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Comparative Performance  
Monitoring

Case Study on Performance Outcomes  
in the  
AGED CARE SECTOR

Second Report on the Health and  
Community Services Industry

Bryan Bottomley and Associates

August 2002

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# EXECUTIVE SUMMARY

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This report presents findings on comparative performance trends in the aged care sector (97/98-99/00). The report also attempts to broaden the basis on which outcomes can be explained.

The analysis of claims data revealed a number of key findings.

Nationally there has been a sustained decrease in lifting claims driven mostly by improvements in the nursing home sector rather than the accommodation for the aged sector. This improvement has not been matched by other muscular stress categories where only marginal reductions are evident. Lifting claims per million rates in all jurisdictions confirm the positive trend shown in the raw numbers and comparison to all industry rates shows reductions in the aged care sector have been noteworthy.

When claims data is disaggregated to nursing home and accommodation for the aged categories there are differences between jurisdictions but generally the claims rate in the accommodation for the aged sector is worse than nursing homes.

The improvement in some injury categories has not flowed through to lower premium rates in most jurisdictions. Nursing home premium rates were still about twice the all industries average and accommodation for the aged rates are still about one and a half times the all industries average across the 97/98 to 99/00 period.

The report identified a number of structural factors likely to be important in understanding OHS outcomes. The results of statistical analysis using these factors in relation to claims data showed that:

- Smaller facilities have better claims rates than larger facilities
- Metropolitan locations have higher claims rates than rural locations
- Charitable, private and to a lesser extent religious owned facilities are associated with higher claims rates
- Local government, state government and community owned facilities are associated with lower claims rates
- Low care is associated with higher claims rates
- “Other occupations” such as cooks and cleaners are associated with higher claims rates

Apart from examining the impact of these structural factors the study also considered aged care sector policy changes, the initiatives of OHS agencies and initiatives of other industry groups.

Aged care reforms with particular relevance to OHS outcomes covered in the study were changes to workers’ compensation funding and the introduction of aged care accreditation requirements. In addition, the Commonwealth funded a number of specific OHS initiatives, and these were implemented in each jurisdiction. In combination these reforms and initiatives have enabled many aged care providers to improve their OHS performance.

The changed method of subsidising workers’ compensation costs in aged care facilities has been a concern for industry representatives but analysis of performance data from one jurisdiction shows that many facilities have been able to improve their performance and keep premium costs below the industry average.

The introduction of the aged care accreditation process that required some basic OHS measures

## EXECUTIVE SUMMARY

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to be in place appears to have been a reasonable predictor of future performance. In the case of one jurisdiction the lack of safety readiness shown in accreditation ratings is apparent in outcome data.

The evaluation of the impact of OHS agency interventions was based on available information but could not be precise in the scope and reach of such interventions. Most jurisdictions have conducted general manual handling campaigns and it is reasonable to conclude these have influenced the improvement in lifting claims. However by the test of sustained claim reductions across all manual handling and all other categories agency interventions could not claim success.

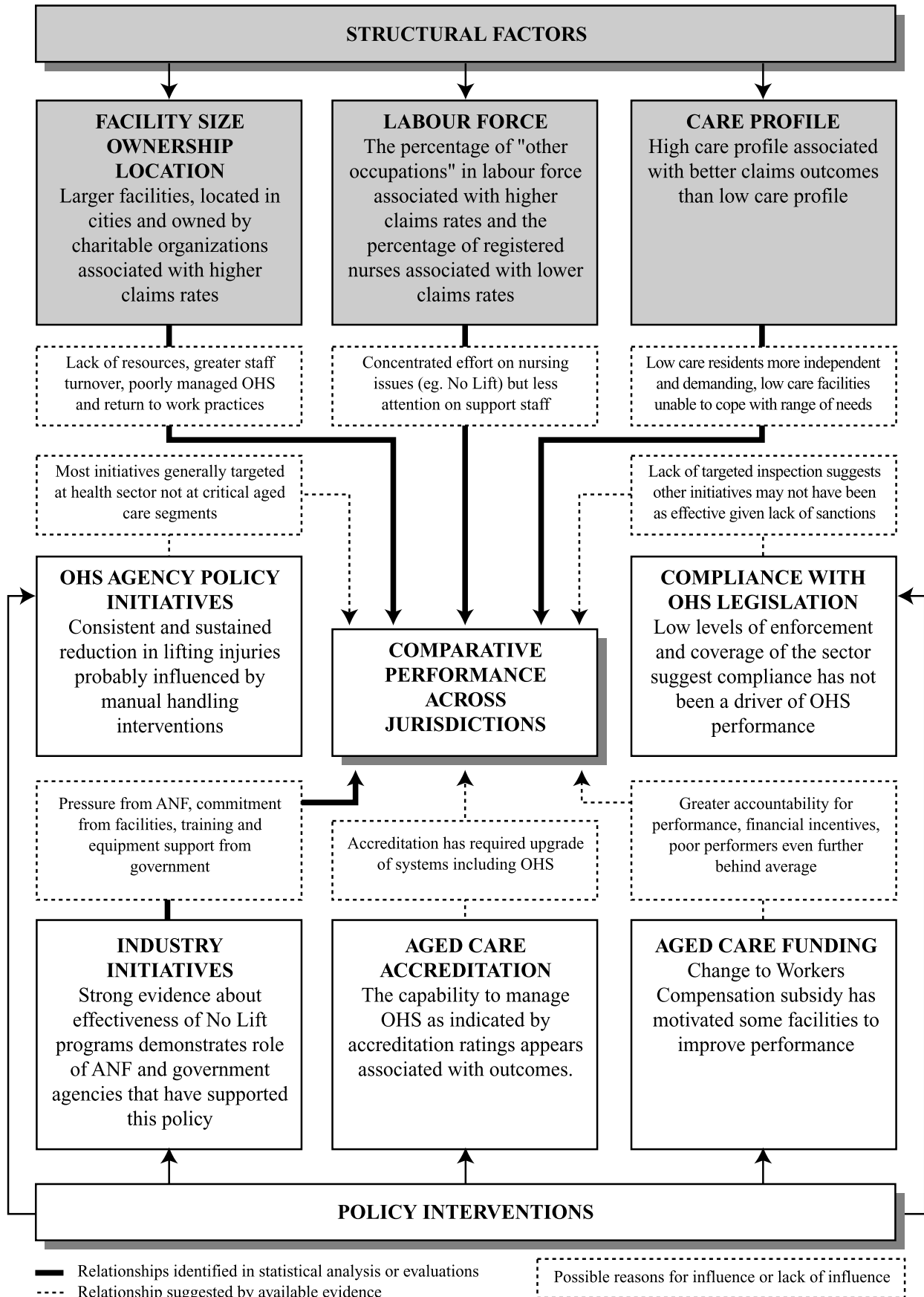
Most agency interventions have been information based or based on longer-term effort to increase the sectors capacity to manage risk and these will take some time to impact on outcomes. A traditional part of any strategy is inspection and audit activities but until recently the sector has been largely free of targeted inspection by OHS agencies.

One of the most successful interventions has been the introduction of No Lift programs largely driven by the Australian Nursing Federation with critical support from OHS agencies, health departments and ultimately facility management. This initiative is considered to have been a factor in the sustained reduction in lifting claims found in the study.

Using the results from the study a model for interpreting outcomes in the aged care sectors was developed. The model highlights that explanations of past performance and the targeting of future initiatives must give more weight to industry factors of the type analysed in this study.

The model illustrating some of the key findings of the study is shown overleaf.

**Figure 1: Model for interpreting comparative performance in the aged care sector**





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# 1. INTRODUCTION

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The aged care sector, like other industry sectors, gradually improved its OHS performance as measured by workers' compensation claims data. In the most recent Comparative Performance Monitoring Report<sup>1</sup> the major trend was the continuing decline in the frequency of workplace injuries and the rising cost of claims. The increase in the severity of injury and the cost of claims raises questions about the factors that may explain these trends both within jurisdictions and between jurisdictions.

The report notes that reduced frequency could be explained by scheme changes, underreporting or a shift to lower risk industries. The increased cost of claims raises the question of the effectiveness of policy interventions and the application of return to work and rehabilitation strategies.

This project has been commissioned to further examine the underlying factors that may explain higher-level macro trends. In particular the project has the following objectives:

- To assist in gaining a better understanding of the different strategic policy settings in each jurisdiction and assess the potential impact on macro outcomes as reported in CPM reports
- To provide an analytical framework that would assist jurisdictions in linking high level outcome data to specific policy settings within the jurisdiction

The project uses the general framework endorsed by the Workplace Relations Ministers' Council to interpret high-level CPM outcomes. This framework identifies structural factors and policy interventions as the two key streams of influence on high-level outcomes.

Previous work done on structural factors for the CPM Working Party<sup>2</sup> indicated that of the variables examined only a few had any significant relationship to injury outcomes and in this project only a limited number of structural variables will be examined.

The range of policy interventions to be considered in this project include:

- Education and information programs
- Training programs
- Knowledge and best practice transfer programs
- Inspection and enforcement programs
- Regulations and codes

Policy initiatives may be at the institutional level (e.g. legislative change), the industry level (e.g. guidance or codes) and the workplace level (e.g. hazard programs, management systems). How these initiatives are delivered may also vary.

From an analysis of the available data any factors that help explain the trends in the aged care sector will be identified. Specific changes in the sector will be also covered including the role of accreditation and the changes to the funding of workers' compensation.

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<sup>1</sup> Comparative Performance Monitoring, Third report, Australian and New Zealand Occupational Health and Safety and Workers' Compensation Schemes, Workplace Relations Ministers' Council, Commonwealth of Australia, 2001.

<sup>2</sup> Pilot Study: Interpreting CPM Outcomes- Property and Business Services, Access Economics, 2001

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The analysis is based on ANZSIC category 8613 Nursing Homes and ANZSIC 8721 Accommodation for the Aged as these categories are most consistent with compensation data. Aged care provision through hospitals and home-based care packages are not included but they do not account for a significant part of the sector.

## 2. OVERVIEW OF THE SECTOR

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The performance of the aged care sector must be seen in the context of the changing profile of the industry. This changing profile is influenced by many factors including demographics, policy and regulatory changes and labour market factors.

### 2.1 *Profile of the sector*

The majority of older Australians care for themselves in their homes or receive support from family or through government programs. A significant minority are cared for in residential aged care facilities that have traditionally been either hostels or nursing homes. The historical distinction between these facilities was that hostels met an accommodation need and nursing homes met a nursing care need.

This distinction is becoming less clear as hostels now accommodate high care residents and facilities are likely to be more general purpose into the future.<sup>3</sup> These changes reflect government policy that has shifted the funding basis from facility type to care needs. The Resident Classification Scale is the basis for determining subsidy levels and this applies whether the resident is in a hostel or a nursing home.

Government policy to encourage “ageing in place” is aimed at improving the flexibility of residential aged care by allowing residents to receive continuity of care as their needs change. Government policy is also directed towards achieving a spread of residential care places such that 40% are nursing homes, 50 % hostels and 10% community care packages. This profile is described in a recent Australian Institute of Health and Welfare (AIHW) report<sup>4</sup>. As a result nursing home places have been reduced and hostel places increased so that there are nearly as many hostel beds as there are nursing home beds. This has had the effect of concentrating high care residents in nursing homes rather than the wider range of care needs previously managed by nursing homes.

The trend of high care residents being concentrated in nursing homes and the increasing role of hostels in managing high care residents may have implications for OHS performance and subsequent premium rates if risk exposure for employees is related to care needs.

The second aspect of these changes that is pertinent to CPM outcomes is that as the composition of nursing homes and hostels change this will be reflected in industry rates set in compensation schemes. Most schemes have separate categories for nursing homes and what is usually called “accommodation for the aged”.

Fifty seven percent of the 3005 aged care facilities recorded at June 2000 were located in capital cities with the balance in regional and rural Australia. Queensland and Tasmania were the exceptions with the majority of places located outside the capital city.

The size of aged care facilities varies across jurisdictions and has become an important policy issue in terms of both quality care and viable operating levels. A little over 50% of facilities have 40 beds or less and submissions to the Productivity Commission Inquiry argued that this size was not viable for profitable operation.<sup>5</sup> This view was not supported by a later review of reforms and the role of supplementary funding to small facilities in remote and isolated communities addresses a major part of the viability issue.

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<sup>3</sup> Nearly 10% of high care residents live in hostels, Nursing Home Subsidies, Inquiry Report, Productivity Commission, AusInfo, Canberra, 1999, p.9.

<sup>4</sup> Residential Aged Care Facilities in Australia 1999-00: A statistical overview Australian Institute of Health and Welfare and Department of Health and Aged Care, Canberra, AIHW Cat. No. AGE 19, 2001.

<sup>5</sup> Nursing Home Subsidies, Inquiry Report, op cit, p.13,

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Smaller homes are concentrated in Victoria and the Northern Territory and smaller homes are found more in rural and remote areas. There has been some rationalisation of facilities with a reduction in the proportion of smaller facilities.

Ownership patterns for aged care facilities vary considerably across jurisdictions. In

the nursing home sector private for profit operators account for nearly half of the sector, followed by the religious and charitable organizations and then a declining government sector. Hostels are in the main owned by religious and charitable organizations with the private sector accounting for less than 10% of hostels.

## *2.2 Labour force and injury trends*

Labour force trends highlight problems with the supply of nurses. A recent report shows the number of full-time equivalent nurses in Australia per 100,000 population has fallen 11.8% during the last decade and that in absolute numbers, the nurse clinician workforce of 197,700 in 1998 was almost the same as the 197,100 employed in 1989<sup>6</sup>. The number of full time positions has decreased whilst the total and patient/resident population has continued to increase.

The report shows a major change in the age profile of Australia's nursing labour force. At the 1986 census, 23.3% of nurses were aged less than 25 years, and 17.5% aged 45 years or more. By 1996, the proportion aged under 25 years had reduced to 9.9%, while the proportion of those aged 45 years or more increased to 28.6%. Between 1993 and 1998 the average age of students starting undergraduate nursing degrees had increased from 21.8 to 24.5 years.

The ageing of nursing population is reflected in the claims profile where the highest proportion of claims is in the 40-49 age group. Another trend is the greater use of ward assistants and personal carers rather than registered and enrolled nurses.

The other aspect of the labour market that may be important is the increasing use of agency nursing staff in nursing homes.

In the Productivity Commission Inquiry considerable attention was given to wage costs and to disparities between the acute sector and the aged care sector. In most jurisdictions the wage differential is in the order of 2% to 14% and the contention is that the aged care sector has difficulty attracting nurses and thus the quality of care may be reduced. Whether this translates to any implications for health and safety is arguable except to suggest that personal carers may account for a greater share of claims.

## *2.3 Aged care reform: funding*

Major policy changes have been embodied in the Aged Care Structural Reform Package introduced by the Commonwealth in 1996-97. The key reform as noted earlier was to fund on the basis of care need not the historical difference between nursing homes and hostels. The basis for the funding formula is the Residential Classification Scale along with various supplements and contributions from residents.

The residential care subsidy varies across jurisdictions as shown in Table 1 drawn from the Productivity Commission report<sup>7</sup>.

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<sup>6</sup> Nursing Labour Force 1998, Australian Institute of Health and Welfare.

<sup>7</sup> Nursing Home Subsidies, Inquiry Report, op cit, p.29.

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**Table 1 Subsidy rates for residential aged care**

\$ per resident per day as at 1 July 1998

<i>Resident classification</i>	<i>National</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>SA</i>	<i>WA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>
1		104	109	90	97	100	110	100	106
2		94	98	81	88	91	100	91	95
3		81	84	70	76	78	86	78	82
4		57	60	49	54	55	62	56	58
5	34								
6	28								
7	22								
8	0								

Source: DHFS.

#### 2.4 Aged care reform: Workers' Compensation

Included in the changes to the subsidy was a change to the funding of workers' compensation premiums. The new system replaced the full cost reimbursement basis with basic funding but with the facility to cover additional costs. Premium savings resulting from improved OHS performance flow back to providers. The policy rationale was to provide an incentive to improve performance.

Prior to the 1997 reform package aged care facilities were subsidised for both direct care costs, standard operating costs and overhead costs including workers' compensation. The latter funding component was initially fully cost reimbursed which meant all workers' compensation costs were Commonwealth funded. This was changed in 1995-96 to an amount equal to the state average workers' compensation cost percentage of payroll.

Currently workers compensation is included as part of the basic subsidy rate and the Commonwealth policy position is that full reimbursement removes any incentive to improve performance. In the inquiry into subsidies there were a variety of views with peak bodies in the main arguing for the restoration of the full subsidy. Some groups such as the ANF argued that the costs of poor performance should be "owned" by those responsible and that fully reimbursing facilities did not provide any incentive for improved performance.

The major industry concern is the impact of sharp rises in premiums in an industry in which costs cannot be passed on and income is regulated. The logic behind this industry view is that every increase in worker's compensation cost is a dollar not spent on OHS.

#### 2.5 Aged care reform: Accreditation

The major regulatory change has been the requirement for aged care facilities to be accredited by the Aged Care Accreditation Agency. Facilities are audited against a number of standards including health and safety and must meet standards to be eligible for funding. Industry submissions to the Productivity Commission Inquiry claimed that the certification process required major capital improvements in order to meet the standards.<sup>8</sup> Others argued that the accreditation process increased administration costs.

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<sup>8</sup> *ibid*, p.93.

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The Aged Care Standards and Accreditation Agency Ltd was established under the Aged Care Act, 1997, and has responsibility for:

- Managing Accreditation for all Commonwealth funded residential aged care services.
- Monitoring of standards of care for services which have not yet been accredited.
- Liaising with the Department of Health and Aged Care about services which present a serious risk to the residents' wellbeing and safety.
- Promoting best practice within the aged care industry.
- Encouraging overall improvement in the quality of care being provided.
- Education and training.

All residential aged care services were required to be accredited by 1 January 2001. The Agency evaluates the performance of residential care services, which are not yet accredited, against the Residential Care Standards.

There are 44 outcomes defined for the standards with criteria set to assess whether outcomes are being achieved. This is then incorporated into a rating system for both individual standards and for the standards as a whole

The Occupational Health and Safety element is a small part of the accreditation process but nonetheless provides an insight into the readiness of the sector to improve performance.

Data on accreditation decisions as opposed to initial assessments has been provided but is difficult to interpret as the "satisfactory" category covers situations of non-compliance but involve a judgement by the agency that these matters can be remedied. As this category dominates the profile of all states any differences in capacity is hidden. The accreditation decision data is shown below in Table 2.

**Table 2: Accreditation decisions on residential aged care services 31 December 2000**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Management systems, staffing and organisational development										
Commendable	%	19.6	5.4	2.7	0.0	5.3	12.1	26.1	0.0	9.3
Satisfactory	%	78.3	92.3	95.1	98.1	92.4	87.9	73.9	86.7	88.6
Unacceptable	%	1.6	1.0	1.6	1.9	2.0	0.0	0.0	13.3	1.5
Critical	%	0.4	1.4	0.6	0.0	0.3	0.0	0.0	0.0	0.6
<b>Total</b>	<b>%</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
Health and personal care										
Commendable	%	20.2	4.7	2.7	0.4	7.2	7.1	13.0	0.0	9.2
Satisfactory	%	77.4	89.7	91.4	94.0	88.5	91.9	82.6	86.7	86.3
Unacceptable	%	2.5	4.9	5.3	5.6	3.9	1.0	4.3	13.3	4.1
Critical	%	0.0	0.7	0.6	0.0	0.3	0.0	0.0	0.0	0.3
<b>Total</b>	<b>%</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
Resident lifestyle										
Commendable	%	20.4	6.9	2.9	0.8	7.2	5.1	21.7	0.0	10.0
Satisfactory	%	78.7	91.0	95.9	99.2	90.5	94.9	78.3	93.3	88.7
Unacceptable	%	1.0	1.6	1.0	0.0	2.3	0.0	0.0	6.7	1.2
Critical	%	0.0	0.5	0.2	0.0	0.0	0.0	0.0	0.0	0.2
<b>Total</b>	<b>%</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
Physical environment and safe systems										
Commendable	%	16.4	4.4	1.0	0.4	8.6	16.2	17.4	0.0	8.2
Satisfactory	%	79.8	91.9	93.2	99.2	88.8	80.8	82.6	100.0	88.2
Unacceptable	%	2.9	2.2	3.9	0.4	2.0	3.0	0.0	0.0	2.5
Critical	%	0.9	1.5	1.8	0.0	0.7	0.0	0.0	0.0	1.1
<b>Total</b>	<b>%</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
Accreditation approvals (a)										
Three-year	%	97.0	91.8	92.4	92.9	93.8	97.0	100.0	93.3	94.1
Two-year	%	0.2	1.0	0.0	1.5	2.0	1.0	0.0	0.0	0.7
One-year	%	2.7	6.5	7.6	5.6	3.9	1.0	0.0	6.7	4.9
Nil	%	0.1	0.7	0.0	0.0	0.3	1.0	0.0	0.0	0.3
<b>Total</b>	<b>%</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
Number of services (b)	no.	928	814	487	266	304	99	23	15	2,936

(a) Accreditation period as at August 2001.

