Queensland Nurses & Midwives' Union

Submission to

Senate Economics References Committee

Inquiry into the financial and tax practices of for-profit aged care providers

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106 Victoria St, West End Q 4101
GPO Box 1289, Brisbane Q 4001
(07) 3840 1444
(07) 3844 9387
qnmu@qnmu.org.au
www.qnmu.org.au

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Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks The Senate Economics References Committee (the Committee) for the opportunity to make a submission to the inquiry into the financial and tax practices of for-profit aged care providers.

Nursing and midwifery is the largest occupational group in Queensland Health (QH) and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all categories of workers that make up the nursing workforce including registered nurses (RN), registered midwives (RM), enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 58,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNMU.

While not an aged care service provider or consumer organisation, the QNMU actively represents members working in the aged care sector at an industrial and professional level, and also draws on the considerable experience the organisation has gained as a stakeholder in safety and quality improvement across all sectors of health care, including aged care. The QNMU believes that its aged care membership base makes the organisation a stakeholder in any debate regarding the quality and safety of aged care services. As a member led organisation which advocates for nurses and unregulated careworkers in aged care, member feedback consistently identifies a range of endemic and systemic issues which impact on the safety and quality of care provided and which effect those receiving and providing care. These issues include staffing and skill-mix, working conditions, governance and regulation, funding and training.

The QNMU, its federal peak body the Australian Nursing and Midwifery Federation (ANMF) and other peak nursing bodies have been lobbying for many years to address the widespread systemic issues that enabled the failures of care at the Makk and McLeay wards at the Oakden facility in South Australia for example, to occur. More recently the Tax Justice Network report *Tax Avoidance by For-Profit Aged Care Companies: Profit Shifting on Public Funds* (2018) provides a compelling argument that for-profit aged care providers are benefiting from significant public funding with little evidence that this funding is translating into high quality, safe aged care (Tax Justice Network, 2018).

Again, the QNMU thanks the Committee for the opportunity to provide feedback to this inquiry.

Background

This submission will provide a response to the following terms of reference for the Committee to support the broader submission from the Federal Office of the ANMF.

> b) the associated impacts on the quality of service delivery, the sustainability of the sector, or value for money for government;
>
> d) whether current practices meet public expectations; and
>
> e) any other related matters

While issues such as assessment wait times, queuing for care packages and funding are priority issues in community based aged care, the QNMU believes that a constellation of endemic, system level, issues are severely impacting the capacity of the sector to provide safe, high quality, residential aged care. These issues include:

- chronic and widespread understaffing
- inappropriate staff and skill mix
- lack of a corresponding culture of safety and quality to that which is now well embedded in the acute care sector
- lack of reporting and transparency around the processes and outcomes of care
- a model of care that relies heavily, and increasingly, on a large workforce component of unregulated care workers at a time when the morbidity, acuity and frailty of those receiving residential aged care services is steadily increasing
- a failure of governance, regulation, and particularly enforcement, that has led to the current crisis in aged care.

As identified by Phillips et al., (2017) the proportion of those aged care residents requiring high levels of care has dramatically increased from 13% in 2009 to 61% in 2016 with aged care facilities increasingly acting as hospices for frail older Australians with complex care needs. As succinctly described by the Royal Australian College of General Practitioners (RACGP, 2006):

> *Older people in residential aged care are the sickest and frailest subsection of an age group that manifests the highest rates of disability in the Australian population. The prevalence of chronic conditions among residents in high care is estimated to be 80% sensory loss, 60% dementia, 40-80% chronic pain, 50% urinary incontinence, 45% sleep disorder, and 30-40% depression. Annually 30% of residents have one or more falls and 7% fracture a hip.*

Older Australians, particularly those receiving residential aged care services, are characterised by significant care needs, multiple diagnoses, comorbidities and polypharmacy. It has been estimated that on average they have 3.4 to 4.5 separate diagnoses, 6

comorbidities, and are taking 8.1 medications (Willis et al., 2016). Research also points to a rising trend of avoidable and premature death in Australian aged care facilities (Ibrahim et al., 2017).

It is the QNMU's view that aged care providers, both for-profit and not for profit, are failing to provide the necessary level of clinical services to meet the care needs of a vulnerable, frail group of Australians with high acuity and associated care needs.

