subsidy arrangements was flawed when initially established, and movements since then have simply exaggerated the inequity.

A society which perpetuates unjust practices on its most senior citizens who are truly in need of care and support, is a society which has no place in Australia. We should take the opportunity presented by this enquiry to redress the injustice, and provide a fair and equitable distribution of funds based on need and real cost levels. We owe it to our residents and Australians generally to ensure that we get the best possible return for every subsidy dollar invested, and there needs to be full accountability.

The Aged Care Act 1997 established the formal promotion and recognition of "Ageing in Place". This acknowledgement of resident freedom of choice cannot be compromised as a result of this inquiry.

FINANCIAL IMPLICATIONS

Our submission outlines the disparity between the substantial increase in resident care needs, and contrasts this with the income levels and cost of inputs. Our submission likewise draws attention to the capital funding requirements brought about through the increasing frailty of our residents.

Recurrent funding should reflect the costs of providing quality care. This is best reflected in the results of the study conducted by the Lincoln Gerontology Centre at the La Trobe University on behalf of Aged Care Australia. Using 100 as the lowest level in the index we have a comparison -

	NSW	VIC	QLD	SA	WA	TAS
Funding for RCS 1 - highest care need	116	121	100	108	111	122
La Trobe study on highest costs	102.8	103.5	104.9	103.5	100	102.9

A summary of the financial data is included here for reference. It has to be highlighted that these adjustments are necessary to correct the situation to June 1998. It makes no provision for the necessary future movements to reflect ongoing needs and costs.

Recurrent

Increase to match existing subsidy levels to the demonstrated increases in care needs as at 300698	$ 4.27 per resident day	$ 179,233.25 per annum

Capital

Provision of capital funds for the purposes of equipment upgrade to cater for the increasing resident frailty based on the last 4 years average	$ 2.56 per resident day	107,456 per annum
To increase the provisions to meet the full needs (the above is only consistent with our current expenditure levels which does not keep pace)	$ 3.47 per resident day	$ 145,653.25 per annum
Depreciation costs on $ 2m refurbishment cost based on refurbishment cycles of 10 years	$ 4.76 per resident day	$199,801 per annum
Interest on $ 2m borrowing for refurbishment @ 9%	$ 4.29 per resident day	$180,000 per annum

Whilst it is acknowledged that accommodation charges and concessional supplements are designed to fund the capital costs, it should be noted that it will take another 2.5 years before we receive such charges and supplements for 100% of residents. Co-incidentally this takes us beyond 1st January 2001 by which time this capital work is to be completed for the purposes of Building Certification.

In summary then our immediate subsidy requirements as at 30th June 1998 are

Recurrent	$ 4.27 per resident day
Capital	$ 12.62 per resident day

It is clear therefore that the recurrent funds are needed urgently, along with adjustment for the ensuing year.

Capital funding is currently being met in part (29% of residents either pay accommodation charges or concessional supplements are received on their behalf).

The additional recurrent funds will then flow directly to the provision of care provision, restoring the quality of care to a more acceptable level.

PEOPLE IMPLICATIONS

The substantial real reductions in care hours available have created a strain on those team members directly providing care to our residents. This has manifested itself in many ways.

- increasingly our people are using their own time to provide emotional support to residents sick leave has increased to stubborn levels
- although workers' compensation claims are plateauing, injuries occurring relate to strains and sprains, and are mainly associated with back injury. The long term social cost is quite enormous
- frustration levels within the teams is rising, as they personally feel they are not providing the level of care that is necessary
- reluctance to take on board the need for other changes such as accreditation requirements

We have restructured, altered staffing mix, reduced hours to align with funds available, and have no further available realignment to make. Our options now are limited to the further reduction of hours, exacerbating the already stretched resource conditions.

We need to find a way to break the nexus, and since we have already improved productivity and efficiency, our way forward is a restoration of subsidies to reflect the care needs of our residents.

WAGE COSTS

The aged care sector is being driven in terms of wage costs by constant arguments of parity with the public sector, and / or acute care, depending which has had the most recent increases. Aged care and acute care are not the same, and should not be linked in any way. State Government obtains funds for additional payments through consolidated revenue and taxation - there is no such opportunity for non-Government aged care providers.

The aged care sector is therefore a "price taker" to a large extent, pressured as a result of concessions granted by others over which we have no control.

On this basis it is imperative that conditions contained within Awards and Certified Agreements reflect the unique nature of non-Government aged care.

REGULATION OF AGED CARE

The industry is unique in that the Federal Government has effectively, through legislation eliminated any opportunity for providers to increase income. The Aged Care Act 1997 has resulted in the industry being treated as a complete welfare recipient.

Cost pressures, particularly in terms of wage escalation, recognises the industry as commercial operators and employers. We therefore are left in a pincer movement with income capped and expenditure under upward pressure. We either reduce expenditure and therefore service provision, or go out of business. The acute sector would consequently be strangled by the demand for beds for aged care, and with their significantly higher cost structure, the overall health budget would not be able to cope with the strain.

The escalating demands of compliance with new and higher standards, coupled with capped income, threatens the viability and sustainability of the industry. Interestingly the causal agents for both are the same - the Federal Government. It is clearly in the hands of Government to therefore correct the situation.

The choices are simple - the Government either adequately funds both recurrent and capital expenditure, or establishes the benchmark requirements and allows the market demands to dictate actions from that point. Decisions on items such as the Building Code of Australia should only be taken with majority support of operators throughout Australia.

Given the major structural changes under way, further changes should be limited to those that add significant value in terms of equity, access, quality and / or viability.

ACCREDITATION

Accreditation should be embraced by industry as a means of demonstrating the high standards achieved. However the Aged Care Standards Agency should be immediately scrapped, and placed within the auspices of JASANZ. Service delivery should be through accredited organisations and accredited assessors, which would be subject to the accountability measures that accompany their accreditation. Costs of the delivery of such certification services would then be structured on a fee for service basis rather than recovery of the total operational costs of an unnecessary national overhead. Such action would provide the guidance that is not currently available, and the resources to make it possible to achieve the accreditation target date.

Residential aged care should use the accreditation system as the main vehicle for industry management, rather than the bureaucratic controls.

Greater consumer access and choice should be promoted by allowing services with 3-year accreditation to offer premium services on a "fee for services" basis.

ADMINISTRATION

Streamlined administrative arrangements focusing on accountability through the accreditation process will deliver substantially better results and cost than an intensive bureaucratic structure.

The current funding process should be reviewed to eliminate the various piecemeal supplements and simplify the process. These supplements have been put into place in a reactionary manner in response to questions raised during the implementation process of the Act. We are now far enough advanced to now eliminate these and consolidate them through the subsidy mechanism.

In conjunction with this it is critical that in this electronic age, we eliminate the need for volumes of hard copy paper required for returns, and replace this with electronic interface. Taking such a move would reduce printing costs, upgrade efficiency, and enhance response times for both providers and the department. It is proposed that there would be very few facilities across the nation who would not have the capacity to access electronic exchange.

METHODOLOGIES

Recurrent funding should align to the nature of regional jurisdiction costs, and the care needs of the residents. This would recognise the vast nature of the continent of Australia. Inefficiency should not be rewarded, and encouragement for improvement given through the funding mechanism. Productivity comparisons would be available through a national benchmarking potential made possible through the proposed funding approach. By such an approach we will clearly demonstrate our capabilities to the market place.