(b) The number of services differs from that shown in other tables because the time period is different and in a number of cases the Aged Care Standards and Accreditation Agency treated co-located services as a single entity.

Source: Department of Health and Aged Care (unpublished).

This brief summary of the aged care sector shows a sector subject to considerable structural and legislative change and also subject to high levels of social and political scrutiny for the level of care it offers. OHS performance could be improved in this reform environment or it could suffer as a low order priority. This project will examine how these changes may have impacted on OHS performance.



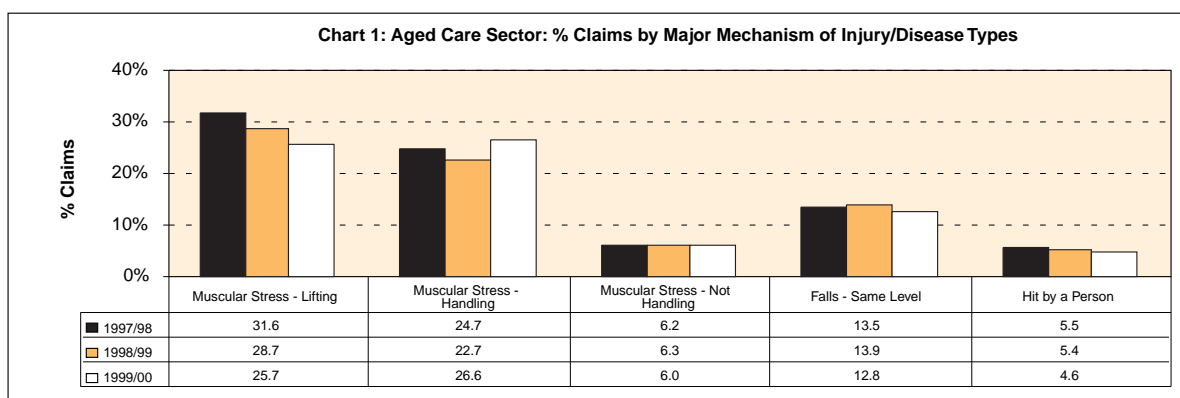
### 3. OHS PERFORMANCE IN THE AGED CARE SECTOR

The objective of this project is to provide a basis for explaining OHS performance in the aged care sector using claims based outcome data. This data is important but should not be considered as the only measure of either risk or ability to manage health and safety<sup>9</sup>. Where possible in this project other sources are used but the bulk of the analysis is dependent on claims data.

Using the National Data Set database (NDS) provided by the National Occupational Health and Safety Commission (NOHSC) a profile of the industry was assembled using similar indicators to those used in the CPM report. The results are summarised below.

#### 3.1 Brief profile of injuries in the sector

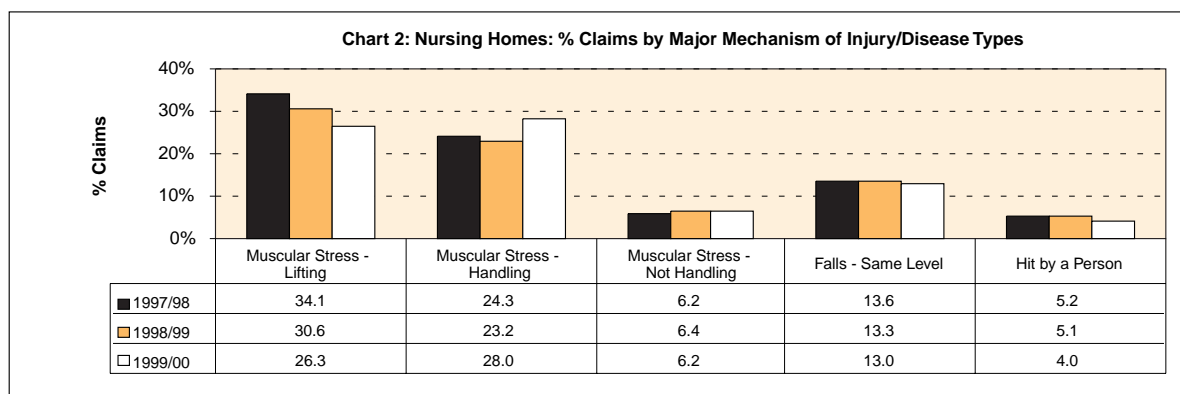
The predominance of manual handling claims has been well established in the sector as demonstrated in chart 1. A continued reduction in the number and percentage of lifting claims is a feature of the national profile. (Note: References to manual handling claims in this report in terms of mechanism of injury covers at least claims due to Muscular Stress- Lifting [Code 41] and Muscular Stress- Handling [Code 42]. However, there are other claims that are related to manual handling that are less evident in coding, so these two codes will understate the total manual handling figure)



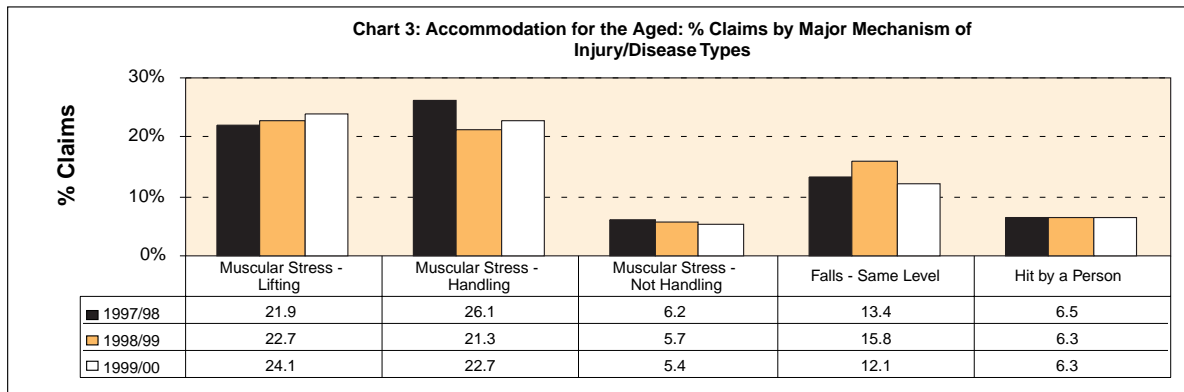
When disaggregated the pattern shows that the reduction in lifting injuries is evident in the nursing homes sector but this is not being sustained in the accommodation for the aged sector where there is a slight increase in the percentage of lifting injuries.

In terms of actual claims numbers the nursing homes sector is the source of improvement and in accommodation for the aged there has been an increase in claims numbers for every category.

Charts 2 and 3 below show the trends for the selected three-year period.

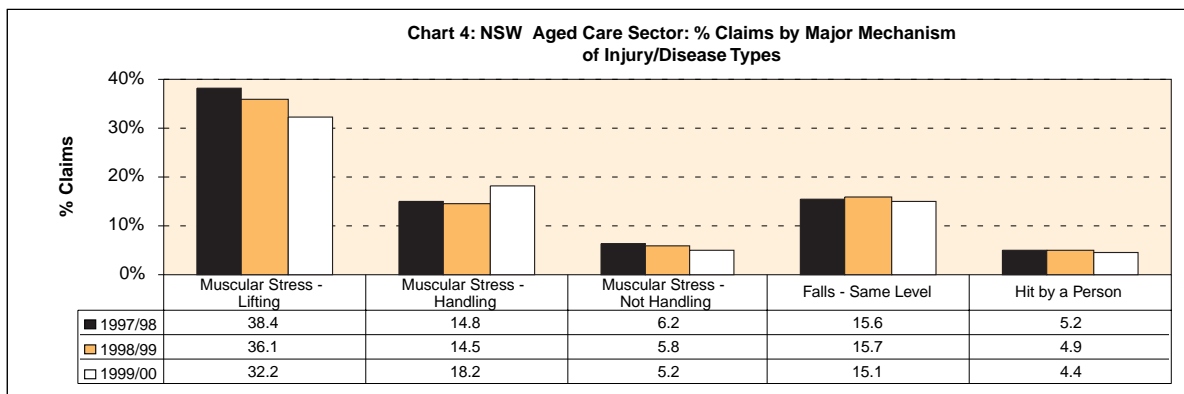


<sup>9</sup> The consultants are aware of the debate about claims data as an indicator of OHS performance and the difficulty in separating out claims outcomes as a measure of risk exposure and claims outcomes as a measure of OHS performance.

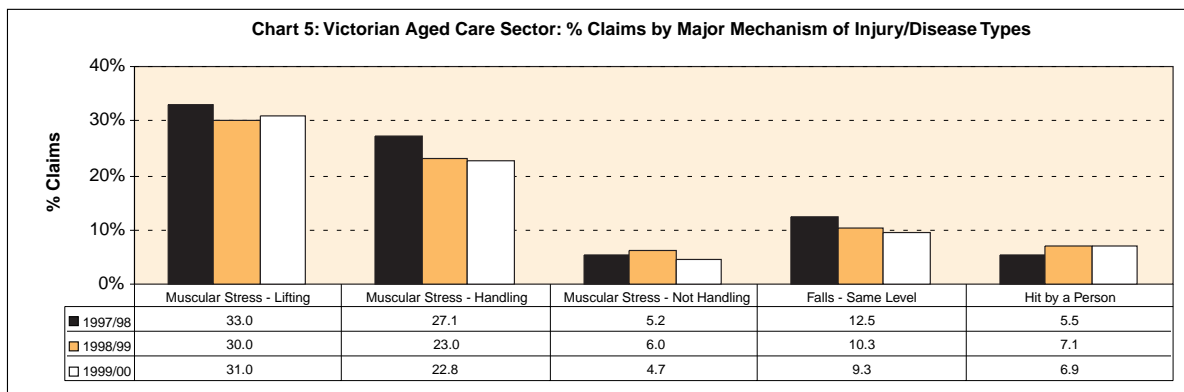


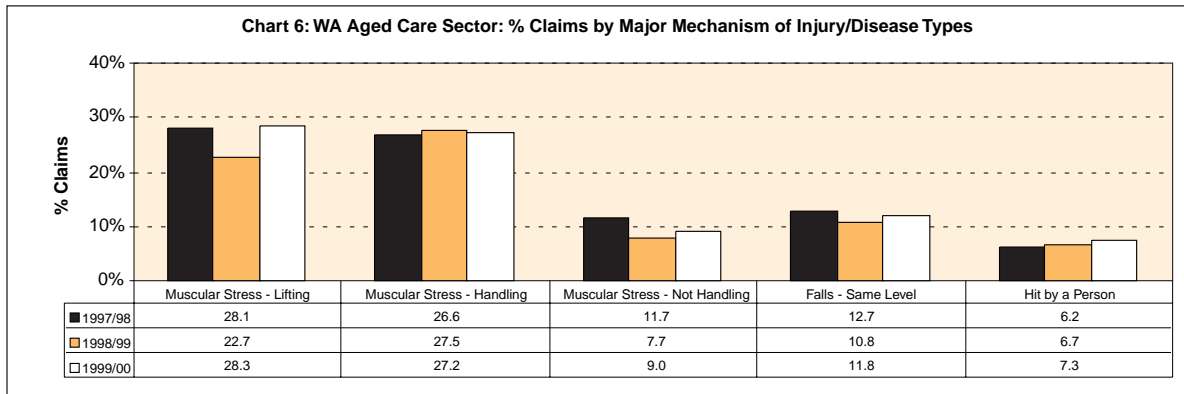
### 3.2 Brief comparison of jurisdictions

A brief comparison of injury patterns in different jurisdictions is outlined in the charts below. Charts are shown for the larger jurisdictions for mechanism of injury, as this is normally an important element in targeting interventions. In the later section on policy interventions these profiles will be used as a benchmark against which the effectiveness of interventions can be assessed.

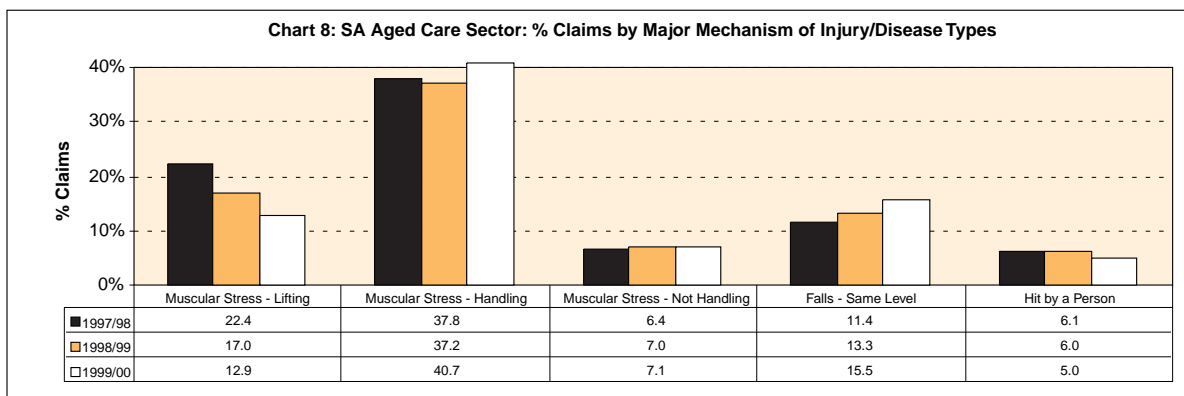
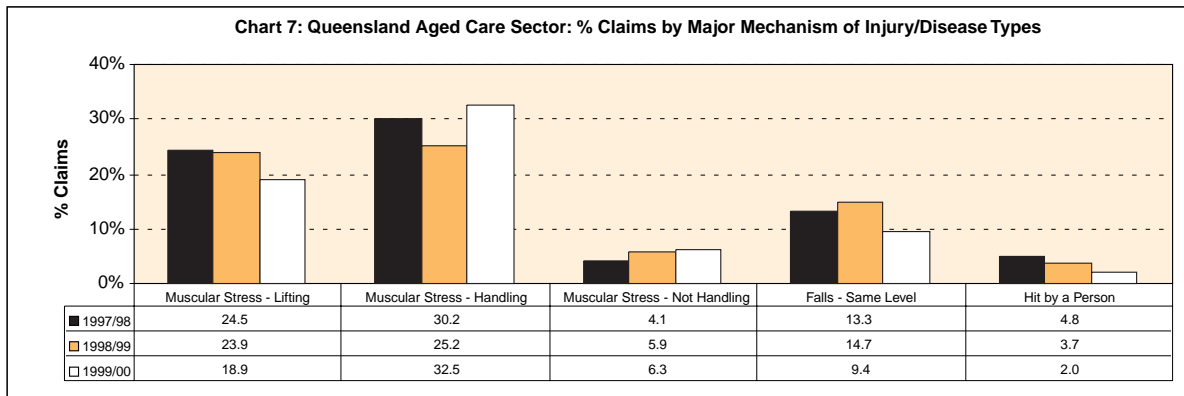


In NSW for the important lifting category there is clear improvement with little movement in other major categories. In Victoria there has been minor improvement in the lifting area and more significant reductions in handling claims. There have been reductions in raw numbers in most categories.

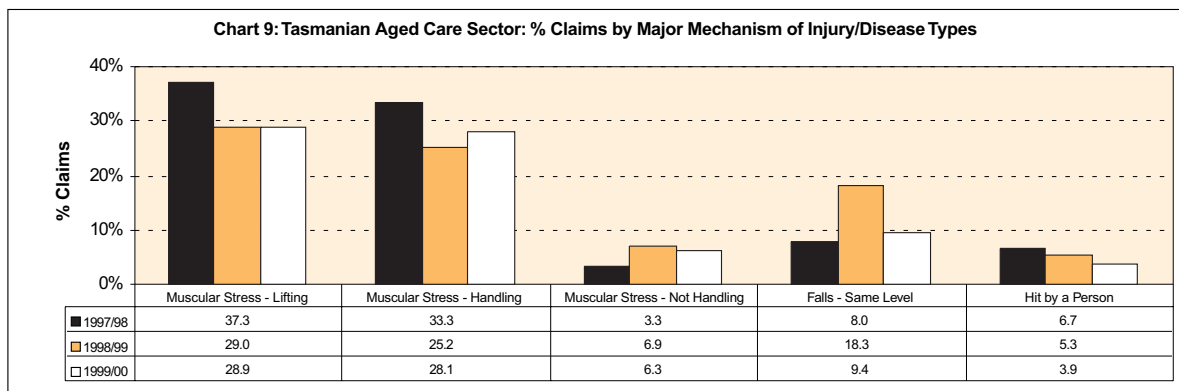




Western Australia has an uneven profile with minor improvement over the three years. Actual numbers in most categories have reduced but are unlikely to represent more than year to year variation. Queensland shows good reductions in lifting claims but this is countered by deteriorating performance in the handling claims category both in percentage share terms and actual numbers.



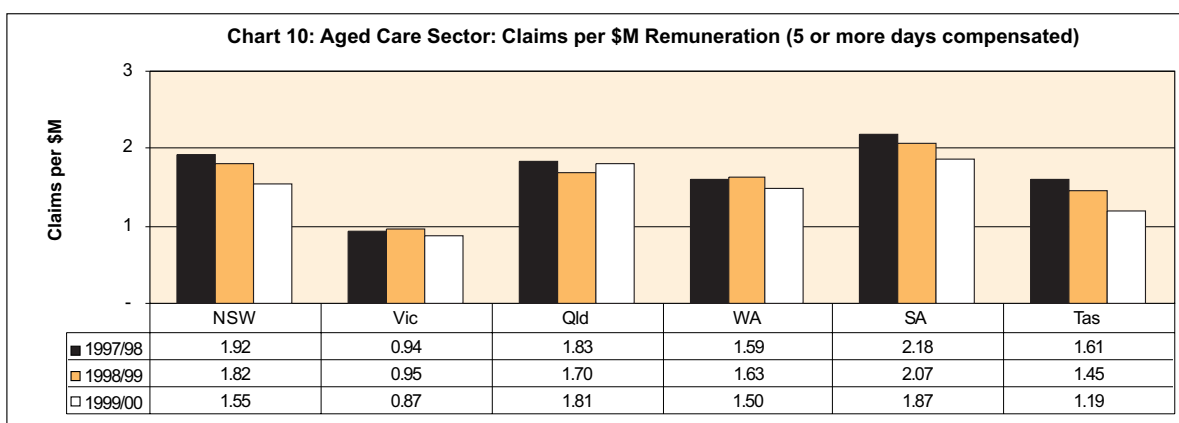
South Australia has the most dramatic reduction in lifting claims almost halving the level in the period but the very high handling claims level and increases in other categories limits the impact on overall measures of performance.



