

**QUEENSLAND
Nurses' Union**

IN ASSOCIATION WITH AUSTRALIAN NURSING FEDERATION QLD BRANCH

ADDRESS ALL CORRESPONDENCE TO THE SECRETARY, G.P.O. BOX 1289, BRISBANE, QD, 4001



IN REPLY PLEASE QUOTE:

18 September 1998

Mr Michael Woods
Residential Aged Care Subsidies Inquiry
Productivity Commission
PO Box 80
Belconnen ACT 2616

All enquiries regarding this correspondence should be directed to:

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Dear Mr Woods

Please find attached a submission from the Queensland Nurses' Union (QNU) to the Productivity Commission's Inquiry into Residential Aged Care Subsidies. We thank you for allowing us an extension of time.

The QNU has been extremely concerned for many years now about the relative under funding of Queensland nursing homes. This submission provides us with another opportunity to detail our concerns and suggest remedies to the situation.

The structure of our submission will be:

- Executive Summary
- Recommendations
- Introduction
- History of the SHR and Labour Costs
- Industry Regulation
- Health and safety
- The way forward
- Conclusion and recommendations
- Attachments

The Commission should also refer to submissions provided by the Australian Nursing Federation Federal Office and other Australian Nursing Federation State Branches.

We look forward to further consultation with the Commission on this important matter.

Please do not hesitate to contact QNU Professional Officer, Bonny Barry or QNU Industrial Officer, Steve Ross by telephoning (07) 3840 1444 should you require any additional information.

Yours sincerely


Gay Hawksworth
Secretary

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PRODUCTIVITY COMMISSION

RESIDENTIAL AGED CARE SUBSIDIES SUBMISSION

**PREPARED BY:
QUEENSLAND NURSES UNION OF
EMPLOYEES**

DATE: 18TH SEPTEMBER 1998

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SECTION 1 - EXECUTIVE SUMMARY

- 1.1 The referral of the issue of current and alternative funding methodologies for nursing homes subsidy rates to the Productivity Commission has occurred at a time of great turmoil within the Aged Care industry. In addition to the historic under-funding of aged care in Queensland through the use of a differential Standard Hourly Rate, other major funding changes are causing great confusion.

On that basis, the QNU contends that the terms of reference for this inquiry are too narrow, and that issues such as levels of funding, quality of care for residents and conditions of employment and job security for nurses should be considered as inherent to the issues being addressed.

- 1.2 Such issues we contend, should have prominent status in any consideration of regulation in Aged Care, lest we return to the days prior to the Giles Report, 1985 when lack of regulation allowed bad practices to flourish. The QNU is also concerned by the cost minimisation emphasis in the approach to regulation and opposes the move to a completely self-regulated industry by peer review.
- 1.3 That said, the QNU does support a quality assurance approach in aged care which pays due attention to inputs, process and outcomes.
- 1.4 In addition to the historic under funding of Aged Care in Queensland, the industry has been facing the increasing burden of extra costs, with even less funding over the last 12 months. Through this submission we have provided evidence of the effect of this on nurses in Aged Care. Mandatory Accreditation will impose further costs on the industry, particularly as the industry is contributing to the costs of the Aged Care Standards and Accreditation Agency. These are in addition to other recent imposts including the cost of an appalling health and safety record and the documentation drive associated with new funding validation requirements.
- 1.5 None of these costs have been taken into consideration in the determination of the currently existing Standard Hourly Rate.
- 1.6 Evidence of increased nursing home resident dependency through illness, debility, a rise in dementia and other behavioural disorders contributing to nursing home placement and the rapid re-admission of residents back to their nursing home following an acute episode of hospital treatment is also unrecognised in the current Standard Hourly Rate.
- 1.7 Funding losses are happening at a time when monitoring of quality in aged care is totally inadequate in the lead up to mandatory accreditation, which will not be fully realised until the year 2001.
- 1.8 The Productivity Commission, in recommending changes to the remuneration rate and pace of coalescence must ensure that the subsidy rate for Queensland is sufficient in quantum and available in time to ensure that Nursing Homes in Queensland can provide high quality care for residents and decent working conditions for employees.
- 1.9 Indeed, this should be the case for all Nursing Homes across Australia, and achieving coalescence should be seen as more than just a mathematical challenge.

SECTION 2 - RECOMMENDATIONS

- 2.1 That the Productivity Commission factors in the unique circumstances of the decentralised population in Queensland in any analysis of state funding needs (see section 3. 1).
- 2.2 That the Productivity Commission in recommending changes to funding for Aged Care takes into consideration the need for an appropriate skills mix level sufficient to provide quality nursing care and a safe working environment (see section 4.1.3).
- 2.3 That the Productivity Commission in recommending changes to Aged Care funding ensures sufficient funding is available to meet skills mix and type requirements (see section 4.2.8).
- 2.4 Registered nurses must retain the responsibility for documentation of residential care needs in nursing homes, as they are the professionals best prepared to do so. Additionally, and in the face of continued validation requirements by the government, sufficient funding must be allocated for this function (see section 5.2.5).
- 2.5 The Productivity Commission in recommending changes to the funding of Aged Care must ensure that adequate consideration is given to the Poisons Regulations in Queensland (see section 5.3).
- 2.6 The Productivity Commission in recommending changes to the remuneration rate and pace of coalescence must ensure that the subsidy rate for Queensland be sufficient in quantum and available in time to enable Queensland facilities to meet accreditation by the preset 2001 deadline (see section 5.4.16).
- 2.7 The Productivity Commission taking into consideration funding for Aged Care must ensure that sufficient funding is available to meet the training and other needs in order to rapidly improve Workplace Health and Safety in the Aged Care industry (see section 6.12).
- 2.8 The QNU calls for the accountability and quarantining of care funds under the joint authority of the Director of Nursing/Nurse in Charge of the service and the provider to be legislated (see section 7.9).
- 2.9 In recommending any changes to Aged Care funding the Productivity Commission must recognise the significant and ongoing contribution of nursing unions as well as their representative function and recommend that any change in Aged Care be introduced in full consultation with nursing unions.

SECTION 3 - INTRODUCTION

3.1 Background

- 3.1.1 Queensland is the most decentralised state in Australia, with its resident population dispersed over a large geographical area and including a number of provincial cities and rural and remote communities. This provides particular challenges to government with respect to the delivery of health services, including aged care services. In addition, Queensland has a significant number of indigenous communities, many of which are found in remote locations, adding to the complexity of health service delivery.
- 3.1.2 The additional costs associated with delivering services in this decentralised setting must be taken into account when determining funding for aged care and other health services. These costs are greater in rural, remote and provincial settings because of the higher cost of living in these areas (due in large part to additional transportation costs) and smaller economies of scale. This "tyranny of distance" compounds the already unacceptable funding deficit for aged care services in this state. The QNU believes that this factor was never properly accounted for in the original Standard Hourly Rate (SHR) methodology. We urge the Productivity Commission to undertake an investigation of the cost differential arising from this decentralisation and include this factor in any proposed funding methodology for aged care.

The QNU recommends that:

That the Productivity Commission factors in the unique circumstances of the decentralised population in Queensland in any analysis of state funding needs (Recommendation 2.1).

3.2 The QNU

- 3.2.1 The Queensland Nurses' Union of Employees (QNU) is the principal union covering workers in the aged care sector in this state. The QNU rules allow for all levels of nurse (registered nurses, enrolled nurses and assistants in nursing) to join the union. The QNU, a state registered union, was formed in 1982. The union has been part of the Australian Nursing Federation (ANF) since 1989.
- 3.2.2 As at 31 July 1998 the QNU had 26,172 members with 4,294 of these members being employed in the aged care sector (16.4%). (According to the most recent nursing workforce data from the Australian Institute of Health and Welfare (AIHW), 20.02% of nurses in Australia are employed in gerontology or geriatric nursing.¹) It should be noted that QNU membership has more than doubled in the 16 years since its formation and membership growth continues to be strong. Growth is strongest in the aged care Sector (over 5% in the last year). Aged Care members are represented on the QNU council, executive, through workplace branches and at the QNU annual conference which is the principle decision making body of the QNU. The team based structure of the union has resulted in the appointment of three Brisbane based aged care organisers. The regional organisers (based in Toowoomba, Rockhampton, Townsville and Cairns) also have responsibility for aged care facilities in their geographical location. One Industrial Officer and two Professional Officers also have carriage of aged care issues for the organisation.