It is the view of the QNMU that the care needs of those older Australians receiving home based or residential aged care services must take precedence over all other factors such as profit as well as concepts of commercial in confidence and shareholder value behind which for-profit providers hide when questions are asked about their business models.

Successive governments have taken an approach that has seen aged care services in Australia delivered largely by the private sector by not-for-profit and for-profit providers. In effect, aged care has been subcontracted, or perhaps effectively privatised, to the private sector underpinned by an ideology of marketisation and individualisation based on the belief that markets (and private sector providers) can provide services that are of greater efficiency, better quality and less bureaucratic than those provided by the public sector (Cardona, 2018). The current crisis in aged care exposed by a plethora of inquiries, reports and media attention attest to the fallacy of this approach. The Tax Justice Network report *Tax Avoidance by For-Profit Aged Care Companies: Profit Shifting on Public Funds* (2018) indicates that for-profit aged care providers seem to be more interested in profit and tax-minimisation rather than care or those they care for.

Approximately 17 billion dollars of government funding went to aged care in the 2015-16 period (Australian Institute of Health and Welfare, 2018). The QNMU believes that in return, the aged care sector owes the Australian public 17 billion dollars' worth of good governance, functional organisational culture and management, high levels of safety and quality and considerable transparency in the way the sector is managed and funds spent and accounted for.

Response to the terms of reference

This submission will not address the terms of reference individually, rather, specific issues will be identified in relation to the for-profit sector. It should be noted however that the QNMU finds these issues to be the norm across all provider types with the only possible differentiation being the degree to which issues manifest at the provider and sector level.

As already identified in this submission, those receiving aged care services, particularly those in residential aged care, are there because they need high levels of care. While residential aged care facilities (RACF's) are not hospitals, they are places where significant clinical care, largely nursing care, takes place. Care must be the primary focus, however the QNMU, ANMF and other state nursing and midwifery unions have been long concerned that appropriate levels and quality of care has been a casualty across all provider types in the aged care sector.

Staff and skill mix

While the acuity of those in RACF's has been steadily increasing and therefore the level of care required (Phillips et al., 2017), perversely, there has been marked shift in the aged care sector workforce that has seen a steady decline in the number of registered nurses (RN) and enrolled nurses (EN) and an increase in a lower-skilled unregulated workforce ill prepared to meet the care needs of those in their charge. According to Mavromaras et al., (2017) there has been a reduction in the percentage of RN's in residential aged care from 21% in 2003 to 14.6% in 2016, EN's from 13% in 2003 to 10.2% in 2016, with unregulated care workers now comprising approximately 70% of the residential aged care workforce.

This decline has been the direct consequence of aged care provider workforce planning decision making and suggests either poor management or a deliberate policy to deskill the aged care workforce. At times, this reduction in workforce can be quite dramatic and is practiced by all provider types. For example, the QNMU was informed in August 2017 that a for-profit provider cut 284 staff hours from its staff roster, ultimately impacting 57 staff. The QNMU has similar, and even greater, examples from the not-for-profit sector that can be provided if required.

In a snapshot audit of eighty-three RACF's undertaken by the QNMU on Saturday 12 May, 2018, the following staff mix was identified.

Table 1 - Skill Mix by Provider Type

Provider Type	RN Percentage	EN Percentage	AIN/PCW Percentage
For Profit	16.58%	7.94%	75.48%
Not for Profit	15.77%	6.56%	77.67%
Grand Total	16.02%	6.98%	77.01%

These figures are consistent with those of Mavromaras et al., (2017) and confirm the shift to a carer based model of aged care provision. As identified by Phillips (2017), the reduced focus on the clinical aspects of residential aged care, and shift to a workforce comprising primarily unregulated care workers, have led to significant reductions in the number of RN's and EN's in aged care and a skill mix where staff have a limited capacity to provide the clinical care required. This shift to a predominately unregulated aged care workforce is also a less costly workforce, and it can only be speculated that this is again a deliberate attempt by aged care providers to reduce costs at the expense of care quality and quantity – a perverse false economy.

The long term decline in licensed nurse numbers in aged care, who lead the assessing, planning, delivery and monitoring of care, particularly complex care, has had a negative impact on the safety and quality of care, leading to the current situation where failures of care are reported almost daily in the media.