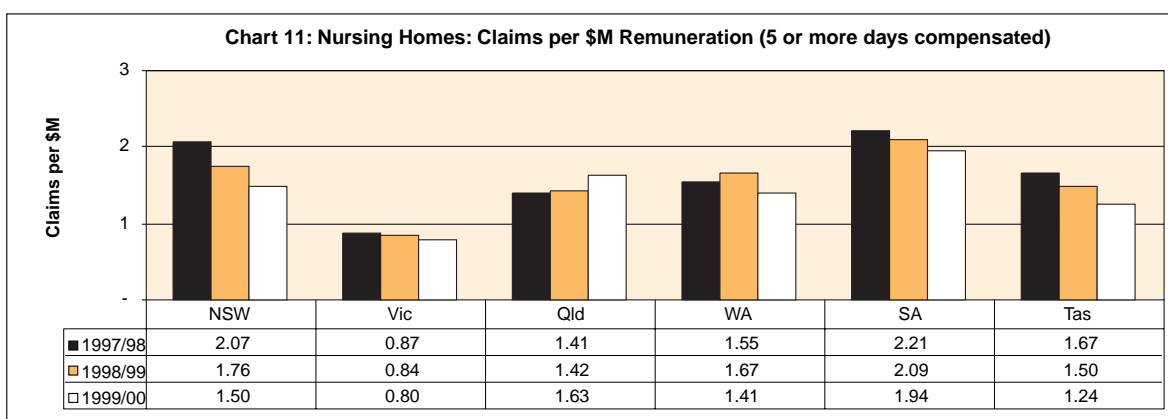
Off relatively small numbers the Tasmanian profile shows reduction in actual numbers and percentage terms in the major manual handling categories.

### 3.3 Comparative performance (Claims per million dollars)

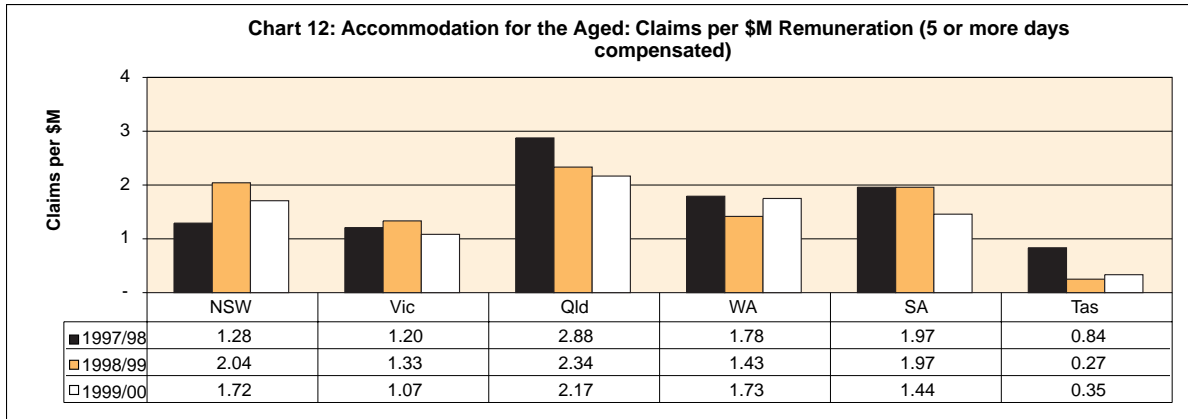
The ABS denominator data was not available at the four-digit level to enable similar incidence and frequency rates to be calculated as in the CPM report. As an alternative claims per \$m was used<sup>10</sup>. A consolidated table for the aged care sector shows that there are considerable differences between jurisdictions.



To delve into these differences a little further the aged sector data is broken down into Nursing Home and Accommodation for the Aged categories.

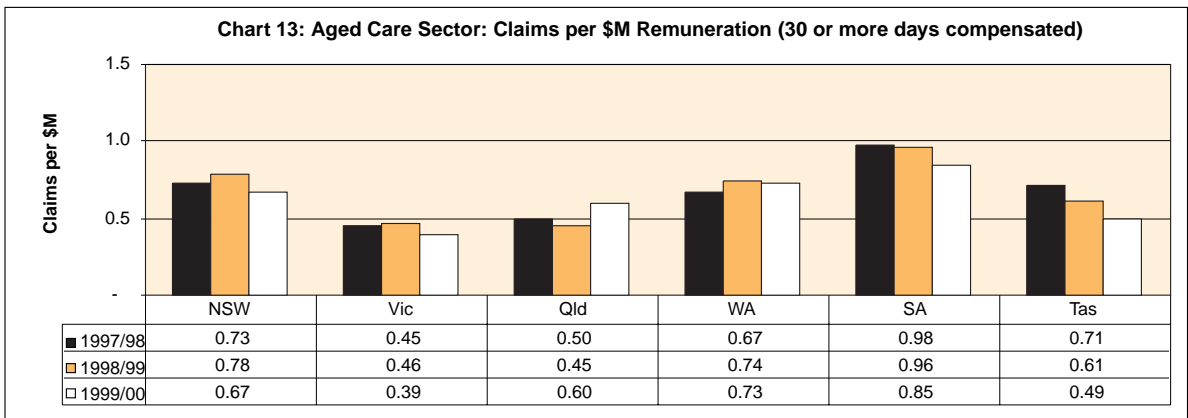


<sup>10</sup> Remuneration data at the four digit level is not kept by NOHSC in the national data set so data was provided by each agency. Adjustments were made for self insurance in the case of SA where there is a significant aged care exempt employer group. Remuneration was also adjusted to exclude employer superannuation contributions.

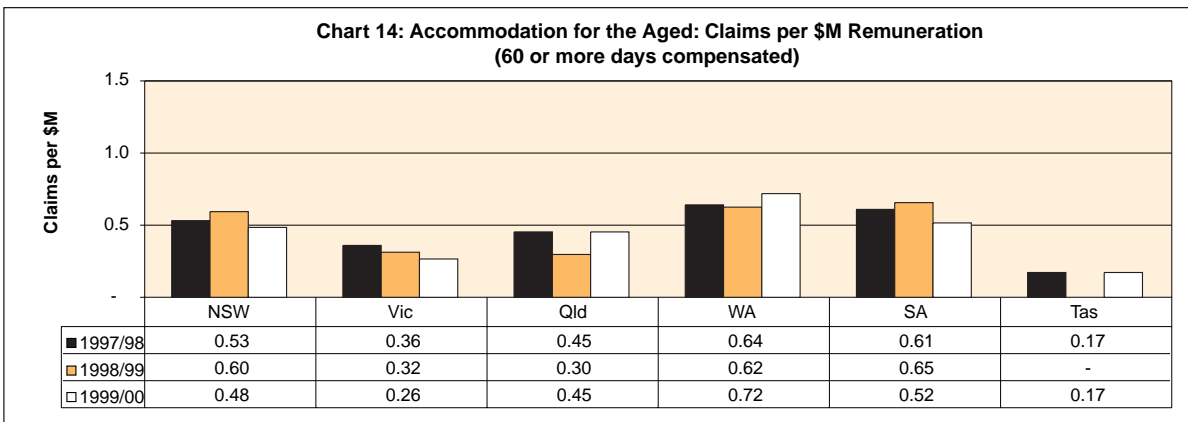


This data suggests that in some jurisdictions such as Queensland overall performance may be driven by the higher claims rates in the Accommodation for the Aged sector.

Severity of injury can be measured by the length of the compensable period and the following table shows the consolidated aged care sector for 30 or more days compensated. The relativities between jurisdictions and the trends within jurisdictions are similar to the 5 days data.



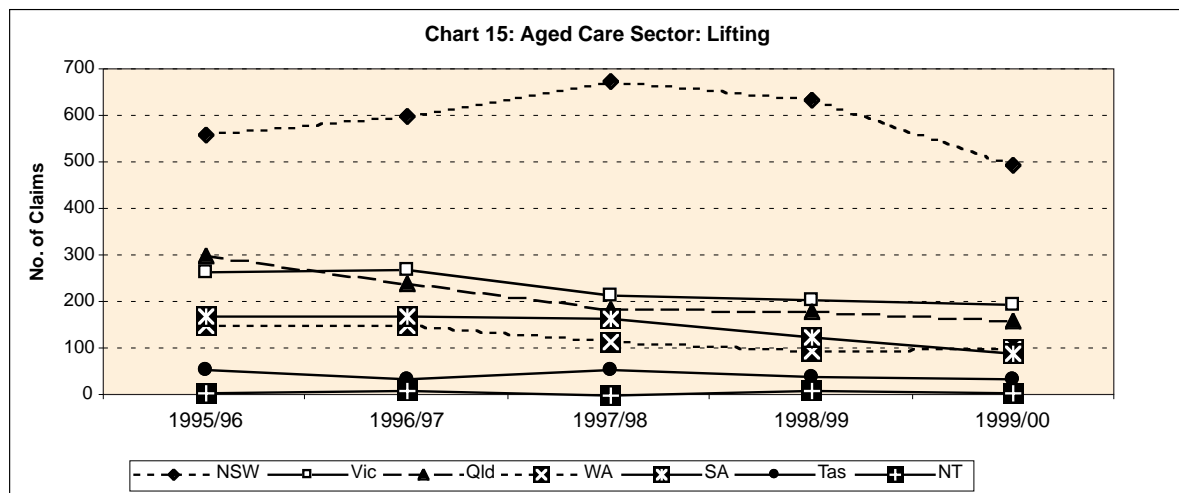
The trend with 60 days or more claims is for marginal reductions or small increases in rates indicating little progress on this front.



Tasmania, Victoria and South Australia and have the most successful clearance rate from 30 to 60 days. These trends are likely to be driven by claims management and return to work practices.

### 3.4 Comparative performance in highest claim/high cost category

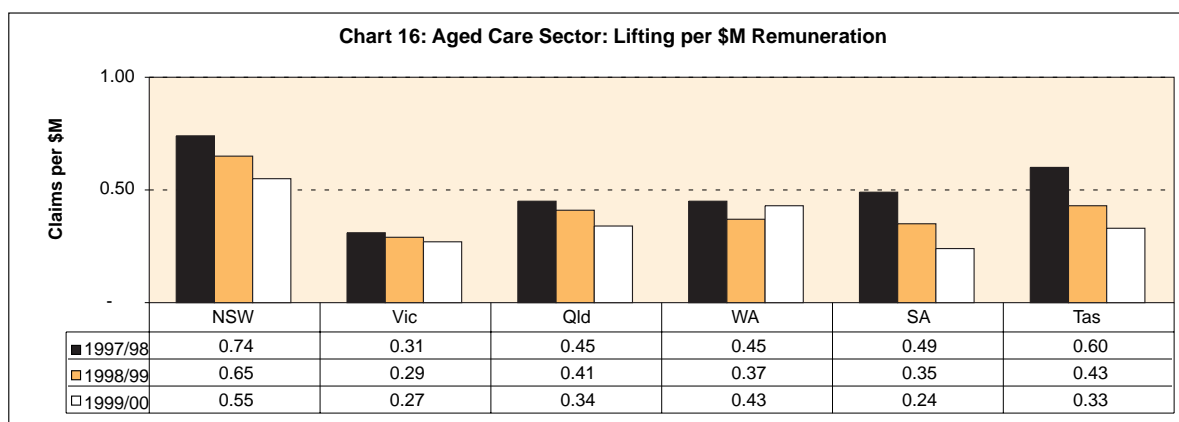
Manual handling claims and related musculoskeletal injuries are the highest frequency and cost claims in the aged care sector accounting for around 60% of all claims. As high frequency /high cost claims drive premium levels and influence overall incidence and frequency rates particular attention was given to these claims. Chart 15 below uses all claims that have been coded as “lifting” claims and shows a stable or slightly improving picture for the total number of lifting claims.



(Note: The above chart uses numbers of claims for each of the jurisdictions. It would be expected on this basis for the higher populated jurisdictions to have a higher number of claims, but the aim of this chart and Charts 17 and 19 below is to show trends in each of the jurisdictions.)

This pattern is mirrored in the nursing home breakdown whilst the accommodation for the aged category is more volatile.

To look at the contribution of these claims to overall performance a lifting claims per \$M remuneration was calculated and this suggests a consistent pattern of improvement in this area. Each jurisdiction has reduced the claims rate with lifting claims and this provides some evidence that the range of policy interventions have had some effect. The reduction in lifting claims also is at a greater rate than for all industries suggesting real change has taken place.



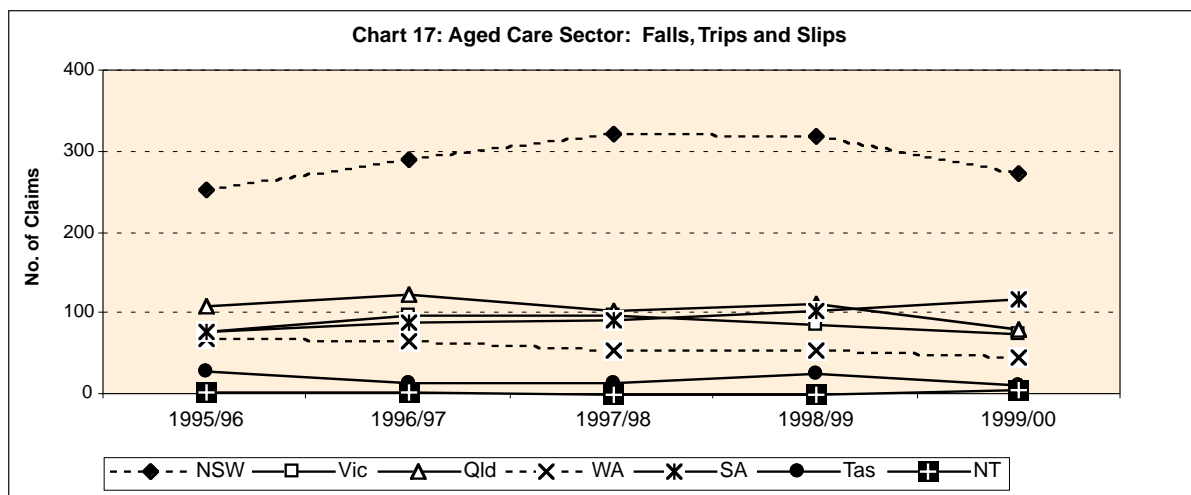
The data also suggests that other types of claims may be getting less attention and limiting the impact of the above claim reductions. In South Australia for example lifting claims are on the decline but slips, trips and fall claims rates have increased.

Data from the most recent CPM report compares lifting claims for all industries across jurisdictions and (noting that a different denominator is used, per 1000 employees) similar trends are apparent except that reductions in aged care seem to be more significant. In Queensland for all industries the incidence rate has increased but decreased in aged care and in Western Australia and South Australia the rate of improvement is greater in aged care.

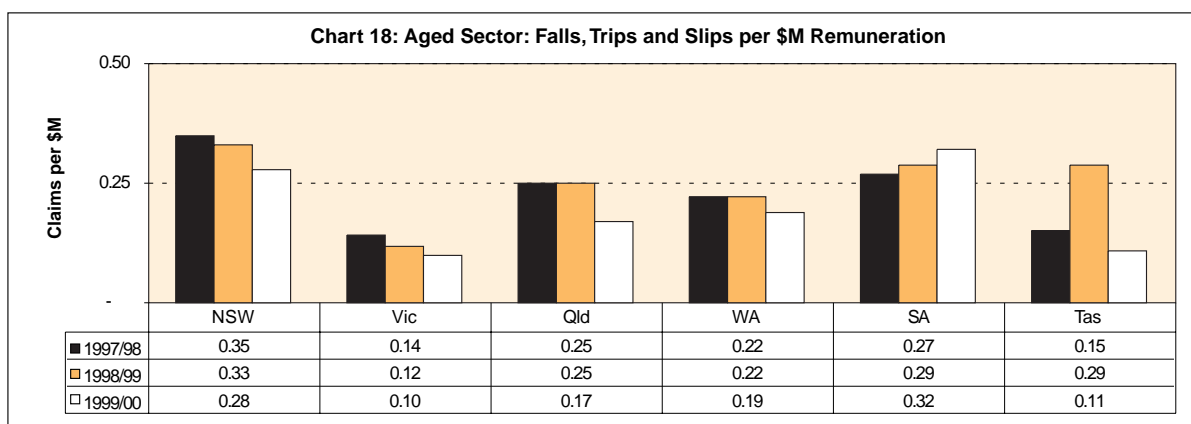
### 3.5 Other Injury data

Another claims category worth noting is slips, trips and falls, as these claims are the third highest category. Chart 17 shows a very mixed picture across jurisdictions. Western Australia is the only jurisdiction with sustained decreases in claims numbers and South Australia has experienced sustained increases in claims numbers.

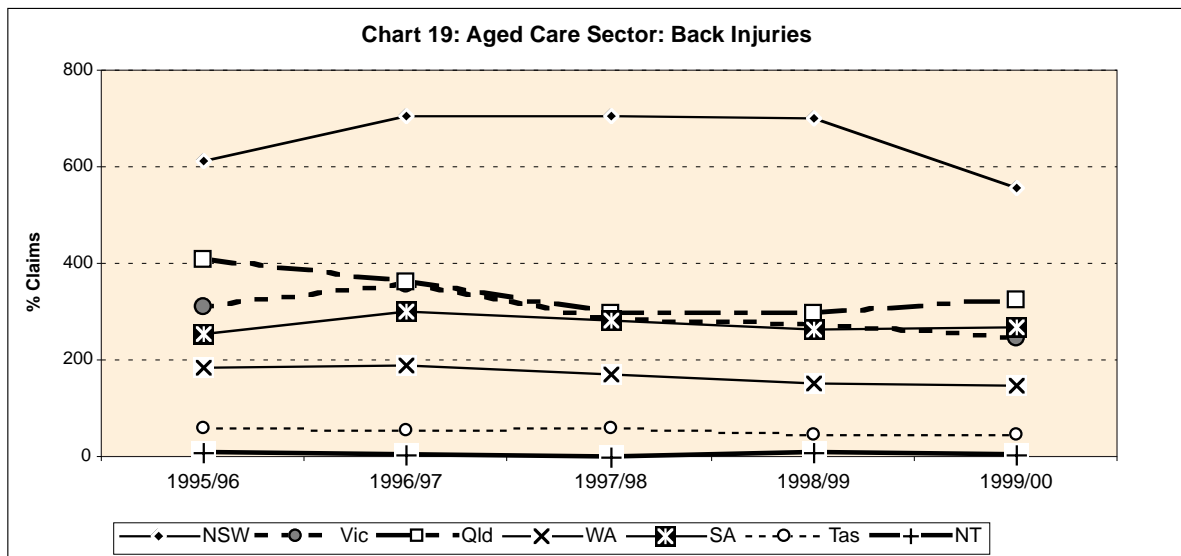
Claims per million rates indicate small but steady improvement in jurisdiction profiles over the study period (Chart 18).



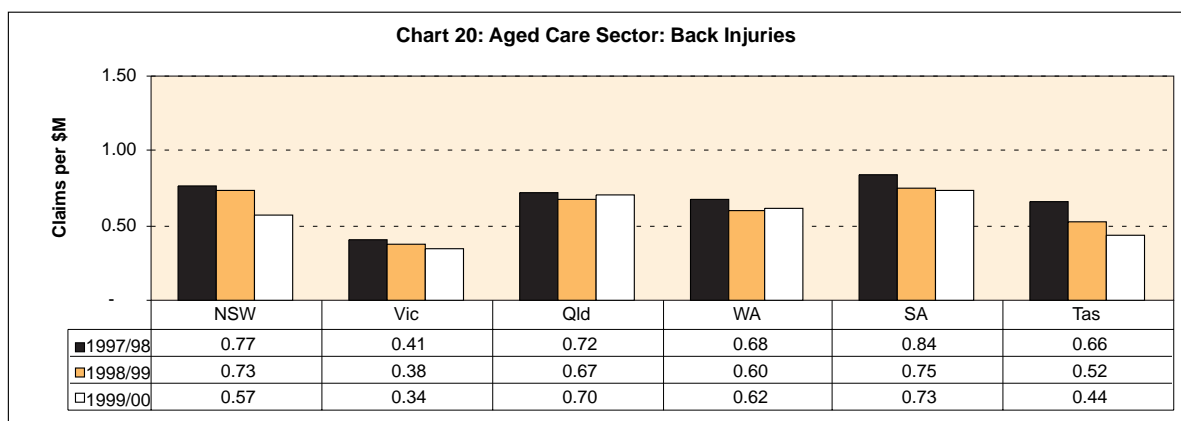
(Note: See qualification on Chart 15)



Back injury data shows all jurisdictions except Queensland experiencing reductions in claims numbers over the period. Back injury claims per million rates have decreased solidly in all jurisdictions. Trends are shown in Charts 19 and 20.



