Submission to the Senate Community Affairs References Committee Inquiry into the Future of Australia's Aged Care Sector Workforce

March 2016

Introduction

The wellbeing of older people in rural and remote areas is a matter of particular importance to the National Rural Health Alliance (the Alliance).

The Alliance is comprised of 36 national organisations. It is committed to improving the health and wellbeing of the almost 7 million people living in rural and remote Australia[1]. Our members include consumer groups (such as the Country Women's Association of Australia), representation from the Aboriginal and Torres Strait Islander health sector, health professional organisations (representing doctors, nurses and midwives, allied health professionals, dentists, pharmacists, optometrists, paramedics, health students, chiropractors and health service managers) and service providers (such as the Royal Flying Doctor Service and the Council of Ambulance Authorities).

The population living in rural and remote Australia is older than that in the cities. There has also been a long term trend of young people migrating to the cities, which is partially offset by the opportunities that come with extending infrastructure - such as the NBN, industry and transport facilities, universities and health care capability - into regional and rural Australia.

As more young people move away from rural and remote Australia to pursue education, work and other opportunities, the rural population gets increasingly old. Adding to this, in recent years the number of older people migrating to country and coastal towns has been on the rise and the increase in 'grey nomads' also presents challenges to rural and remote health and aged care providers. Communities on the 'round-Australia' routes frequently find themselves needing to provide more specialised health services, such as certain medications, that are not in demand from their resident population.

Given their higher proportion of elderly people, the demand for aged care services is proportionately greater in rural and remote Australia than in metropolitan areas. However, availability of aged care services in rural and remote Australia is often very limited. To access care, especially residential aged care, often means moving away from home, family, friends, familiar places and support networks. Similarly, carers in rural and remote Australia also face difficulty accessing support services[2].

Aged care service providers in rural and remote areas often face more acute pressures, such as higher unit operating costs and challenges to workforce supply, training and support. These increase with remoteness and for communities of small size. These challenges are not unique to aged care services. However, the nature and constant requirements associated with delivering aged care mean shortages entail real risks for a segment of the population that is often very vulnerable.

Further, and importantly given the growing emphasis on market-based approaches, older people in rural areas are often further constrained by having lower levels of education and incomes on average and greater levels of disability, all of which are associated with worse health outcomes[3].

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[1] Throughout this submission references to remoteness areas are based on ASGC-RA, in which category 1 is Major cities, 2 is Inner regional areas, 3 Outer regional, 4 Remote and 5 Very remote. Because of small numbers, Remote and Very remote are often reported jointly. In the submission, references to 'regional areas' mean Inner plus Outer regional; and references to 'remote areas' mean Remote plus Very remote.

[2] http://ruralhealth.org.au/sites/default/files/fact-sheets/fact-sheet-22-carers%20in%20the%20bush_0.pdf

[3] For an overview of the relative circumstances of people living in rural and remote Australia and the broader population see http://ruralhealth.org.au/book/little-book-rural-health-numbers. A valuable summary of these issues can also be found at ***Healthcare in Australia 2012-13: Comparing outcomes by remoteness – supplement to the report to the Council of Australian*** (26 June 2014).

This limits their choices but also has implications for the viability of providers. While funding arrangements acknowledge and help to deal with the different cost structures rural and remote operators face, the evidence indicates they do not redress the imbalance. There is a need for further support, including to develop, recruit, retain and support aged care workforce in rural and remote Australia. This, together with coherent workforce planning and further support for innovative, collaborative service models (such as Multi-Purpose Services), would improve the prospects for aged care service capacity and quality of life experienced by aged persons living in rural and remote Australia.

The sustainability and efficiency of the aged care system could be enhanced, and the quality of service improved, with additional government investment in the aged care workforce. Unfortunately, however, funds are being from the aged care system, jeopardising the wellbeing of aged care recipients in rural and remote Australia.

Innovative approaches exist, have support and show considerable promise of improving service capability in rural and remote Australia: services which recognise and address issues of scale, sustainability and service integration.

The Alliance wants to ensure that Australia's aged care system works for everyone who needs it, including older people in rural and remote areas. There are challenges in addressing the needs of older people in rural and remote Australia, but well planned and collaborative approaches show these are not insurmountable. A skilled and supported aged care workforce is crucial.

This Submission aims to support the development of policy and programs going forward that:

a) increase access for people in rural and remote Australia to appropriate, affordable and sustainable aged care services;
b) recognise that aged care workforce development and support is a crucial investment and necessary for better access; and
c) are coherent, integrated, have cross-sectoral support and are in place long enough to deliver a structural improvement in the aged care available to Australians living in rural and remote Australia.

