NSW NURSES' ASSOCIATION

Response to

Productivity Commission

INQUIRY INTO NURSING HOME SUBSIDIES
POSITION PAPER

November 1998

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Productivity Commission

INQUIRY INTO NURSING HOME SUBSIDIES

POSITION PAPER (October 1998)

1. INTRODUCTION

This response to the Productivity Commission *Inquiry into Nursing Home Subsidies* Position Paper (October 1998) is submitted on behalf of the members of the NSW Nurses' Association. The Association is the professional and industrial body which represents all nurses in NSW. The Association is also the NSW Branch of the Australian Nursing Federation. Association membership includes Directors of Nursing, registered nurses, enrolled nurses and assistants in nursing. The Association has consulted widely within our membership in the preparation of this response.

The Association's response is structured to address the thirteen preliminary proposals outlined by the Productivity Commission in their Position Paper (October 1998). The opportunity for consultation and comment on this very complex issue is appreciated.

2. GENERAL COMMENTS

The Association strongly supports the position taken by the Productivity Commission that *equity of access to quality aged care must be the main criterion for assessing alternative subsidy regimes.* The Association also supports efficient and responsive service provision, elimination of unnecessary administrative costs, and a transparent system.

3. PRELIMINARY PROPOSAL 1

The Association supports the Commission proposal that coalescence of basic subsidies for high care residents in nursing homes and hostels should not proceed in its current form.

The arguments put forward by the Commission for a nationally uniform basic subsidy rate have been considered. The Association does not find the arguments in relation to labour costs convincing. Nursing salaries, for example, vary considerably between jurisdictions and there is no reason to assume that this situation will change in-the foreseeable future. In relation to nursing salaries, the Association does not agree that the *differential in award rates has fallen by close to 70% over the last five years* (p. 34) *(see Attachment* 1). It is also important to remember that there are many other factors apart from the amount of funding available to proprietors which determines salary levels (eg the bargaining power and ability of employees and/or their representatives; whether there is an undersupplied or oversupplied market; salary movements in other sectors).

The Commission has noted that the available cost data is not conclusive (p.33); that the estimates of differences in standardised costs vary considerably and are quite sensitive to the underlying assumptions (p.33); that the choice between uniform and regionally differentiated subsidies is finely balanced (p.34); and that an unfunded cost penalty of even a few percentage points can be significant for home viability. A move to nationally uniform basic subsidy rates should therefore be undertaken with extreme caution and be based on accurate and comprehensive data.

4. PRELIMINARY PROPOSAL 2

This proposal is strongly supported. The requirement for accreditation and certification of facilities is supported, however both have significant cost implications. If accreditation and certification are a Government requirement, then the funding that facilities receive from Government should enable them to meet this requirement.

5. PRELIMINARY PROPOSAL 3

This proposal introduces a number of concepts which require further clarification. Benchmarking is an exhausting, time consuming and costly process. What will be the benchmark level of care? How will it be determined, by whom, and by what process? How will a facility's compliance with providing the benchmark level of care be assessed and monitored? What will be the relationship between the benchmark level of care and the accreditation and certification requirements.

The Association is seriously concerned by the reliance of the Commission on the accreditation process to ensure a satisfactory level of care. This process is still to be tested. There are 1500 nursing homes to be accredited and monitored over time, plus hostels, in an industry which is unfamiliar with this requirement. The experience of the acute health care sector in meeting accreditation requirements should be explored.

What is meant by an efficient sized facility? How is this to be determined, by whom, and by what process? Does this mean that all other facilities are inefficient? Will such a concept force residential aged care to only be provided in *efficient sized* facilities. The Commission suggests that rationalisation is necessary and should not-be impeded (p.42). Even if this position were supported, which it is not, rationalisation is a slow process. The Commission notes that half of the current nursing homes have 40 beds or less, with Victoria and the Northern Territory having 70% of nursing homes with 40 beds or less. What is to become of these homes and their residents if this size is deemed not to be efficient?

What is an average input mix? How is this to be determined, by whom, and by what process. Is it possible to calculate an average input mix while still supporting flexibility and diversity in order to meet specific client population needs, and philosophical approaches such as *ageing in place* (eg ethnic specific or dementia specific facilities).

The Association also questions the proposal that additional funding support be only available for small nursing homes in rural and remote areas. What definition is the Commission using for rural and remote. Why only small facilities. Rurality and remoteness has an impact on cost additional to size. What of homes with specific target populations (eg ethnic specific)?