A "basket" of goods and services necessary for the operations of nursing homes should be developed and agreed by industry. This basket would then be costed across various regions. Significant extremes then would be identified and need to be investigated with targets established for bringing performance within acceptable bands.

Subsidies would be established and reviewed annually only. Concurrent with subsidy adjustments would be the changes in resident's fees. The subsidy basket should never be locked in for all time, but be sufficiently flexible to cater to the changing needs of the residents.

Through the nationally consistent approach there would be a mechanism for accountability productivity and efficiency, along with national benchmark comparisons, which have never been made available before.

This approach then provides an opportunity for planning improvements in the industry, along with the long-term plan for aged care in this country.

Capital funding should be provided immediately to address any shortfalls in the built fabric of facilities. The Federal Government should then retain concessional supplements and accommodation charges for a stipulated period of say 5 years. This would return the funds to Government, deliver an appropriate quality of facilities today, and provide for the future capital requirements of the industry.

In terms of accommodation charges, residents should be given the freedom of choice to determine whether they prefer to pay through accommodation charges or accommodation bonds. Currently the system does not have the flexibility to allow such freedom of choice.

IMPLEMENTATION

The process of coalescence should be scrapped immediately recognising the ill conceived nature of the concept. The basket of goods and services could be available within a period of weeks, and evaluated and costed within two months. The ABS retains the resources to conduct such an economic assessment. Funding could then be adjusted and the process concluded within a maximum time frame of 6 months. The critical part of the implementation process is to ensure that Government does not over complicate or fragment the efforts of the industry during this critical period.

The long-standing capital shortfall as indicated in the Gregory report will not be addressed adequately through the accommodation charge mechanism, and the introduction of options for incoming residents needs to be considered. Contrary to the complaints through the press when nursing home fees were discussed, the vast majority of people are prepared to pay their way, especially when the truth is known.

Many of the vexed questions surrounding this subject go back to some basic fundamentals. First and foremost, the Aged Care sector in Australia is responsible for more beds than is the acute sector. It is true that the Government's budget for Aged Care is $ 2.2bn and is a considerable sum, however it pales into insignificance when considered as a component of the overall health budget in Australia.

Under the current Heath system we have two separate sources of funds supporting the acute sector. Financial support for acute care comes from

- the Medicare levy providing substantial funds for the support of the health system
- private health cover making contributions to supplement Medicare
- user pays fees for the "gap" in expenses

Indeed there is encouragement to taxpayers to take out private health insurance by way of taxation concessions. Such forward planning consideration should be encouraged and positively acknowledged.

Where is the same level of planning for Aged Care? Health Insurance is taken out to cover the potential that it will be needed - hence the term "insurance" meaning roughly "just in case". On the other hand, an "assured" event, that is, growing older (and living longer) does not enjoy any such plan. Why is there not an "Agecare" levy to be used to fund capital infrastructure and deliver quality care to those who need such services? Surely there should be some scope for insurance companies to offer products, which could cover expenses in Aged Care facilities in the same manner as acute care.

Much comparison is made between the two sectors, particularly in relation to "parity" of wages and conditions. It is a substantial fact however that the often-mentioned relativity's between the two sectors are tenuous at best. Planning for Aged Care must occur, along with responsible steps being taken for future funding requirements. Government and operators should not allow an acute care agenda to drive actions in aged care, from any perspective.

Nursing Homes are not centres of acute care. Certainly there are some elements of acute care, but the vast majority of the requirements of the residents relate to assistance with the activities of daily living with the objective of delivering an optimum quality of life.

Although it is generally accepted that the provision of residential aged care is less expensive than acute care, we have constant pressures to achieve parity.

If aged care had to be funded to the same level as acute care we would see substantial increases in the aged care budget to cope simply with resultant wage costs. We would submit to the Commission therefore that any argument that attempts to use the acute sector circumstances to justify additional costs in the aged care sector should be disregarded as unsustainable.

FUNDAMENTAL PRINCIPLES

There is a series of fundamental principles, which need to be considered within the context of this inquiry.

- Every Australian has an inalienable right to expect a quality of care consistently regardless of their geographical location. If absolute consistency can be maintained on income tax rates, why should the same concept not apply when satisfying the care needs of older Australians?

- Natural justice should be at the forefront in the allocation of scarce resources.

- Government is funding a relatively small percentage of those requiring care, and yet place an administratively complex set of expectations on the industry without an appreciation of the resultant dilution of care resources

- Government has legislated in such a way as to remove the ability of the operators in the Aged Care industry to self generate income. If it is the Government's intention to totally regulate the industry then this must include capital funding for infrastructure. If this is not the intention, then the industry must be deregulated to allow innovation and initiative to provide solutions to the demands of our residents.

- Care Centres (Nursing Homes) should be recognised as what they are -centres for the delivery of care and assistance in the activities of daily living. The industry is large enough to have its own competency standards and should not be dictated to by the happenings in the acute sector. Adequate staffing coverage of Care Centres should be a fundamental aspect of future change.

- Government paperwork and subsidy methods should be simplified and efficient to allow the maximum amount of the subsidy funds to flow to the resident care. To continue to complete reams of paper forms in this electronic era is inefficient, cumbersome, and subject to error.

- Government should set the minimum standards required and then allow industry to achieve and improve on the standards. Theoretical exercises such as the Building Code of Australia, whilst the intentions are positive, are adding literally millions of dollars of cost to industry without delivering one single cent in improved care.

- Countless examples of impediment to market forces are evident which do nothing but dilute the level of funds eventually allocated to resident care.

- The Hilmer Report made it clear that a regulator should not have an exclusive right of monitoring compliance due to conflict of interest, and the two components should be separated. Under the Aged Care Act the Aged Care Standards Agency has been established as the regulator, with the provision of exclusive provision of compliance evaluation services. If such a monopoly situation occurred in general industry Professor Fels would apply the full powers of the ACCC to address and eliminate the monopoly. It appears acceptable however to support such a monopolistic structure, and substantially reduce the amount of funds going to resident care delivery

- The measures in place to deliver capital for infrastructure will not deliver sufficient funds for many years hence. If the Government is so convinced that their figures are correct, then they should be prepared to fund the capital investment and take the income from the accommodation charges in repayment. Industry would see this as a very positive option, and such an action would evidence the Government contention on providing capital funding adequacy.

We have a fundamental concern with the Commission evaluating the comparative costs of providing care across states. Such an approach may deliver an answer that the status quo should remain. There is a distinct possibility of a "self fulfilling prophecy". Put simply, operators spend funds received on Nursing Home operations. Those states enjoying significantly higher levels of funding, spend accordingly - Queensland operators have to be more frugal given the subsidy levels. Perhaps we have had to learn how to reduce costs and remain very efficient at what we do more so than our
colleagues in other states.

PROFILE OF COSTS OF PROVIDING SERVICES

We have included a profile of our cost structure for the Commission's reference.

The financial comparisons of the last four years operations are presented. We have chosen four years, as we believe that any data provided which is more historical fails to be statistically relevant.

James Grimes Nursing Home - Financial Result Comparisons

Element	94/95	95/96	96/97	97/98
Income:				
Government Subsidies	2,901,326	3,209,901	3,479,752	3,679,548
Resident Fees	1,029,423	1,079,737	1,112,144	986,840
Expenditure:	3,930,033	4,332,078	4,458,470	4,844,155
Operational Result:	716	-42,440	133,426	-177,767
Capital Expenditure:	90,334	74,006	122,300	138,563
Funding Subsidy by Sundale:	89,618	116,446	-11,126	316,330

NB: The balance change between subsidies and resident fees in 97/98 has been brought about through the change in the manner of payment of rent subsidies by the Government.

