Submission to the Senate Inquiry into Aged Care

LHMU
(Liquor Hospitality and Miscellaneous Union)

LHMU: Shine the Light on Aged Care

July, 2004

Executive Summary

The LHMU has two strong interests in Australia's aged care sector: the first is for our members and their working lives and the second is the type of care older Australians receive.

The aged care workforce has a number of well documented issues, such as heavy workloads, constant understaffing, high levels of paper work, large amounts of unpaid work, low pay, low attraction and retention levels and health and safety concerns.

The Minister for Ageing's Workforce Committee report, 'The Care of Older Australians: A picture of residential aged care workforce report', which only takes into account care staff, indicated that almost 70% of employees do not believe that they have been able to spend enough time with residents delivering care(Richardson 2004). This has manifested into unpaid overtime, which is heavily reliant on the goodwill and pride that the aged care workforce takes in their work. Aged care workers regularly work unpaid overtime, just to meet their own sense of obligation to older Australians that are dependant on their care.

The delivery of personal care or increased care requirements are not the only factors that impact on the workload of aged care staff. In fact only about 62% of the aged care workforce, according to the governments own aged care workforce report, believe that two thirds of their time is spent on any given shift delivering personal care. Paperwork is one of the major factors that draw care staff away from personal care.(Minister for Ageing 2002)

The Minister for Ageing's Workforce Committee report clearly explains why care staff are disenchanted with their pay, as almost 50% earn less than $500 per week and over 60% of personal care attendants earn less than $500 per week (Richardson 2004). Low pay does not only constitute a crisis for aged care workers. It also constitutes a looming crisis for providers and consumers of care, who struggle to retain staff that cannot make a livable wage from care work.

The aged care industry estimates that 78% of total costs in residential aged care facilities is wages (NACA 2001p20). Industry through NACA have argued that the current funding for aged care does not bear any relationship to the actual cost of providing care. The industry is now calling for a benchmark of care to be established, that would create a direct relationship between care delivery costs to funding requirements.

The establishment of a national benchmark of care will ensure that older Australians get the care they deserve when they need it most and to ensure that best practice care forms the basis of the benchmark. The national benchmark of care would encompass all aspects of care in both residential and community settings, including the establishment of minimum staffing levels and skills mix for delivering care.

The workloads of aged care staff is determined by care needs, however there is no requirement for providers to staff to care needs. This leaves aged care workers who work in understaffed aged care facilities, working harder to meet care needs, while putting their health and safety at risk.

Attraction and retention of staff to work in aged care is indicative of the issues in the aged care sector. In order for the aged care industry to get the upper hand in the attraction and retention of staff, both the image of working in aged care and the value that we place on aged care workers needs to change. Aged care workers cannot afford to be considered a class below their public hospital counterparts.

The 2004 Federal Budget did not resolve the funding issues in aged care. The federal budget, in fact, provided no guarantees at all for the aged care workforce. While the government has promoted this money as being able to assist providers to pay for more competitive wages to the aged care workforce, the money is not tied to wages at all (Australian Government 2004).

Aged care providers receive approximately 75% of their total funding from the Australian taxpayer, however they have been crying poor for many years claiming that it is not enough to provide the care older Australians require. The Hogan Report has suggested that the daily charges paid by residents is increased to provide extra funding for aged care. However this may not stop aged care providers from crying poor. The federal government should make aged care providers accountable for the money that they are provided, so that providers cannot cry poor and still make large profits and ensure that Australian taxpayer funds are directed into care.

The establishement of an office of the Aged Care Ombudsperson would create an environment that would provide transparency and accountability in the management of complaints, in both residential and community care settings. The Ombudsman would also have the role to educate residents, families and the broader community about the rights of older Australians that receive aged care services.

Older Australians deserve quality aged care. The benchmark of care would determine how much aged care providers require from the government in order to provide aged care. The national benchmark of care would go some way to resolve understaffing related workload issues, as the benchmark of care would set minimum staffing levels based on care needs.

The national benchmark of care would assist in making aged care providers accountable for taxpayer funds they receive. Establishing a national benchmark of care, in partnership with all stakeholders will be an innovative step forward for the aged care industry, its employees and those that consume aged care services.

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1. Introduction: Shine the light on Aged Care

1.1. Older Australians have built, fought for and love this country. Older Australians deserve our respect, support and our care when they require it.

1.2. When older Australians can no longer live independently without support, they deserve to be supported by those that have prospered from their toil, the Australian community. If they require home care, community care or residential care they should have access to it. If they require home care, community care or residential care it should be of the highest quality. It should be akin to the level of respect and regard we have for older Australians.