The Alliance notes in particular item (k) of the Inquiry Terms of Reference - *the particular aged care workforce challenges in regional towns and remote communities*. The Alliance thanks the Committee for recognising that rural and remote communities face particular issues with regard to the aged care workforce. The Inquiry Terms of Reference are broad and appropriately reflect the complex interactions that make a system work or not. Too often ad hoc decisions have negative impacts across the system: aged care workforce is a case in point.

Like other Submissions to this Inquiry[4], the National Rural Health Alliance calls for the development of a national, coherent workforce development strategy for the aged care sector, and considers Government has a responsibility to lead this work. The Strategy must involve and be informed by stakeholders. It must also take account of linkages and implications for other areas of the health and community services workforce. A central theme of the Strategy must be to address the development, retention, support and distribution of aged care workforce capacity to meet the needs of people living in rural and remote Australia.

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[4] Several submissions make similar calls, including submissions from Rural Health Workforce Australia (RHWA) – Submission 133; and the National Aged Care Alliance (NACA) – Submission 77.

Executive Summary

This submission argues that the particular issues affecting people living in rural and remote Australia, notably the aged, should be considered carefully and acted on accordingly in designing and delivering aged care policy, programs and services.

As is well known, the health of people living in rural and remote Australia is poor when compared with that of people living in major urban centres. Addressing such significant and general health inequalities requires a whole of government, multi-sectoral and social determinants approach - not just effective work in the health sector itself. The same is true of aged care - the distinction between it and health care often being obscure at best.

The Alliance is pleased that people who live in rural and remote Australia have been recognised in relevant aged care legislation as being "people with special needs" since at least 1997, but notes also that the legislation has not been enough to remedy the disparity in services they have access to relative to the broader aged population.

Recent government decisions, including major reductions in funding for aged care workforce development, are of great concern to the Alliance and appear to fly in the face of need.

It is apparent that the Government is looking to the aged care industry to take a greater role in developing the aged care workforce, including the development of a workforce strategy.

It is not clear from the evidence available that the aged care industry is inclined or able to take on that role at present or to address the present structural difficulties that see elderly Australians living in rural and remote Australia being unable to access timely, affordable, high quality services within reasonable proximity of family, friends, support networks and familiar environments.

The evidence is that much more is needed to ensure aged people living in rural and remote Australia have access to care and support that is similar to that enjoyed by the broader aged population. This submission draws on that body of evidence.

Reports, such as the recently released *Financial Issues Affecting rural and Remote Aged Care Providers* (February 2016) prepared by the Australian Government Aged Care Financing Authority,[5] demonstrate the difficulties facing rural and remote aged care providers. The report shows they face more difficult financial environments than metropolitan and regional providers. They generally run at a loss, have higher service costs, have difficulty attracting and retaining staff (and so pay premiums to meet basic staffing requirements) and are often unable to commit the resources needed to address these difficulties.

The need for aged care is an increasing reality for more Australians. It will continue to grow. We must develop sustainable, high quality aged care arrangements to meet this need. This requires continued leadership from government and close engagement by all stakeholders interested in the health and wellbeing of our population, wherever they live.

Inevitably the success or otherwise of our efforts in this regard will rely on having a skilled and available aged care workforce. This cannot be assumed or taken for granted. It is a crucial investment.

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[5] https://www.dss.gov.au/sites/default/files/documents/02_2016/11415_acfa_financial_report.pdf

Inquiry Terms of Reference

On 1 December 2015, the Senate referred ***the future of Australia's aged care sector workforce*** to the Senate Community Affairs References Committee for inquiry and report.

The **terms of reference** of the Inquiry are:

a. the current composition of the aged care workforce;
b. future aged care workforce requirements, including the impacts of sector growth, changes in how care is delivered, and increasing competition for workers;
c. the interaction of aged care workforce needs with employment by the broader community services sector, including workforce needs in disability, health and other areas, and increased employment as the National Disability Insurance Scheme rolls out;
d. challenges in attracting and retaining aged care workers;
e. factors impacting aged care workers, including remuneration, working environment, staffing ratios, education and training, skills development and career paths;
f. the role and regulation of registered training organisations, including work placements, and the quality and consistency of qualifications awarded;
g. government policies at the state, territory and Commonwealth level which have a significant impact on the aged care workforce;
h. relevant parallels or strategies in an international context;
i. the role of government in providing a coordinated strategic approach for the sector;
j. challenges of creating a culturally competent and inclusive aged care workforce to cater for the different care needs of Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups and lesbian, gay, bisexual, transgender and intersex people;
k. the particular aged care workforce challenges in regional towns and remote communities;
l. impact of the Government's cuts to the Aged Care Workforce Fund; and
m. any other related matters.