In terms of capital injection, the capital program for the last four years focused principally on equipment changeover. This included a program of upgrades to beds and special mattresses necessary through the ever-increasing frailty of our residents, and equipment necessary to deliver palliative care. These are care aspects not recognised, and which remain unfunded by Government.

The comparisons are obvious of expenditure to income show a concerning trend.

Expenditure Classifications as a % of Income

Classification	94/95	95/96	96/97	97/98
Recurrent Expenditure	100.0%	101.0%	97.1%	103.8%
Capital Expenditure	2.3%	1.7%	2.7%	3.0%
Total Expenditure	102.3%	102.7%	99.8%	106.8%

There is no way in which financial performance of this type can be sustained in any environment, commercial or charitable. Whilst our Government boasts about reducing deficits, this has been achieved through imposing operational deficits on to the Aged Care sector.

EXTENT OF DIFFERENCES IN THE COSTS OF SERVICES

We do not have the facilities to provide the Commission with interstate comparative data on costs, other than to indicate that costs of supplies to an area such as ours predominantly carry transport costs and time delays.

The contribution made to the local economy in a rural 1 remote location cannot be underestimated. The wages paid through our Nursing Home operation
alone amounted to $ 3.7m in 97/98. If we take into account the multiplier effect of around 2.7 this has a contribution to the local economy of almost $1Om. Additionally, since we take our community responsibility very seriously, we have a policy that we will support local suppliers, provided that their cost to us is not more than a margin (between 2% and 5% depending on the product) above the cost we can achieve by going "out of area".

We would therefore have to conclude that there is a cost differential between our operations and those of metropolitan Brisbane, however this cannot be accurately quantified. As a pure guesstimate, we would say that operational "non wage" related cost differentials amount to around 2.5% - 3%.

IMPACT OF FACILITY SIZE / OWNERSHIP ON SERVICE PROVISION

The size of the Sundale organisation provides efficiencies in costs through our buying power. A Nursing Home of 115 beds is quite a substantial size, and indeed with wing sizes of 44, 33, and 38 - each wing is about the size of other "normal" size Nursing Homes. The size of our operation therefore leads us to believe that we are achieving economies of scale better than average.

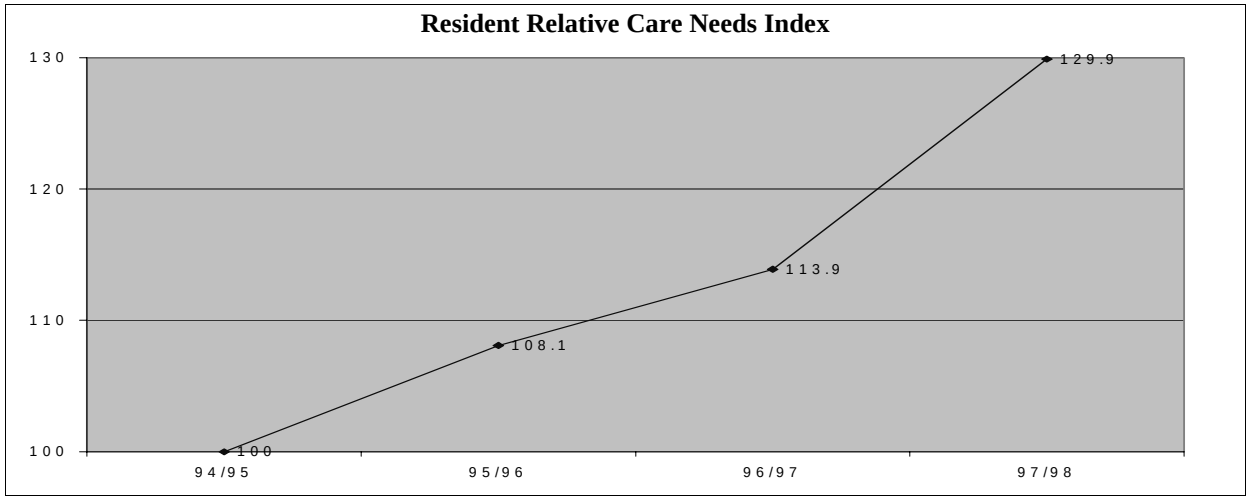
As has been demonstrated previously, the nature of our ownership has meant that as far as possible, the operation of the James Grimes Nursing Home has been subsidised through other operations of Sundale. This approach is no longer sustainable, and would not have been featured in the first place if this had been a commercially driven organisation.

RESIDENT CARE NEEDS

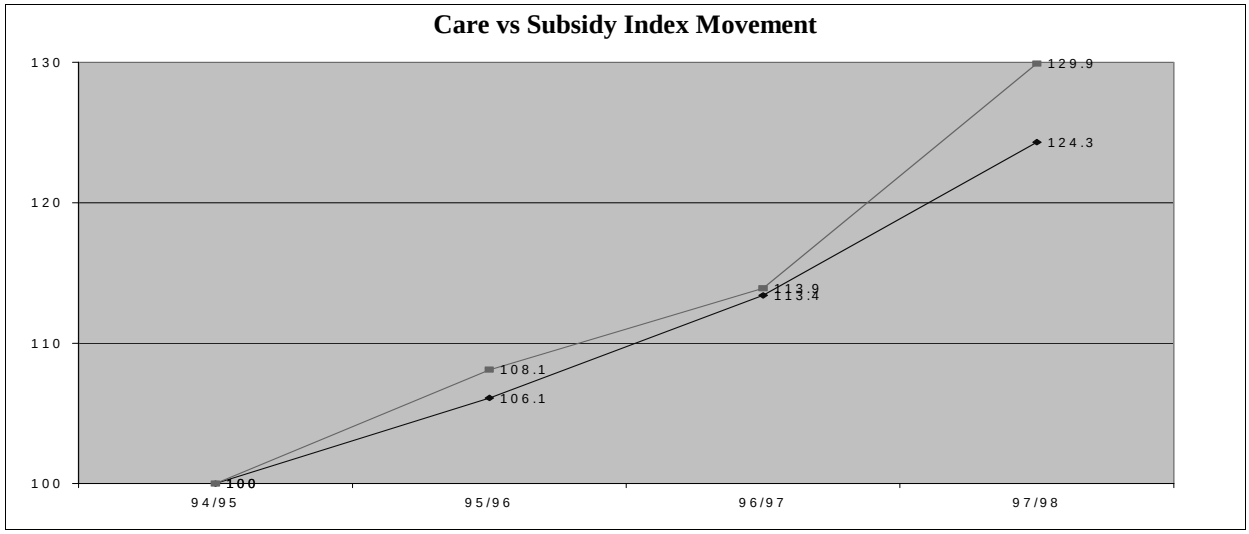
Before embarking too far on the cost profiles of the operation, it is important to indicate to the Commission the relative care needs of our residents. The most recent information available on the distribution of the most in need residents through the RCS shows -

State	RCS 1	RCS 2	Total
Queensland	7.8%	23.4%	31.2%
Tasmania	5.2%	21.6%	26.8%
Victoria	8.4%	25.6%	34.0%
West Australia	3.7%	22.9%	26.6%
National Average	7.1%	24.3%	31.4%
SUNDALE	**42.6%**	**49.6%**	**92.2%**

The following comparison has been put together on the basis of the average subsidy received compared back to the RCI / RCS classification scale. The relevant care scale has then been compared to an index using 94/95 as the base of 100.