1.3. The LHMU has two strong interests in Australia's aged care sector: the first is for our members and their working lives and the second is the type of care older Australians receive when they need care. As such this submission is prepared on behalf of all LHMU members. The LHMU intends to highlight through this submission that the aged care sector is in a genuine crisis and that we really need to 'Shine the light on Aged Care'.

2. Membership of the LHMU

2.1. The LHMU (Liquor Hospitality and Miscellaneous Union) represents over 130,000 workers in Australia, most of whom during their lives will come into contact with the aged care sector, whether they work in the sector, receive some level of care as they become older or have a family member or friend that receives care.

2.2. The LHMU is a diverse union, with members in both manufacturing and service industries. The largest groups of LHMU members are found in cleaning, security, hospitality, and a range of care and support work, including aged care, home care, childcare and teaching assistant work.

2.3. These are also industries that are predominately made up of a female work force, which is reflected in the membership of the LHMU. Over 50% of the unions membership is female and approximately 91% of the unions aged care membership is female.

2.4. The Aged Care section of the LHMU has continued to record good membership growth in recent years. This is reflective of not just the growth of the aged care workforce, but also is a reflection on the performance of the LHMU in advocating and representing members.

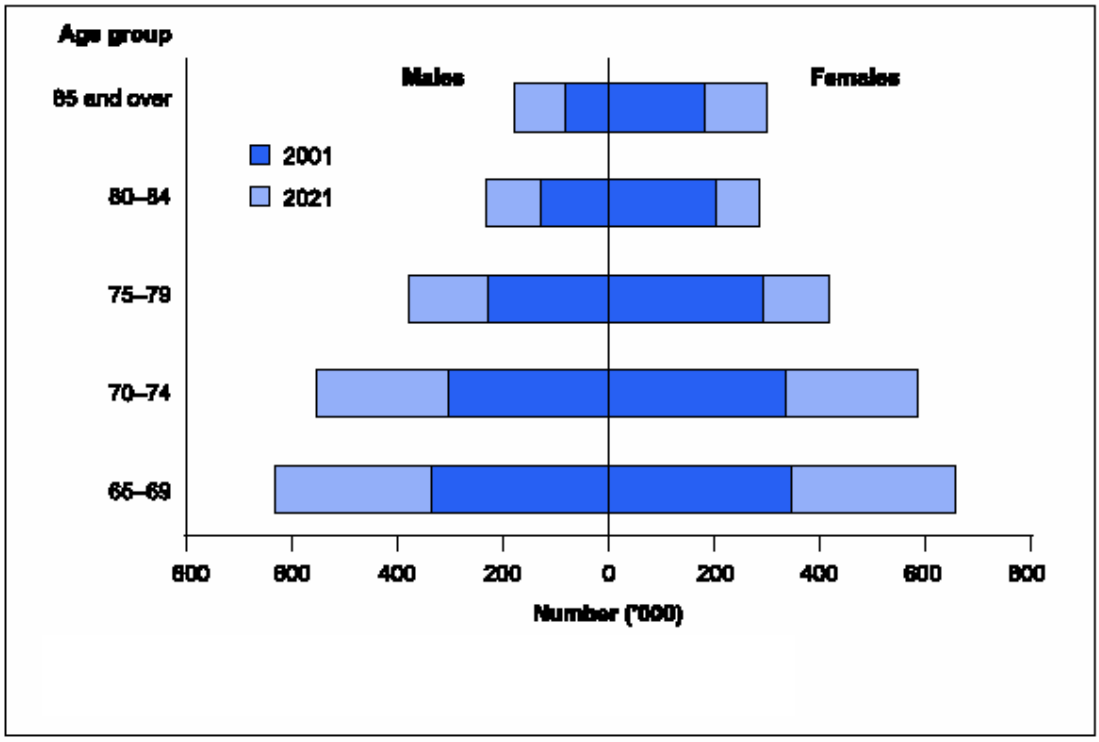
3. Shining the Light On Australia's Aged Care requirements

3.1. There is no dispute that Australia is an ageing population. There are a number of reports that suggest that by 2051 persons over the aged of 70 will triple, from 1.8 million to 5.6 million (Minister for Ageing 2004 p1). It is estimated that this will represent over a quarter of Australia's total population [ABS 2000:16]

3.2. Australia's ageing population is a direct result of a decreased birth rate and increased mortality. The increased mortality rate is key to this debate as a combination of medical technology and medical interventions have enabled the population in general to live longer. It is expected that on average people will live 20 years longer than a century ago.