(Note: See qualification on Chart 15)



### 3.6 OHS performance and premium levels

Jurisdictions can be compared using premium data however the problem of obtaining data at the sector level was again apparent and so the focus must be on changes within jurisdictions. A complete set of data on industry rates and average premium rates was not available but in table 3 an outline of premium rates is shown. The rates are as supplied by each jurisdiction and are not based on any national data set standardisation.

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**Table 3: Industry rates 1997/1998 to 1999/2000**

<b>Jurisdiction</b>	<b>1997/98</b>	<b>1998/99</b>	<b>1999/00</b>
<b>New South Wales</b>			
Nursing Homes	5.57	5.57	6.40
Accommodation for the Aged	4.84	5.57	5.57
All Industries	2.84	2.94	2.84
<b>Victoria</b>			
Nursing Homes	3.95	3.95	3.95
Accommodation for the Aged	na	3.95	3.95
All Industries	1.84	1.94	1.95
<b>Queensland</b>			
Nursing Homes	4.22	3.90	3.70
Accommodation for the Aged	1.75	1.62	1.61
All Industries	na	1.70	1.43
<b>Western Australia</b>			
Nursing Homes	3.68	5.15	6.36
Accommodation for the Aged	2.60	4.02	5.79
All Industries	na	na	na
<b>South Australia</b>			
Nursing Homes	6.60	6.90	6.50
Accommodation for the Aged	4.40	4.70	4.40
All Industries	2.95	3.01	2.91
<b>Tasmania</b>			
Nursing Homes	4.97	4.96	5.88
Accommodation for the Aged	4.88	4.45	4.73
All Industries	2.78	2.62	3.00

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Western Australia and Tasmania have seen increased rates over the period whilst other states have been fairly stable and tracked changes in the all industries rate. In most jurisdictions the nursing home rate is approximately double the all industry rate and the accommodation rate is 40-50% higher than the all industries rate.

Average premium rates paid are often higher than the published rate and data from the Victorian WorkCover Authority illustrates this.

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**Table 4: Premium rates Nursing Homes Victoria<sup>11</sup>**

Financial Year of Coverage	Premium Rates					Average Premium Rate
	Workplace premium rate ranges					
	Worst 10%	Worst 25%	Median	Best 25%	Best 10%	
1997/98	5.73	3.79	3.08	2.43	1.13	3.84
1998/99	6.12	4.10	3.27	2.48	1.46	4.00
1999/00	6.45	4.39	3.40	2.50	1.69	4.21
2000/01	8.73	6.05	4.46	2.94	1.30	5.30
2001/02(p)	9.17	5.89	4.74	3.01	1.71	5.13

The average premium rate has been consistently higher than the published rate and has been increasing in the period. The spread of premium performance shows that the best 10% have been paying a much lower rate than the average and at the other extreme there are 10% of employers paying a rate about 60% higher than the average.

Premium data in the sector indicates that half the employers have been able to stay below the industry rate and thus the impact of new aged care funding arrangements have not impacted negatively on their operation. Using the Victorian data there remains a group of employers whom been unable to bring their experience into line with the industry average.

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<sup>11</sup> Data supplied by Victorian WorkCover Authority

## 4. STRUCTURAL FACTORS THAT MAY EXPLAIN AGED CARE OHS PERFORMANCE

The framework established by DOWRAC lists a series of structural factors including industry composition, size of firm, industry structure, and labour force that may influence outcomes.

### 4.1 Labour force characteristics of the aged care sector

The aspects included in the study design here are:

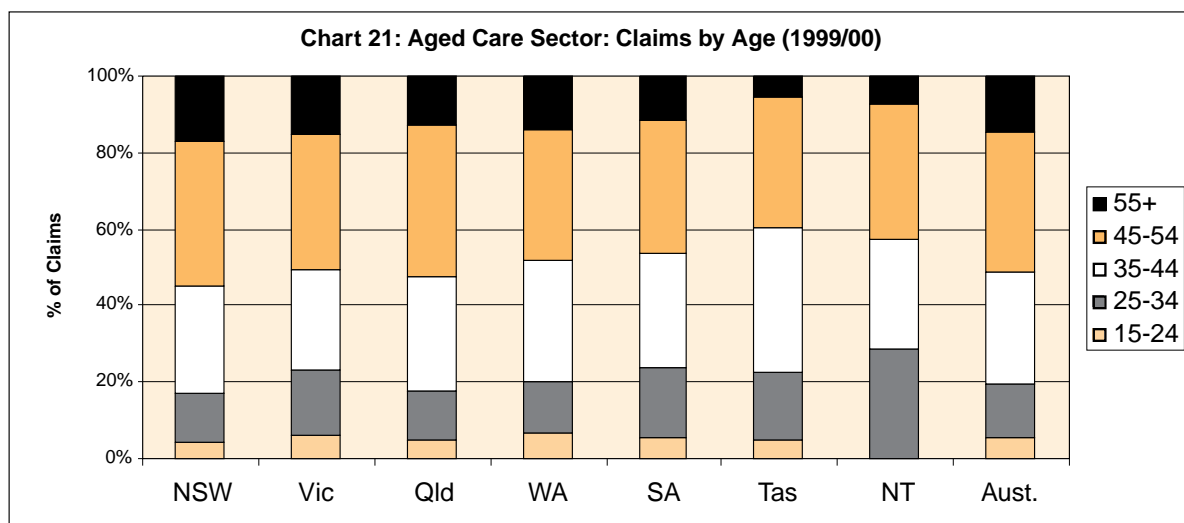
- Occupational profile
- Gender
- Age

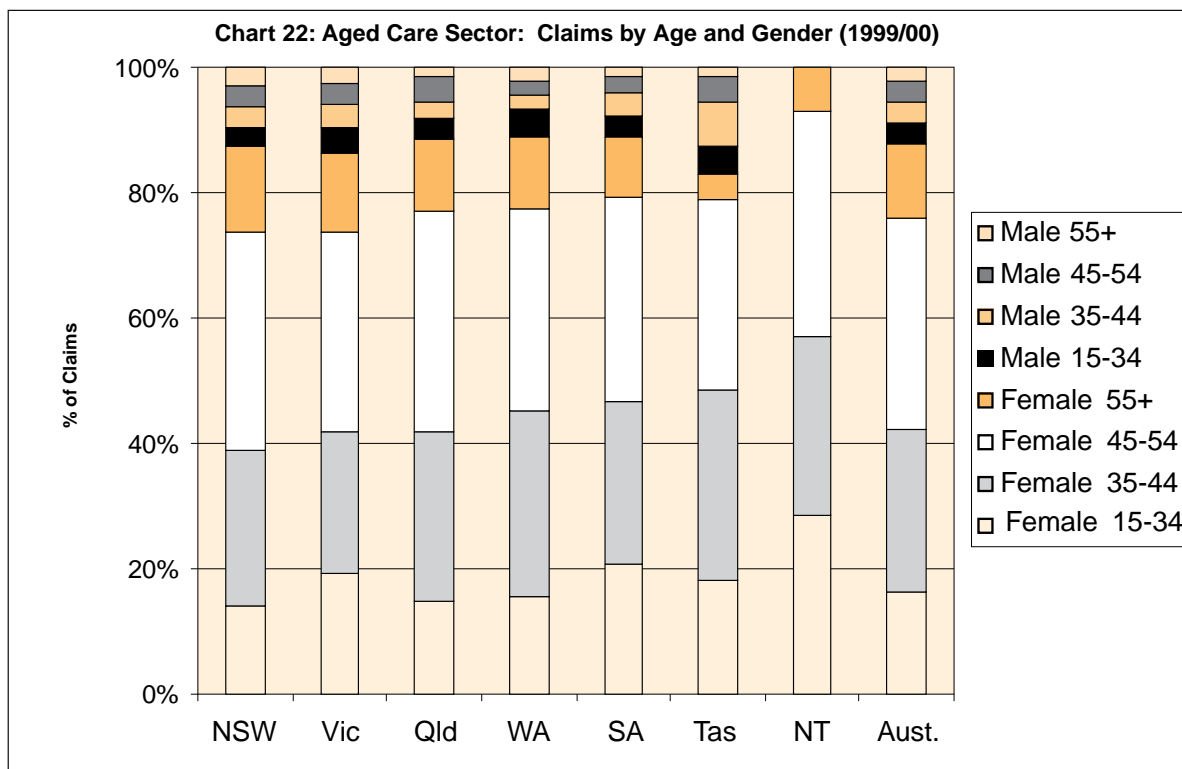
ABS data at the four-digit level for some of these variables was not available (eg. employment status, hours of work) so any comparison of the claims database and industry sector labour force data has not been possible.

In some cases extrapolation from other industry data has been used to estimate the impact of some of these factors.

### 4.2 Age and gender

Using the claims data base the following charts show age and gender trends.





Across the sector the 45-54 age group account for most claims a pattern that is also evident when the sector are disaggregated into nursing home and accommodation for the aged categories.

The combined age and gender chart 22 reflects the percentage of females working in the sector with around 90% of claims made by females. The 45-54 aged group is again the dominant age group for claims. A recent labour force profile of nursing reports that the average age of nurses working in aged care was 43.5 years, older than nurses in general, and in marked contrast to those working in medical and surgical practice<sup>12</sup> The average age of nurses did not vary greatly across jurisdictions suggesting the age profile is unlikely to be a discriminator for claims trends. The percentage of claims in the 45-54-age category is 36%, about twice the national figure for all industries.<sup>13</sup>

### 4.3 Occupation

As noted above ABS denominator data was not available and this makes use of claims by occupational category difficult to interpret. Occupational classification within compensation data can be unreliable but aged care is expected to be more reliable, particularly in the coding of registered and enrolled nurses. Trends in claims by occupational category at the macro level are likely to be influenced by the broad trends noted in the overview. There are fewer nurses in the aged care sector and there has been an increase in the proportion of registered nurses and a decrease in the proportion of enrolled nurses.<sup>14</sup> It is thought that the reduction in enrolled nurses is related to the greater use of patient carers in combination with a well qualified registered nurse.

<sup>12</sup> Nursing Labour Force 1999, Australian Institute of Health and Welfare 2001, AIHW cat. no. HWL 20. Canberra: AIHW (National Health Labour Force Series No. 20), p.12.

<sup>13</sup> Comparative Performance Monitoring, Third report, op cit, p.18.

<sup>14</sup> Nursing Labour Force 1999, op cit, p.9.

Using the NDS claims database the distribution of nursing home claims across major occupational categories is shown in the tables below. In non-nursing categories a number of similar occupations have been combined.

**Table 5: Claims profile for Nursing Homes by Occupation**

<b>Nursing Homes - 8613 Occupation</b>		<b>Australia</b>					<b>Total</b>
		<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	
3401	Registered Nurses	769	729	665	594	524	3281
6603	Enrolled Nurses	453	504	468	521	487	2433
Comb	Other Carers	1490	1628	1509	1303	1203	7133
Comb	Other Occupations	949	954	922	910	824	4559
<b>Total</b>		<b>3661</b>	<b>3815</b>	<b>3564</b>	<b>3328</b>	<b>3038</b>	<b>17406</b>
3401	Registered Nurses	21%	19%	19%	18%	17%	19%
6603	Enrolled Nurses	12%	13%	13%	16%	16%	14%
Comb	Other Carers	41%	43%	42%	39%	40%	41%
Comb	Other Occupations	26%	25%	26%	27%	27%	26%
<b>Total</b>		<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

This table shows a very stable claims profile with little change in the major categories.

Jurisdiction trends show:

- A stable pattern in NSW with reductions in nurse categories over the period
- In Victoria registered nurses have experienced large reductions in claims numbers whilst enrolled nurses have increased their share and number of claims
- Queensland data shows other carers as the only category experiencing reductions in claims numbers of any significance
- All categories have experienced small reductions in WA
- Very mixed pattern in South Australia with the % of claims for enrolled nurses doubling in the period and the share of other carers decreasing significantly in the period
- Tasmania has a very stable profile with reductions in claims numbers for all categories

Without ABS data the only possibility of understanding these profiles was to use Nurse Labour Force data published by the Australian Institute of Health and Welfare in their regular reports. The 1999 report<sup>15</sup> provides a data point for nursing staff for the year 1997, which is within the project window. Linking this with claims data from 1997 allows the calculation of an incidence rate for that year of 34.4 claims per 1000 employees (1233 claims for 35,867 nurses employed in nursing homes). This compares to a rate of 18 for all industries in 1997-98 and of 17.4 for the Health and Community Services industry<sup>16</sup>.

<sup>15</sup> *ibid*, p.16

<sup>16</sup> Comparative Performance Monitoring, Third report, *op cit*

Data is not available to undertake the same analysis of accommodation for the aged. Accommodation for the Aged claims profile is more dynamic with a reduction in claims for enrolled nurses and an increase in the carer's category as shown in the table 6.

**Table 6: Claims profile for Accommodation for the Aged by Occupation**

Accommodation for the Aged - 8721		Australia					Total
		1996	1997	1998	1999	2000	
3401	Registered Nurses	40	48	50	81	98	317
6603	Enrolled Nurses	81	71	62	56	77	347
Comb	Other Carers	338	428	475	569	578	2388
Comb	Other Occupations	211	236	317	391	367	1522
Total		670	783	904	1097	1120	4574
3401	Registered Nurses	6%	6%	6%	7%	9%	7%
6603	Enrolled Nurses	12%	9%	7%	5%	7%	8%
Comb	Other Carers	50%	55%	53%	52%	52%	52%
Comb	Other Occupations	31%	30%	35%	36%	33%	33%
Total		100%	100%	100%	100%	100%	100%

Jurisdiction comparisons show:

- Increases in claim numbers in all categories in NSW
- Big increases in claim numbers for Other carers in Victoria
- In Queensland numbers have not improved in any category to any great extent
- WA profile is stable with small reductions in most categories
- SA data shows increases for other carers and reductions for enrolled nurses
- Small numbers in Tasmania make interpretation difficult

ABS data was available for all ASCO codes covering the study period and all jurisdictions. The data however did not specify the industry in which the occupation was found. Using data from the Nurse Labour Force report the percentage of registered and enrolled nurse working in each state in geriatrics/gerontology was used as an initial filter to link occupation to the aged care sector<sup>17</sup>. Of this group those working in nursing homes and hostels were included and hospital and community health centre nurses were excluded given the working definition of aged care used in this study<sup>18</sup>.

<sup>17</sup> Nursing Labour Force 1999, op cit, table 15, p.36.

<sup>18</sup> ibid, table 59, 82% of nurses in geriatrics worked in nursing homes or hostels for Australia, 1997, p. 92.

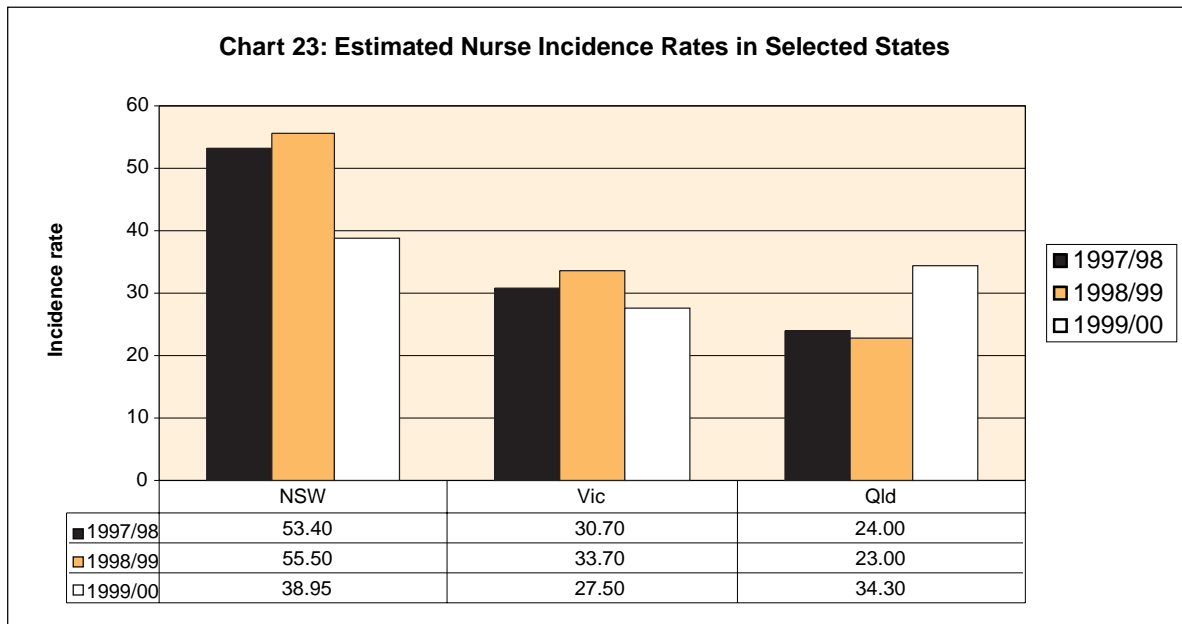


Table 23 shows an estimated claims incidence rate for all nurses using the filtering method described above. Data are included for three of the larger jurisdictions and rates for Western Australia and South Australia were significantly higher but not included because of the difficulty in confirming the rates with comparative denominator data.

#### 4.4 Size of facility

Size of organization is expected to be a factor in both exposure to risk and ability to manage the risk but there are few studies that test this. The Economic Associates study found no consistent relationship between size and outcomes<sup>19</sup>.

The size of the organization can be measured by number of employees, remuneration or the by number of beds. Data supplied by the Victorian WorkCover Authority (99/00 data) shows that for nursing homes over half of the facilities have remuneration of \$1m or less which would be considered to be a small to medium sized enterprises.

South Australian WorkCover's analysis of trends<sup>20</sup> in the nursing home sector shows that for the year 2000/2001 the claims rates per million remuneration varied with the highest rate for employers with \$250,000-\$1m remuneration and the lowest for employers with remuneration above \$25m. The next best claims rate was for the smallest employers.

A recent report sets out the size of facility distribution across jurisdictions:

The size of the aged care homes differed across jurisdictions. At the larger end of the continuum were homes in the Australian Capital Territory (averaging 65 places per home), New South Wales (53) and Queensland (52). At the smaller end were homes in the Northern Territory (averaging 24 places per home) and Tasmania (37). Tasmania and Western Australia had a large proportion of small (20 or fewer beds) homes—about 23% and 16% respectively. In the Northern Territory, however, over half the homes (60%) fell into this category, and none had more than 60 beds.

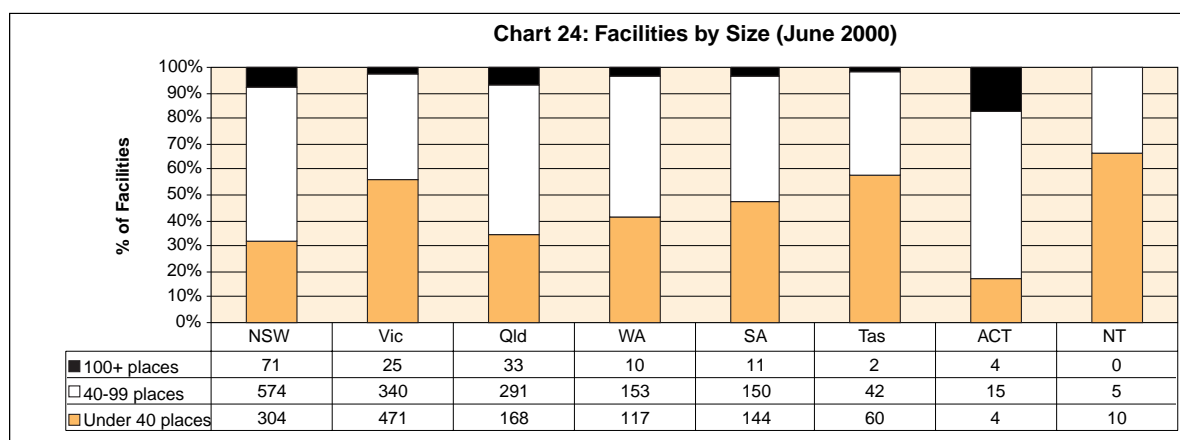
Over half the homes in the Australian Capital Territory had more than 60 beds, as did 29% of those in New South Wales and 26% of those in Queensland. Victoria, Western Australia and Tasmania had relatively few homes of this size (less than 14%).<sup>21</sup>

<sup>19</sup> Pilot Study: Interpreting CPM Outcomes- Property and Business Services, Access Economics, 2001,

<sup>20</sup> WorkCover Corporation, South Australia. Report for exempt and non-exempt employers within the industry classification 814301 covering the years 1995/96-2000/2001, 2002.