This profile shows clearly the rapid increase in the care needs of our residents over a relatively short period of time. The frailty of people entering residential facilities is increasing at an accelerating rate. When compared with the subsidy base, there is obviously a shortfall.



As a consequence of the subsidy failing to keep pace with the relative care needs of the resident, there is a shortfall of approximately $ 4.27 per resident day based on the 1997/98

averages (using the average subsidy per resident day for the facility). The shortfall is indeed higher than this since funding levels for the highest categories of care were reduced in absolute terms in moving from the RCI to the RCS. Having the first three months at the higher RCI level therefore distorts the annual result through exaggeration, making it look better than it is in reality.

It is therefore clearly concluded that the mechanism used by the Government for the allocation of funds to the James Grimes Nursing Home has failed to keep pace with the relative care needs of our residents (and the time needed to provide quality care), even before we consider the movements in costs.

The study conducted by the Lincoln Gerontology Centre at the La Trobe University (refer Aged Care Australia 1 Aged Care Queensland submissions), clearly indicates Queensland as a higher cost state, with the lowest funding rates. The following indices have been assembled using the lowest level as index 100.

	NSW	VIC	QLD	SA	WA	TAS
RCS Category 1 Subsidy Rate	116	121	100	108	111	122
La Trobe University Cost Study	102.8	103.5	104.9	103.5	100	102.9

Given our facilities are multi site we have the advantage of centralising some services and spreading these costs through a levy system, based on the respective sizes of facilities and the services they consequently require. The following data provided on wages therefore is slightly under stated as we do not have the facility to simplistically dissect the recharge levy structure to break out wages and on costs as a separate item.

The wage and wage related cost movements are probably best indicted through a comparison of these costs as a percentage of income.

Wage Costs as a % of Income

Classification	94/95	95/96	96/97	97/98
Care	61.77	62.08	61.66	60.85
Housekeeping / Foods Services' Laundry	20.0	19.0	18.6	18.0
Maintenance	1.7	2.1	1.2	1.2
Administration	2.0	1.9	2.2	2.8
Sub Total	85.5	85.08	83.66	82.85

The COPO arrangements were designed to prevent supplementation for productivity based increases by discounting average wage costs. In reality, the labour / service intensive nature of residential aged care services means that potential productivity gains are limited, and are unlikely to match some other sectors. The acute care sector for example, with which aged care is often compared, has significant productivity potential through technology enhancement than does aged care.

As the Aged Care Australia / Aged Care Queensland submission verifies, the use of COPO has resulted in a substantial under-compensation of Nursing Home subsidies for wage movements since 1996.

The estimate of this reduction in real value of high-level care subsidy is $128m. Continuation of this approach will damage the viability or quality standards of nursing home operations.

Our downward movement in relative care costs has been achieved though three principle actions

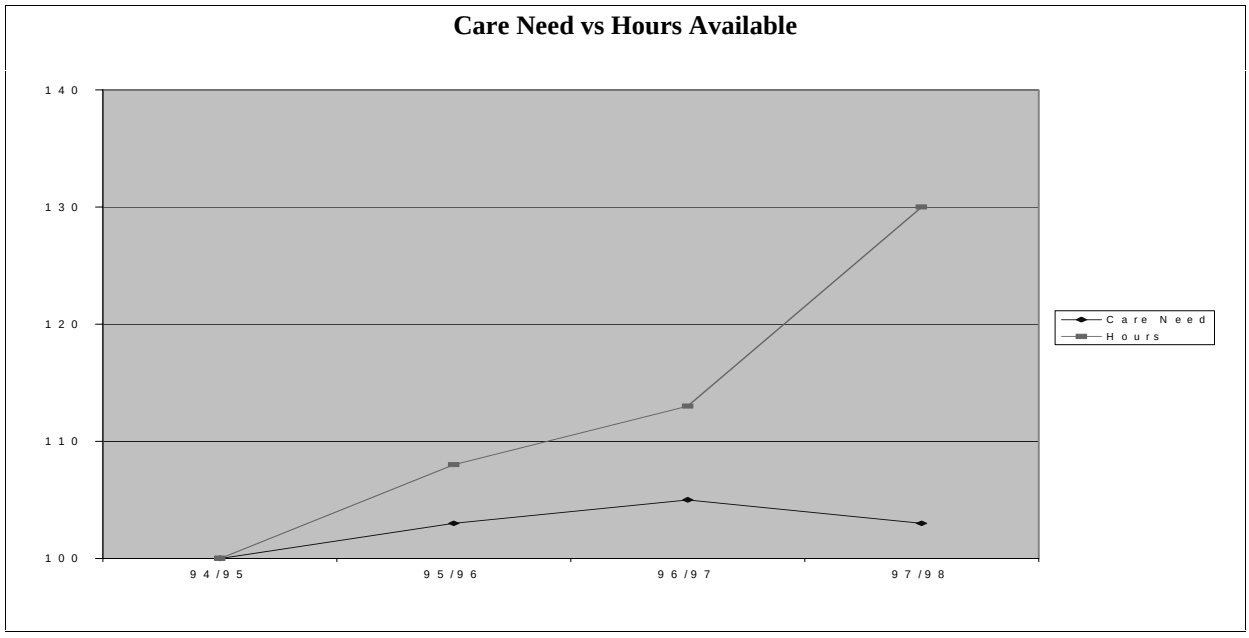
- the removal of the Deputy Director of Nursing position
- the alteration in the personnel staffing mix within the Nursing Home
- a reduction in hours available to match the income levels.

We can demonstrate the effect of this through the examination of the care hours by classification and the comparison of the care costs.

Care Hours and Costs Per Resident Day Comparisons

Classification	94/95	95/96	96/97	97/98
Care Hours	121,340	123,127	128,430	126,310
Hours Per Resident Day	2.92	2.96	3.08	3.05
Care Wages Cost	2,427,931	2,663,220	2,831,370	2,839,278
Cost Per Resident Day	$58.43	$63.99	$68.00	$68.48

An examination of the trends using a base index of 1994/95 shows the relationship between the relative care needs of our residents and the hours available per resident day.



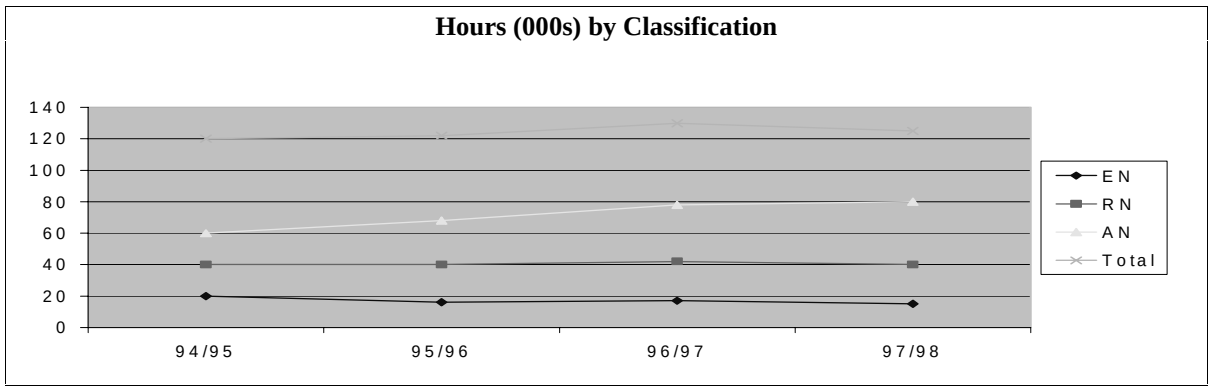
The gap between the respective indices reflects the unmet needs of our residents due to the combination of inadequate funding and increasing costs.