3.3. Australia's declining birth rate is also a factor that will impact on our future workforce and should be considered when analysing future workforce needs. The ABS has estimated that Australia's replacement birth rate needs to be 2.1 births per female. The current birth rate in Australia is 1.7 births per female, which is well below the peak of 3.5 births per female, at the height of the baby boom in 1961(Costello, 2004).

3.4. If we take a short-term view, we are able to see the impact of the baby boomers, which will result in a large growth in the number of people over 65 years old. The following table shows the growth in the number of Australians above 65 years old by 2021(Costello, 2004).



3.5. It is predicted that if the current birth rate is maintained or declines further, then Australia would have a small working population supporting a much larger older population. This is part of the rationale behind the government's current policy concerning mature aged workers working past retirement age, 65 (Costello, 2004).

3.6. The Department of Treasury in 2003 predicted that growth in the working population would slow to zero by 2042. The working population has been traditionally been defined as those between 15 to 64, with those under 15 and over 65 considered to be of non-working age (Costello, 2004).

3.7. If we consider the current trend, which is retiring at 65 years old, it creates a very large dilemma for the aged care sector. The residential aged care workforce report, produced by the National Institute of Labour Studies, states that 57% of the aged care workforce is over the age of 45 (Richardson 2004). This means that in 20 years almost 60% of the current aged care workforce would have left the aged care workforce through retirement only.

3.8. This is based on the gross assumption that those over 45 remain in the industry until they turn 65. The facts clearly state otherwise. The reality of turnover of the aged care workforce is that 40% of the workforce will be turned over in the next 3 years(Richardson 2004). This may be for a range of reasons that do not just encompass retirement.

3.9. The turn over of the aged care workforce is supported by the data that stipulates that only 31% of the workforce has been in their present position for more than 5 years(Richardson 2004).

3.10. The other interesting profile of the aged care workforce is that 94% of the workforce is women(Richardson 2004). When this is brought together with the age of the workforce, it presents an interesting picture.

4. Shining the Light on Aged Care Workforce Issues

4.1. The LHMU welcomes the opportunity to shine the light on the issues that affect LHMU members every time they go to work. The LHMU strongly believes that the current proposals, including the 2004 budget, have not adequately addressed the issues faced by the aged care workforce. The LHMU also believes that the Aged Care Standards and Accreditation Agency has not been affective in ensuring the health and safety of the aged care workforce and ensuring that aged care facilities provide best practice care.

4.2. The Hogan report puts forward a number of positive recommendations. However this report is largely an economic report and is unfortunately inadequate when dealing with workforce issues.

4.3. The aged care workforce has a number of well documented issues. The majority of them can quite simply be placed under the heading workload. However there are other issues such as low pay, occupational health and safety and attraction and retention of staff.

4.4. Workforce issues were also prevalent in a recent aged care phone-in that the union undertook. The phone-in enabled aged care workers, those that receive aged care services and those that come into contact with aged care services to raise their concerns.

Workload

4.5. Workload issues in aged care are abundant. They arise in all comprehensive surveys of staff as they impact on the majority of aged care workers. This view is supported by government surveys of the workforce, such as the Minister for Ageing's workforce committee report titled ‘The Care of Older Australians: A picture of residential aged care workforce report’. Similar surveys conducted by the LHMU and the Health Services Union also support this view. Workload issues are also acknowledged by the Industry as a whole, particularly through the National Aged Care Alliance.

4.6. The governments aged care workforce report, which only takes into account care staff, indicated that almost 70% of employees do not believe that they have been able to spend enough time with residents delivering care(Richardson 2004). This is supported by LHMU data that suggests that 50% of LHMU members that work in aged care feel pressure to work harder in their job. The HSU has also discovered, that members were not able to complete their work in the paid time allotted by their employer. The HSU survey also revealed that aged care workers do not believe that there is sufficient staff at their workplace, to deliver the care that is required and the added workload expectations of the employer (Susie O'Brien 2003).

4.7. The LHMU aged care phone-in highlighted the lack of time aged care workers have to deliver care. At one aged care facility it was reported that 3 care workers had 60 minutes to get 49 residents out of bed, showered, dressed and into the dinning room for breakfast in the morning. The aged care workers claimed that depending on their allocation of residents, they had between 3 minutes to 4 minutes per residents to deliver the care they required.

4.8. Some of the other workload issues that were raised by aged care workers through the LHMU phone in included care hours being cut in half while the workloads remained the same, staff numbers being cut staff, staff working extra shifts to cover for the lack of staff, staff doing double shifts and the giving of care turning into a production line, rather than catering to the specific care needs of those requiring care.