- 3.2.3 Since its formation the QNU has been active in lobbying for change in the aged care sector. For example, the union has made a number of submissions to government over the last 12 years in either our own name or in collaboration with the ANF, ACTU, other health unions, consumer groups and nursing home operators. Several of these documents are referred to in this submission. Governments (of both persuasions) have failed to implement many of the recommendations made in these submissions.
- 3.2.4 Over the years the principle focus of the QNU has been on the following issues:
- 3.2.4.1 The relative under funding of Queensland aged care facilities;
 - 3.2.4.2 The effect that this funding deficit has had on both standards of care provided and the nurses employed in the sector; and
 - 3.2.4.3 Concerns regarding the tools utilised to determine funding, the Resident Classification Instrument (RCI) and later the Resident Classification Scale (RCS).
- 3.2.5 In addition, various QNU aged care campaign committees have operated during the union's history. This is clear evidence of the commitment of the QNU and its members to contributing in a positive way to continuous improvement in aged care. The union has not only identified problems in this area but has also provided alternatives and proposed solutions. The union's activities in this area have resulted in significant expenditure by the QNU and its members, in both financial and physical resources and this commitment continues to this day.
- 3.2.6 The QNU has been an active participant in consultations with the current government about its aged care reform agenda. In particular officials of the union and the current QNU Aged Care Reference Group, comprising a cross section of QNU members, have provided detailed comment on the current RCS tool and the framework for accreditation. Our comments are always firmly grounded in the experience of QNU members employed in the aged care sector. We have also undertaken monitoring of the impact of the recent changes in the aged care area. The 12 month report is provided as Attachment 1.

3.3 The Framework of the Inquiry

- 3.3.1 The general policy guidelines of the Productivity Commission largely relate to economic imperatives - improving economic performance, reducing regulation of industry, encouraging growth of industries, facilitating adjustment to structural changes in the economy, reducing tariff and non-tariff barriers and so forth. These are of course qualified. For example, regulation is to be reduced "where this is consistent with the social and economic goals of the Commonwealth Government"ⁱⁱⁱ. The Commission is placed in a difficult position if the social and/or economic goals of the government are unclear, confused or unstated or if matters are referred to it because of political reasons. The QNU is concerned that these circumstances apply to The Residential Aged Care Subsidies Inquiry.

- 3.3.2 The Howard government's aged care policy framework is confused to say the least. The only policy constant has been the shift towards a "user pays" model for aged care. There have been significant and frequent changes in policy direction over the term of this government. These changes have resulted in high levels of anxiety and anger in the general community, especially amongst the elderly.
- 3.3.3 The issue of coalescence was always going to be a contentious issue, one that was likely to draw criticism from a variety of quarters, especially nursing home proprietors and state governments. All of this in the lead up to a federal election. An inquiry would "take the heat out of the issue" as the government can say that no decision has been made on the matter as they are awaiting the outcome of the Commission's investigation. An inquiry has the added benefit of concentrating the efforts of those with concerns into providing submissions to the inquiry rather than providing public comment on a contentious and emotive issue during an election campaign. (The current "Inquiry into Pig and Piguement Industries: Safeguard Action against Imports" can also be viewed in this light.)
- 3.3.4 The QNU views the provision of care in nursing homes as a health issue - residents are not there out of choice but rather because they require nursing and personal care. We therefore hold the conviction that the needs of nursing home residents must be seen in a health context. We would strenuously resist moves towards a two tiered health system and user pays models in public health, and would equally argue against such trends in nursing homes. The same principle applies - access to either general health care or nursing home care must not be based on ability to pay but rather clinical need.
- 3.3.5 The QNU is concerned therefore about the potential for the adoption of a narrow economic framework by this inquiry given the relative inexperience of the Commission in undertaking inquiries into the service sector. Any inquiry into nursing homes must have as a fundamental consideration the likely impact on the frail elderly residents of these homes as well as the workers in the sector. The Nursing Homes Subsidies Inquiry obviously stands apart from other current inquiries by the Commission in this respect (although inquiries into other "industries" do of course have a human component, in terms of impact on employment and security for workers in that sector). The added dimension in this Inquiry is the duty of care that governments have for the frail elderly in our community.
- 3.3.6 Although we acknowledge that the Commission has a record of inquiries in service areas, we equally hold concerns about how the government has utilised recommendations from these to achieve economic imperatives to the detriment of other considerations. An example of this is the child care sector, an area that will no doubt be raised as being in many ways similar to aged care. The Economic Planning Advisory Committee (EPAC) Child Care Taskforce was commissioned to investigate the nature of child care in Australia and make recommendations about the provision of services in the future. Its final report, "Future Child Care Provision in Australia"ⁱⁱⁱ, was handed down in November 1996. This report made 46 recommendations which were wide ranging in nature.^{iv}

- 3.3.7 The childcare and aged care sectors are similar in many respects. They are typified by the necessity to ensure that quality of care is maintained, duty of care considerations, the importance of government funding arrangements, state and federal government regulatory regimes, the delay in implementing a uniform quality assurance framework for services and a predominantly female and precariously employed workforce. Given these similarities and the fact that the government effectively used the EPAC report on childcare as a vehicle for change in that sector, the QNU suggests that the Commission closely considers the impact of recent government changes to childcare policy. We believe that there are obvious lessons to be learnt from the social impact of economically and ideologically driven agendas in a service sector such as childcare that are applicable to this current Inquiry.
- 3.3.8 The QNU is also concerned that the terms of reference for this inquiry are narrow given that they are dealing solely with the issue of Residential Aged Care Subsidies. It is our strong belief that the issues of funding (the level of subsidies provided), quality of care for residents and conditions of employment and job security for nurses in aged care are inextricably linked. We are aware that the Commission has the ability to consider other related or peripheral matters during the course of this inquiry but we wish to place on record that we see the quality of care and employment related matters as being central to the debate about funding. Our reasoning for this will be detailed at greater length later in this submission.
- 3.3.9 With respect to indicators that are specific to aged care, we wish to place on record that we are concerned about some indicators being suggested for aged care. For example, "specific reductions in existing regulatory requirements in nursing homes and hostels" has been identified as an effectiveness indicator. The QNU would strongly argue that this is not an indication of effectiveness. Regulation is seen by some as an unnecessary cost impost, this is a point that we would hotly contest. The QNU is extremely concerned not only about the assumptions inherent in the statements made in this section of text but also the designation of the indicator as demonstrating effectiveness. '
- 3.3.10 As we will outline later in this submission, it is our strongly held view that the aged care sector needs additional regulation and accountability mechanisms if standards of care are to be maintained. It is of extreme concern that the current federal government has a clearly stated policy agenda of reducing regulation on business, especially small business. (As you would appreciate a significant proportion of nursing home proprietors are small business people.) The Office of Regulation Review within the Productivity Commission has been established to perform a vitally important function in this respect. Part of their brief is to ensure that regulation is minimised wherever possible, something that we would passionately argue against in this instance. We would welcome the opportunity to share our reasons for this with the Office of Regulation Review.

SECTION 4 - HISTORY OF THE SHR AND LABOUR COSTS

4.1 History of the Standard Hourly Rate

- 4.1.1 The most significant aspect of aged care service provision is the work force. The qualifications, skills, staffing levels, health and well being as well as the wages and conditions of employment of the workforce are therefore all of considerable significance to the operations of the Aged Care industry. These factors have a direct impact on both the quality of care provided and the extent of that care.

The Standard Hourly Rate (SHR) for care staff was developed using a methodology based on a number of these factors. However while in some instances objective data was used (eg wage rates), in others extrapolations based on sampling occurred (staffing levels and skills mix). This resulted in a bias in funding levels against some states, especially Queensland.

While the SHRs have been adjusted to reflect changes in some of the factors incorporated in the original methodology, the inherent biases have never been addressed.