Measures of the hours of care per resident day and the subsequent cost have been generated through the staffing mix. The carer profiles can be demonstrated through the following table.

Care Hours Comparison by Classification

Classification	94/95		95/96		96/97		97/98	
Hours in 000's	Hour	% Total	Hour	% Total	Hour	% Total	Hour	% Total
RN	37.7	31.1	36.7	29.8	39.2	30.5	36.1	28.5
EN	16.5	13.6	13.6	11.1	14.3	11.1	12.6	10.0
AN	67.1	55.3	72.7	59.1	74.9	58.4	77.6	61.5
Total	121.3	100.0	123.1	100.0	128.4	100.0	126.3	100.0

Diagrammatically this is represented as -



The staffing mix has altered quite considerably in response to the level of funding available for the care of the residents. It is critical that the health interventions are planned and monitored by a Registered Nurse.

However, by and large these interventions are implemented and reported on through the Enrolled and Assistant Nurses. A Nursing Home is not an acute care setting, and the predominate activities of support for the resident revolve around supporting their activities of daily living. The time needed to deliver this care most often relates to the health status of the individual and their ability to help themselves.

It should not be interpreted by the table above that the quality of care has diminished, although this depends on the definition of "quality care". It is clear that residents are being attended to by the care teams, however it is true to say that time to spend with the residents and to engage them is what has dissipated. People providing care in such a setting are by nature very caring and giving people. It is evident that the emotional support being given to residents by the care teams, if available, is provided outside of normal work hours.

While the residents are merely numbers to Government, they are real people to the operators of facilities - and indeed in many ways become "family" - especially if they have no direct family of their own in this area. It is impossible to be dispassionate about the residents for whom we care.

When we examine the movement in average wage rates by classification there is not a significant movement between the classifications, other than the impact that removing the DDON position has had in the last financial year.

Average Hourly Rate Movement Comparisons

Classification	94/95		95/96		96/97		97/98	
	Rate	Index	Rate	Index	Rate	Index	Rate	Index
RN	23.19	100	25.35	109.3	25.52	110.0	26.89	115.9
EN	15.81	100	17.31	109.5	17.74	112.1	18.86	119.3
AN	13.35	100	14.46	108.3	15.38	115.2	15.77	118.1
Average	16.74	100	18.03	107.7	18.74	111.9	19.25	115.0

There is no doubt that the wage cost increases achieved have been higher than the movements within the general economy. With respect to wage increases, our industry is generally regarded as "price takers" subject to the actions of State Government and the acute care sectors.

NON WAGE COSTS

As previously indicated the ratio of wage to non-wage costs for Sundale is not 75 / 25 as indicated through the COPO index. There are a number of issues mentioned in relation to the non-wage cost area in the issues paper which we will address here.

SCOPE FOR SUBSTITUTION OF EQUIPMENT FOR LABOUR INPUT

The opportunities for productivity gains in the nursing home sector through substitution of technology for labour inputs are very limited for the following reasons -

- nursing homes provide personal care to frail and highly dependant people on a full time 24 hour 7 days a week basis - there must be appropriate staff on duty all of the time and most of the personal care needs are delivered on a "one to one" basis

- compared to other industries, ours has a very flexible and committed work force, with clear evidence that our people already give of their own time in providing care to our residents

- the personal service nature of the industry means that the scope for labour / equipment substitution is very limited. In some cases, equipment substitution may see dependence rise, contrary to the spirit of the outcome standards (eg continence aids should only be used when continence management programs such as regular toileting are not effective. Substitution of the aids would be more time effective, but is not the outcome required of any quality service provider).

- In comparison with the public hospital sector, our industry already achieves a much higher level of productivity, and there is considerable pressure to address this by increasing remuneration for the current productivity delivered.

- The new accreditation system is a "people intensive" process in all areas of activity**, and is completely unfunded.**

The extensive capital expenditure over recent years has focused almost exclusively on the introduction of improved equipment. This has been in direct response to the care needs of the residents, a matter which the Government has not factored into the subsidy rates.

Our program of equipment replacement over the last four years has equated to $2.56 per resident per day, and the program is not kept current due to the limitations on capital.

Our focus on equipment has been designed to address appropriate beds and mattresses (particularly as needed to deliver palliative care). Further equipment change over has aimed at the reduction in the risk of injury to our residents and our people. We have achieved a considerable improvement in our management of injury risk and prevention, but have further to go. It is anticipated that in the current year our capital needs will exceed $ 150,000 just for the Nursing Home, in addition to an estimated $ 2m for refurbishment to meet what we understand to be the expectations under the BCA.

SCOPE TO VARY PROPORTIONS OF STAFF

We have demonstrated that the staffing mix has indeed been varied in accordance with the care needs of the residents, balanced against the availability of funds.

There are some indications that some organisations are moving to replace Assistant Nurses with Personal Care Assistants, who have a lower hourly rate. There is no doubt that this has a short term appeal financially, however there is no getting away from the fact that the work conducted in the Nursing Home is more physically draining than that experienced in hostels (where PCAs currently operate). As a consequence the expectations in terms of wage rates would be one of eventual parity, and it would not solve any problems which currently exist. We would simply be deferring the inevitable.

We have, as a society, a responsibility to reward people for the tasks that they do - especially when they do it well, and in many cases above and beyond the call of duty. We also, as employers, maintain a legal responsibility to ensure that our people are not placed in dangerous situations brought about by fatigue caused through constant heavy lifting of residents.

As a direct result of these two responsibilities, we should not be looking to the replacement of ANs with PCAs - this approach is quite simply a short term and inappropriate one, which simply should not be acceptable.

LABOUR ON COSTS

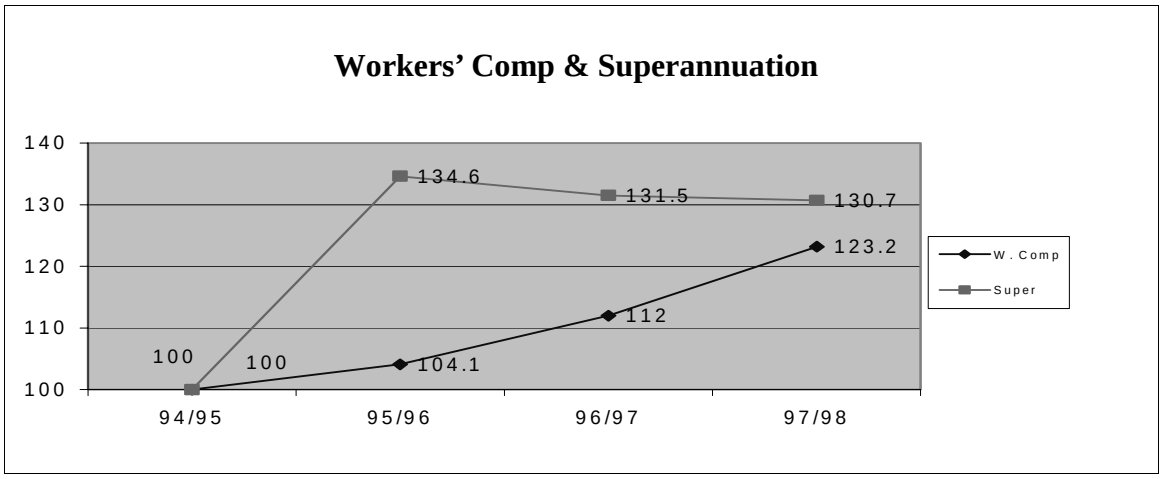
As would be expected superannuation shows similar quantum movements to the wage structures. Effective from 1st July this year, an additional 1 % has gone onto the superannuation guarantee, however this is outside of the scope of the time period being examined for the purposes of this submission.