The Inquiry's Terms of Reference are broad. They reflect the complex array of issues that impact on the size, distribution, capability and distribution of the aged care workforce and their crucial role in meeting the care needs of older Australians, particularly those who are vulnerable and in need high levels of care.

- The Alliance welcomes the Committee's decision to consider the specific issues and challenges with regard to aged care workforce in rural and remote Australia.
- The Alliance also notes that every aspect of the Terms of Reference has implications for rural and remote Australia, and encourages the Committee to ensure each element of the Terms of Reference takes account of the implications for people living in rural and remote Australia.

Noting the Committee's interest in considering ***'any other related matters' (item m)***, the Alliance encourages the Committee to consider the implications of the following:

- skills shortages – especially as they exist in rural and remote Australia;
- limitations in the availability and accessibility of education and training opportunities locally that may constrain growth of a local, appropriately qualified workforce;

- the impact of uncertainty and changes in the vocational education and training sector, and the extent to which this may be hindering the development and growth of the health and aged care workforce in rural and remote Australia; and
- the impact of other Government funding decisions on aged care workforce supply, such as the coincident reduction in Commonwealth health workforce development, which is expected to limit the capacity for universities to place and support health professions students on clinical placement in rural and/or aged care settings[6].

Each of the issues identified, and the Government's commitment to aged care, could be usefully:

a. assessed considering the ***outcomes and impacts*** the community expects and the Government wants to achieve through aged care;
b. ***assessed objectively and in detail***; and
c. applied as part of ***a coherent, national aged care workforce strategy*** aimed at ensuring we have the capability to meet the aged care needs of the community into the future.

[6] The measure *Streamlining Health and Aged Care Workforce Programme Funding* announced in MYEFO reduced health and aged care workforce funding by $595.1 million over the four years to 2018-19 inclusive. As part of this measure $225M funding was redirected to rurally based health workforce development. The redirection of the funding to bolster rural health workforce development is welcome, however the magnitude of the overall cut is such that there may be reduced capacity to support (non-medical at least) health workforce education and training in rural settings and in in aged care facilities across the board. Further detail on the redirected funds is available at https://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley150.htm?OpenDocument&yr=2015&mth=12

Section 1: Aged Care in Rural and Remote Australia – context and factors impacting workforce

It is generally acknowledged that consumers of aged care services in regional, rural and remote communities are not able to access the breadth and choice of services available to those residing in metropolitan settings. In addition, the challenges for the workforce employed in regional, rural and remote communities includes significant travel; professional isolation; lack of supervision and/or debrief support; and limited access to training delivered outside of local initiatives or through e-learning platforms. Although the lack of supervision and mentoring support is a factor identified in particular for all employees undertaking work within the community rather than residential setting, this can be particularly salient for a regional workforce which spends the majority of its working hours travelling between client visits and away from other colleagues and an organisational base.

The workforce in regional and remote areas is often required to traverse service settings (i.e. residential and community) and client groups (e.g. older persons and people with a disability). Service providers in these areas are also more likely to employ a single manager to oversee and coordinate service delivery and staff management to meet the needs of both disability and aged care clients within a community.

Through consultations, the lack of culturally appropriate aged and community care training specifically designed for Aboriginal and Torres Strait Islander people who wished to enter or remain working within the industry was reported to be a significant impediment to the attraction, recruitment and retention of this workforce group.

Source: Department of Social Services: *Stocktake and Analysis of Commonwealth Funded Aged Care Workforce Activities – Final Report*, 11 August 2015. (Page 49-50, Appendix C)

Aged Care Workforce – status, trends, demand and distribution[7]

Demand for the health and community sector workforce will continue to grow, as it has for the past decade. Supporting workforce development in this area is an investment in system sustainability and quality care for our older people, as well as a source of employment in rural and remote communities.

The composition of the aged care workforce - size, professional profile, age and other characteristics – is well described in several research publications, and in a number of submissions to this Inquiry. It is described extensively in the *The Aged Care Workforce, 2012 – Final Report*, which was commissioned by the then Department of Health and Ageing and undertaken by the National Institute of Labour Studies[8].