- 4.1.2 The Commonwealth in devising the methodology for each state's SHR:

[C]alculated [the SHR] by taking into account the hourly cost of each staff classification based on an extensive data set drawn from a representative sample of costed rosters.^{vi}

The basic data was then further adjusted to take into account matters such as sick leave, public holidays and estimates of award increases (untested assumptions were also made as to the amount of sick leave).

There was no analysis at that time, or subsequently, of the effectiveness of the staffing levels and skills mix reflected in the sample rosters. Staffing ratios and skills mix at that time were governed by regulation in Victoria. No such regulation existed in Queensland.

- 4.1.3 Therefore there has been no capacity in Queensland to improve skills mix and staffing ratios since the inception of the SHR. This is despite the poor position of this state relative to other states at the time of the SHR's introduction and the increasing acuity of residents since that time as discussed elsewhere in this submission.

The QNU recommends that:

That the Productivity Commission in recommending changes to funding for Aged Care takes into consideration the need for an appropriate skills mix level sufficient to provide quality nursing care and a safe working environment (Recommendation 2.2).

4.2 The Industrial Context and The Industrial Framework

- 4.2.1 The wages and conditions of nursing staff employed in aged care in Queensland have been governed by state awards. Initially, the relevant award was the Hospital Nurses Award - State however since August 1990 a specialist aged care award, the Nurses Aged Care Interim Award - State has operated. However, while the award was tailored to the aged care industry, the nursing classification structure and the wages and conditions have remained consistent with other sectors since that time. (Attachment 4 contains four tables. Table 1 is the history of rates of pay for nurses in Aged Care over the past decade and Table 2 is the history of public hospital rates of pay for the same period. Table 3 sets out the difference in wage rates between public hospitals and Aged Care as at 31st August, 1998. Table 4 sets out movements in certain allowances under the Aged Care Award).
- 4.2.2 With the introduction of legislative changes in 1994 shifting the emphasis from awards to enterprise bargaining, the QNU sort to investigate the capacity of the industry to adapt to the new approach. The QNU was successful in obtaining a grant jointly with the two principle employer organisations operating in Queensland (Australian Nursing Homes and Extended Care Association and Aged. Care Queensland) from the then Queensland Department of Employment, Vocational Education, Training and Industrial Relations to conduct research into this issue.
- 4.2.3 The report was completed in 1996 and provided a valuable profile of the workforce at that time. Of significance is the fact that the report found a distinct lack of experience, structures and skills across all sections of the industry necessary to conduct enterprise level industrial relations.^{vii}
- 4.2.4 At the beginning of 1996 no enterprise agreements had been reached in aged care. The employers felt constrained by the lack of funding for enterprise, as opposed to award based outcomes, yet the legislation prevented movements in award wages other than safety net increases. Enterprise agreements had been reached in the public sector and in private hospitals. The wages of Aged care nurses were falling behind as a consequence of the lack of any enterprise based outcomes.
- 4.2.5 Following a QNU industrial campaign the Queensland Industrial Relations Commission terminated QNU bargaining periods and varied the award to provide for wage increases of 7%. This restored a level of parity between the various sectors at that time.
- 4.2.6 Since 1996 a further legislative change resulted in even greater emphasis on enterprise bargaining. The QNU has actively pursued enterprise agreements in the Aged Care industry, however, to date only seven agreements exist in the industry covering nursing staff. One of these the QNU unsuccessfully opposed.
- 4.2.7 The QNU has currently notified bargaining periods against over 200 aged care employers and is pursuing agreements with them that address both staffing levels and skills mix as well as wages and conditions. However, employers continue to cite funding as an impediment to reaching agreements that maintain parity for nurses in aged care.

- 4.2.8 As a consequence the QNU has also lodged an application in the Queensland Industrial Relations Commission to vary the Nurses Aged Care Interim Award -State to provide for skills mix and staffing ratios.

The QNU recommends that:

That the Productivity Commission in recommending changes to Aged Care funding ensures sufficient funding is available to meet skills mix and type requirements (Recommendation 2.3).

SECTION 5 - INDUSTRY REGULATION

5.1 The Trend to Deregulation

As stated above the QNU is concerned the trend towards deregulation and the impact of that trend on the Aged Care Industry. The QNU supports an effectively regulated industry based on principles of quality assurance, accountability and resident care.

This section will examine three areas of regulation that we believe the commission must consider.

They are:

- i) Validation of funding through documentation;
- ii) The Queensland Poison's Regulations; and
- iii) Accreditation.

5.2 Validation of Funding through Documentation

5.2.1 Funding for services provided in nursing homes is determined by an instrument called the Resident Classification Scale (RCS). This is a system where a resident's relative care needs, identified by answering 22 questions about their care, are added together and one of eight possible classification categories is assigned to them. The funding subsidy rate is determined by this classification category.

Most residents in nursing homes are 'high care' residents that is RCS categories 1, 2, 3 & 4.

The rate of remuneration for these categories is state based and Queensland has the lowest rate in the country.

5.2.2 The Aged Care Act 97 pursuant to Section 88 - 1 (1) (a), provides that:

(1) An approved provider must:

(a) keep records that enable:

- (i) claims for payments of subsidy under Chapter 3 to be properly verified, and*
- (ii) proper assessments to be made of whether the approved provider has complied, or is complying, with its responsibilities under Chapter 4.*

An approved provider must keep records that enable claims for payments of subsidy to be properly verified. These records include a care recipient's individual care plans, medical records, progress notes and other clinical records.

As a consequence of this regulation a resident's complete care record must be available for the perusal of Commonwealth validation officers to ensure that the RCS claim is an accurate reflection of the care provided.

The failure of such records to adequately demonstrate the level of verification required by such officers can lead to a category down grading and subsequent refund payable to the department by the nursing home. Conversely, it can occur that documentation shows the resident's care category is set too low and an upgrade can occur.

This validation of funding through documentation activity is, in health care, unique to aged care.

5.2.3 Professional nursing documentation

Documentation of nursing care has always been part of a nurse's work. Nursing documentation provides a record of the care given; it communicates the plan of care and demonstrates the client's response to nursing actions. It is also used to provide evidence of such care in legal and professional circumstances. The style of this documentation is usually driven by professional nursing models specific to the speciality.

In aged care however, documentation is more often driven in style by the structure of the RCS than by professional models. This is despite the assertion by the Commonwealth that:

"The appraisal completed on the Resident Classification Scale should be a by product of the care planning process and not drive that process"^{viii}

The fact remains that funding is dependent upon successful validation. Unless documentation clearly demonstrates the care is consistent with the claim made against the RCS, funding may be lost.

- 5.2.4 Since the introduction of the previous classification instrument the Resident Classification Index (RCI) in 1987, nurses have copiously documented in order to protect the nursing home's funding income against validation losses. This practice continues under the RCS.^{ix} (Attachment 5 is the QNU Submission on the RCS).

Registered nurses, the ones responsible by the Queensland Nursing Council through their Duty of Care for planning, assessing and evaluation of nursing care, can spend in excess of four hours a day on resident documentation in many nursing homes. However, as the validation regulation is only found in aged care, it is not possible to benchmark the volume of documentation generated against other areas of health care. It is not possible to say that nurses in other health sectors would not respond in such an extreme fashion if they had a similar validation process

- 5.2.5 The introduction of the RCS in October 1997 with its lack of supportive educative materials and training has only increased the burden of documentation in nursing homes. It is the QNU's belief that the significant time spent by nurses on this activity is over and above that done by nursing to meet professional and legal requirements.

This activity remains unaccounted for in the RCS instrument and therefore is unfunded despite the significant time that it takes. The funding difficulties already experienced by Queensland are further exacerbated by this situation.

The QNU recommends that:-

Registered nurses must retain the responsibility for documentation of residential care needs in nursing homes, as they are the professionals best prepared to do so. Additionally and in the face of continued validation requirements by the government, sufficient funding must be allocated for this function (Recommendation 2.4).