4.9. Unpaid overtime is heavily reliant on the goodwill and pride that the aged care workforce takes in their work. This was reflected in the LHMU survey of members, which showed that 72% of our members are satisfied in their work. The governments workforce report uncovered that almost 75% of the care workforce are satisfied with their job (Richardson 2004 p42)

4.10. There is no questioning that the profile of the aged care worker is directly related to the pride that they have in their work. There is however definitely a large question as to whether they are satisfied with what they are able to achieve in any given working day or whether they are satisfied because they feel the work that they do benefits the elderly.

4.11. Unfortunately relying on this type of satisfaction does not last forever. Aged care workers regularly work unpaid overtime, just to meet their own sense of obligation to the frail and aged Australians that are dependant on their care. Aged care workers often go home exhausted and struggle to fulfil their own family commitments, let alone have time or the energy to spend with family and friends.

4.12. Employers are recognising that goodwill only stretches so far. Wendy Morey from the Resthaven Nursing facility in Leabrook, South Australia stated in 2002 that “nurses are very committed to their work but the good will is becoming drawn down – and it’s only going to get worse” (Susie O’Brien 2002). This is a clear indication that the goodwill of aged care workers in the past, will not continue indefinitely.

4.13. It is not just the delivery of personal care or the increased care requirements that has impacted on the workloads of aged care staff. In fact only about 62% of the aged care workforce, according to the governments own aged care workforce report, believe that two thirds of their time is spent on any given shift delivering personal care. This is further highlighted in the personal care attendant’s category, where almost 50% of personal carers believe that they do not spend between one to two thirds of their time delivering personal care.

4.14. One of the major factors that draw care staff away from personal care is quite simply the paperwork. Care staff are required to complete excessive amounts of paperwork, so much so that when Kevin Andrews was the Minister for Ageing he wrote a letter to the South Australian newspaper the Advertiser stating:

4.14.1. “I have recognized that paperwork is cause of much frustration for nurses and care staff and am tackling the issue. I am determined to reduce paperwork and red tape so that nurses can do what they are trained to do – that is, care for our most frail older Australians”. (Minister for ageing 2002)

4.15. Kevin Andrews, as the Minister, had an industry working group come together to reduce the amount of paper work that was required by residential aged care facilities. The LHMU understands that a trial was successfully conducted and that a roll out of the new documentation requirements were squashed when the 2004 budget announced that it would be scrapping the 8 level classification system for a 3 level system.

4.16. From the budget statements, the 3 level system will be developed in consultation with industry, to be implemented in 2006. This means that those aged care workers will continue to be drawn away from providing care, for at least the next 18 months to 2 years. As such the workload for this time will continue to be the same despite a successfully trialed documentation tool sitting at a department level.

Low pay

4.17. The fact that so many aged care workers are being unpaid for work that they perform also adds to the disenchantment they already have regarding their pay levels. Almost 60% of LHMU members are not satisfied with their pay. The government aged care workforce report clearly explains why care staff are disenchanted with their pay, as almost 50% earn less than $500 per week and over 60% of personal care attendants earn less than $500 per week (Richardson 2004). This would be much larger amongst the non-care staff like cleaners, cooks and maintenance workers.

4.18. The LHMU aged care phone-in further highlighted that aged care workers do not believe that they are properly paid. One aged care worker highlighted that staff at her facility leaving to work at public hospitals. This aged care worker claims that they are doing the same job and receiving a lot more money and better conditions of employment.

4.19. The caring skills that are required to carry out this work have historically been unrecognised, perhaps because they have been considered to be somehow innate in women. In addition, inadequate Federal and State funding for care and support work suppresses wages for providers of care. This is even more prevalent in award free sections of the workforce, such as some sections of the home care workforce.

4.20. Low pay in the aged care sector does not only constitute a crisis for workers. It also constitutes a looming crisis for providers and consumers of care, who struggle to retain staff that cannot make a livable wage from care work. This coupled with high turnover prevents the frail aged from receiving the continuity of care that they need. This is a crisis that must be addressed with the provision of fair wages and decent work for care and support workers.

4.21. Any assumption that low paid aged care workers are sometimes part of high-earning households applies primarily to female workers who are deemed to be 'second earners'. The assertion is that being located in households, with higher incomes ensures that such workers are not in poverty and are therefore not in need of higher minimum wages. Even where low-wage women are located in households with higher incomes, the assumption that their poor remuneration is acceptable is wrong on two counts:

4.21.1. Such an assumption contains the outmoded view that women should earn less in the sphere of work because of their position within the domestic sphere. On the contrary, to ascribe a monetary value to women's work by judging their needs against a male partners' income is to discriminate against women.