Workers' compensation premiums on the other hand follow the claims performance rather than the wage rates, and likewise reflect the risk premiums associated with differing areas of activity.

Workers' Compensation & Superannuation Comparisons

Element	94/95	95/96	96/97	97/98
Workers' Compensation	88262	91904	98843	108771
WC as % income	2.25%	2.14%	2.15%	2.33%
Superannuation	113631	153001	149381	148531
Super as % income	2.89%	3.57%	3.25%	3.18%

In terms of movements from the 94/95 base, these comparisons are displayed in the following graph.



As can clearly be seen there have been some considerable increases over the period, although the superannuation reflects the changes in the level of hours and staffing mix.

STAFFING PROFILES

Research conducted by Alan Pearson et al in 1990 found that the quality of care for residents is determined by a wide range of factors, including: the attitudes and motivation of staff; leadership and management style; and the physical and social environment. It concluded that it is difficult to produce defensible, prescriptive percentages for optimal staffing mix.

Details of our profiles were provided earlier in this submission. It is important however that the Commission be appraised of the likely direction of industrial claims being made at present in Queensland, in particular by the Queensland Nurses' Union. In addition to the requests for increases in wage rates and benefits, the QNU is seeking to introduce nurse 1 resident ratios.

There is a consistent push by the union to achieve parity between Nurses working in Aged Care to those that exist for Acute Care or public sector Aged and Acute Care employees.

The granting of improvements in wages and conditions to the public or acute sectors therefore has a significant impact on Aged Care providers. Facilities which are Government operated, or have access to outside funding can perhaps cope with such extreme claims. In the case of Aged Care subject to Federal Government subsidies, the Government has removed completely the ability of the operators to improve income streams, unless the operator takes a completely different direction out of Aged Care. Organisations similar to Sundale are exploring such possibilities with a view to cross subsidisation to enable an appropriate level of care to be delivered.

The results of "negotiation" between the public sector and the unions will ultimately flow through to Aged Care operators unless there is a clear and concise breaking of the nexus between the sectors. This will require a strong will on the part of all parties to recognise that Aged Care is not the same as Acute Care, and that Government does not simply give concessions as if income was limitless. Queensland Aged Care operators are therefore vulnerable to the whims of such negotiations.

Sundale has undertaken a comparison between existing hours and rates, as against those proposed by the QNU. The indicative results are as follows.

The comparison was conducted against the care hours worked in July, and the estimate of income for the year was based on the July resident profile and subsidy rates.

Expected annual income - James Grimes Nursing Home. **$4,792,250**

Element	Current	Existing Rates - Proposed Ratios	Proposed Rates and Ratios
Hours / Fortnight	7390	10609	10609
Cost / Fortnight	$113,646	$179,205	$187,353
Annual Cost	$2,954,796	$4,659,330	$4,871,178

With the proposed ratio and rates, the cost of wages (not including on costs) for nurses alone would rise $ 1.916m, reaching $ 79,000 above the total income for the Nursing Home. This does not account for food, cleaning, laundry, administration or any other associated costs.

The above calculations also ignore the requirements for pre determined ratios of Registered Nurses of Level 2, nor for the fact that the QNU states that further increases will be required over the next 2 years to maintain parity.

There are further elements of the claim submitted to the Industrial Commission, a summary of which is included in this submission for the reference of the Commission.

With Government limiting income, and cost pressures of this magnitude coming through, it is no wonder that questions are being legitimately asked about the future viability of Aged Care facilities. Likewise it is understandable that some operators are looking to replace nurses with personal care assistants. Such actions are akin to a drowning person grabbing at whatever options are within reach. A required guarantee of hours to part time employees, with overtime penalties to apply to any hours beyond this agreement will remove flexibility for both the employers and employees. This action alone will lead to a casualisation of the work force simply to maintain the flexibility to deal with varying care needs of the residents.

There are a significant number of other non-wage-related issues, which create implications for operators of Aged Care facilities. The above examples however are sufficient to indicate an alarming trend.

BUILDING REGULATIONS

The service provider has no influence in this area what ever, and the whim of the Government Department can add significant requirements for capital injection without any direct care benefit to the resident. The attempt to cover any and every "what if" scenario is both unrealistic and represents economic suicide.

ACCREDITATION

A new agency has been established for the purposes of the accreditation process. It is interesting to note that industry in general in Australia generically comes under the auspices of JASANZ with respect to quality systems. Other than attempting to protect employment for standards monitors, there is no discernible reason why there should have been a new agency established for Aged Care. JASANZ has already responded to various industry sectors with their own tailored approach, and could have done the same for Aged Care.

Instead we now have an industry overhead, with the funds to support it coming directly from the care budgets of facilities around Australia. Effectively the operational cost of this agency is a real reduction to subsidies nationally.

It is believed that the Hilmer Report recommended that the roles of regulator and compliance assessment should be kept separate.

In this instance we have them not only combined, but the Aged Care Standards Agency has been given an absolute monopoly. Aged Care providers have no choice of supplier of services, and the agency indeed is price setting for the market place. Such price setting we understand is to cover the complete costs of operation of the agency. It is not clear if the costs of operation are to be restricted to a level that is economically viable.

There has to be real doubt if this action complies with the requirements under the Australian Competition and Consumer Commission.

There is no argument that there needs to be an accreditation system, and that operators should be held accountable for the quality of services provided to the market. There needs to be a level of comfort for the community that they can be assured of reputable standards being maintained. This is provided in other sectors through Certification Bodies certifying to]SO standards or industry standards, or through organisations such as the ACHS. Under these circumstances there is true competition. With respect to the ISO Certification Bodies, they are regulated through JASANZ directly and indirectly through ISO internationally. This ensures that these bodies maintain continuous improvement in their own right, and indeed are audited to ensure that they have appropriate systems in place. Where is the plan to audit the Agency and indeed to ensure efficient and effective systems - there is apparently no such plan!

Significantly there is no assessment and accountability of the agency performance, and likewise there are no controls on the level of income that the Agency can generate simply by altering its own rules on reassessment. Should such an uncontrolled monopoly exist in our society today - we suggest not!

The level of stress being applied to the industry to be accredited by 1st January 2001 is significant. The Agency themselves are at least 9 months behind implementation schedule, effectively crunching industry response time by at least 25%. Decisions taken by some operators to have people trained as assessors for the accreditation standards came unstuck when the agency decided not to accept the qualification. Several months later the modest further training requirements were advised. A total waste of time and resources for industry, again for no gain.