5.3 Queensland Poison's Regulation

The Queensland Poison's Regulations ensure that Registered Nurses are available in nursing homes 24 hours per day for the purpose of possessing and issuing drugs at the nursing home. This is essential for safe medication practice. Sufficient funding must be specifically available to meet this requirement.^x The QNU draws the Commission's attention to the Health (Drugs and Poisons) Regulation 1996 - Section 61(1) & (2), 61(1), 162., 169.(1) & (2), 175.(1) & 263.

The QNU recommends that:

The Productivity Commission in recommending changes to the funding of Aged Care must ensure that adequate consideration is given to the Poison's Regulations in Queensland (Recommendation 2.5).

5.4 Accreditation, Quality Assurance and Accountability

5.4.1 The system for measuring the standards of care delivered and other operations of Aged Care facilities has changed under the current Federal Government from one based on Government monitoring (outcome standards) to one based on self regulation (accreditation). While the outcome standards were styled as nationally consistent, this was not the case in their application. The shift to an accreditation system based on quality assurance will not ensure adequate standards unless it is accompanied by complementary controls in the expenditure of funds. In addition, sufficient resources have to be provided to enable aged care facilities to meet their obligations under accreditation.

5.4.2 Since 1988, the only nationally consistent measure of nursing home quality has been the Outcome Standards. The standards were introduced in response to the call for improved accountability for government funding through the introduction of formal measurement of quality in nursing homes.

Tracey McDonald stated:

"The Outcomes Standards provide a benchmark for evaluating the results of nursing home services according to local needs and circumstances, and as such provide a means by which the public is assured of reasonable accommodation conditions and competent nursing and allied nursing services as well as access to competent medical and allied medical services."^{xi}

5.4.3 Outcome Standards a True measure of Quality?

In the past decade however, there has been a view emerging within the industry and amongst nurses that the Outcome Standards and the accompanying monitoring processes were in need of further development. Indeed, the standards were in jeopardy of becoming better known for what they didn't measure than for what they did!

In some nursing homes, the arrival of the Standards Monitoring Team (SMT), usually with prior warning, meant that the SMT was not viewing 'normal' practices, but those adopted specifically to pass inspection.

Nurses tell stories for example, of the "S.M.T. trolley" - a personal care trolley stacked with fresh fluffy linen, mountains of gloves, toiletries and napkins, not usually seen in the home - being wheeled out of its locked cupboard in preparation for the team's visit.^{xii}

Such stories gave credence to the view that Outcome Standards monitoring was a 'one off' test to be passed, rather than a true measure of a homes quality culture.

- 5.4.5. This view was supported by the Department of Health and Family Services (DHFS) in their Submission to the Senate Affairs Committee Inquiry into Funding of Aged Care Institutions.

"The system is a regulatory and minimalist approach which, while identifying either compliance or non compliance, does not acknowledge quality service. Monitoring provides a snapshot and so can focus on isolated incidents of non compliance rather than establish evidence for systemic weakness. The system encourages facilities to concentrate on compliance with no requirements or incentives for good practice or improvement"^{xiii}

Whilst the Department acknowledged that the overall standard of care had improved in the ten (10) years of standards monitoring the current arrangements had limitations.

- 5.4.5 Previously, Queensland has been frustrated in its attempts to achieve Standard Hourly Rate (SHR) equity by the argument, that despite the lowest level of SHR remuneration and the poorest skills mix and resident to nurse ratios in the country, the majority of homes met Outcome Standards regularly. Table 1 sets out comparative state figures of outcome standard compliance, it does not however illustrate which of the 31 standards were met.

Table 1.

Table 51: Average percent of outcome standards met by all nursing homes and hostels^{xiv}

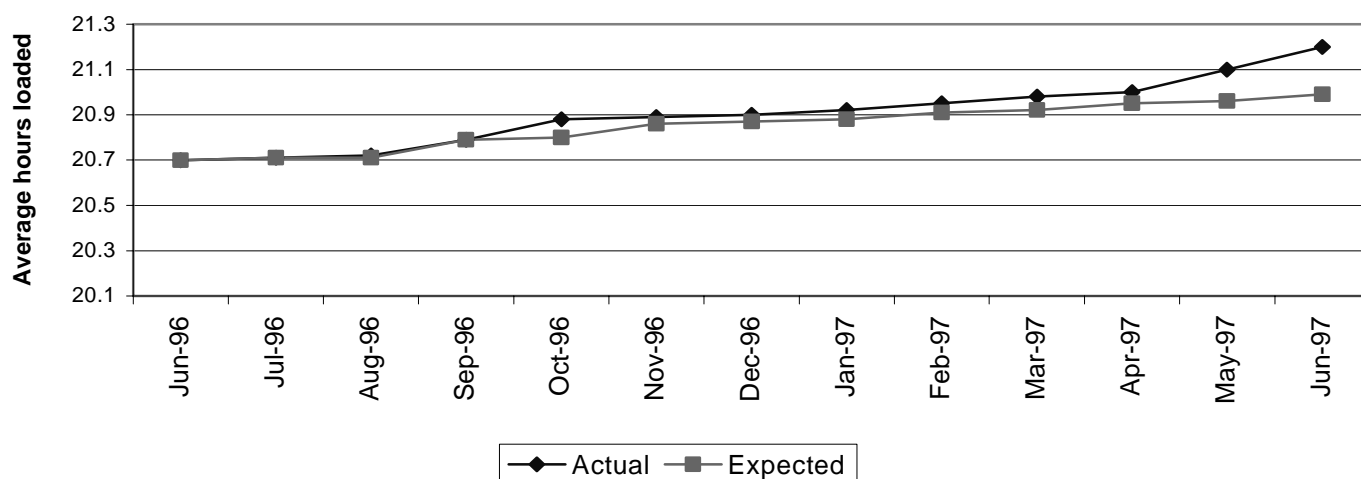
Nursing homes	%		Hostels	
	1995-96	1996-97	1995-96	1996-97
State/Territory				
NSW	72.2	69.2	87.7	80.5
Vic	72.7	74.1	87.6	77.4
Qld	71.3	79.9	85.0	77.2
SA	61.0	82.9	78.8	78.1
WA	78.0	67.7	76.0	66.1
Tas	74.6	71.2	81.1	68.2
ACT	78.6	85.3	75.7	85.5
NT	91.5	50.0	78.0	0.0
Aust	70.9	73.6	83.9	76.2

- 5.46 It is the QNU's view, that the Outcome Standards developed in 1988 do not measure contemporary quality of care in nursing homes. In particular, they do not measure the professional nursing care needs of today's nursing home residents.

There is significant evidence of increased nursing home resident dependency through illness, debility, a rise in dementia and other behavioural disorders contributing to nursing home placement. There is also significant evidence of the rapid re-admission of residents back to their nursing home following an acute episode of hospital treatment. These developments have occurred without significant change to the Outcome Standards. See Graph 2 below.

Table 2.

Figure 28 - Growth in Nursing Home Dependency June 1996 - 1997^{xv}



The Outcome Standards have been applied utilising a risk management approach to monitoring that has meant that 'low risk' homes were inspected on average only every three years.

They were originally developed as a mechanism for funding accountability however, they became defacto evidence that residents' care needs were being met, both for accommodation and health care without true validity.

It is our view that any inquiry into productivity in nursing homes would be remiss in concluding that the achievement of Outcome Standards in Queensland equated to an acceptable standard of care being delivered.

- 5.4.7 The relationship between residents and nurses is more complex than consumer and worker performing tasks; it is a relationship where the resident and nurse are at least companions, often friends. It is the health of this relationship and the outcomes that it has for residents that is part of any true measure of Quality of Life or productivity in nursing homes!^{xvi}

5.4.8 A New measure of Quality

Under the Aged Care Act 1997 Section 42-(4) it became law that all Residential Aged Care facilities would be required to achieve Accreditation status by January 2001 or would have Commonwealth funds withdrawn.

The Commission will note that the requirement under the Aged Care Act 1997, for mandatory Accreditation by January 2001, does not distinguish between States or facilities.

- 5.4.9. In the Coalition policy 1995/96 on aged care it is clear that there will be a cost impost on the industry.

The emphasis of this system will be on peer review and self-regulation under the supervision of an independent Aged Care Standards Agency funded by both industry and Government,^{xvii}

In addition to capital activity, work such as policy and planning, self assessment and training and education for the significant cultural shift towards a continuous improvement approach to care is required to enable a health facility to meet Accreditation.