4.21.2. The ‘second earner’ issue applies only to a proportion of low-paid women workers, and at certain periods of their lives (when partnered). Almost one quarter of LHMU women, for example, *are in fact the principal bread winner*, often relying on low-paid and inadequate work to support households.

4.22. For reasons of both equity and survival, there is a strong imperative to raise the pay and address the insecurity found in much female dominated work in the low-paid labour market. The ‘modest but adequate’ income for single person renting private housing in1998 has since been indexed by ACOSS for inflation (ACOSS 2003). The weekly wage required is $550 per week.

4.23. The industry estimates that 78% of total costs in residential aged care facilities is wages (NACA 2001p20). Industry through NACA have argued that the current funding for aged care does not bear any relationship to the actual cost of providing care. The cost of providing quality care could become part of what the industry describes as the benchmark of care. The benchmark of care would create a direct relationship between care delivery costs to funding requirements. The current funding system also does not allow for cost differentials across Australia.

4.24. Industry argues that the current funding model, Commonwealth Own Purpose Outlays [COPO] is an inappropriate method of indexing funds for residential aged care (NACA 2001pii). This is further highlighted by the fact the Department of Veterans Affairs have moved away from this funding model to fund its programs.

Occupational Health and safety

4.25. Occupational Health and Safety is another issues that the aged care workforce has to deal with on a daily basis. Statistics produced by CCH Australia Limited, have highlighted the fact that Australian workplaces are more dangerous than our roads. For example there were 2002 work related deaths, compared to 1750 deaths on Australian roads. While deaths attributed to aged care might not be so prevalent, four out of the seven highest factors in causing workplace injuries can be found in the aged care industry (CCH 2004).

4.26. The Governments National Occupational Health and Safety Commission found that about half of all new workers compensation claims and almost half of compensable fatalities have occurred in four industries over the past 6 years, with one of those industries being the health and community services industry, of which aged care is a part (NOHSC 2004).

4.27. NOHSC also identified that over the past 6 years body stressing incidents such as manual handling have accounted for more than half of all workers compensation claims. While the risks of being hit or hitting objects with part of the body, falls, trips and slips accounted for a further 30% of compensation claims(NOHSC 2004). This is supported by CCH as it argues that manual handling, slips and trips, hazardous substances and new and young workers, which can all be found in the aged care industry, are part of the highest factors in causing workplace injuries(CCH 2004).

4.28. The South Australian WorkCover aged care industry newsletter identified that the largest number of stress claims come from the Health and Community Services sector. The newsletter points out that medically diagnosed stress is a result of a number of identified workplace factors, such as increased workload, increased hours, decreased resources, decreased autonomy and uncertainty (WorkCover 2001).

4.29. Understaffing is one concern that has been identified by LHMU that has a direct result on the safety of our members in the workplace. Unfortunately workload is determined by care needs and there is no requirement for providers to staff to care needs.

4.30. The LHMU aged care phone-in has raised some concerns about occupational health and safety and the workcover process in aged care. One aged care worker reported that management at her facility has spent money on a trip, but would not spend money on infection control. Another aged care worker stated “staff members have been told that residents will have to go without to pay for their workcover claims”.

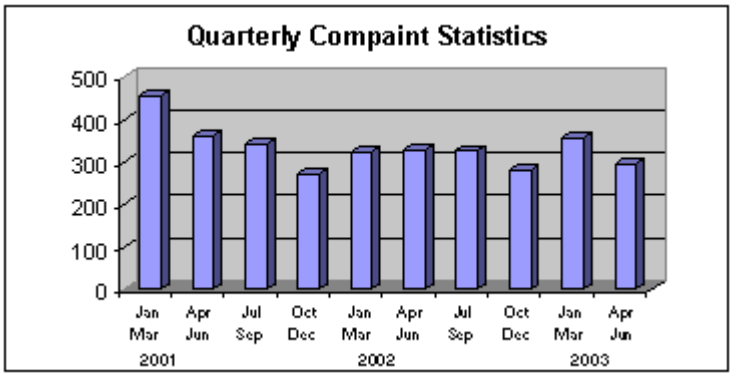
4.31. Another serious matter regarding workcover, that was brought to the attention of the LHMU through the phone in was that aged care workers that have injured themselves are not telling their employer because they are scared that they will be bullied by their employer. What this means is that there are a number of injured workers in the industry suffering silently.

4.32. The aged care workforce is becoming a situation of survival of the fittest. This is despite clear evidence that understaffing posses a serious risk to residents and means an unsafe working environment for staff.