<sup>21</sup> Residential Aged Care Facilities in Australia 1999-00: A statistical overview, Australian Institute of Health and Welfare and Department of Health and Aged Care, Canberra, AIHW Cat. No. AGE 19, 2001, p.9.

Chart 24 shows all aged care facilities by the number of beds with the key feature the higher level of small facilities in Victoria

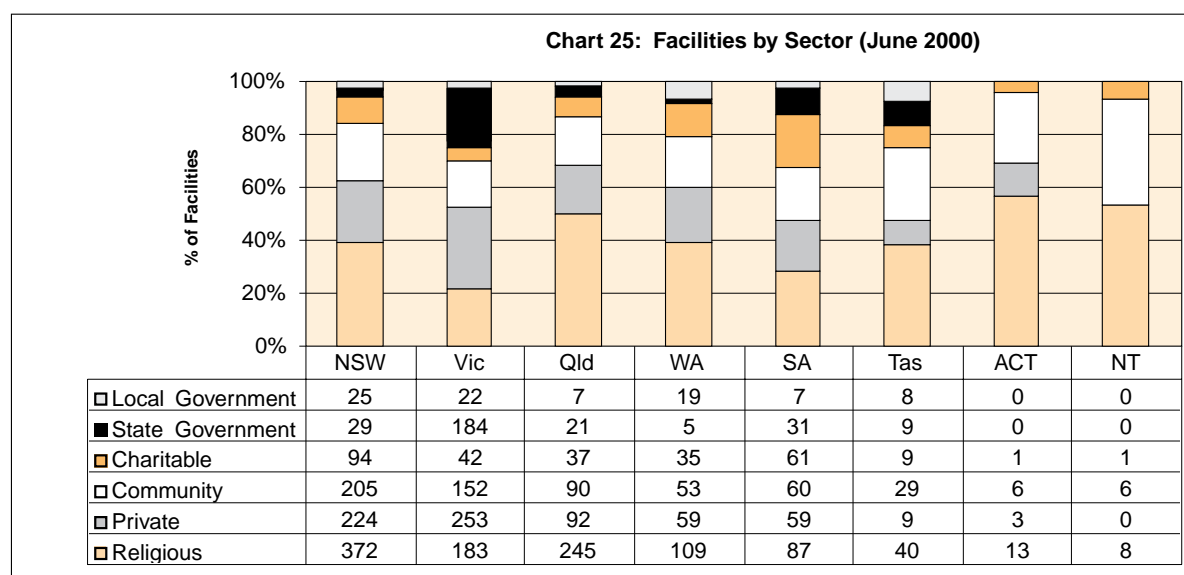


#### 4.5 Ownership

Specific studies of the role of ownership on OHS performance are limited to general comparisons of public and private ownership. For example private hospitals and public hospitals usually have separate industry classifications under workers' compensation premium rates. The Economic Associates study of Property and Business Services did not find any relationships between ownership and OHS.<sup>22</sup>

The role that different ownership patterns play is largely unexplored but in the aged care sector it appears to be a factor that may influence performance.

Chart 25 below outlines the various ownership patterns in each jurisdiction. The features include a high proportion of state government facilities in Victoria and a high proportion of religious organization ownership in Queensland.



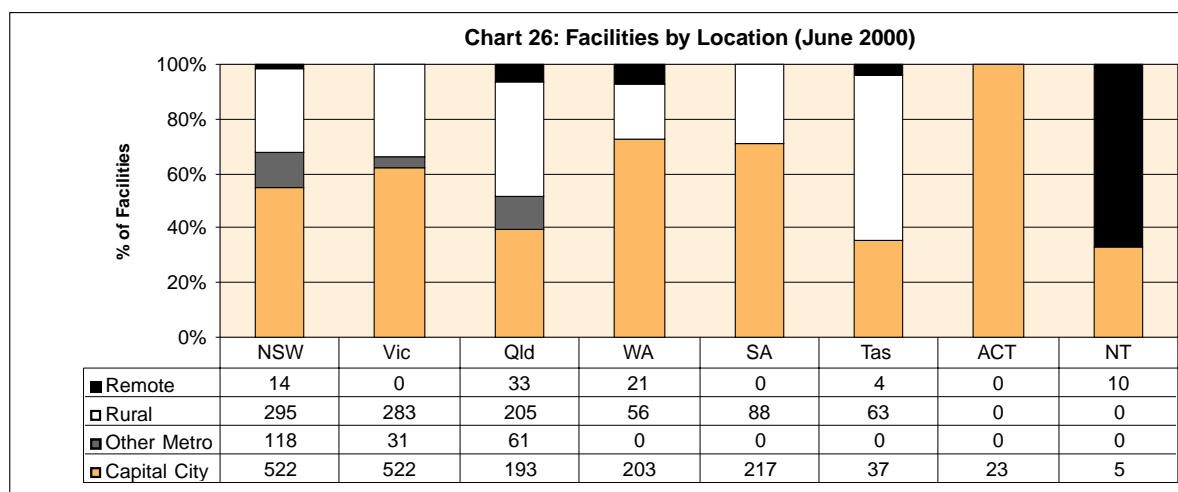
<sup>22</sup> Pilot Study: Interpreting CPM Outcomes- Property and Business Services, op cit, p.22.

#### 4.6 Geographic location

There have been no detailed studies of the impact of geographical location on OHS outcomes. The Economic Associates study of Property and Business Services found a correlation between capital city location and increased incidence rates<sup>23</sup>. The Productivity Commission stated that location affected costs through the price of goods and services, different awards and workers' compensation arrangements and differences in care required particularly in rural and remote areas.

Whether any of these factors about location translate into OHS performance has not been established. It is however important to consider whether local labour markets have any impact on return to work prospects of injured workers. Small employers in depressed rural labour markets may face fewer options than larger employers in more buoyant regional or city areas.

Chart 26 below shows the distribution of facilities in each jurisdiction.



#### 4.7 Classification on the residential classification scale

The aged care sector because of the nature of the screening process for residents provides an opportunity to use another proxy for risk. The RCS is relevant as the basis for assessing care needs is closely related to the care tasks and consequent risks for employees. The scale is based on 20 elements with a weighting for different responses. The weighted points score then becomes the basis for classification

An analysis of the scale and its focus shows that at least 60% of the assessment weighting is towards care tasks with manual handling type risks. Research from the AIHW cited in the Productivity Commission report noted:

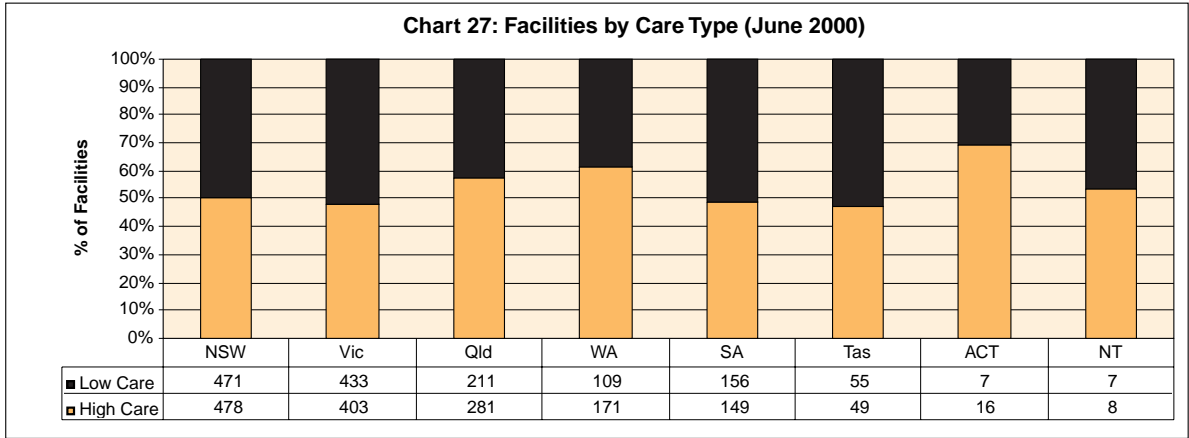
“virtually all nursing home residents required at least some help with washing and dressing (90% required help), 90 percent required at least some help with eating (one third needed total help) and 95 percent at least some help with mobility and transfers (63 percent total help).

Between 30 June 1998 and 30 June 2000, the proportion of residents classified as high care (RCS 1 to 4) rose from 57.8% to 61.8%, while those classified as low care (RCS 5 to 8) fell from 42.2% to 38.3%<sup>24</sup>.

<sup>23</sup> *ibid*, p.22.

<sup>24</sup> Residential Aged Care Facilities in Australia 1999-00: A statistical overview, *op cit*, p.6.

Chart 27 shows that there are differences in the distribution of classifications across the jurisdictions. High care (RCS1-4) and Low care (5-8) comparisons for year 2000 is shown below.



*4.8 Safety capability*

The Aged Care Accreditation Agency data shown in section 2.5 compares accreditation decisions across jurisdictions following a process of assessment and follow up on deficiencies. As a proxy for health and safety capability, assessor ratings for the sub element on occupational health and safety were sought from the agency.

As noted earlier the category “satisfactory” is broad and accounts for non-compliances that are considered to be capable of speedy resolution. All the jurisdictions had relatively high levels of satisfactory ratings with South Australia and Queensland having the lowest level. In the case of Queensland this was combined with the highest “unacceptable” level with South Australia and New South Wales with the next highest levels (some of the smaller jurisdictions levels were based on very small numbers and are not included in the comparison). Both South Australia and New South Wales however also had a larger “commendable” component than other jurisdictions except Tasmania.

On the basis of these initial ratings Tasmania, Western Australia and Victoria had the highest level of health and safety capability. In table 7 below the OHS rating is compared to the overall rating for the Physical Environment and Safe Systems standard both within and across jurisdictions.

**Table 7: Accreditation rating comparison**

<b>Jurisdiction in order of OHS rating levels best to worst compared to</b>	<b>Physical Environment and Safe Systems Standard in jurisdiction</b>	<b>Physical Environment and Safe Systems Standard for Australia</b>
Tasmania	Better	Better
Western Australia	Worse	Better
Victoria	Better	Better
New South Wales	Worse	Worse
South Australia	Worse	Worse
Northern Territory	Worse	Worse
ACT	Worse	Worse
Queensland	Worse	Worse

The league ladder is determined primarily by the level of unacceptable ratings and is less influenced by the commendable rating. The most outstanding feature is the relative lack of capability of Queensland facilities when initially assessed. This is partly reflected in accreditation decisions with Queensland having the lowest level of three year approvals.

One other possible proxy for preparedness is the fire and safety rating made as part of the physical quality certification process. All facilities were assessed in 1997 and targets have been set for facilities to achieve a safety score of 19 out of 25 by 2003. Table 8 shows the results<sup>25</sup>.

States such as South Australia and Queensland that have lower capability ratings but higher infrastructure ratings may have their performance most influenced by local management rather than limitations imposed by the age or quality of the facility.

**Table 8: Average certification safety score (a)**

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
October 1997	19	16	19	18	21	15	20	16	18
January 1998	19	16	19	18	21	15	20	16	18
April 1998	19	16	19	18	21	15	20	16	18
July 1998	19	16	19	18	21	15	20	16	18
October 1998	19	16	19	18	21	15	20	16	18
January 1999	19	16	19	18	21	15	20	16	18
April 1999	19	16	19	18	21	15	20	16	18
July 1999	19	16	19	18	21	15	20	16	18
October 1999	19	16	19	18	21	15	20	16	18
January 2000	19	16	19	18	21	15	20	16	18
April 2000	19	17	19	18	21	15	20	18	18
July 2000	19	17	19	18	21	15	20	19	18
October 2000	19	17	20	18	21	15	20	19	18
January 2001	19	17	20	18	21	15	20	19	19
April 2001	19	17	20	18	21	15	20	19	19
July 2001	19	17	20	19	21	16	20	18	19
September 2001	19	18	20	19	21	16	20	18	19

(a) Maximum score is 25 points.

Source : Department of Health and Aged Care (unpublished).

#### 4.9 *Interrelationships between facility data*

As noted in the overview of the sector there are clusters of facility types across and within jurisdictions and in this section some of these clusters are noted. The unit record facility database was provided by the Commonwealth to enable cross tabulations of the various aspects to be undertaken<sup>26</sup>. A large number of tables have been generated but one on size is used to illustrate some of the patterns.

<sup>25</sup> Report on Government Services, Steering Committee for the Review of Commonwealth/State Service Provision.2002, attachment 12A.

<sup>26</sup> Data supplied by the Commonwealth Department of Health and Ageing based on 2002 data.

Using size of facility cross tabulated with locality and ownership some of the patterns are evident. There are more small non-private facilities in rural areas and more large private facilities in the city areas. Religious organizations dominate the urban provision of services and community organizations are the most significant deliverers of rural services. Table 9 shows these interrelationships.

**Table 9 Facility characteristics (based on 2002 data)**

<b>Small Facilities (Less than 40 beds)</b>						
<b>Class/Sector</b>	<b>Locality</b>					<b>Total</b>
	<b>Capital</b>	<b>Other Metro</b>	<b>Remote</b>	<b>Rural</b>		
Charitable	4%	1%	0%	3%	8%	
Community-based	7%	1%	3%	17%	27%	
Local Government	1%	0%	1%	2%	4%	
Private	13%	1%	0%	2%	17%	
Religious	17%	2%	1%	8%	27%	
State Government	3%	0%	1%	13%	17%	
Total	45%	5%	5%	45%	100%	

<b>Mid-size Facilities (40-99 beds)</b>						
<b>Class/Sector</b>	<b>Locality</b>					<b>Total</b>
	<b>Capital</b>	<b>Other Metro</b>	<b>Remote</b>	<b>Rural</b>		
Charitable	7%	1%	0%	2%	10%	
Community-based	7%	1%	0%	7%	16%	
Local Government	2%	0%	0%	0%	2%	
Private	20%	2%	0%	5%	27%	
Religious	27%	4%	0%	9%	41%	
State Government	1%	0%	0%	3%	4%	
Total	64%	9%	1%	27%	100%	

<b>Large Facilities (100+ beds)</b>						
<b>Class/Sector</b>	<b>Locality</b>					<b>Total</b>
	<b>Capital</b>	<b>Other Metro</b>	<b>Remote</b>	<b>Rural</b>		
Charitable	10%	1%	0%	0%	11%	
Community-based	3%	1%	0%	4%	8%	
Local Government	0%	0%	0%	0%	0%	
Private	31%	3%	0%	3%	36%	
Religious	29%	2%	0%	3%	34%	
State Government	5%	3%	0%	3%	11%	
Total	78%	9%	0%	13%	100%	

Data on high care/low care was not able to be included in the cross tabulations but table 10 drawn from the Report on Government Services 2002<sup>27</sup> shows the distribution of care patterns.

<sup>27</sup> Report on Government Services 2002, op cit

**Table 10: Size and distribution of residential aged care services with over 80 per cent high care residents, June 2001 (a), (b), (c)**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Residential services	no.	460	424	209	108	147	46	7	7	1 408
Places	no.	28 276	16 961	12 009	5 595	6 641	1 942	629	213	72 266
Occupancy rate	%	97.7	97.5	96.9	96.7	99.2	97.8	96.2	87.4	97.5
Places by locality										
Metropolitan areas	%	79.5	74.8	63.4	82.0	84.9	43.4	100.0	41.4	75.5
Rural areas	%	20.3	25.2	34.2	14.1	15.1	56.4	-	-	23.5
Remote areas	%	0.2	-	2.4	3.9	-	0.2	-	58.6	1.0
Service size										
1–20 places	%	3.0	12.5	5.7	2.8	1.4	15.2	-	42.9	6.7
21–40 places	%	24.1	54.5	38.6	33.3	51.0	41.3	-	14.3	39.3
41–60 places	%	31.3	23.6	21.9	39.8	35.4	30.4	28.6	42.9	28.7
61+ places	%	41.5	9.4	33.8	24.1	12.2	13.0	71.4	-	25.3

(a) The occupancy rate is defined as the number of residents in care as a proportion of available places.

(b) Services have been defined a high, low or mixed care based on the proportion of high care and low care residents in each service. Excludes MPS and flexibly funded services.

(c) See footnotes to table 12A.2 for detail on regional data classification.

– Nil or rounded to zero.

Source : Department of Health and Aged Care (unpublished).

This table shows that high care places are predominantly city based and more likely to be in a small facility. There are jurisdictional variations of note. New South Wales has most places in larger facilities whereas the opposite is the case for Victoria and South Australia.



## 5. RELATIONSHIPS BETWEEN OUTCOME DATA AND STRUCTURAL FACTORS

Most analysis of OHS performance is based on interpretation of descriptive data of the kind presented in this report. A number of initiatives of DOWRAC have begun the task of searching for explanatory variables that underpin high-level outcomes data. The Economic Associates pilot and the Comparison between Queensland and New South Wales Hospitals Exploratory Cross-jurisdictional Case Study<sup>28</sup> commissioned by DOWRAC both have attempted to identify explanatory variables.

The Economic Associates' report as noted earlier found some correlations between structural factors but the low risk nature of the industry made it difficult to identify consistent relationships that may assist in building an explanatory model for that industry.

Similarly, the hospitals study sought to examine the reasons behind differential OHS performance in two jurisdictions. The role of policy interventions was a key issue considered in the study and a comprehensive examination of initiatives introduced in each jurisdiction was undertaken. The study however does not identify key differences or offer possible explanations for any differences. The study does identify many variables likely to be influential at the workplace level but as is the nature of case study methodologies these were not assessed for their explanatory power.

A more general study that might assist in determining which structural factors might explain outcomes is the work done by Wooden in 1998.<sup>29</sup> In this study Wooden used multi-variate analysis to conclude that 90% of the variation in claims rates between industries was explained by differences in:

- Hazards
- The extent of shiftwork
- Working hours
- Firm size
- Workforce experience

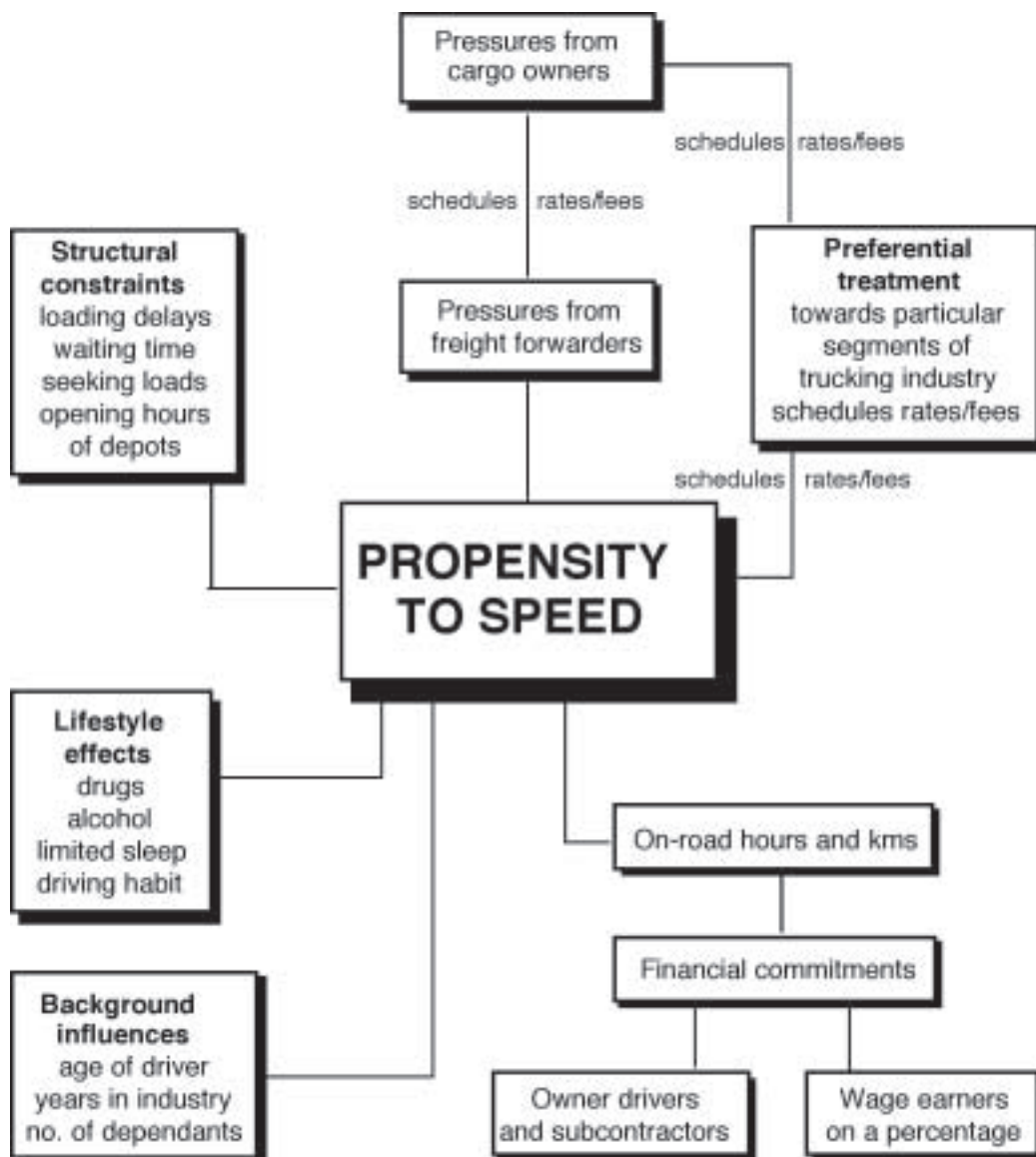
Another study that attempts to link industry structure factors to health and safety outcomes is Hensher's<sup>30</sup> study of the relationship between economic reward and on road behaviour. His research shows strong relationships between freight rates and income uncertainty and on road issues like fatigue, speeding, stimulant use and night driving. The model used by Hensher is shown below and is perhaps the kind of approach that OHS research should be aiming for.