QNU members report the employment of consultants, quality improvement officers, purchasing of policy manuals, computer hardware and software and training packages to assist with Accreditation are all occurring and acting as a drain on the overall money pool received by Queensland nursing homes. This reduces staffing hours, skills mix and therefore, quality of care.

- 5.4.10 QNU has been monitoring the impact of Aged Care reform on our members over the past 12 months. Results indicate that provider claims, to our members, of budget over runs has resulted in considerable nursing hours being cut.^{xviii} (see Attachment 1).

The question remains therefore: How will Queensland with its current poor Standard Hourly Rate pay for Accreditation?

- 5.4.11 The QNU believes that some of these budgetary claims of over runs are likely to be attributable to the need of many homes to meet capital rebuilding or refurbishment outlays to meet certification and accreditation.
- 5.4.12 Whilst being unable to state with any certainty, (due to the loss of accountability for care funding), the extent of transfer of care subsidy to capital expenditure, the QNU believes that a continued poor SHR remuneration will result in an exacerbation of this unacceptable situation. The transfer of care subsidies towards other purposes will continue to escalate with the move to Accreditation.
- 5.4.13 The QNU considers that it is true inefficiency in resource allocation when a reported overall increase in funding for Queensland under the RCS, results in residents receiving less total nursing care hours than before Aged Care Reform.
- 5.4.14 Unless the current subsidy rate in Queensland is improved urgently the result of this unfunded regulation will continue to negatively impact on Queensland's nursing home residents. Accreditation is a sophisticated system of proving continuous quality improvement, and in related health care facilities such as hospitals is predominantly undertaken by a skilled work force characterised by relatively stable employment.

The aged care work force in Queensland residential aged care facilities is characterised by a high level of unqualified staff who have little expertise in accreditation processes.

- 5.4.15 A number of funding related questions emerge from the accreditation process. In order to achieve Accreditation on time, will Queensland providers be able to employ the level of skilled staff (skills as exists in the hospital sector or interstate aged care facilities) in order to undertake the work necessary for Accreditation, or will they simply have to make do?

Will the Accreditation Agency charge more to accredit nursing homes on Thursday Island or in Longreach. The accreditation agency is a private organisation and expensive travel will be involved to such remote sites.

- 5.4.16 The QNU believes that the cost for Accreditation inspection will be relevant to the overall costs incurred by the Agency in each state.

To not address the unique nature of Queensland homes and the impact of the costs of Accreditation is to risk failure in Queensland to meet the new mandatory standards for quality in Aged Care.

It will defeat the purpose of improved quality of life through Accreditation.

The QNU recommends that:

The Productivity Commission in recommending changes to the remuneration rate and pace of coalescence must ensure that the subsidy rate for Queensland is sufficient in quantum and available in time to enable Queensland facilities to meet Accreditation by the preset 2001 deadline (Recommendation 2.6).

SECTION 6 - HEALTH AND SAFETY

- 6.1 The Aged Care Industry in Australia has a very poor health and safety record. The Industry is characterised by high injury rates and high workers compensation premiums. Very few workplaces have a documented health and safety system.

While a number of measures have been introduced over the past few years to improve this record there remain considerable challenges to the industry before an acceptable standard is achieved.

The Workplace Health and Safety difficulties in Queensland are accentuated by poor staffing skills mix and low staffing levels. These are directly attributable to the lower relative funding of Aged Care in Queensland.

- 6.2 As Gregory^{xix} (1993) pointed out, one of the inhibiting factors to improved Workplace Health and Safety was that the industry was fully funded for its workers compensation costs.

This system was changed by the Labour Government in 1993/94 with the new arrangements beginning 1995/96. This was due to a dramatic increase in premiums over the previous three years - \$55 million to an estimated cost of \$78 million^{xx}. The new system determined a state average cap and Nursing Homes were funded at the average cost in the current year. An upper cap was set and subsequently reduced each year.

TABLE 1

Workers Compensation Costs (as a % of payroll)

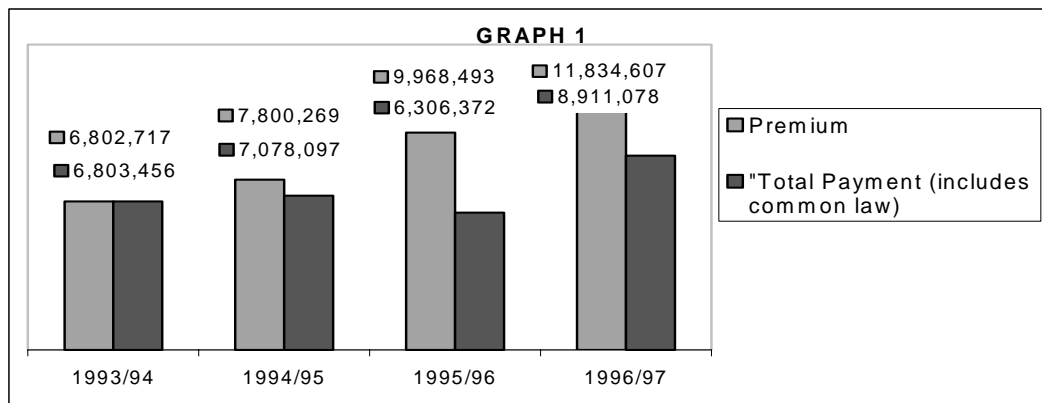
	NSW	VIC	QLD	WA	SA	TAS	NT	ACT
1993/94	3.28	3.91	2.63	3.99	5.92	4.66	2.54	2.85
1994/95	3.89	3.74	2.7	4.03	5.73	5.37	2.99	4.69
1995/96	5.25	3.74	3.1	4.03	6.02	5.5	3.26	4.87
1996/97	4.9	3.7	4.7	4	5.8	8	3	4.7

Data from Pam Pryor and Associates.^{xxi}

As you can see in Table 1, the increase in premiums has continued until the 1996/97 financial year where all states except Queensland and Tasmania have decreased.

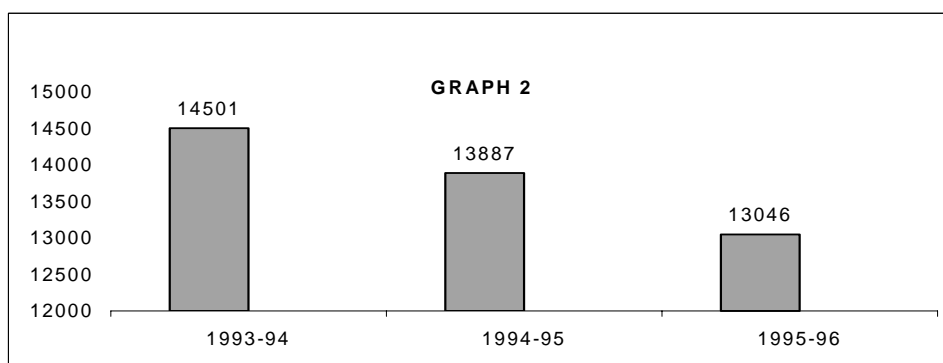
Furthermore, as seen from Graph 1, Queensland premium increases and compensation payouts (including common law) increased, while staff numbers decreased over the same period - graph 2.