The Association is disappointed with the Commission's proposal that the *industry cost base should reflect nursing wage rates and conditions applicable in the aged care sector rather than in the acute care sector (p. 44).* Unless there is parity with the acute care sector in remuneration and conditions of employment, the aged care sector will not be in a position to recruit or retain qualified nursing staff. It is unrealistic to suggest that nurses will be attracted to work in the aged care sector if wages and conditions are less than those available in other sectors. The Commissions own data acknowledges that 95% of nursing home residents have high care needs (RCS classifications 1-4) (p.2). Providing quality care to these residents will necessitate, not only the employment of qualified nursing staff, but the employment of nursing staff with contemporary knowledge, skill and experience in gerontology. Recruitment and retention of nurses with the necessary knowledge, skill and experience will not be able to be achieved if there are significant differences in remuneration and conditions between the aged care and acute care sectors.

6. PRELIMINARY PROPOSAL 4

This proposal assumes that a standardised input bundle and a benchmark level of care can be satisfactorily established. The proposal to increase subsidies on an annual basis is supported.

The Association questions the capacity of the sector to provide productivity offsets, particularly on an annual assessment. It would be useful if the Commission were to identify where it considers productivity gains can be made. The impact of such a proposal on a sector which the Association considers has very few opportunities for productivity gains should be carefully considered.

The proposal for periodic review of the industry's cost base and of the adequacy of subsidies in the light of changes in care requirements is supported.

7. PRELIMINARY PROPOSAL 5

This proposal is supported.

8. PRELIMINARY PROPOSAL 6

It is the Association's view that the payroll tax supplement should be linked to payroll tax actually incurred. Many nursing homes regularly depend on agency nursing staff. Many homes also contract out services such as laundry, food, cleaning and maintenance. These factors need to be considered.

9. PRELIMINARY PROPOSAL 7

This proposal is not supported. The Association is aware that there are significant differences in workers' compensation costs between jurisdictions which the industry has only a limited capacity to influence. The industry has a high injury rate which will not be addressed if workers' compensation costs are not adequately reimbursed. A balance needs to be achieved between reimbursement for actual costs, those which are beyond the control of the industry, and performance incentives.

10. PRELIMINARY PROPOSAL 8

While this proposal is supported in principle, it is essential that careful consideration is given to the short term impact on government run homes and those transferred to the non government sector, particularly in relation to total funding, resident mix, and current staffing profile. It is the Association's experience that unless there is a long lead time, the funding impact on government homes is considerable. Time is required to adjust resident mix and staffing profiles to the change in funding.

11. PRELIMINARY PROPOSAL 9

The Association supports in principle the allocation of special needs funding. Our earlier comment is equally relevant to this proposal. What definition is the Commission using for rural and remote. Why only small facilities. Rurality and remoteness has an impact on cost additional to size. What of homes with specific target populations (ie ethnic specific populations)?

The Commission suggests that there should be a *rebalancing* of Commonwealth support to allow special needs funding. The Association assumes that the Commission is suggesting that the special needs funding should come from the existing funding pool. This is not supported. The existing funding pool is already not sufficient to ensure a satisfactory standard of care. Special needs funding must be additional funding to the existing funding pool.

12. PRELIMINARY PROPOSAL 10

This proposal is not supported. The Association has consistently sought some form of acquittal for the care component of funding. The complexity of and dissatisfaction with previous acquittal arrangements is acknowledged. It is our view however that accreditation itself and the capacity of the Accreditation Agency to monitor compliance with the accreditation process is not tested and will not be sufficient to ensure a satisfactory standard of care for each resident in each aged care facility.

13. PRELIMINARY PROPOSAL 11

This proposal is supported.

14. PRELIMINARY PROPOSAL 12

The proposal to replace the current quota on extra service places with a monitoring system aimed at identifying any cases where extra service provision is reducing access to basic care is not supported. The Association is convinced that replacing the current quota on extra service places will lead to reduced access to basic care. The Association also questions the capacity of existing mechanisms to adequately monitor the effect of replacing the current quota system.

15. PRELIMINARY PROPOSAL 13

This proposal is not supported. The Association considers that additional funding should be urgently allocated to those states and territories where the basic subsidy rate is currently inadequate. Funds intended for the indexation of current subsidies should not be used for this purpose. This will disadvantage other jurisdictions who will then face funding inadequacies. It is not appropriate to make such a decision until decisions are made about how future funding is to be provided and for what level of care.