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<sup>28</sup> Comparison between Queensland and New South Wales Hospitals Exploratory Cross-jurisdictional Case Study, K Smith., P Keidge., M McLeod, report for Department of Employment, Workplace Relations and Small Business, 2001.

<sup>29</sup> Factors associated with inter-industry differences in workers' compensations claims rates, Wooden., M., Journal of Occupational Health and Safety Australia and New Zealand, 14 (4), pp 349-356, 1998.

<sup>30</sup> Economic Reward and On-Road Performance of Long Distance Trucking: An Econometric Assessment, Hensher et al, ITS-WP-93-3, Sydney, Institute of Transport Studies, 1993.



From an aged care sector perspective the 1999 Productivity Commission Inquiry is a useful source of factors that may explain industry performance. In its consideration of appropriate subsidy levels the Commission identified a number of cost drivers in the sector which whilst not directly related to OHS may be pertinent to OHS performance. The cost determinants were:

- *Resident mix* as indicated by RCS
- *Quality of care* which may reflect staff numbers or experience
- *Home size* with larger homes better able to spread overheads and take advantage of economies of scale
- *Service integration* with co-location a means of spreading costs
- *Ownership* with possible differences between for profit and not for profit operators
- *Location* influences costs through different goods and services pricing, different land and building costs, different industrial and workers' compensation arrangements and the nature of care required in certain areas (eg. remote)

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Some of these cost determinants are similar to structural factors covered in the Access Economics study and also the report done by this author for the Department of Health and Aged Care.<sup>31</sup> In the previous section some of these factors are outlined to provide a framework in which OHS performance can be considered. In this project we have used the Economic Associates and The Productivity Commission factors as a starting point to identify potential explanations for OHS performance as measured by claims. In a later section the range of policy interventions used is considered in the interpretation of both descriptive and relational trends.

### *5.1 Correlation*

As an initial step in data sorting correlation of variables with the dependent variable Claims per \$m was undertaken<sup>32</sup>. The results of the initial correlation analysis are shown in table 11 along with further analysis on 30 and 60 day rates that provide an insight into severity issues.

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<sup>31</sup> Analysis of Workers' Compensation Arrangements in the Aged Care Sector, Bryan Bottomley and Associates, unpublished report for Department Of Health and Aged Care, 2000.

<sup>32</sup> The same data sources noted were used; NDS claims data for 1997/98-1999/00 and DHAC facilities data

**Table 11: Selected Correlations**

		Claims per \$M Remuneration	Claims (more than 30 days) per \$M Remuneration	Claims (more than 60 days) per \$M Remuneration
% of Services (High Care)	Pearson Correlation Sig. (2-tailed)	-0.349* 0.037	-0.203 0.223	-0.231 0.157
% of Services (Low Care)	Pearson Correlation Sig. (2-tailed)	0.349* 0.037	0.203 0.223	0.231 0.157
% of Services (<40 beds)	Pearson Correlation Sig. (2-tailed)	-0.612** 0.000	-0.601** 0.000	-0.611** 0.000
% of Services (40-99 beds)	Pearson Correlation Sig. (2-tailed)	0.617** 0.000	0.621** 0.000	0.637** 0.000
% of Services (100+ beds)	Pearson Correlation Sig. (2-tailed)	0.538** 0.001	0.474** 0.003	0.457** 0.003
% of Services (Capital City)	Pearson Correlation Sig. (2-tailed)	0.167 0.331	0.570** 0.000	0.651** 0.000
% of Services (Rural)	Pearson Correlation Sig. (2-tailed)	-0.367* 0.028	-0.13 0.437	-0.057 0.73
% of Services (Remote)	Pearson Correlation Sig. (2-tailed)	0.169 0.324	-0.506** 0.001	-0.550** 0.000
% of Services (Religious)	Pearson Correlation Sig. (2-tailed)	0.338* 0.044	-0.187 0.262	-0.270 0.096
% of Services (Private)	Pearson Correlation Sig. (2-tailed)	0.038 0.828	0.426** 0.008	0.489** 0.002
% of Services (Community)	Pearson Correlation Sig. (2-tailed)	-0.369* 0.027	-0.579** 0.000	-0.593 ** 0.000
% of Services (Charity)	Pearson Correlation Sig. (2-tailed)	0.399* 0.016	0.521** 0.001	0.507** 0.001
% of Services (State Govt)	Pearson Correlation Sig. (2-tailed)	-0.434** 0.008	-0.15 0.369	-0.122 0.461
% of Services (Local Govt)	Pearson Correlation Sig. (2-tailed)	-0.389* 0.019	0.049 0.770	0.235 0.149
% of Claims (30-39 yrs)	Pearson Correlation Sig. (2-tailed)	0.277 0.102	0.457** 0.004	0.326* 0.043
% of Claims (40-49 yrs)	Pearson Correlation Sig. (2-tailed)	0.492** 0.002	0.658** 0.000	0.322* 0.045
% of Claims (50+ yrs)	Pearson Correlation Sig. (2-tailed)	-0.344* 0.040	-0.584** 0.000	-0.406* 0.010
% of Claims (back injuries)	Pearson Correlation Sig. (2-tailed)	0.496** 0.002	-0.003 0.986	0.032 0.848
% of claims (Other Occupations)	Pearson Correlation Sig. (2-tailed)	0.169 0.323	0.455** 0.004	0.494** 0.001

\*\* Correlation is significant at the 0.01 level (2-tailed).

\* Correlation is significant at the 0.05 level (2-tailed).

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There are a number of high correlations that should be expected as they are a subset of claims per million. Slips per million, lifting per million and back injuries per million exhibit high levels of positive correlation with claims per million as they are major contributors to the claims rate. These are not shown in table 11, as they do not provide any further information. There were also correlations with variables based on numbers of particular characteristics and these also have not been included as percentage figures are seen as more useful in the analysis.

There are a series of correlations with the structural variables the project has used.

The high care/low care variables are statistically significant and support some anecdotal evidence that low care does not equate with low risk. High care facilities are dealing with more frail residents who do not present the same problems as more active and independent low care residents.

There is a strong set of correlations on the size of the facility. The greater percentage of services with less than 40 beds the lower the claims rate is a correlation that may be surprising given the potentially greater pressures on small facilities. The larger facilities are associated with poorer claims rates. The pattern here holds, as the claims get more severe with smaller facilities having a lower share of long term claim and larger facilities having a higher share.

Location also presents a number of associations with capital city location strongly associated with higher and more severe claims rates and remote facilities associated with lower claims rates.

Ownership presented some of the strongest correlations in the analysis. The correlation with the percentage of local government services, state government and community owned services shows the greater representation of these categories the lower the claims rate. Conversely charitable, private and to a lesser extent, religious owned facilities are associated with higher claims rates. The correlation with charitable services is very strong and is evident across each claims per million category. Private facilities have a very high correlation with more severe claims rates.

The age related correlations suggest that the greater the % of claims in the 30-39 and 40-49 age group the higher the claims per \$m rate and secondly that the higher the % of 50 plus years claims the lower the claims rate.

The association with back injuries and a higher claims rate is expected and finally the only occupational category associated with higher claims rates was “other occupations” which includes cooks, kitchen staff and cleaning staff.

A further series of correlations was done for each jurisdiction and there were very few significant correlations. When the data was split between nursing homes and accommodation for the aged some of the high correlations shown were simply a function of variables with little movement over time. The structural variables (size, ownership etc) within a jurisdiction could not be relied on to describe variation because of the stability over time. By contrast these variables have been able to highlight differences across jurisdictions.

## 5.2 *Multiple regression analysis*

The next step was to examine a range of possible variables that separately and in combination influence the claims frequency rate. Multiple regression analysis was undertaken on all the variables defined in the study.

Using stepwise regression a reasonable model emerges. This model indicates that the claims rate in any aged care industry in any jurisdiction can be explained by four influential variables:

- % Back injury claims
- % Claims from registered nurses
- % Services charitable
- % Services with 100+ beds

**Table 12: Regression Analysis Summary**

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	0.617 <sup>a</sup>	0.380	0.362	0.43730
2	0.699 <sup>b</sup>	0.489	0.458	0.40320
3	0.798 <sup>c</sup>	0.637	0.603	0.34492
4	0.827 <sup>d</sup>	0.685	0.644	0.32673
5	0.854 <sup>e</sup>	0.729	0.683	0.30805
6	0.852 <sup>f</sup>	0.726	0.690	0.30472

- a Predictors: (Constant), % of Services (40-99 beds)
- b Predictors: (Constant), % of Services (40-99 beds), % of Claims (back injuries)
- c Predictors: (Constant), % of Services (40-99 beds), % of Claims (back injuries), % of claims (Registered Nurses)
- d Predictors: (Constant), % of Services (40-99 beds), % of Claims (back injuries), % of claims (Registered Nurses), % of Services (Charity)
- e Predictors: (Constant), % of Services (40-99 beds), % of Claims (back injuries), % of claims (Registered Nurses), % of Services (Charity), % of Services (100+ beds)
- f Predictors: (Constant), % of Claims (back injuries), % of claims (Registered Nurses), % of Services (Charity), % of Services (100+ beds)

Another variable (% services 40-99 beds) is included in iterations of the model and can still be considered to be an important variable although it does not feature in the final model. Table 13 shows the coefficient values and the direction of variation. Registered nurse % of claims is the only negative variable such that a greater share of registered nurse is likely to reduce the claims rate.

Regressions using South Australia, Queensland and Western Australia have been run and given the small numbers of data points and the many variables the models all produce relatively strong links to the claims rate. The feature of these regressions is the link to age categories and the dominance of the 40-49-age category reflecting the claims profile in all jurisdictions.

Generally the limitations of the data when analysed at individual jurisdiction level makes regression analysis unproductive for the same reasons as noted under the correlation section.

**Table 13: Coefficients in regression model<sup>a</sup>**

Model	Unstandardized Coefficients		Standardized Coefficients		Sig.
	B	Std. Error	Beta	t	
1 (Constant)	-0.521	0.456		-1.141	0.262
% of Services (40-99 beds)	4.119	0.902	0.617	4.569	0
2 (Constant)	-0.816	0.435		-1.874	0.070
% of Services (40-99 beds)	3.441	0.870	0.515	3.956	0
% of Claims (back injuries)	1.805	0.683	0.344	2.645	0.012
3 (Constant)	-0.633	0.376		-1.685	0.102
% of Services (40-99 beds)	2.617	0.778	0.392	3.363	0.002
% of Claims (back injuries)	3.096	0.684	0.591	4.524	0
% of claims (Registered Nurses)	-2.081	0.575	-0.454	-3.618	0.001
4 (Constant)	-0.858	0.371		-2.314	0.027
% of Services (40-99 beds)	2.475	0.74	0.371	3.344	0.002
% of Claims (back injuries)	2.974	0.651	0.567	4.571	0
% of claims (Registered Nurses)	-1.582	0.592	-0.345	-2.674	0.012
% of Services (Charity)	2.659	1.231	0.242	2.159	0.039
5 (Constant)	6.83E-02	0.546		0.125	0.901
% of Services (40-99 beds)	-0.994	1.719	-0.149	-0.578	0.568
% of Claims (back injuries)	3.014	0.614	0.575	4.911	0
% of claims (Registered Nurses)	-1.77	0.564	-0.386	-3.136	0.004
% of Services (Charity)	4.128	1.338	0.376	3.085	0.004
% of Services (100+ beds)	14.677	6.648	0.554	2.208	0.035
6 (Constant)	-0.217	0.233		-0.930	0.360
% of Claims (back injuries)	2.950	0.597	0.563	4.941	0
% of claims (Registered Nurses)	-1.694	0.543	-0.370	-3.120	0.004
% of Services (Charity)	3.752	1.157	0.342	3.243	0.003
% of Services (100+ beds)	11.165	2.670	0.422	4.182	0

a Dependent Variable: Claims per \$M Remuneration



## 6. INVENTORY OF POLICY INTERVENTIONS

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The focus in this section is the range of policy interventions that may have impacted on OHS performance in the aged care sector. Specific initiatives targeted at the age care sector will be examined to see if there is any connection with outcomes. The initiatives include OHS agency initiatives, health and aged care department initiatives and initiatives driven by industry associations.

It is important to understand the wider context in which agency initiatives are undertaken and to have some understanding of the common strategic settings across jurisdictions. There are a number of common strategies that have been applied and these are important in trying to identify any distinctive impact that a specific jurisdiction may have had.

### 6.1 *Awareness campaigns*

In the last 5 years most jurisdictions have had some sort of awareness raising campaign directed at employers and employees. These campaigns have generally been climate setting campaigns to underpin more specific interventions. The impact of these campaigns is unclear although traditional advertising recall measures show that messages are recognised by a high percentage of the viewing audience.

A NOHSC attitude survey compared the impact of television campaigns across jurisdictions and concluded that:

The impact of television campaigns in Victoria, Western Australia and Tasmania is clearly evident in the results, with the great majority in these States referring to television as a source of information.<sup>33</sup>

The main message taken by respondents was to “be aware and take care” which is really the most fragile form of risk control and thus the transfer of awareness into practice is unlikely to have resulted in real impacts at the workplace.

However whatever the conclusion one draws about the impact of media campaigns they have been a common element of OHS strategies. Victoria and Western Australia have had the most sustained media campaigns.

### 6.2 *Manual Handling and Patient Handling Initiatives*

The predominant injury category in the aged care sector is manual handling and thus it is important to look at the policy initiatives that have been taken to reduce injury levels. These initiatives have not been targeted at aged care but apply to all workplaces, as manual handling injuries are widespread across all industries. Health and aged care however have been always prominent in manual handling initiatives because of the known risks associated with patient handling and patient care.

The introduction of a manual handling regulation or code of practice is the principle element of the policy interventions of all jurisdictions. It is reasonable to suggest that the greater time that a regulation or code has been in force and the greater the effort to support the regulation by information, advice, training and enforcement the greater the potential impact on injury levels.

The following table summarises the regulatory form in which manual handling is managed in each jurisdiction.

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<sup>33</sup> Comparative Study of Approaches to Community Safety and Health Awareness Campaigns, NOHSC, 1999, p.48.

**Table 14: Status of Adoption<sup>1</sup> of the National Standard for Manual Handling As at June 2001**

National Standard Key Element	Clause	Consistency by Jurisdiction										*11
		NSW	Vic	Qld	WA	SA	Tas	NT	Cwth	ACT		
1 Objectives	2.1	Y	Y	Y	Y	Y	Y	Y	Y	Y	P <sup>9</sup>	<b>8</b>
<b>Design (employer obligations are applicable to)</b>												
2 Plant, equipment and containers	3.1	Y	Y	Y	M <sup>5</sup>	M <sup>6</sup>	Y	Y	Y	Y	Y	<b>7</b>
3. Work practices	3.1	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	<b>9</b>
4 Work environment	3.1	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	<b>9</b>
<b>Risk Assessment</b>												
5 Employer to ensure risk assessment undertaken	4.1	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	<b>9</b>
6. Risk assessment in consultation with employees and their representatives	4.2	Y	P <sup>2</sup>	Y	Y	Y	Y	Y	Y	Y	Y	<b>8</b>
7 All relevant risk assessment factors must be considered	4.3 (a) to (n)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	<b>9</b>
<b>Risk Control</b>												
8 Employer to ensure risks controlled, as far as workable.	5.1	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	<b>9</b>
9 Risk control undertaken in consultation with employees and their representatives	5.2	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	<b>9</b>
10 Employer to redesign to eliminate or control risks and to ensure employees receive all training.	5.3 (a) to 5.4 (b)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	<b>9</b>
<b>Other</b>												
11 Where employee trained, employee shall make use of it where possible.	6.1 to 6.2.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	<b>9</b>
12 Definitions	7.1	Y	P <sup>3</sup>	M <sup>4</sup>	Y	M <sup>7</sup>	Y	P <sup>8</sup>	Y	P <sup>10</sup>		<b>4</b>

**Y**-the key element has been fully adopted in the jurisdictional framework; **M**-most of the key element has been adopted in the jurisdictional framework; **P**-only a portion of the key element has been adopted in the jurisdictional framework; **N**-the key element has not been adopted in the jurisdictional framework; and **?**-status of adoption yet to be determined.

The profile of manual handling regulatory instruments is only useful to the extent that there is evidence that these interventions have had some impact. The second problem is to establish

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the relative influence of regulatory interventions against other measures such as economic incentives through the compensation schemes.

A report commissioned by NOHSC on the effectiveness of the manual handling standard provides some evidence pertinent to this project.<sup>34</sup>

The evaluation looks at trends in the level of manual handling injuries and sought the views of stakeholders and users of the regulations and codes on the relevance, clarity and effectiveness of the approach.

The study found that firms that had used the code were more likely to record a reduction in injuries than those that had not used the code. Overall awareness of the standard was 90% for large firms, 60% for medium firms and 40% for small firms and that 50 % of these firms had used the code of practice.

The survey found that of those who used the code nearly three quarters conducted training on the regulations and codes and in focus groups there was general agreement that without initial training the code was seen as too technical and complex.

The Victorian WorkCover Authority prepared an issues paper<sup>35</sup> as part of the consultation process for the review of the Manual Handling Regulations 1988 that were due to sunset in 1998. As such the paper constitutes a relatively recent examination of trends in manual handling injuries and the effectiveness of the regulatory regime.

WorkCover conducted a survey of employers to gather data about levels of compliance and the costs and benefits of the current regime. The findings about the Codes of Practice are outlined below.

#### “Use of Manual Handling Code of Practice

- 43 per cent of manual handling establishments reported that they used the Manual Handling Code of Practice for their risk assessments. Small establishments were more likely to use the code of practice (47 per cent) than were larger establishments (42 per cent).
- Of those employers who reported not using the code of practice, 49 per cent indicated that they used some form of internal checklist, 8 per cent indicated that they used the Code of Practice for Plant and 5 per cent used consultants or WorkCover advisers. Note, 19 per cent of employers did no assessments or were unable to nominate the guidance they used in conducting assessments.
- Large establishments were more likely to report using internal checklists (59 per cent) than were small establishments (20 per cent).”