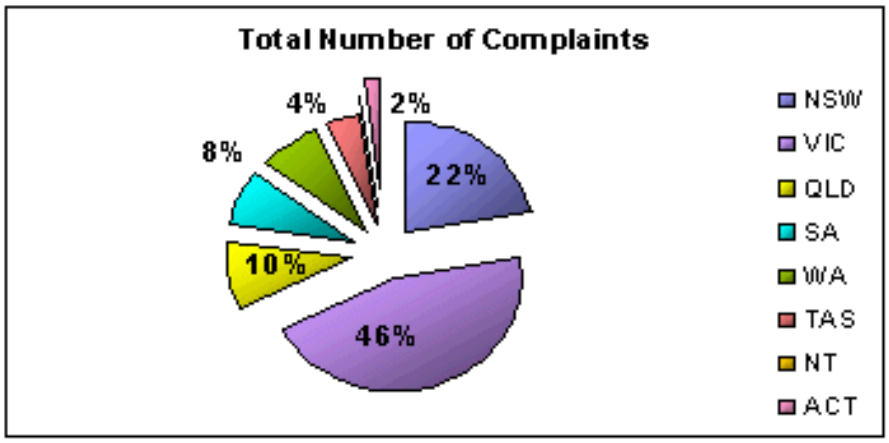
4.33. An aged care facility in South Australia recently tried to reduce its staff hours by over 270 hours. This was not only a concern for the staff that were losing hours, but also for the residents and their families. The residents and their families understood that this would result in understaffing, a lower quality of care and present a safety risk to both the staff and the residents. As such the residents and their families joined in the campaign with the union to ensure that the hours were not lost. Mark Butler LHMU SA Branch State Secretary said at the time of the dispute “Cuts to staff hours in aged care facilities not only reduces the quality of care for residents but increases the strain on workers who are already overworked” (Butler 2003).

4.34. The aged care residential setting becoming an unsafe workplace has manifested itself into 1227 complaints to the commissioner of complaints in the financial year 2002-03. The most common causes of complaints are largely derived from issues that can be linked to understaffing, stressed and tired staff, such as resident safety, staff behaviours that could be considered inappropriate, clinical care, catering and communication (Commissioner of Complaints 2003).

4.35. Complaints to the Commissioner have been relatively consistent over the past few years. The table below highlights the number of complaints from the March quarter 2001 to the June quarter 2003. it is evident over this period of time that the number of complaints has averaged around 300 per quarter(Commissioner of Complaints 2003).



4.36. The majority of complaints have come from Victoria, with 46% of all complaints in the period 2002-03, followed by New South Wales with 22%. 10% of the complaints were in Queensland, 8% in South Australia and Western Australia, 4% in Tasmania, 2% in the ACT and 0.3% in the Northern Territory. This can be seen in the chart below(Commissioner of Complaints 2003).



Attraction and Retention of Staff

4.37. The attraction and retention of staff is indicative of the issues in the aged care sector. It is almost a vicious circle that continues to spin, which culminates in very few people working in the aged care industry and even less wanting to work in the industry.

4.38. Retention of the existing staff is key to attracting new staff. However in order to retain the existing staff in the aged care industry the issues outlined above such as workload, low pay and occupational health and safety need to be addressed.

4.39. If government and the industry are able to stop the mass exodus of employees leaving the aged care sector then they have a basis on which to recruit new employees to the sector. If they are able to retain staff then firstly it will look more attractive as people will not want to leave and secondly they will not leave and tell anyone who is even remotely thinking about working in the sector how bad their experience was.

4.40. In order for the aged care industry to get the upper hand in the attraction and retention of staff, the image of working in aged care needs to change. Whilst it may never be considered glamorous, the image and reality should be that, you put in a hard days work, you are treated fairly and with dignity and you are properly compensated, comparable with other people doing the same work in the public system. Aged care workers cannot afford to be considered a class below their public hospital counterparts.

5. Shining the Light on the Funding Crisis?

5.1. The 2004 Federal Budget has not resolved the funding issues in aged care. It has provided an initial cash injection to employers, but it is largely a back end budget for employees, if at all.

5.2. Private for profit operators who in the financial year 1999-2000 received 74% of their income from government funding, while the not for profit providers only received 66%, welcomed the 2004 budget, not as a saviour but a good short term solution. The for profit operators welcomed the $3500 per resident, due prior to the end of the 2003-04 financial year and the millions of dollars in other funding that was coming their way.

5.3. In fact it wasn't only the aged care providers that saw the budget as being a significant cash injection. The share market also recognised that it was a large win for the for profit providers. The Sydney Morning Herald reported after the budget that shares in the DCA Group increased by 4% after the budget was announced (SMH 2004).