16. SUMMARY

The Association supports the provision of a nationally consistent quality of care for residents of aged care facilities. It is our view that any funding methodology must be sufficient in quantum to allow a nationally consistent quality of care to be achieved; must be cost sensitive and vary to the extent that costs vary between jurisdictions; and must be reviewed and adjusted regularly.

Urgent adjustment must be made to those states and territories currently receiving inadequate daily subsidies, however additional funding should be used for this purpose, not funds earmarked for indexation.

Any funding methodology must take into account the additional cost burden for service providers of meeting accreditation and certification requirements, including the education and training needs of staff to meet accreditation standards.

Concepts such as *benchmark level of care*, *efficient sized facility*, and *average input mix* need careful definition and research.

Attachment 1

Weekly Wage Rates for Registered Nurses in Nursing Homes
NSW, Queensland, Western Australia and Victoria

STATE	CLASSIFICATION	1998	1997	1996	1995	1994	1991-3
NSW	RN 1st year	561.60	550.60	503.10	495.80	488.50	469.70 **(1991)**
	RN 8th year	788.60	773.10	700.00	689.80	679.60	653.50 **(1993)**
QLD	RN 1st year	546.15	532.15	522.15	479.50	471.5	471.50 **(1991)**
	RN 8th year	718.90	708.90	698.90	644.55	636.55	636.55 **(1991)**
WA	RN Pay Point 1	471.60	471.60	471.60	471.60	471.60	471.60
	RN Pay Point 8	636.60	636.60	636.60	636.60	636.60	612.10 **(1991)**
VIC	RN Grade 1 Year 1	503.70	493.70	485.70	485.70	477.70	469.70
	RN Grade 2 Year 6	655.40	645.40	637.40	637.40	629.40	621.40

Sources:
1. **NSW: Nursing Homes &c., Nurses (State) Award, 1991 - 1998**
2. **QLD: Aged Care Interim Award - State, 1991 - 1998**
3. **WA: Nurses (ANF WA Private Hospitals and Nursing Homes) Award 1991 - 1998**
4. **VIC: Nurses (Victorian Health Services) Award 1991 - 1998**

Comments by Commissioner Wood on Association Submission
September 1998

Page 1:

Geriaction is the specialist professional association for nurses and other workers in aged care. Geriaction has established standards for the aged care sector.

Page 2:

In their October 1998 Position Paper, the Commission states that the choice between uniform and regionally differentiated subsidies is *finely balanced*, and that an unfunded cost penalty of even a few percentage points could be significant for home viability (p.33). This seems to suggest that the differences between states and territories to warrant differential subsidies need only be very slight.

For examples of wage differentials see table provided.

Page 3:

The resident classification scale does not cost all aspects of care. It only gives a weighting to a selection of care needs which allow a classification level to be determined. The instrument is designed to fund relative care needs not actual care needs. The resident classification scale generally does not specify which staff category should provide the care.

The accreditation standards are commendable. The effort and cost however of accrediting all facilities in the time frame is an enormous task. If accreditation were to be used as the benchmark level of care, considerable resources would have to be allocated to assist facilities to meet accreditation requirements, and for monitoring compliance with accreditation standards over time. To accredit and for three or five years and then not regularly monitor is placing the well being of residents at risk.

Where are the productivity gains to be made in the residential aged care sector?

Staffing levels and skill mix are just one factor in quality of care. With a global bucket of funding, proprietors can choose whether they will employ highly skilled staff, improve care, make savings elsewhere and accept reduced profits or they can choose to employ less skilled or unskilled staff, run the risk of decreased standards of care and increase profits, or any variations on those two themes. Care standards do differ between homes depending on the priorities of the proprietor.

It would be difficult to develop a national position within the industry on staffing levels and skill mix in residential aged care, mainly because of different points of view and historical developments between different jurisdictions. When an attempt was made to do so in relation to nursing in the Principles to the Aged Care Act 1997, proprietors and government put extraordinary pressure on nursing unions and consumer groups to agree to the removal mandatory requirements for 24 hour nursing care. The nursing unions would like to see some minimum requirements combined with local flexibility.

1 do not think that a standardised input bundle is feasible. It would depend on what was included. There are vast differences in resident mix between homes. Costs associated with accreditation, certification, education and training would need to be included.

Page 5:

There is a limit to productivity offsets. There comes a point where you can no longer do more with less. Productivity improvements should be a part of a continuous improvement process, not linked to wage increases.

HEALTH OUTCOME PERFORMANCE INDICATORS (HOPIs): *MONITORING HEALTH IMPROVEMENT*

MAY 1997

AMENDED FEBRUARY 1998

NSW HEALTH DEPARTMENT