The review showed that whilst manual handling claims numbers and total claims cost have been steadily declining their share of all claims has remained relatively stable. The report argued that the Victorian manual handling claim rate was the lowest in Australia but that there was no correlation between rates and types of government intervention across jurisdictions.

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<sup>34</sup> Evaluation of the Effectiveness of the National Standard for Manual Handling and it's associated Codes of Practice, report stage 1, David Caple and Associates for Worksafe Australia, July 1996.

<sup>35</sup> Issues paper: Review of Manual Handling Regulations 1988 and associated Codes of Practice, Victorian WorkCover Authority, September 1998, p.21.

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### 6.3 *Specific Aged Care Jurisdiction Initiatives: South Australia*

The Aged Care Industry was identified by WorkCover Corporation to be included in the SAfer Industries strategy. The strategy involves a long-term commitment from WorkCover Corporation to work with the industry to identify the key sources of injury, illness and claims cost and to develop plans to address them.

SAfer Industries has grown out of the 1995 high-risk industries program, the Aged Care Industry being one of those industries targeted at that time. An industry committee, the SAfer Aged Care Working Party, was formed in September 1995. In November 1995, the first three-year OHS&W strategic plan for the Aged Care Industry was developed in consultation with the industry.

WorkCover South Australia has developed a detailed and industry endorsed aged care strategy. The strategy has the following objectives:

- The Aged Care Industry will support and implement a consistent approach which provides a safe working environment.
- By the year 2001, to have evidence of a reduction in injuries of 20% as measured by WorkCover Corporation's claims statistics (using 1996/97 as the base year).<sup>36</sup>

To achieve these objectives the following goals were set:

- Aged Care Industry will implement OHS&W management systems which promote participation and ownership at all levels by 31 December 2001.
- To develop and provide tools and resources beneficial to the attainment of continuous improvement in OHS&W in the Aged Care Industry by 31 December 2001.
- Peak bodies to provide a lobbying mechanism for financial support to assist the Aged Care Industry to provide a safer working environment by 31 December 2001.
- To eliminate or minimise risks in the Aged Care Industry by improving the design of equipment, buildings and environment by 30 June 2000.
- To identify, map and promote the use of communication networks throughout the Aged Care Industry by 30 June 1999.<sup>37</sup>

The broad objective of reducing injuries by 20% in a 3-year period was a challenging one, but no doubt set for that very purpose. To achieve this target a range of specific strategies were defined. The strategies were aimed at implementation of existing guidelines, incorporation of recommended practices at all levels in the industry, increasing facility level and industry level OHS competency and introducing measures that reduce risks at the design stage.

Each strategy had a timeline and for the purpose of assessing any impact on outcomes both the timeline and the nature of the strategy are pertinent. For example, promoting the Practical Guide was a short term "push" strategy that would be difficult to track whilst design based initiatives may be easier to identify and link to injury and mechanism categories.

The results of an initial assessment of the strategy by the Working Party are shown in table 15.

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<sup>36</sup> Aged Care Industry within South Australia, Occupational Health, Safety and Welfare Strategic Plan, Aged Care OHS Working Party, 1998, p.4.

<sup>37</sup> Ibid, p.4.

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**Table 15: Summary of Outcomes from Aged Care Strategy<sup>38</sup>**

<b>Strategy/action</b>	<b>Outcome</b>
National Practical Guide promotion, evaluation	Practical guide promoted and assisted in its evaluation
Develop induction guidelines	Not achieved
Community Care: Develop guidelines, implement and evaluate	Guidelines developed, training workshops held, evaluation of sample via phone survey
Executive Management OHS Strategy	Guidelines developed, piloted with a group of Managers, currently under review, no wider implementation plan
Injury Reporting	Article developed and promoted via newsletter
Manual Handling Trainer Accreditation	Grant application completed by sub committee, unable to secure grant
Develop resources for smaller aged care facilities	<ul style="list-style-type: none"><li>• First Steps” developed with Commonwealth Grant.</li><li>• Training workshops completed.</li><li>• Evaluated with Commonwealth.</li><li>• Feedback used to redevelop National Guide</li></ul>
Identify Resources addressing Aged care Specific Hazards	Endorsement and support offered to committees for following grant projects: <ul style="list-style-type: none"><li>• Resident Resistance to care</li><li>• RDNS Violence project</li><li>• ANF No Lift No Injury</li><li>• Workplace bullying Project</li><li>• Better health and Safety Awards and State Aged care OHS Awards</li></ul>
Develop guidelines for safe manual handling of people	Working group formed and manual handling CD developed and promoted to health and aged care industries
Secure support from stakeholders to identify at risk groups. Identify target groups to be lobbied and expected outcomes.	<ul style="list-style-type: none"><li>• Manufacturers and suppliers approached to assist with ohs awards (\$1800 secured)</li><li>• Industry Concerns forwarded to accreditation agency</li><li>• Issues papers forwarded by employer groups to major parties re industry funding</li></ul>
Contribute to Workplace design Guidelines	Working party involved in the development, promotion and implementation of “Designing Workplaces for the Safer Handling of Residents”
Review overseas design initiatives	European visit conducted, report completed and presented to working party
Assist facilities with implementation of guidelines	Facilities assisted by working party members, over 200 copies distributed to industry, promotion via newsletter, checklist for equipment purchase developed based on work at Resthaven

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<sup>38</sup> Information drawn from WorkCover SA presentation

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#### 6.4 Specific Aged Care Jurisdiction Initiatives: Commonwealth

In response to the relatively poor claims experience of the aged care sector the Commonwealth undertook a range of measures to improve OHS in 1995-96.

The Federal Budget allocated \$660,000 over four years to address OHS and a National Steering Committee was established under the auspice of the then Commonwealth Department of Health and Family Services to oversee a national strategy to improve OHS in residential aged care facilities.

The strategy's main components were:

- A Practical Guide to Implementing Occupational Health and Safety in Residential Aged Care supported by information and training.
- The Better Health and Safety Awards for Residential Aged Care.

The Department engaged consultants to review the progress of the strategy in 1998 and their report<sup>39</sup> concluded that:

- The claims performance of the sector was improving but not at the same rate as other industries
- There was greater awareness of OHS and facilities were investing in OHS improvements
- Rehabilitation and return to work practices required considerable improvement
- The major agent of advice the *Practical Guide to Implementing Occupational Health and Safety in Residential Aged Care* had been influential but further changes to the manual would improve its usability
- The Better Health and Safety Awards for Residential Aged Care had attracted a good level of interest and many in the industry were aware of the awards

A series of recommendations to build on the progress so far were made and a number have been undertaken.

The results of a mail survey used in the evaluation provide an insight into the effectiveness of policy interventions in the sector. Table 16<sup>40</sup> shows the areas that facilities have invested in. The focus on awareness and training suggests the sector is just beginning to develop rudimentary systems and that these systems are dependent on behavioural risk controls. For example, there is no mention of design based controls.

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<sup>39</sup> The Right Direction: Occupational Health and Safety in Residential Aged Care, Prepared by NE&A for the Commonwealth Department of Health and Aged Care. 2001.

<sup>40</sup> *ibid*, p.5

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**Table 16: OHS SYSTEMS DEVELOPMENT BY TOTAL RESPONDENTS**

<b>Area of development</b>	<b>Proportion of total respondents nominating area</b>
Staff training and development	35
Increased staff awareness	25
Setting up OHS Committee	22
Education in manual handling	19
Policy development/formulation	12
Hazard reporting/identification	12
More formalised procedures	12

The survey also asked facilities what they saw the future needs in order to improve OHS and the table 17 summarises responses.<sup>41</sup>

**Table 17: AGED CARE FACILITIES' OBJECTIVES FOR OHS IMPROVEMENT OVER THE NEXT 3 YEARS**

<b>Total (737)</b>	<b>%</b>
Staff training/education	43
Staff awareness/understanding	18
Reduced injuries/accidents	17
Manual handling education/awareness	13
No lifting policy/aim towards a no lifting policy	12
Continuous improvement	12
Reduce workers compensation claims	12
Equipment upgrade/maintenance	11
Reduce hazards/increase safety	10
Staff compliance/commitment	9
Meet accreditation standards/requirements	9
Staff involvement/input/participation	7
Establish/formalise policies and procedures	7
Regular audits/reviews/monitoring	6
Building upgrade/refurbishment/renovations	6
Risk/hazard infection assessment	6
Fire safety/smoke alarms/sprinklers	5
Other (4% or less)	56
Unstated	7

These results confirm the emphasis on software changes rather than hardware changes and may reflect actual or perceived cost barriers. Most of the hardware changes are listed as lower priorities (eg, fire protection, building upgrades, equipment upgrades).

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<sup>41</sup> *ibid*, p.9

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### 6.5 *Specific Aged Care Jurisdiction Initiatives: Victoria*

The main initiative has been the development of design guidelines for hospitals and aged care facilities.

In 1998, the Victorian WorkCover Authority facilitated an industry Workplace Design Working Party. The aim of this working party was to document best practice information and minimum standards in the building design & layout of the main areas where patient handling occurred.

As an outcome, a publication titled “Designing workplaces for safer handling of patients/residents – Guidelines for the design of health & aged care facilities” was developed and released in December 1999. The guidelines provide information about how ergonomics and effective consultation can add value to the design phases of a health facility construction project. In the long term, good building design will lead to a reduction of injuries, and workers compensation costs.

To support these guidelines WorkSafe Victoria has recently funded the Victorian Hospitals Industrial Association to manage a series of programs to promote the use of the Guidelines in the health and aged care sector. The proposal has three objectives:

- Increase the capacity within the health sector to identify and implement design based changes that reduce risks to employees and patients/clients/residents
- Identify through design audits in over 100 facilities areas where design changes can improve the effectiveness of other measures and reduce patient/resident handling risks
- Provide specific ergonomic advice to facilities undertaking new works or refurbishment to reduce patient/resident handling risks

The project commenced in October 2001 and is only in the early stages of undertaking the various interventions.

A checklist to assist facilities assess the effectiveness of their current patient-handling program, (*Criteria for evaluating the core elements that support a best practice patient / resident handling training program in the health and aged care sector*) was released in 1998. Another checklist *Pre-purchase Criteria to use in the Selection of Equipment & Furniture– Health & Aged Care* was also released in 1998.

### 6.6 *Specific Aged Care Jurisdiction Initiatives: New South Wales*

NSW has established a Health and Community Services (HAC) industry team to focus effort on an industry basis. The aged care sector is covered by this team and activities cover the range of information, education and compliance interventions.

A related aspect is the Health and Community Services Industry Reference Group (IRG) that provides a forum for industry input. The IRG has also initiated a number of interventions.

Over two years from 1998/99 a checklist was developed for the purchase of beds in the Health Industry. It involved contributions from manufacturers, health industry workers such as nurses, cleaners and maintenance workers. The checklist addressed the OHS hazards nurses face when making beds, transferring patients to and from beds, using beds as trolleys, pushing or pulling beds and adjusting bed rests.

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Another initiative has been to encourage and promote reduced direct client lifting systems in the health and community services industry. The aim of this project is to identify and profile facilities in the HACS industry that have or are planning to implement reduced client lifting systems. Of particular interest will be how the facility defines “reduced lifting system”, what processes it followed to develop and implement the policy/ system, any problems identified during the implementation phase, any barriers identified to its successful implementation and any impact on costs. These include costs associated with implementing the system and savings associated with reduced frequency and/or severity of injuries associated with patient/client handling.

A program to promote the implementation /adoption of the Manual Handling Competencies for Nurses by the HACS industry and relevant teaching and tertiary institutions was also initiated by the industry reference group. The aim of this project is to raise awareness in the HACS industry of the existence of the competencies, promote their adoption, identify any barriers to their uptake, and identify any tools that may encourage their utilisation by facilities.

Arising from the recommendations from the Manual Handling Competencies for Nurses project, a Manual Handling Training for Nurses project to develop a short course to address the three manual handling competency levels has been initiated. It will also develop support materials for the short course such as trainer and learner guides, and audiovisual materials.

Other projects include:

- A project to research barriers and solutions to injury management and return to work in the HACS industry for workers with manual handling injuries, and make recommendations for ways to disseminate those solutions to industry.
- A project to update the WorkCover NSW publication Safety Pack: A Guide to Occupational Health and Safety (for the community service organisation) produced by NSW Council of Social Service (NCOSS).
- A project to update the Manual Handling in Aged Care Package which was developed under the WorkCover NSW Injury Prevention, Education and Research Grants Scheme. This project will review and update the package in accordance with the OHS Act 2000 and the OHS Regulation 2001.

Most of the above projects cannot be expected to have an impact in the study period although there have been other targeted projects in the study period including:

- Health, Aged Care & Allied Industries Committee Backwatch Project – Public Hospitals Survey-July 1997
- Manual Handling Intervention – Nursing Homes Project Plan-1996
- Improving Health and Safety in Residential Care – A project conducted by Pam Pryor & Associates Pty Ltd.
- Draft NSW Health Department Policy and Guidelines for the Prevention of Manual Handling Incidents in NSW Public Health Care Facilities – 30 September 1996.

The Backwatch program represents the most intensive intervention in the study period and the program is currently being evaluated.

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## 6.7 Queensland

In the CPM Hospitals study<sup>42</sup> an inventory of activities was listed and many of these has application in the aged care sector. Many of these were publications including the following:

- A Worker's Guide to Back Care Brochure
- A Worker's Guide to Work Involving Repetition, Force or Awkward Postures Brochure
- An Employer's Guide to Back Care Brochure
- An Employer's Guide to Work Involving Repetition, Force or Awkward Postures Brochure
- Handling Cytotoxic (Anti neoplastic) Drugs and Related Waste Guide
- Skin Penetrating Injuries at Work Brochure
- Stress at Work - Information for Employer's Brochure
- Violence at Work Guide
- Workers and Hazardous Substances Brochure

These publications are likely to have had application in the aged care sector in the study period. The CPM hospitals study identifies 1997 as a peak year for activity particularly on manual handling.

Queensland introduced a specific code on people handling in 1992 to add to the coverage provided by the general manual handling code. This code was updated in 1999-2000, to be gazetted in December 2001 as the Manual Tasks Involving Handling People Advisory Standard 2001. Commencement of this standard was supported by a series of state-wide public seminars and media campaign.

Further the Division of Workplace Health and Safety supported Queensland Health's initiative with the Patient and Materials Handling Project Team's development and promotion of their Think Smart Programs (No Lift Programs).

Aged care is covered by an Industry Sector Standing Committee (Health and Community Services) and an examination of the committees minutes for the last

three years shows that the major areas with application to the aged care sector was promotion of Design Guidelines for Facilities, monitoring of the Manual Handling Tasks audit program and involvement in a program of People Handling Workshops held throughout the state.

In 2000 Queensland commenced a joint research project funded by Workcover Queensland Q-Comp and the National Health and Medical Research Council. Partnering this project is the University of Queensland, Curtin University of Technology and the Queensland Division of Workplace Health and Safety. The project targets four industry sectors, including nursing homes and accommodation for the aged and incorporates a pre and post state-wide Manual Tasks Blitz measuring the effectiveness of an ergonomics intervention for improved health and safety standards.

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<sup>42</sup> Comparison between Queensland and New South Wales Hospitals Exploratory Cross-jurisdictional Case Study, op cit.

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## 6.8 *Western Australia*

Worksafe has prepared several publications specific to Aged Care;

- Strategies to reduce the risk of back strain in nursing homes
- Slide sheets for moving patients in bed
- Sit, slide and stand pad for moving patients to chairs and wheelchairs.

Manual Handling has been a Priority Area for WorkSafe WA over the period 1997/98 - 1999/00 (and will continue to be in 2002/03).

## 6.9 *Industry initiatives*

It is not possible to reflect the range of initiatives that may have been undertaken at the industry and particularly at the facility level in this section. In the review of the Commonwealth OHS program many of the major industry initiatives are captured in the sense that industry support and participation was critical to the effectiveness of the programs. The key involvement at the industry level has been with:

- The Practical Guide to Implementing Occupational Health and Safety in Residential Aged Care
- The Better Health and Safety Awards for Residential Aged Care.

The most influential industry initiative has been the promotion of No Lift programs in the health sector including the aged care sector. This initiative has been driven by the Australian Nursing Federation and its state affiliates and has increasingly been seen as the industry standard. Many of the larger aged care employers have introduced this approach across all their workplaces. This approach is one of the few interventions that have been evaluated by independent researchers.

A study by Engkvist<sup>43</sup> conducted in Melbourne compared a hospital with a no lift program to two hospitals functioning without such a program. The results showed that nurses at the control hospitals had twice the relative risk of back injury. Another study

by Silverstein et al<sup>44</sup> in Washington evaluated three different approaches to reducing the incidence and severity of back and shoulder injuries due to patient handling in nursing homes. One group of nursing homes was offered a 15% discount on workers compensation premiums if they implemented a “zerolift” approach, another group was offered a job modification subsidy for injured workers and the third group acted as the control group. All nursing homes were provided with general information about zerolift through newsletters and seminars.

The results showed that the decrease in incidence and severity rates for zerolift facilities was greater than the second option and in the general group rates increased.

Another initiative along these lines has been undertaken by the Victorian Department of Human Services<sup>45</sup>. In 1998 the Department commenced a funding initiative to assist public hospitals to

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<sup>43</sup> Introduction of No Lift Policy, Engkvist, I-L, paper presented at WorkCongress5, Adelaide, 2001.

<sup>44</sup> Reducing Back and Shoulder Injuries in the Nursing Home Industry: The Washington State “Getting to Zero” Initiative, Silverstein, B.A., Rockefeller, K., Howard, N., Kalat, J., Washington State Department of Labor and Industry, <http://www.lni.wa.gov/insurance>.

<sup>45</sup> New Millennium, New Practices. Nurses Back Injury Prevention Program. Preliminary results. Department of Human Services, 2000., p.13

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implement programs designed to eliminate or minimise manual handling associated with moving or transferring patients. The initial funding of \$2 million was allocated to 51 facilities in 1998 and an additional \$1.2 million was allocated in 1999 to 28 facilities.

The funding provided for training, purchase of mechanical aids, electric beds, slide sheets and other equipment designed to reduce risk exposure for nurses. A total of \$6.2 million has been committed to the Project to date. 51 health care facilities were funded in Round 1 of the Project, 28 in Round 2 and a further 32 facilities in Round 3. A secondary component of Round 3 included the provision of additional funding to 72 health care facilities funded in Round 1 and 2 to rollout their nurses' back injury prevention program within their facility.

The funding does include aged care facilities, particularly where they are part of a hospital network. As a condition of participation organizations have to be able to demonstrate the following:

- Their nurses' back injury prevention program is supported by a designated program coordinator and that adequate time and resources are allocated to the position.
- Comprehensive training and refresher training for nurses is formalised and incorporates a structured and regular process for assessing staff competency regarding back injury prevention practices.
- A comprehensive assessment of the handling needs of each patient or resident, which considers the physical and cognitive abilities of the patient or resident, forms part of routine practice and incorporates a review process.
- Regular equipment audits involving nursing and OH&S representatives are structured part of the program.
- Clinical nurses are adequately represented on the Committee overseeing the ongoing implementation of the program.
- Processes for monitoring the ongoing effectiveness and sustainability of the program are formalised with results fed back to staff.
- The program, including the policy to support the nurses' back injury prevention program, is regularly reviewed and updated to reflect current best practice principles<sup>46</sup>.

These conditions could be seen as the success factors in reducing back injury risks and the initial results of the evaluation of the project are very promising. On the process measures the results show greater use of lifting equipment, greater involvement in consultative processes and greater take up of no lift policies.

The results of the most recent evaluation of the program have not been publicly released but indications from the evaluation team and the department are that there are significant and substantial reductions in lifting claims in the facilities taking up a No Lift approach.<sup>47</sup> The reductions in claims in this study group are well beyond any changes shown in the jurisdiction level data discussed in previous sections of this report. About 40% of the facilities involved in the evaluation are aged care and thus the results have important implications for understanding the scope for improvement.

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<sup>46</sup> Victorian Nurses Back Injury Prevention Policy, Department of Human Services, Victorian Government, December 2001, p.2.

<sup>47</sup> Victorian Nurses' Back Injury Prevention Project: Evaluation of the effects of Round 2 funding, Keating, J, Mitchell, M. Proceedings of the Safety in Action Conference. Melbourne. Victoria. Australia, 2002.