At odds with, and in contrast to, the current staff and skill mix situation across the aged care sector, Willis et al., (2017) has established an evidence based staffing and skill mix model that consists of RN's (30%), EN's (20%) and unregulated care workers (50%). Such a staff and skill mix realigns the aged care workforce to meet the care needs of a population with significant and complex care needs.

Levels of care

Hand in hand with skill mix is the capacity of the aged care workforce to deliver appropriate levels of care to aged care residents based on their acuity and individual care needs. Research has established that, on average, residents of RACF's require 4.3 hours of direct care per twenty-four hour period. However, the evidence suggests that direct care hours are on average 2.86 hours, a deficit of 1.44 hours (Willis et al., 2016). These figures are supported by the findings of the QNMU snapshot audit of RACF's undertaken on Saturday 12 May which identified that the average care hours per resident day were 2.48 hours (for-profit providers).

Table 2 - Hours of Care per Resident per Day by Provider Type

Provider Type	Average hours of care per resident per 24 hours
For Profit	2.48
Not for Profit	2.67
Grand Total	**2.61**

Currently there are no minimum staffing and skill mix requirements for RACF's. Again, it can only be assumed that these significant care hours deficits, in the face of evidence that they should be considerably greater, are more about reducing costs under the guise of management speak terms such as "efficiency" and "flexibility" rather than any genuine attempt to meet the needs of those being cared for.

There is now considerable evidence that links the quality and outcomes of care with the staff levels (quantity) and skill mix (quality) of the workforce providing that care (Queensland Nurses and Midwives' Union, 2017, NSW Nurses and Midwives' Association, 2018). Given the profits, and attempts to minimise tax liabilities, made by for-profit aged care providers (Tax Justice Network, 2018), there seems significant capacity for improvements in staffing and skill mix to achieve evidence based minimum levels.

Replacing staff unable to work

Not only does it appear that systemic understaffing occurs in the aged care sector, respondents to the snapshot audit undertaken by the QNMU on May 12, 2018 indicated that there was a 60% negative response rate to the question "Are staff replaced when they can't come to work?" While a number of reasons can be speculated, including issues of availability of staff, these practices of not replacing staff when they are not able to work only add to the workload pressures experienced by staff.

Capacity to provide care and missed care

A significant negative consequence of understaffing and a deskilled aged care workforce identified by Willis et al., (2016) is the issue of missed care. Missed care is manifested by the difficult decisions that care staff have to make in understaffed work environments in relation to such things as pressure injury care, falls surveillance, feeding residents, mobility assistance, assisting with activities of daily living and responding in a timely manner to requests for assistance.

Concerns by staff regarding their capacity to provide care was also identified as part of the snapshot audit undertaken by the QNMU on May 12, 2018. Data from for-profit facilities indicated that 83% of respondents believed that staff to resident ratios were not safe and limited their capacity to provide quality care. The following ranked issues provides a clear indication that the current staffing and skill mix within the for-profit sector is directly related to a range of care issues and staff concerns.

Table 3 - Care Issues Identified (For-Profit Providers)

Care issues	Responses
Residents waiting longer than they should when they ask for assistance/help	70.83%
Residents not being repositioned as often as needed	62.50%
Increased falls	62.50%
Not enough time to complete hygiene cares for residents	54.17%
Increased pressure injuries	50.00%
Residents not being mobilised as often as needed	50.00%
Not enough time to properly feed residents	45.83%
Not enough time to document care	41.67%
No time for shift handover	41.67%
Increased skin tears	37.50%
Not enough time to attend/complete wound care	33.33%
Medications being missed or not given at the right time	16.67%

Mindful of the need to protect members from their quite legitimate concerns regarding employer retribution, examples of quality of care issues identified by members working in for-profit facilities include:

- RN's being off site and remotely on call via the telephone for a number aged care facilities
- allegations that management have received bonuses to contain costs with actions such as locking up consumables, e.g. gloves and incontinence pads and not replacing items when they run out.

These concerns simply reinforce a picture of aged care providers where the bottom line, rather than care, is the primary concern.