5.4. The federal budget, in fact, provided no guarantees at all for the aged care workforce. There were on the surface promises, but looking past the gloss aged care workers really do miss out.

5.5. Under the Budgets Conditional Incentive supplement initiative, the government announced that it would provide $877.8 million over 4 years (Australian Government 2004). This announcement is in line with the Hogan recommendation that the government should introduce an incentive supplement that is worth1.75% of the supplement for each resident on an annual basis.

5.6. Hogan recommended that this conditional supplement be tied to aged care providers demonstrating productivity gains, improving efficiency and training their workforce. The government according to budget documents has not followed Hogan's recommendations. The government has tied the conditional payment to aged care providers giving staff information and opportunities regarding workforce training, rather than actually training them, making audited public accounts available on an annual basis and taking part in a periodical workforce census.

5.7. The government promotes this money as being able to assist providers to pay for more competitive wages to the aged care workforce (Australian Government 2004). Yet the money is not even remotely tied to wages in aged care. There is no requirement placed on the employers at any level if they receive this conditional supplement to direct it into wages. What this clearly means is that employers can receive this conditional supplement and put it straight into profits.

5.8. The government announced $101.4 million to develop better skills for better care workforce (Australian Government 2004). But this is well short of what was recommended by Hogan. Hogan recommended that the government should support 12,000 Enrolled Nurses to complete medication management over the next 4 years. The government fell short by 6750 places. In fact the government only increased training places for ENs to undertake medication management by 1500 on top of what has already been provided (Australian Government 2004).

5.9. Hogan recommended that the government should support aged care providers to assist at least 6000 personal care attendants to complete certificate IV and 24,000 PCAs to complete Certificate III over the next 4 years. The government budget has not met the recommendations. In fact they have created a shortfall of 14250 training places in the vocational education and training sector.

5.10. The government has also stated that it will work with the state and territory governments to expand the number of aged care places in the vocational eduction and training sector. The government clearly is required to do this as the states manage this training sector. The federal government has no ability to directly increase the number of training places without the assistance of the states and territories. This then creates a potential buck passing situation, as the federal government can blame the state governments if they cannot increase the number of training places to meet the government budget announcements and industry expectations.

5.11. $81.9 million has been allocated to free the administrative burden on staff and provide greater income security to providers workforce (Australian Government 2004). The major aim of this process is to reduce the classification levels and simplifying the payments that are made to aged care providers. Hogan recommended that the current 8 level classification structure be collapsed into 3. The government has committed to working with the industry to develop what will become the new structure, in line with Hogan's recommendation (Australian Government 2004). It is anticipated that this will reduce the paper work burden on staff.

5.12. Highlighted earlier was the fact that the government has already spent a significant amount of time and resources in developing modified documentation based on the existing classification structure. It is the understanding from the LHMU that this tool has been put on the back shelf, despite it being ready to be implemented. It is also the understanding of the LHMU that this tool would significantly reduce the amount paper work, allowing for more time to be spent on care.

6. Shining the light on how Australia can improve Aged Care

6.1. Establishment of a National Benchmark of Care.

6.1.1. The establishment of a national benchmark of care will ensure that older Australians get the care they deserve when they need it most. The national benchmark of care would be established with the industry, to ensure that best practice care forms the basis of the benchmark.

6.1.2. The national benchmark of care would encompass all aspects of care in both residential and community settings. This would include establishing minimum staffing levels and skills mix for delivering care. Staffing levels and skills mix would need to be developed in accordance with the level of care required and the complexity of that care.

6.1.3. The benchmark of care would be fully costed, in terms of all aspects of care required and as such could be used as the tool to determine the funding that the government provides for care.

6.2. Reduction of the paperwork burden

6.2.1. The trialed documentation tool, based on the current class structure, needs to be released as an interim measure. This will immediately free care staff, to deliver care.

6.2.2. Paperwork is one of the largest barriers to the direct delivery of care. It is also one of the largest frustrations of those that work in aged care. The release and utilisation of the document that was developed in conjunction with industry, if only as a short term measure would be welcomed.

6.3. Establish parity in wages between Aged Care and the Public Hospital system.

6.3.1. One of the biggest issues that face the aged care sector today is the disparity in wages between aged care workers and their public hospital counter parts. It is widely acknowledged across the industry, that there is a significant gap in the amount of money a worker in the aged care sector takes home and their public hospital counter part.

6.3.2. The government has provided for extra money to be paid to the aged care providers, however none of that money has to be tied directly to wages.