Premiums/Total Payments - Qld



Data supplied by Work Cover Queensland^{xxii}

Total No's Workers - Nursing Homes - Qld



Data supplied by Work Cover Queensland
(NB 1996/97 data not available due to changed data collection)

The figures produced by Pam Pryor in industry terms equated to \$572 per bed in 1993/94 to \$740 per bed for 1995/96.^{xxiii}

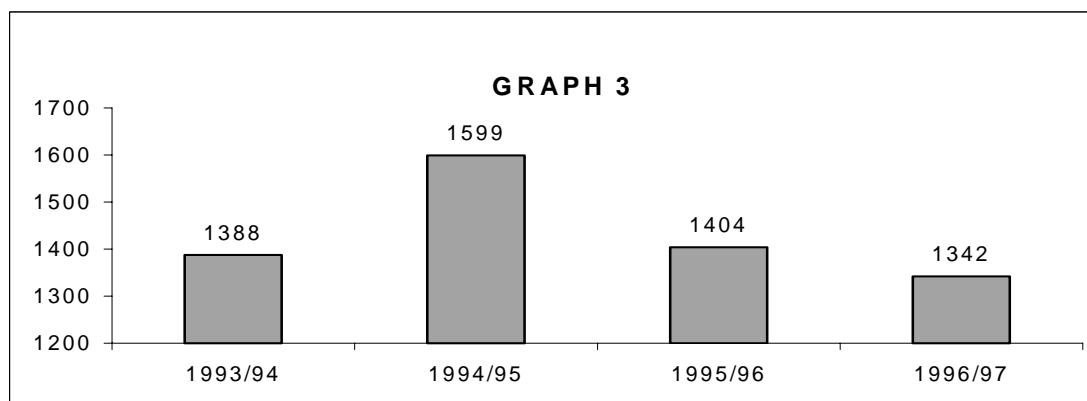
- 6.3 Data collection for Occupational Health and Safety on a national basis is very difficult to collect due to the different data bases kept and the different workers compensation legislation in each S

However, Pam Pryor,^{xxiv} using Work Safe Australia data reported the following for the 1992/93 period:

"The injury incidence rate for nursing homes is 73% higher than for the industry average, the incident rate for, nursing homes is also significantly higher than for hospitals and psychiatric hospitals. The incidence rate is even more concerning when we compare the incidence rate of the predominantly female nursing home workforce with the industry average for female workers. The incidence rate for nursing homes is 200% greater than the average for female workers."

- 6.4 In Queensland, although it appears the number of claims have decreased since 1994/95 (refer graph 3) we must keep in mind that the numbers of employees have also decreased.

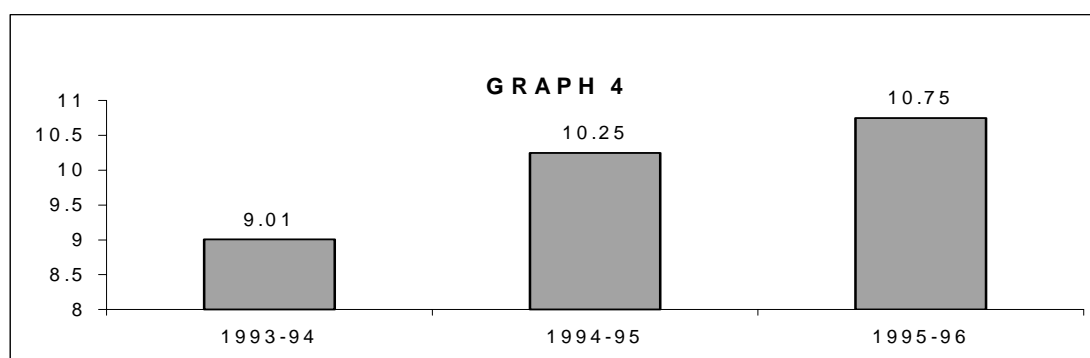
Total No's Claims - Nursing Homes - Qld.



Data supplied by Division of Workplace Health and Safety.

Notwithstanding this, the incidence of injury has increased (refer graph 4). This is despite some Nursing Homes reporting a dramatic decrease in numbers of claims once they have implemented safer people handling systems of work.

Rate Injury per 100 Workers - Nursing Home - Qld



Data Supplies by Division of Workplace Health and Safety.

As a comparison, in 1995/96 the incident rate for Hospitals in Queensland per 100 workers was 8.06.^{xxv}

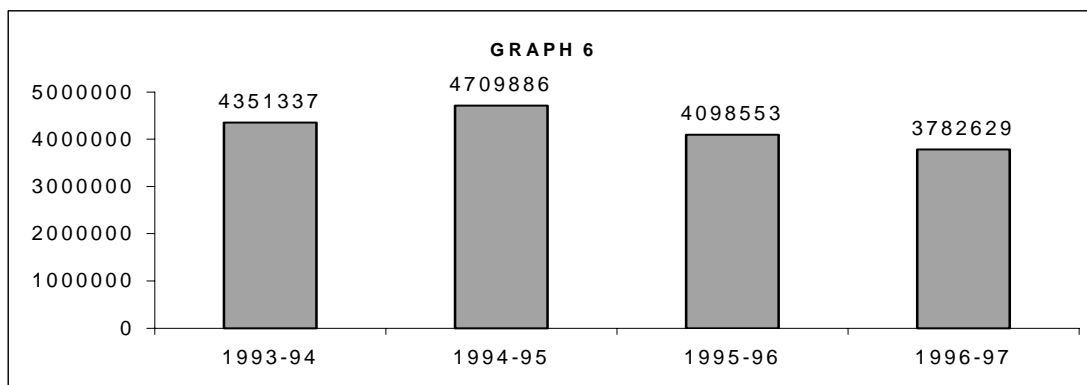
6.5 In a study done in Victoria^{xxvi} it was reported that:

- Nursing Homes employing more "untrained" staff have a higher claims rate.
- Nursing Homes employing more "untrained" staff have higher claims costs.

We believe this trend would be replicated in Queensland, however this information came about through a special project accessing the Department of Health and Family Services data, which we do not have access to in Queensland. But, as Queensland has a substantially higher number of untrained staff in their facilities than in Victoria, one could assume that this information would translate to Queensland.

6.6 In Queensland, statutory compensation payments have decreased minimally.

Statutory Payments - Nursing Homes - Qld.



Data Supplied by Work- Cover Queensland.

In 1991 the then Workers' Compensation Board of Queensland introduced the concept of Rehabilitation Co-ordinators. This concept was only implemented in very few nursing homes until approximately 1994 when the Board actively assisted the industry to implement proper rehabilitation systems.

Although some workplaces implemented very good systems at an early stage, rehabilitation programs were very "hit and miss" until legislation brought in compulsory requirements for policy procedures and Rehabilitation Co-ordinators in 1998. Once again there had been no financial incentive for nursing homes to do so.

- 6.7 In 1994 the Division of Workplace Health and Safety commenced a random audit program of 100 registered Nursing Homes in Queensland. This resulted in 170 improvement Notices being issued.

Also at this time, QNU held the Chair of the Division of Workplace Health and Safety Community Services Industry Committee (tripartite committee). Through this committee it was decided that work was required to assist nursing homes with their Manual Handling Issues. This resulted in a seminar being held in November 1995 and the Committee reforming as the Occupational Health and Safety in Residential Aged Care Committee, which is still in existence today. QNU holds the Chair of this Committee.

One of the areas that the Committee originally looked at was formal education on Health and Safety given to nursing staff as part of their training.

The Queensland Nursing workforce consists of Registered Nurses, Enrolled Nurses, and Assistants in Nursing who all receive varied training in Health and Safety. In a survey of Universities in Queensland, it was found that only an average of 8 hours in the whole three years of an undergraduate nursing course was spent on Occupational Health and Safety. This was done primarily in a laboratory situation.

Enrolled Nurses who receive their training though TAFE in Queensland undergo 20 hours off the job and 5 hours on the job training in health and safety. At this time Assistants in Nursing did not undertake a recognised course. However, the newly introduced Certificate 111 in Aged Care Course for Assistants in Nursing includes 15 hours of training in occupational health and safety.

- 6.8 There are many hazards that affect nurses, eg shift work, stress, violence, chemicals, etc. with the major hazard being manual handling. These affect their every day life on the job so it is not unreasonable to expect that they receive a reasonable amount of training in the area of health and safety. This is currently not the case.

When Health and Safety training falls back on the employers or Nursing Home Proprietor, the training is varied and inconsistent.

Only mandatory training is given in Procedures and Manual Handling in most facilities. Members report that they receive a minimum of one hour each on a yearly basis.

- 6.9 There are however some facilities who give considerably more. Some are now providing up to 8 hours induction on Manual Handling with annual competency checks.

Up until the new funding system, this training was an allowable expense under CAM funding. Employers, however, argued that this money was needed for the provision of nursing care and could not be spared.