Primary care and cost shifting

A particular area that the QNMU believes should be addressed as a matter of urgency relates to the capacity of aged care facilities to provide appropriate primary care services and facilities on site. According to the Queensland Health Minister, over 25,000 aged care residents were transported to emergency departments in the period in FY2016-17, a 17% increase in the past year (Bita, 2018). For example, the for-profit provider Regis has been identified in the media as a provider which, it is alleged, has a low threshold for transferring residents to emergency departments (Morton, 2018). An increase of 25% in emergency department transfers from aged care facilities has also been reported in Victoria (Bachelard, 2017). According to the Australian Medical Association (2018), one third of presentations of residents to emergency departments who subsequently returned to their RACF could have been avoided by incorporating primary care services at the facility level. Such facilities include both the physical infrastructure and the skilled staff needed, e.g. registered nurses and general practitioners. Again, the capacity of RACF's to provide primary care and to practice hospital avoidance has been significantly impacted though systemic deskilling of the aged care workforce and a model of care that deemphasises the clinical aspects of residential aged care.

While acknowledging that the majority of transfers from aged care facilities are appropriate, for those third of transfers that the Australian Medical Association identifies as avoidable, it can only be assumed that aged care providers are only too happy to transfer responsibility and cost to the hospital system and underinvest in staff capacity and infrastructure. This, despite the fact that the providers business model is primarily funded from the public purse.

Workforce climate of fear

Unfortunately, feedback from members indicates that employment conditions for some aged care workers are often difficult due to a prevailing climate of fear. This can take the form of nurses and carers being worried about victimisation or reprisal if they come forward to report issues. The culture of for-profit organisations must be such that nurses have no fear of reprisal for raising concerns or issues and management should have a process in place to act on these concerns.

QNMU members working in the aged care sector frequently report they are afraid to speak up for fear of employer reprisal such as reduction in rostered hours to their contracted minimum for example. Aged care workers, particularly unregulated care workers, are poorly paid, and are often in tenuous financial positions where a reduction in working hours can cause economic hardship.

An examination of QNMU member servicing records regarding the level of over-representation of members employed in aged care as compared to other sectors highlights

the more punitive work environment in the aged care sector compared to other health care sectors. Although representing 12.3% of total QNMU membership, members employed in aged care currently make up 25% of the total number of individual member representation matters handled by the QNMU.

Working in aged care is already often stressful with difficult working conditions, low pay, low esteem, insecure working arrangements and often irregular hours of work (Burgess et al., 2018). These challenges are compounded by provider cost savings that sees aged care staff having to monitor the use of basic supplies needed to provide care. Staff should not be pressured to ration the use of disposable items for the sake of reducing costs. This culture of fear only comes at the expense of quality service delivery for aged care residents.

Industrial

As a member based industrial and professional organisation, the QNMU strives to improve the wages and conditions of members in all sectors. The QNMU is equally committed to improving the quality of care and safety of those who receive care. For example, the implementation of patient to staff ratios in public hospitals in Queensland (including the commitment by the Queensland government to introduce minimum ratios in state government RACF's) in partnership with the state government is an example of this commitment to safety and quality. The national campaign for minimum staffing and skill mix in aged care also reflects these aims.

While the introduction of nurse to patient ratios in Queensland public hospitals has been achieved under a shared interest based framework, the industrial climate in the aged care sector is universally adversarial, only differing by degree between providers. Enterprise bargaining with aged care providers, irrespective of type is hard work and consumes considerable resources even to just maintain worker conditions. This adversarial approach often results in only modest wage rises for a group that is already poorly paid let alone achieve outcomes that benefit both parties in terms of productivity, cooperative work environments, job satisfaction and certainty of employment.

Bargaining is often characterised by aggressive provider bargaining agents and postures, provider representatives who appear to have little understanding of the wide-ranging care issues associated with providing aged care and a lack of clinicians on provider bargaining teams to deal with the clinical and professional practice issues that arise during bargaining. Some providers simply choose to use the national Aged Care and Nurses Awards (and associated wages framework) which, at best, should only be regarded as the minimum safety net standard rather a default wages and conditions position. Proposals by providers for contracting out services further increase the insecurity felt by aged care workers.

However, at times, even the national award safety net is preferable to the enterprise agreements made with providers. For example, the QNMU spent many months in the Fair Work Commission opposing a TriCare (a for-profit provider) enterprise agreement that had

fallen below award minimums. This enterprise agreement was finally terminated by the Commission in 2017. TriCare has simply not chosen to reengage with the QNMU regarding a new enterprise agreement, opting instead to undertake a significant infrastructure program rather than respect and reward the hard-working staff who keep TriCare facilities functioning, with a mutually beneficial enterprise agreement.