6.3.3. Without a significant shift in the rate of pay that aged care workers receive, both the shortage of skilled workers and the retention of those skilled workers will continue to develop. This culminates into workload issues that develop from the lack of staff that are available to aged care facilities.

6.3.4. The government has argued that it cannot dictate to employers what it should pay its staff, however the government can ensure that a proportion of funding that is given to employers goes directly to paying staff for care. This would be directly aligned to the fully costed benchmark of care.

6.4. Create a system that is accountable to the tax payer

6.4.1. Aged care providers receive their primary income from the Australian taxpayer. They are paid to deliver care to older Australians when they require it. Aged care is a service that the Australian Government outsources.

6.4.2. Once the money is handed over to the aged care providers there are no requirements on the way they spend that money, or if they spend that money at all. Aged Care providers have been crying poor for many years. Providers reduce services, staffing levels, hours and they claim they cannot afford pay rises. Other than the providers themselves no one really knew the state of the industry. Now it has been reported

that no one will ever really know, except for Hogan and his team, as the original data collected by the Hogan review has been destroyed (Baden 2004).

6.4.3. The government should make the aged care providers accountable for the money that they are provided. This would clear the muddied waters and enable the taxpayer and the government to clearly see if providers are actually not receiving enough funding or if they are making large profits, yet crying poor. If it is the view of the current government that by doing this, it may highlight that they are truly under funding the aged care sector then this is socially irresponsible and very much un Australian, to treat older Australians with such distain.

6.4.4. This would be an easy process to manage and has been alluded to in order for providers to obtain the conditional incentive supplement. If it can be achieve in the process to get extra funds, it should also be able to be achieved for all monies that are provided by the government.

6.5. Establish an office of the Aged Care Ombudsperson

6.5.1. Establishing an office of the Aged Care Ombudsman would create an environment that would provide transparency and accountability in the management of complaints, in both residential and community care settings.

6.5.2. The ombudsman would have the power to investigate all complaints and promote effective resolutions.

6.5.3. The Ombudsman would also have the role to educate residents, families and the broader community about the rights of older Australians that receive aged care services.

6.5.4. The LHMU aged care phone in highlighted a number a issues in the aged care sector. These issues were raised by aged care workers, residents and the residents families and friends. Foe example, aged care workers having to reduce the level of care and services provided due cuts in staff and hours, residents and families of residents too scared to raise their concerns for fear of being targeted by management and the falsifying of records to cover the facilities potential liabilities and to ensure that they receive accreditation.

7. Conclusion

7.1. Older Australians deserve quality aged care. They are the foundation of our country and deserve to be treated with the utmost respect. Caring for the needs of our older Australians when they need it most should be a priority for any government. They should not be the centre of a political game.

7.2. The first thing that should be the highest priority for any government is to understand what care needs of older Australians are and then how much it is going to cost. This is now what is commonly being referred to as the benchmark of care by the industry, which would be based on best practice. It is an industry view that the benchmark of care would set the standard of care that older Australians can expect and deserve, being best practice, and then the determined benchmark of care being properly costed, that is the inclusion of all costs that are incorporated in the delivery of that care.

7.3. The benchmark of care would determine how much aged care providers require from the government in order to provide aged care. It is the view of the LHMU that the establishment of the benchmark of care will go some way to removing the financial crisis in aged care. Having a real picture based on best practice will determine not only the care that is being delivered, but also who will be delivering that care and how many people are required to deliver that care.

7.4. Industry and government know that one of the major deterrents of working in the aged care sector is the low pay, especially when you can receive more money working in the public system. The reality is that in order to attract and retain staff, aged care providers need to pay competitive wages and have competitive terms and conditions.

7.5. The national benchmark of care would go some way to resolve understaffing related workload issues, as the benchmark of care would set minimum staffing levels based on care needs.

7.6. A national benchmark of care would also impact on the recruitment and retention issues that are currently experienced in the sector. Aged care at a minimum would be comparable to other industries that compete with them for workers.

7.7. The national benchmark of care would assist in making aged care providers accountable for taxpayer funds they receive. By having a properly costed benchmark of care, based on best practice, that encompasses all aspects of the delivery of care. This will mean that if money is diverted away from care it will be easily identified. That is, industry will say that $X is the amount they require to deliver care, based on the benchmark, but only spend $Y, the government and the taxpayer can ask where has the money gone and why it hasn't been spent on the delivery of care.

7.8. Establishing a national benchmark of care in partnership with all stakeholders will be an innovative step forward for the aged care industry, its employees and those that consume aged care services. A step forward is the least that older Australians deserve.

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