- 6.10 In Queensland, each workplace with 30 or more workers is required under the Workplace Health and Safety Act 1995 to have an accredited Workplace Health and Safety Officer (WHSO). Proprietors with more than one establishment may seek permission for one to cover all of their sites. The training given to WHSO's is a general service industry course and is not Aged Care specific. This is recognised by industry but they have not sought to develop their own course.

- 6.11 The cost of injury to industry is approximated as seven times^{xxvii} the compensatable costs with the personal costs to injured workers unable to be quantified. The Queensland Nurses' Union is very concerned about the injury rate to nurses in this industry and have embarked on a campaign of "No lifting by the year 2000". Queensland's campaign has now been picked up by the other ANF branches.

The campaign was primarily aimed at the Aged Care Industry but is relevant to all areas of health. The aim is to minimise manual handling and therefore minimise injury.

- 6.12 As can be seen, the QNU has been very active in this area for the past five years and we are finally seeing some of the benefits of our work. However, the industry has a long way to go. Employers have an obligation to provide a safe system of work and must implement policies and procedures to protect their workers. One of the real impediments to improved Health and Safety in Aged Care in Queensland has been, and continues to be, the low funding levels and consequent poor skills mix. Until this is addressed other improvements will only have marginal impact.

The QNU recommend that:

The Productivity Commission in taking into consideration funding for Aged Care must ensure that sufficient funding is available to meet the training and other needs in order to rapidly improve Workplace Health and Safety in the Aged Care industry (Recommendation 2.7).

SECTION 7 - THE WAY FORWARD

- 7.1 In order to address the issue of the distribution of Commonwealth funds for nursing homes subsidies, the QNU believes the Productivity Commission must first acknowledge that the SHR remuneration for Queensland is too low and, in addition, that a seven year rate of coalescence is untenable for Queensland.

Unless these issues are immediately addressed Queensland will become a second, perhaps third rate provider of residential aged care within the nursing home sector despite the best efforts of employees. These adjustments should not be at the expense of other states however.

- 7.2 During the 1980's Australia had already experienced the shame of a public examination that determined we cared for our elderly in an unacceptable manner. The Australian public no longer will accept poor standards of care for their elderly. The matter of aged care remains a sensitive issue for government because of the high expectations the public has for such care.

Whilst the brief to the Productivity Commission emphasises the examination of the form of funding rate rather than the quantum, the QNU clearly believes that a failure to increase the overall funding level to Aged Care is a failure to address many of the problems in the Industry.

- 7.3 The QNU believes that the Productivity Commission must, as a matter of urgency, address the raising of the remuneration rate of states such as Queensland and South Australia. However, to concurrently reduce states such as NSW, Victoria and Tasmania merely shifts the problem. In the face of Commonwealth statistics of increased resident acuity, continual cost escalation and increased expectation of quality of service provision both from government through mandatory Accreditation and public pressure, to reduce available funds is to lower residents quality of life. This is an untenable situation.

- 7.4 In order to have regard to the objectives of the Commonwealth's residential Aged Care Program a clear outcome of the PC inquiry is that all states must have sufficient funding in' nursing homes to afford an acceptable standard of professional nursing and residential care. Achievement of this for Queensland is through the immediate and substantive increase in the Standard Hourly rate.^{xxviii}

- 7.5 The provision of aged care within the nursing home sector must be recognised by the Commission as the care of the sickest and most dependent of our elderly citizens. The admission of residents to a nursing home is upon the acknowledgement of both the resident and/or family that care cannot be provide for in their homes.

Their care needs are simply too onerous for home or supported living environments to provide appropriate care. Their admission is an acknowledgement that despite community and assisted living supports they need more help.

The admission to a nursing home is not one of choice of accommodation.

- 7.6 Many residents come from home situations where there are community care packages, domiciliary nurses, home help, handyman services, meals on wheels in attendance and for many, the constant and caring presence of family. Despite this comprehensive 'package of care' the resident requirements are more than can be provided for. Admission to a nursing home is a difficult and often emotional course of action for many families.

To then admit them to a nursing home where the attention they receive from their nurses is (according to anecdotal information from QNU members) at times less than 1.8 hours a day and where the access to registered nursing staff averages between one RN to between 30 to 60 residents (as high as 150 has been advised) is not an improvement in care provision. It simply maintains the resident in a custodial care situation not a high care nor a home like residential situation.

Nursing home care should NOT result in less care 'time' being provided. Families do not expect this as a consequence of their difficult decisions to admit their loved one to a nursing home.

The Productivity Commission must recognise that sufficient funding should be available in Queensland to provide sufficient numbers of nurses of appropriate skills levels to provide nursing home residents with health care as well as home like care.

- 7.7 The move to Accreditation is one that the QNU hopes will address a resident's real needs as opposed to the current static minimalist standard of care. However, this is not achievable in Queensland at this time. Mandatory and appropriate accreditation is a cost impost, unfunded for in the Standard Hourly rate.

In order for Queensland to achieve Accreditation sufficient funding must be available. Such funding should be sensitive of our decentralised geography and available in sufficient time to meet the deadlines set by government.

- 7.8 The QNU does not advocate the extension of Accreditation deadlines as we are already concerned about the deficit in quality monitoring processes at this time. Rather we seek an urgent redress of the Standard Hourly rate in order to make meaningful progress towards Accreditation.

- 7.9 The QNU believes that the regulation for validation of funding through professional nurse's care planning and documentation is vital to quality care delivery - documentation is an inefficient use of resources.

However, validation of a resident's category for the purposes of funding by a rigorous and often subjective examination of a nurse's documentation is unnecessary.

Such validation seems futile when accountability for where the money is spent is NOT required by providers for the money received.

The message from government appears to be that they do not trust the nurse in charge of care planning to not cheat the government out of funds by false classification - but trust implicitly the provider to ensure such funds are used to maximum effect in the provision of nursing and personal care.

The QNU rejects this attitude.

- 7.10 It is clear from the QNU monitoring of the last 12 months of aged care reform, that nursing hours cuts are the single most significant result of the loss of accountability for care funds. The nursing home "dependency increase" trends clearly indicate that residents require more care not less. As stated previously, it is truly an inefficient resource allocation when a purported increase in government spending in aged care leads to less nursing care time for residents than before reform.

No increase in the Queensland Standard Hourly Rate can be deemed to be effective or efficient if not accompanied by measures that ensure maximum effect for residents in nursing homes.

The QNU recommends that:

The QNU calls for accountability and the quarantining of care funds under the joint authority of the Director of Nursing/Nurse in Charge of the service and the provider to be legislated (Recommendation 2.8).

- 7.11 The high cost to all involved in the Aged Care Industry of a disgraceful health and safety record is a major inefficiency. By increasing funding levels sufficiently to ensure an optimum skills mix and adequate staffing levels in addition to a sound training base, real and long term savings can be achieved.

- 7.12 Before Queensland can move forward we need to stop the deplorable loss of nurses from aged care. There must be explicit recognition that high care residents need nurses. To suggest anything else is to be contemptuous of the value the our aged care residents.

The nursing profession has never advocated a position of a fully registered nursing work force in aged care. We do however advocate the position that all nurses must be possessing of a minimum standard of educational preparation before working in aged care. The nature of the work and nursing Duty of Care responsibilities demands this.

We do advocate that it is the registered nurse supported by enrolled nurses and working in conjunction with Assistants in Nursing that form the team that provides the best of care for our elderly.

Nurses must therefore be able to conduct their work in an environment that enables them to care for their residents in a meaningful and professionally satisfying manner, ever cognisant of the relationship between nurse and resident and what this contributes to quality of life.

- 7.13 Equally important is the value that is placed on the 'worker' in aged care. The current disparity between wage rates in aged care and other sectors of nursing has and will continue to see an exodus of nurses from aged care. It will exacerbate the inability to attract, recruit and retain nurses in the aged care sector. This situation is acknowledged by the National Ageing and Research Institute in its government commissioned examination of the nursing workforce in aged care.^{xxix}

Wages along with the professional attraction to the work in aged care are two critical factors in recruiting and retaining nurses. In order to address the haemorrhaging of nurses from aged care any decisions on when and how to change subsidies rates must take into consideration the critical stage we are at in Queensland.