Even when issues are proposed during enterprise bargaining that relate to standards of professional practice and the safety of aged care recipients, which should be an area of agreement, aged care providers across all provider types are dismissive. For example, the QNMU routinely proposes clauses relating to minimum staff and skill mix and medication management practice as part of the claims tabled on behalf of members.

Funding model

An essential element that must be considered in any review of the aged care sector, in particular residential aged care, is a funding model that can provide sustainability and certainty into the future.

The Aged Care Funding Instrument (ACFI) has been justifiably criticised as no longer being fit for purpose with an urgent need to replace it with a more sustainable funding model where there is an expectation that an efficient price will be paid for an efficient service cost (McNamee et al., 2017). Such a model would hopefully reflect the actual cost of care (including workforce) and provide a sustainable, predictable basis on which to undertake workforce planning at the facility, organisational and national levels.

In feedback to the Department of Health regarding the report *Alternative Aged Care Assessment Classification System and Funding Model,* the QNMU provided in principal support for the development and implementation of an activity based funding model (casemix based) for funding residential aged care. Comment on the Consumer Directed Care funding model for home based aged care is beyond the scope of this submission, however, as with the National Disability Insurance Scheme, the QNMU has significant concerns regarding this approach to funding critical services for the aged and those living with disability, particularly from a market failure and safety net perspective.

Like the activity based funding model for the hospital sector which has operated successfully for many years, the introduction of such an aged care funding model would mean that considerably more data will be available regarding both the recipients and providers of care. A major concern of the QNMU is the current lack of data and transparency around aged care provision, particularly regarding how providers spend public funding. An activity based funding model for residential aged care offers the opportunity to significantly increase the granularity of data about how aged care funding is spent by providers, and on whom. Such a system, if implemented effectively, would overcome the current lack of transparency and reporting by providers around funding and expenditure. Provided that the actual costs of care

were reflected in the activity based funding model, the QNMU supports the urgent implementation of such a system to replace the current ACFI model.

Conclusion

In Australia, the provision of aged care services is regarded as a public good. However, unlike the acute health sector, these services are largely provided by the private sector and without the universality and lack of cost associated with acute sector care. The queuing for home based care packages and the often long wait times for assessment and placement in a RACF attest to these differences.

The QNMU believes that a long standing lack of appropriate governance and regulation of the aged care sector has resulted in a situation of "as you sow, so shall you reap" in relation to the safety and quality of care provided to older Australians.

As indicated in this submission, the issues within aged care are multifactorial and interrelated and cannot be dealt with in isolation. While this Senate inquiry is welcomed, the financial and tax practices of for-profit aged care providers must be seen within the wider context of the provision of a public good.

The QNMU believes the current aged care roadmap, based on marketisation and individualisation rather than being primarily person centred, has demonstrably failed to provide the level of care and safety that older Australians are entitled to, and deserve. It is time to consider the following:

- That aged care is health care, not personal care with some health care elements, which should be planned, funded, provided and evaluated, like any other health service.
- Enforceable standards for aged care that are compatible with those accepted as normal and essential in the acute health sector.
- What organisations have the privilege to provide aged care services and what organisational structures are compatible with providing such a public good?
- Is it time to consider that only certain types of corporate or organisational structures are permitted for those providing aged care services?
- A service philosophy that places care and safety obligations above all else, including shareholder value, profit, or operating surplus beyond a level deemed acceptable (if necessary through legislation or regulation).
- Public and transparent reporting requirements relating to funding and costs, outcomes of care and safety and quality that are mandatory irrespective of corporate or organisational structure and prudential and other regulatory reporting requirements.
- Aged care funding that reflects the actual costs of care, e.g. an activity based funding model where the efficient cost of care is reflected in an efficient price paid by the government as funder.

- Public funding for care services, within the broader aged care funding model, must be tied to, and quarantined, for care services, with any funds not expended on care in the relevant financial year to be returned to the government as was the practice under the former Care Aggregated Module (CAM) and Standard Aggregated Module (SAM) funding arrangement.
- An admission by all sides of politics that the "quasi" market based aged care model experiment has failed and a commitment that older Australians are entitled to the universality of aged care like that all Australians expect when receiving health services under Medicare.

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