BUILDING CERTIFICATION

It has been claimed that consultation has been a feature of the development of the Building Certification requirements for Nursing Homes. The industry can only wonder at the quality of this consultation when one sees some of the outcomes.

Nursing Home residents by definition have a high level of care need. It is a rare occurrence that a resident can toilet or shower / bath themselves. In spite of this the Building Certification standards will require a resident / toilet and resident / shower ratio of 3:1.

It is totally unrealistic to require such a ratio when it is only possible to use the number of toilets or showers which relate to the maximum number of staff that can be on roster at any one time. The result - considerable capital cost - no improvement in care service delivery - and rooms which will become unused storage capacity.

Under building requirements there is a required hall way width. This is for the purposes of fire safety and also for the ability to move people in the normal course of activities. In our Nursing Home we have sliding doors on rooms -some doors are cavity sliders and others slide on the outside of the walls. In either event they are safe, and provide security and privacy to our residents, having been in place for many years. Likewise they are economical in terms of space, and do not intrude on to the hallways nor cause any danger in opening onto an individual moving through the hallway. Under the propose de-regulations we will be required to remove the siding doors, and replace them with out ward opening doors. Again, significant amounts of capital - no improvement in care delivery - and indeed introducing a high risk of potential injury to both residents and staff when doors have to be opened. We don't know as yet whether we will be required to somehow increase the width of the hallways.

Building Certification requirements should be delayed until there is true consultation on the elements involved, and a practical application of the issues examined.

The Government is of course not prepared to fund facilities to meet these new requirements. Our priorities should surely be to improve safety and comfort for our residents - not responding to unnecessary and expensive alterations to provide nothing but a warm feeling to those who spend their time coming up with constantly changing new rules.

METHODOLOGIES

The funding arrangements effective since 1st October 1997 are essentially a fee for service, however there is no direct link between inputs or outcomes, and consequently does not present a transparent basis for funding. There should be a much stronger link between funding and outcomes (expressed in terms of the quality of care delivered to consumers) than is currently the case.

STATE BASED SUBSIDIES

Recurrent Funding

It is submitted that the state-based arrangement, which has existed for some years now, has some potential to be a useful mechanism. There was a fundamental flaw in the initial calculation of this mechanism. The selection of "typical" facilities was subjective only, and the cost analysis could only be described as being superficial.

It is evident given the geographical characteristics of Australia, and the main sources of equipment for our sector, that there will be variations in costs between the states (and more specifically for regional jurisdictions).

An "ideal" subsidy system should recognise movements in legitimate costs, but at the same time reward productivity increases and not support inefficiency. To be meaningful therefore there needs to be a system of comparative benchmarking. It is therefore proposed that -

- An analysis of costs for operations should be undertaken on a regional jurisdiction basis

- The cost analysis should be undertaken on a "basket" of goods and services developed in conjunction with industry - indeed allow industry to develop the basket on a national basis with a nationally consistent basket

- Recognition should be given to the increasing care needs of residents as they proceed through the care continuum, and funded accordingly

- Recognise movements in the "basket" by regional jurisdiction, however through the benchmarking mechanism identify those regions that are becoming less competitive. They should then justify why they should be allowed to continue without a competitive profile. Where the causes of the loss of competitive edge is one associated with Government, this should be addressed by the Federal Government and rectified

- Subsidy movements to be standardised to an annual event without incremental movements during the course of the year. Resident contributions should likewise be standardised to align with movements in the subsidies.

- Maintain the RCS instrument given the significant extent of pain that the industry has gone through in its implementation, although recognise the need for restoration of subsidy funds in the higher categories.

- There also needs to be recognition given to facilities that achieve rehabilitation of residents, improving their category to lower levels. Currently the incentive is to increase the dependence of the resident and this needs to be reversed.

An approach such as that outlined would provide the best of all options. There would be a nationally consistent basis of comparison, and it would take account of the regional jurisdictional differences. It also provides a basis for comparison and benchmarking, identifying those who are doing better with their improvement programs and making this information available to the rest of the industry. This could also identify areas of research necessary to address stubbornly high levels of cost with a view to either reduction or elimination through substitution.

Capital Funding

- Government clearly does not have the available capital funds to support the work which needs to be done on Aged Care facilities. This lack of available funds will only exacerbate over time as we move through the "baby boom" hump in the population.

- There is a concern that facilities should meet minimum standards of building infrastructure, and this is reasonable. What is unreasonable is that Government wishes to continue to dictate building standards without reference to the recipients of the service. If facilities are not up to standard then the population will not subscribe to those services. The historical basis of bed license allocation has been a causal agent of the decline in standards as reported by the Government. Through the licensing system that effectively rations available beds, it has removed freedom of choice from the recipients of the service and has drastically limited true competition.

- Potential residents, who have the resources, would choose accommodation based on their requirements, given a choice. The current approach is a "product driven" not "market driven" approach.

- The Government has important choices to consider

  If it is not going to fund capital for facilities, it needs to establish the baseline then remove itself from the process. Without being an investor the Government has no further right of involvement. Provided that the operator complies with the required building regulations there should be no additional layers of requirement.

- The elimination of the current exercise of licensing bed places should be considered and actioned. There would be a degree of concern at developing an "open ended" approach, however it must be recognised that going into a Nursing Home is not a preferred accommodation choice for people.

- People go into Nursing Home care because they are not able to cope alone, nor can their family network provide sufficient support. There is therefore a finite demand, and commercial decisions taken on the basis of market demand will result in facilities being built in the areas of greatest need. Investors in the industry will make more timely estimates and decisions because it is their money at risk. Decisions currently taken by the DH&FS are predicated on obsolete data, and without the knowledge of the front line of the market place. This is not a criticism - the estimates are done with the best intention and the best secondary data available. Operators have the primary data and the interest to "get it right".

NATIONAL SUBSIDIES

The current national subsidies are clearly discriminatory. It has been said by the DH&FS that Queensland delivers quite adequate care with the funds available. There is no doubt that the quality delivery from Queensland given the funding situation is certainly one which should be used as an example to other states. What is not seen by the department however is the true cost of this quality delivery on the quality of life for those delivering the care.

It is an accepted view that past funding practice (CAM) simply recompensed expenditure. If wage structures or expenditure escalated in an unjustifiable manner, the costs were simply met by the taxpayer through the CAM system. Had the situation been more accountable, would the same decision had been made in some states accepting artificial ratios without regard to the care needs of the residents in their care?

A focus on national subsidies presupposes that there will be some who unfairly benefit and others who unfairly suffer from the ups and downs of an averaging process. It is submitted that regional jurisdiction is a more appropriate measurement which would more equitably distribute the available subsidy funds for the best possible result.

Impact of Coalescence on Structural Changes

The policy of coalescence assumed that it was appropriate to move to a national rate, but this was not based on any empirical evidence. If changes are to be made, we should not repeat the mistakes of the past.

It is clear from the data provided that the first aspect that must be addressed through additional funds would be the elimination of the deficits being generated in the Nursing Home today. Once this is addressed, the additional funds would go directly to the provision of care.

From the perspective of others that would see reductions in funding, there is little doubt that provision of care would suffer from any funding reductions.

Coalescence as a principle is fundamentally flawed both from a sense of economic sustainability and also from the perspective of justice and equity. The basic premise that because there has been discriminatory practice for some years, then it is acceptable to continue this for another 7 years doesn't present a sense of balance.