SECTION 8 - CONCLUSION

- 8.1 The QNU does not support coalescence over seven years . This fails to address Queensland's historical and unacceptable underfunding.
- 8.2 The QNU seeks the urgent redress of a substantial nature to the current Standard Hourly Rate in Queensland.
- 8.3 We do not support the current methodology of funding determination used for the standard hourly rate.
- 8.4 We reject the validity of the original funding methodology used in the 1980's.
- 8.5 We support a funding formula that is sensitive to the unique nature of each state.
- 8.6 We seek the acknowledgement of the decentralised nature of Queensland and it's particular needs in the cost of the provision of aged care.
- 8.7 The use of 'averaging' techniques to determine subsidy rates results in disadvantage to some Queensland homes that is so significant as to cause failure to provide satisfactory care to their residents and to meet regulatory requirements.
- 8.8 We seek that the commission recognise that aged care is the delivery of a service to the most vulnerable of Australians.
- 8.9 The need for rigorous regulations was well demonstrated in the years prior to the 1985 Giles report.
- 8.10 Inconvenience and the hurt feeling of providers that the government does not trust them is no justification for the exposure of older Australians to the mercy of market forces and deregulation.
- 8.11 Market forces failed to assist them in the years prior to 1985. It was regulation and the presence of nurses that made aged care in this country a service we were proud of.
- 8.12 The QNU believes there is no justification for either the failure to address Queensland's poor Standard Hourly Ratio immediately or to decrease available funding to other states in order to "balance" the government books in aged care.
- 8.13 Wage parity for nurses in aged care and appropriate remuneration in the subsidy rate as matter of urgency is the only way to demonstrate the value that we afford our aged care residents.
- 8.14 If coalescence proceeds that Queensland and other states below the national average must make substantial gains towards the level afforded to Victoria and NSW.
- 8.15 Nationally consistent outcomes for aged care must not result in the level of those national consistent outcomes falling.

- i. Australian Institute of Health and Welfare
- ii. Productivity commission establishment documents
- iii. Future Child Care Provision in Australia
- iv. With the taskforce recommendations in hand the imperative for the government was economic - to contain the cost to government. Utilisation of childcare was increasing every year and so too was the cost to government. A similar imperative exists for the government in the provision of services for the aged given the ageing of the Australian population.

The QNU believes that it is useful to examine briefly what has occurred in the childcare "industry" since the handing down of the EPAC Report. A good summary of this can be found in the submission to the recent Senate Inquiry into childcare from the Queensland Child Care Coalition (QCCC). (A copy of the body of this submission and the most recent survey of childcare services by QCCC can be found at Attachments 2 and 3 of this submission.)

"The QCCC sees the childcare policy changes in the context of the EPAC Future Child Care Provision in Australia Report (1996). A significant proportion of the recommendations contained in this report are being implemented by the Federal Government. These are in the main economically driven. We believe that the imperative is the dollar bottom line rather than the quality of care for Australian children. This is a disturbing development."

The negative impact on quality of care provided to children, access to services and affordability of care are all detailed in the attached QCCC submission and their February 1998 survey report "Child Care Cuts are Crippling". (It should be noted that the soon to be published third survey by QCCC indicates that these disturbing trends are continuing in Queensland.) The rhetoric of the government (maintaining quality and affordability, ensuring choice for families and so forth) does not match the reality for families or childcare services. The QCCC is extremely critical of the philosophy underpinning recent changes in child care.

"Perhaps one of the most disturbing developments is that the philosophy underpinning these changes is one that "commodifies" children and families. Decisions about childcare are couched in terms of "economic necessity", framed in terms of concepts of "oversupply" and the need to place limits on the supply and demand for services. The QCCC rejects this narrow reduction of children and families to mere commodities and believe that it is a fundamental role of our Coalition to advocate on behalf of families for the need to maintain a choice of quality affordable services."

The government used the EPAC report into childcare as the vehicle for achieving economic outcomes and we are concerned that they will attempt to use this Productivity Commission Inquiry to achieve similar ends in the nursing home sector.

- v. 1996-97 Annual Report of the Commonwealth Department of Family Services (page 162)
- vi. Nursing Home Circular No. CNH 88003 Department of "Community Services and Health. 20 June 1987. (p41)
- vii. Sue Forster Enterprise Bargaining Project Report QNU and ors, April 1996. (A copy of this report is available upon request from the QNU).
- viii. Documentation and Accountability Manual p 5.6
- ix. The commission is referred to the submission to the RCS Review which identifies that nurses can write care planning documents up to 26 pages long. (Attachment 5)
- x. Queensland Health Act 1937.
- xi. Tracey McDonald and Phillip W. Bates Duty of Care and Outcome Standards for Australian Nursing Homes Consultancy Commonwealth Department of Community Services and Health. Canberra 1988 (page 6).

- xii QNU File Note - Nursing Home Visit 1996.
- xiii The Department of Health and Family Services (DHFS) in their Submission to the Senate Affairs Committee Inquiry into Funding of Aged Care Institutes, Page 12, April 1997.
- xiv Ref. Commonwealth Department of Health and Family Services - Annual Report 1996-97:Canberra:1997;p189
- xv Ref. Commonwealth Department of Health and Family Services - Annual Report 1996-97:Canberra:1997;p185
- xvi The QNU directs the commission to work done by the Institute of Medicine (IOM) Committee on the Adequacy of Nursing Staff in Hospitals and Nursing Homes in the book The Adequacy of Nursing Staffing in Hospitals and Nursing Homes - Chapter 6 "Staffing and Quality of Care in Nursing Homes"
- xvii Coalition Parties Aged Care Policy 1995/1996, Page 47.
- xix Gregory R (1993) Review of the Structure of Nursing Home Arrangements - Stage 2
- xx Weedon D (1995) Nursing Home Manual Handling Issue. The Federal Perspective. Department Human Services and Health.
- xxi Pryor P (1997) paper No. 3 An Analysis of Health and Safety in the Nursing Home Industry. How does your Nursing Home Compare.
- xxii Data supplied by the Division of Workplace Health and Safety.
- xxiii Op cit Pryor.
- xxiv Op cit Pryor.
- xxv Data supplied by the Division of Workplace Health and Safety.
- xxvi Richardson, Jacobson, Hatton and Pryor (1998) Combining Workers Compensation and Labour Force Data to Target National OHS strategies for Aged Care. Victorian Work Cover Authority.'
- xxvii Division of Workplace Health and Safety Indicator.
- xxviii Productivity Commission Issues Paper - Nursing Home Subsidies (p5)
- xxix The Nursing Workforce: Residential Aged Care Workshop ..Report on Discussion Sessions. December 1997.

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Queensland Child Care Coalition *Submission to 1998 Senate Inquiry into Child Care and February 1998 Survey of Child Care Services*

Queensland Government *Health Act 1937 - Health (Drugs and Poisons) Regulation* 1996 Queensland 1997

Steering Committee for the Review of Commonwealth/State Service Provision *Report on Government Services* 1998 Industry Commission, Melbourne 1998

The Age - Melbourne, Tuesday 1 September 1998: pA 15 "How both parties failed the old".

Tracey McDonald and Philip W. Bates., Commonwealth Department of Community Services and Health *Duty of Care and Outcome Standards for Australian Nursing Homes Consultancy* Canberra 1988

ATTACHMENTS

1. 12 Month Report on Impact of Hour Cuts
2. Queensland Child Care Coalition Submission to Senate Inquiry into Child Care Funding March 1998.
3. Queensland Child Care Coalition Child Care Cuts are Crippling: Report on the findings of the Queensland Child Care Coalition (QCCC) Survey of Child Care Services in Queensland February 1998.
4. Table 1 - Aged Care Rates of Pay 1988 - 1998
 Table 2 - Public Hospital Rates of Pay 1988 - 1998
 Table 3 - Difference in Wage Rates - Public Hospitals and Aged Care 31.08.98
 Table 4 - Movements in Allowances - Aged Care Interim Award - State.
5. QNU Submission on The Review of the Resident Classification Scale January 1998.