WorkCover South Australia has also promoted the use of No Lift policies through the funding of the Australian Nursing Federation (SA branch) to conduct No Lift/No Injury training for staff in aged care facilities.

### 6.10 Compliance and enforcement trends

In this section it is proposed to examine if there are differences in the enforcement profiles across jurisdictions and to describe the matters that are most regularly enforced. This is considered important as field based effort accounts for at least 60 % of the time and effort OHS agencies and the role of compliance activity is an important part of each agencies overall strategy.

WA, Victoria and South Australia provided data and some Queensland data was extracted from an industry report. The data provided highlights the problems in getting useful inspection data that is clearly linked to specific industries. Given the nature of current inspection information systems is not possible to productively tap into the reservoir of data about risks rather than incidents as generated by claims data.

The data provided by jurisdictions was not easily comparable and each set was incomplete because of difficulties in the way the data is recorded against industry classifications.

Inspection data from Victoria was provided for 1999-2001 which is partly in the study period. The number of inspections has increased significantly from 202 in 1999 to 697 in 2001. The number of improvement and prohibition notices has increased from 2 in 1999 to 168 in 2001. No information was available about the type of issue addressed in visits. This change in profile is a result of both specific targeting of aged care and of a more active enforcement focus. The impact of this effort will not be shown in the claims data analysed in this project but at least does indicate the likely scale of inspection activity if the sector is targeted.

South Australian inspection data records 50 visits in the 1999-2001 period. Most of the visits could be described as reactive, being responses to complaints or incident notifications. Most visits were concerned with chemicals and dangerous goods issues.

WorkSafe Western Australia provided data for 1995-96/1999-00 and the table 15 below shows enforcement activity for the selected Aged Care workplaces over a five-year period.

**Table 18: Enforcement activity for selected Aged Care workplaces 1995-96 to 1999-00, Western Australia**

Year	Investigations	Names Investigated	% of Names	Activities	Improvement Notices	Prohibition Notices
1995-1996	34	24	1.1	N/A	0	0
1996-1997	66	57	2.5	N/A	0	0
1997-1998	38	32	0.85	34	17	0
1998-1999	33	23	0.5	50	6	1
1999-2000	54	47	0.9	103	35	0
Totals	225			187	58	1

Of the 225 investigations conducted, 41% were for a dangerous incident or breach of legislation, 28% were for injuries or diseases, 2% were for plant audits and 28% were for construction issues.

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The only available Queensland data is drawn from a Manual Tasks Blitz undertaken in late 2000<sup>48</sup>. The manual tasks blitz focused on assessing compliance with the range of risk management issues contained in the Manual Tasks Advisory Standard 2000. Nursing homes were among the sectors targeted in the program which involved 204 workplaces. Results included the issue of 158 improvement and 3 prohibition notices mainly on manual handling issues.

The paucity of data makes any comparisons or conclusions difficult. The lack of data may be a reflection of a low enforcement profile in the aged care sector. The Victorian data with its increasing focus on the industry suggests that this low profile might be changing and the relatively poor performance of the sector is now attracting the full suite of regulator responses rather than dependence on information and advisory services alone.

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<sup>48</sup> Manual tasks Blitz Report, Division of Workplace Health and Safety, Queensland Government, 2001.

## 7. FINDINGS AND CONCLUSIONS

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This project afforded the opportunity to examine in more detail broad changes in OHS performance as measured by claims data. There were some data limitations experienced in comparing performance at the industry sector level such as the lack of usable denominator data (ABS data at four digit level) that has made translation of findings from the CPM report more difficult.

Despite these limitations other data sources have been used to enable inter-jurisdictional comparisons and to build a more detailed model to interpret any significant variations. Where possible, statistical analysis has been used to identify candidate variables likely to be important in explaining performance differences. In other cases the report draws on available evidence to interpret differences between jurisdictions.

The variables defined as structural variables (eg. occupation, facility characteristics) however are not as meaningful in drawing conclusions about patterns within jurisdictions. This is a result of the stability of structural variables within jurisdictions over time and the need to incorporate workplace-based factors (eg. resources, skills, management systems) likely to help explain why some facilities perform better than others. The study whilst aware of the workplace level factors has not set out to identify and weight such factors.

The impact of policy initiatives is considered in this section. Given the lack of precise data about these interventions conclusions drawn about their impact are necessarily tentative.

The findings are presented with a focus on the larger jurisdictions as some of the smaller states and territories are subject to volatility in performance because of small numbers.

The approach to setting out the study findings is to briefly summarise results in answer to key questions the study sought to investigate.

### *7.1 In the study period were there significant differences in claims outcomes across jurisdictions?*

Nationally there has been a sustained decrease in lifting claims driven mostly by improvements in the nursing home sector rather than the accommodation for the aged sector. This improvement has not been matched by other muscular stress categories where only marginal reductions are evident.

South Australia, Queensland and New South Wales all have made progress in reducing lifting claims but have not been able to have a similar impact on other claims categories. Victoria while not having such an impact with lifting claims has experienced reductions across all categories. This raises the question why lifting claims might be reduced but other handling claims increase in the same period.

Examining claims per million remuneration trends allows a more reliable comparison. Remuneration was used as an alternative denominator given the lack of ABS industry data. Claims per million comparisons show Victoria has almost half the rate of most other jurisdictions although other jurisdictions seem to be improving their rate more rapidly. This trend is apparent in the nursing home sector but in the accommodation for the aged sector Victoria's advantage is less apparent with Tasmania having the lowest rate. Queensland's accommodation for the aged rate is significantly higher than all other jurisdictions.

Lifting claims per million rates in all jurisdictions confirm the positive trend shown in the raw numbers and comparison to all industry rates shows reductions in the aged care sector have been noteworthy.

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Rates for falls, trips and slips, and show New South Wales and South Australia have rates at nearly double that of other jurisdictions.

### *7.2 Have any of the improvements in claims rates been reflected in lower premiums?*

Queensland, South Australia and Victoria all reduced or maintained their industry rate in both nursing homes and accommodation for the aged classifications in the study period. New South Wales, Tasmania and Western Australia all experienced increases in rates for one or both classifications. Most of these changes have been in parallel to changes in the all industries average premium rate however the relativity with the average rate has changed little in the period.

Nursing home premium rates were still about twice the all industries average and accommodation for the aged rates are still about one and a half times the all industries average across the 97/98 to 99/00 period.

At the end of 99/00 Queensland had the lowest premium rate for the sector and New South Wales and South Australia had the highest rates but the relativities within schemes does not appear to have changed. The lack of consistent and sustained improvement across all injury categories appears to be the major reason why good improvements in key areas such as lifting are not translating into reduced industry rates. The time lag before claims numbers and costs changes being reflected in premium rates also has to be noted.

### *7.3 Were there differences in structural factors that could have impacted on OHS performance?*

The study examined age, occupation, size of facility, location of facility, ownership of facility and residential care levels as specific structural factors in the aged care sector.

Denominator data for the sector was not directly available but the Nurse Labour Force survey indicated a similar age profile across jurisdictions. Consequently age is unlikely to be a discriminating factor in understanding OHS performance. The data does show age is important in all jurisdictions with the average age of nurses working in aged care older than other parts of the health industry and that claims are concentrated in the 45-54 age bracket. This concentration was over twice the national figure for all industries.

The sector is female dominated but again this was not a source of variation across jurisdictions.

Occupational analysis of claims showed that the “other carers” category accounted for most claims in both nursing homes and accommodation for the aged sectors. In the nursing home sector generally there have been reductions in each occupational category over the period whereas in accommodation for the aged the opposite is the case.

Estimated nurse claims incidence rates illustrated considerable variation across jurisdictions. Estimated incidence rates for “other carers” and “other occupations” were both higher than the estimated national rate for nurses.

The distribution of large and small facilities varied across jurisdictions with Victoria having a larger share of small facilities than other states and New South Wales having the highest concentration of large facilities. Location patterns were predictable with

smaller facilities concentrated in rural areas and larger facilities in the city. Queensland and Tasmania had the highest proportion of rural and remote facilities and Western Australia the largest proportion of capital city facilities.

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Each jurisdiction had different ownership patterns with New South Wales, Victoria, Queensland and Western Australia with high proportions of religious and private owned facilities and South Australia with the highest proportion of charitable owned facilities. As later analysis has shown ownership patterns are important in discriminating jurisdictional performance.

The final structural variable was resident care levels and this was included as a potential proxy for risk with high care indicating more risk for employees. There were not dramatic differences in the care profile of jurisdictions and later analysis suggested that if care levels were a proxy for risk it was in the opposite direction to that initially assumed.

Each of these structural variables played some part in understanding differences between jurisdictions. Clearly there are other structural variables that might also be important but this mix of variables impact on the aged care workforce, the workplace setting and the nature of work.

#### *7.4 Which structural factors are most likely to explain differences in jurisdiction performance?*

The statistical analysis found each of the structural variables associated with claims per million frequency rates. These results are correlations that are statistically significant and while not implying causality are good differentiators of performance.

In summary the results showed:

- Smaller facilities have better claims rates than larger facilities
- Metropolitan locations have higher claims rates than rural locations
- Charitable, private and to a lesser extent religious owned facilities are associated with higher claims rates
- Local government, state government and community owned facilities are associated with lower claims rates
- Low care is associated with higher claims rates
- “Other occupations” such as cooks and cleaners are associated with higher claims rates

Regression analysis supported the direction of the correlation analysis introducing the % of back injuries as a factor likely to increase claims rates and the percentage of registered nurses claims as a factor associated with lower claims rates. This is probably the other side of the “other staff” coin and again suggests a focus on nurse back injury prevention is having an impact but there is not a similar effort in non-nursing areas.

These results should be understood as factors that if present in a jurisdiction are likely to impact on the overall claims rate. For example, the high proportion of small facilities, and low proportion of charitables in Victoria may help explain lower claims rates whilst in South Australia a high proportion of capital city facilities, a high proportion of charitables and a high proportion of larger facilities may help explain higher claims rates.

#### *7.5 Is there any evidence that specific aged care reforms may have an impact on performance?*

The study could not take into account the complexity of the total aged care reform package and concentrated on the accreditation process and the changes to workers’ compensation subsidies.

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The specific funding of OHS initiatives by the Commonwealth is dealt with separately. In combination they appear to have motivated many facilities to improve their OHS performance.

The data from initial rating of facilities suggested Tasmanian facilities were better OHS managers than Queensland for example. Queensland stands out as having the lowest level of preparedness from these initial ratings and whilst not the worst performer across jurisdictions claims rates are at the high end. In the accommodation for the aged sector Queensland while improving has a claims rate six times higher than Tasmania. From this data it is possible that the poorly rated facilities were in the old hostel sector and that the state of facilities and the quality of OHS management has led to poor OHS outcomes.

The other aspect of reform pertinent was change to the method of subsidising facilities compensation costs to a shared cost model. From 1995-96 facilities were subsidised at the rate equal to the state average premium rate for the industry classification along with various caps and top ups.

As noted above premium levels have not changed dramatically (except Western Australia) in the period with more increases than decreases across the jurisdictions. Industry representatives have expressed concern about the funding formula and in some cases believe that the compensation costs are threatening the viability of some

facilities. Data on spreads of performance was only available from Victoria and it shows that 50% of nursing homes were paying less than the industry rate and the average premium rate across the study period (table 4). This suggests that changes to the funding formula did not prevent half the sector from out performing the average.

The final point to reiterate is that the “ageing in place” policy has at least two important consequences. Firstly, the distinction between nursing homes and accommodation for the aged categories in the compensation system is largely irrelevant and secondly, former hostels may now cater for different needs as resident care needs escalate. This may create increased risks because of mismatches in facility design and staff skills if not managed with future needs in mind.

#### *7.6 Is there any evidence that OHS agency policy interventions have had an impact on OHS performance?*

Lack of comprehensive information about agency initiatives makes assessments difficult, as does the lack of evaluation of interventions by agencies. Secondly, agencies only play a limited role in influencing outcomes which ultimately rest with the management of the particular facility.

One way of assessing the impact of initiatives is to take the results of the data analysis and ask whether initiatives addressed the possible critical factors.

Most jurisdictions have conducted general manual handling campaigns and it is reasonable to conclude these have influenced the improvement in lifting claims. In the case of South Australia, with the most significant reduction in claims, the funding of the ANF to conduct No Lift training may have provided the additional boost required to generate claim reductions. However by the test of sustained claim reductions across all manual handling and all other categories agency interventions could not claim success.

Most agency interventions have been information based or based on longer term effort to increase the sectors capacity to manage risk. For example, purchasing and design programs will take some time to impact on outcomes.

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One of the most direct impacts an agency can have is through inspection and audit activities. Due to the lack of data, and comparability of available data, it is difficult to reach any firm conclusions on the role enforcement activity played in this sector. It is also noted most jurisdictions use a mixture of tools to enhance compliance in an industry and this industry is no exception. Whether the advisory and educative approaches used by jurisdictions would be more effective with an active enforcement strategy could not be fully tested, but some evidence indicates this might have been the case..

The evaluation of the Commonwealth funded initiatives show that improvements have been made at facility level because of the assistance provided by the initiatives. The evaluation also demonstrates that OHS systems to manage all hazards are not well developed and this may explain the success with a “headline” hazard (lifting) but lack of progress with other hazards.

The role of facility size, ownership, care profile and location is not apparent in the nature and targeting of OHS agency interventions. This reflects an ability to target specifically for injury or hazard but not for industry characteristics that increase the potential for risk exposure.

Finally the occupational data shows that nurses have claims incidence rates (estimated) in some jurisdictions that require continued attention. Finally the higher estimated incidence rates for “other carers” and “other staff” does not seem to be reflected in OHS agency priorities in the period.

#### *7.7 Have other industry initiatives had an impact on OHS outcomes?*

This section does not claim to canvass all the major industry driven initiatives in the period but concentrates on some well recognised interventions.

The Practical Guide to Implementing Occupational Health and Safety in Residential Aged Care has been widely distributed and used and industry associations have played an important part in it achieving a key role in workplaces. The impact of the guide is not possible to estimate.

Introduction of No Lift policies has been a major initiative of the ANF and there are a number of evaluations showing this approach dramatically reduces risks and consequent claims. In Victoria the Department of Human Services supported this approach with subsidies to facilities to purchase lifting equipment and to train staff. In South Australia funding was granted to the ANF to train nurse in no lift policies and in other jurisdictions support for this policy has been provided by OHS agencies.

The success of this policy appears related to its single focus, its occupationally specific application, its direct impact on risks and active support by the ANF at all levels.

#### *7.8 Is it possible to develop an explanatory model to assist in understanding comparative performance data?*

The analysis conducted in this study does provide a basis for a more sophisticated model for interpreting OHS outcomes. For any sector there are three levels of intervention that are likely to influence outcomes:

- **Institutional level:** covers workers’ compensation schemes, OHS legislative framework etc.
- **Industry level:** covers structural factors relevant to sector, industry networks etc.
- **Workplace level:** covers management system and approach, communication and consultation arrangements etc

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In the aged care sector the institutional level may not be very powerful given the large number of small facilities relatively unaffected by their own claims experience and unlikely to be subject to compliance pressure from the regulator.

The industry level which has been the focus of this study will be influenced by the operational and competitive pressures of the kind identified here as structural variables.

Finally, the workplace level picks up the kind of issues identified in the hospitals study<sup>49</sup> such as management systems and communication and consultation arrangements. It is at this level that the reasons for differences within jurisdictions are most likely to be found. For maximum impact on performance actions at each level need to be mutually reinforcing.

As a starting point we have developed a model for interpreting the industry level issues as they vary across jurisdictions. The model shown in figure 1 uses the analysis from the report as well as some interpretation of other evidence and some speculation about underlying reasons.

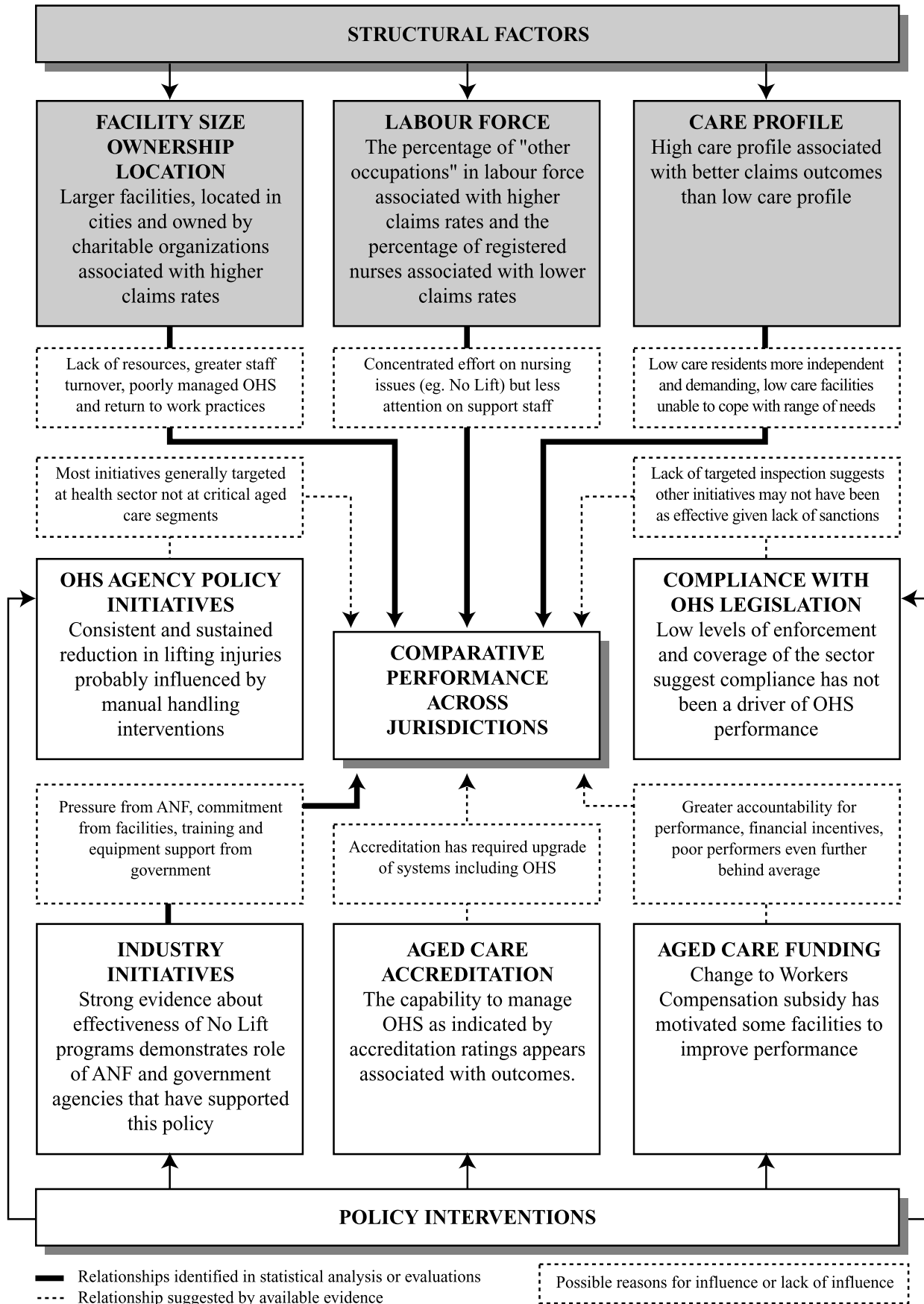
As more data and evaluation results are available this model could be fine tuned and some attempt could be made to weight the impact of different variables. Another industry sector would generate a different combination of structural factors and policy interventions. For example, building and construction would have to capture contractual arrangements, type of construction, and working hours as part of the structural variables. Inspection and enforcement would be an important policy intervention and the role of on site worker representatives would be important.

The key point the model highlights is that explaining past performance and targeting future initiatives must give more weight to industry variables rather than rely on ever more sophisticated ways of manipulating injury data.

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<sup>49</sup> Comparison between Queensland and New South Wales Hospitals Exploratory Cross-jurisdictional Case Study, op cit.

**Figure 1: Model for interpreting comparative performance in the aged care sector**





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