The economic basis is unsound given that even with coalescence it appears that there would not be a national rate actually achieved at any point in the future. Coalescence sees a percentage of the differences between states "coalesced" per year. It does ignore the fact that each year the goal posts move through indexation. A fixed percentage of a greater number is not equal to a fixed percentage of a lesser number. The mathematical reality is therefore that there would not be a uniform rate of funding achieved throughout the country, even after 7 years.

The question posed as to whether coalescence would speed up or slow down the process of structural change is relatively redundant. Coalescence by its very nature refers to recurrent expenditure. Structural change will rely very heavily on capital injection. The two elements are mutually exclusive given the fact in the case of Sundale that no surplus funds are generated through the subsidy mechanism.

OPTIONS

Subsidy as a percentage of costs

There appears to be an assumption that somehow capital funds come from somewhere in the "never-never". If there is no generation of surplus funds from operations there is no capital available to address equipment and care issues let alone built fabric. Using the approach of subsidy as a percentage of costs would revert to the CAM model where productivity and efficiency were neither recognised nor encouraged.

The disadvantages of this approach include: administrative complexity; focus on inputs and not outcomes; pressure to cap payments will diminish flexible responsiveness; and price 1 quality signals could be confused.

At the end of the day we need a competitive model which can recognise and reward initiative and improvement. The fundamental is the need to reach and exceed quality service delivery criteria. If an organisation can do this and return a surplus for reinvestment then they should be encouraged to do so.

Government to fund a minimum acceptable quality of care

This concept has some merit, but it appears to presuppose that Government does not do this already. Those exceeding expectations are doing so through their own endeavours, by subsidising their operations in another manner, or through the dedication of a group of quite remarkable people.

This approach does however indicate a sliver of hope that the elimination of the ability of operators to take action to produce their own income beyond Government subsidies may be reversed. It is essential that we ensure a safety net for those who do not have the resources to contribute further to their care. It is absolutely essential to remove the shackles of Government regulation preventing the industry from generating its own much-needed funds.

Payments to residents rather than providers

The removal of the administrative burden of constantly reporting to Government and having to deal with the problems associated with the current centralised system would be welcomed by operators. The onus for accurate processing would rest solely with the Government, and operators would be accountable to the resident, typical of any supplier / customer relationship.

There would still need to be a system recognising care need, and we would need as a society to ensure that additional funds for care needs actually came through to the facility.

It is clear that such an approach fails to recognise the special characteristics of nursing home residents or features of the nursing home market. It would not ensure universal access to quality care irrespective of capacity to pay. Quality care is best facilitated through the accreditation system rather than relying on the bargaining power of residents.

Appendix One

Queensland Nurses' Union Claim

AGED CARE

enterprise bargaining information for nurses

Summary of QNU Wages and Conditions Claim 1998

The following represents a summary of the key elements of the QNU claim in respect of enterprise bargaining in the Aged Care sector. Nurses working in the Aged Care sector should be entitled to the same wages and conditions as nurses working in other sectors. The current claim seeks only to achieve parity with other sectors. It is based on the claim served last year, but has been updated.

WAGES...

Nurses working in Aged Care should receive the same level of pay as nurses working in the public sector. AIN's receive additional wage increases consistent with changes in work value.

In order to achieve wage parity with public sector nurses, a wage increase of between 4% and 9% is required immediately for Aged Care nurses – dependent on classification. Additional increases will be required over the next 2 years to maintain parity.

ASSISTANTS IN NURSING PROPOSAL:

Assistant in Nursing Level	Descriptor	Proposed Award Rate of Pay
One	Trainee	
Two	Trainee	
Three	Certificate Level 3 or demonstrated equivalent experience	$451.20 (plus EB increase)
Four	Competencies and experience greater than Level 3	$462.48 (plus EB increase)
Five	Competencies and experience greater than Level 4	$473.76 (plus EB increase)

(Please note: The QNU supports the process of RPL or Recognition of Prior Learning, which would mean that Assistants in Nursing who already have the skill and knowledge should have these skills recognised without having to complete formal studies)

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Authorised by G. Hawksworth, Secretary

STAFFING RATIOS...

Staffing ratios are extremely important, not only in regard to workloads issues at the workplace, but also in regard to professional nursing practice. All nursing work needs to be adequately supervised by Registered Nurses – indeed this is a requirement of nursing practice by the Queensland Nursing Council. Registered Nurses are responsible for any nursing work they delegate, and are therefore liable for the actions of those they delegate nursing work to. The following tables set out the minimum standard for skills mix and staffing ratios in high care and low care facilities:

High Care Facility:

Day and Evening Shift	Night Shift
1 Registered Nurse + 1 Enrolled Nurse + 1 Assistant in Nursing for 15 Residents	1 Registered Nurse + 1 Enrolled Nurse + 1 Assistant in Nursing for 20 Residents
OR	OR
1 Registered Nurse + 2 Assistants in Nursing for 10 Residents	1 Registered Nurse + 2 Assistants in Nursing for 15 Residents

Low Care Facility:

Day and Evening Shift	Night Shift
1 Registered Nurse + 1 Enrolled Nurse + 1 Assistant in Nursing for 20 Residents	1 Registered Nurse + 1 Enrolled Nurse + 1 Assistant in Nursing for 25 Residents
OR	OR
1 Registered Nurse + 2 Assistants in Nursing for 15 Residents	1 Registered Nurse + 2 Assistants in nursing for 20 Residents

CONDITIONS OF EMPLOYMENT...

All conditions contained in the Nurses Aged Care Interim Award – State should be preserved as an absolute minimum. Nurses working in Aged Care should be entitled to the same conditions of employment as nurses working in the public sector. On that basis, the QNU is seeking the following improvements in working conditions:

Long Service Leave

Employees should be entitled to 13 weeks long service leave after 10 years of service. (Note, in addition to the public sector, the majority of nurses working in private hospitals also have this level of long service leave.)

Parental Leave

6 weeks paid maternity leave – public sector nurses have had paid maternity leave since June 1997 and some private hospitals have now agreed to this condition.

Training and Education

One week's paid Industrial Relations Training leave – the public sector currently have 5 days trade union training leave. Provisions for study and conference leave – the public sector currently has a range of provisions under which nurses may participate in professional development programs.

Certainty of employment

Part-time employees must be guaranteed some security, particularly in relation to the number of hours they are to work each week. The QNU's claim seeks to ensure that each part-time employee is given a letter of appointment which clearly specifies the actual hours they are to work each week. There is to be an appropriate agreed process established where employers wish to vary these hours.

Workplace Health and Safety

In accordance with workplace health and safety legislation and common practice in other workplaces, there are to be workplace health and safety representatives who are elected by employees. There is to be a workplace health and safety committee established to allow for proper consultation and discussion of these important issues between management and elected workplace health and safety representatives. In addition, the Department of Community Services and Health Workplace Health and Safety Manual, which was developed specifically for the aged care sector is to be properly implemented in each aged care residential facility, in consultation with elected workplace health and safety representatives.

Workloads

In accordance with common practice in other health institutions, there are to be agreed procedures put in place to monitor and control workloads.

Consultative process

Proper consultative procedures are to be put in place at each workplace. Consultative procedures must include proper elected representation for employees, appropriate time and resources for representatives to carry out their functions, and discussion of the role of management.

Grievance and dispute settling procedures

This is a standard clause in all agreements, which puts in place procedures for dealing with grievances and disputes at the workplace.

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