Other detailed information is available in the National Aged Care Alliance (NACA) Reform Series paper on Workforce (2012).[9] This material provides consistent evidence of the need to grow and increase the capacity of the aged care workforce to meet current and future demand.

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[7] An overview of Australia's aged care system is available from the Report on government Services produced annually by the Productivity Commission, available at: http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/community-services/aged-care-services/rogs-2016-volumef-chapter13.pdf

[8] https://www.dss.gov.au/sites/default/files/documents/11_2014/rdp004-nacwcas-report.pdf

[9] http://www.naca.asn.au/Age_Well/Workforce.pdf

Aged and Community Services Australia (ACSA) has summarised the trends in workforce demand as follows.

> *"The aged care and services workforce has grown significantly in recent years. According to a report on the Aged Care Workforce conducted on behalf of the Australian Government, the number of direct care staff working in residential aged care rose from 78,849 in 2007 to 94,823 in 2012.2 Over the same period, the number of direct care staff working in Commonwealth subsidised community aged care services (packaged care, now known as Home Care Packages) rose from 74,067 to 93,359."* [10]

Government is also well aware of the growing demand and trend:

> *"Over the next 35 years it is expected that the aged care workforce will be required to triple from 352,145 people to 827,100 people in 2050"*[11].

What we know

- Regional Australia has an 'older population' than metropolitan Australia.
- Remote and Very Remote Australia is not as 'old' as regional Australia – partly because people need to move from Remote and Very Rremote areas to access aged care services.[12]
- Access to residential aged care decreases with remoteness.
- People in rural and remote Australia generally wait longer to access residential aged care, and are more likely to be cared for in hospitals due to a lack of alternative care services and options.

An older population

The proportion of the population identified as 'aged' is significantly higher in regional than in metropolitan Australia. The proportion of people living in remote Australia who are aged is similar to that of metropolitan Australia (albeit from a much smaller population base). This is due in part to the need for people to move away from remote areas as they age to larger centres where there are health, aged care and other services.

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[10] http://www.agedcare.org.au/news/copy_of_2014-news/acsa-position-paper-the-aged-care-workforce-in-australia (page 8)

[11] https://www.dss.gov.au/ageing-and-aged-care/workforce-development-programs/stocktake-and-analysis-of-commonwealth-funded-aged-care-workforce-activities-final-report. Executive Summary, citing the 2012 National Aged Care Workforce Census and Survey – the Aged Care Workforce, 2012, Final Report and the Department of Health and ageing (2010) Submission to the Productivity Commission Inquiry Caring for Older Australians. **Note:** Work on the 2015-16 National Aged Care Workforce Census and survey is underway.

[12] Statistical analyses can mask the actual situation of rural and remote Australia, as the analyses are not necessarily designed to identify the decisions people in rural and remote Australia make in order to access services. For example, age population data will show higher portions of aged Australians living in inner and outer regional areas that remote and very remote. This is not simply a measure of population age but also rather a demonstration (not necessarily obvious from a reading of the statistics) that many older people in remote areas of Australia have to move away the homes and familiar environments in order to access care.

Table 1: Number of 'aged' people, by remoteness area, 2011

	Indigenous 50+	Non-Indigenous 70+	Total "aged"	Total population	% "aged"
Metropolitan/ City	28703	1429602	1458305	15684540	9%
Inner Regional	19075	463953	483028	4111029	12%
Outer Regional	20488	201343	221831	2026429	11%
Remote	7685	19818	27503	314676	9%
Very Remote	12295	5933	18228	203350	9%
Australia	88246	2120649	2208895	22340024	10%

Source: derived from http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3238.0.55.001June%202011?OpenDocument

Rural and remote aged care – harder to find and harder to access

Per capita access to residential aged care is lower in regional and especially in remote areas. Access to community aged care places, however, is also lower in regional areas, but similar in remote areas compared with major cities.

Table 2: Residential and community aged care places per 1000 population aged 70 years or over and Indigenous aged 50–69 years, by remoteness, 30 June 2015

	Residential aged care places per 1000 population (b)	*Community aged care places per 1000 population* (c)
Major cities	82.2	31.2
Inner Regional and Outer Regional	72.2	25.6
Remote and Very Remote	49.0	31.9

(a) Population is people aged 70 years and over plus Indigenous Australians aged 50–69 years at 30 June 2015.

(b) Count is of operational residential places delivered in Australian Government subsidised residential aged care facilities at 30 June 2015 and includes Multi-Purpose Services and places delivered under the National Aboriginal and Torres Strait Islander Flexible Aged Care and Innovative Care Programs delivered in a residential aged care facility.

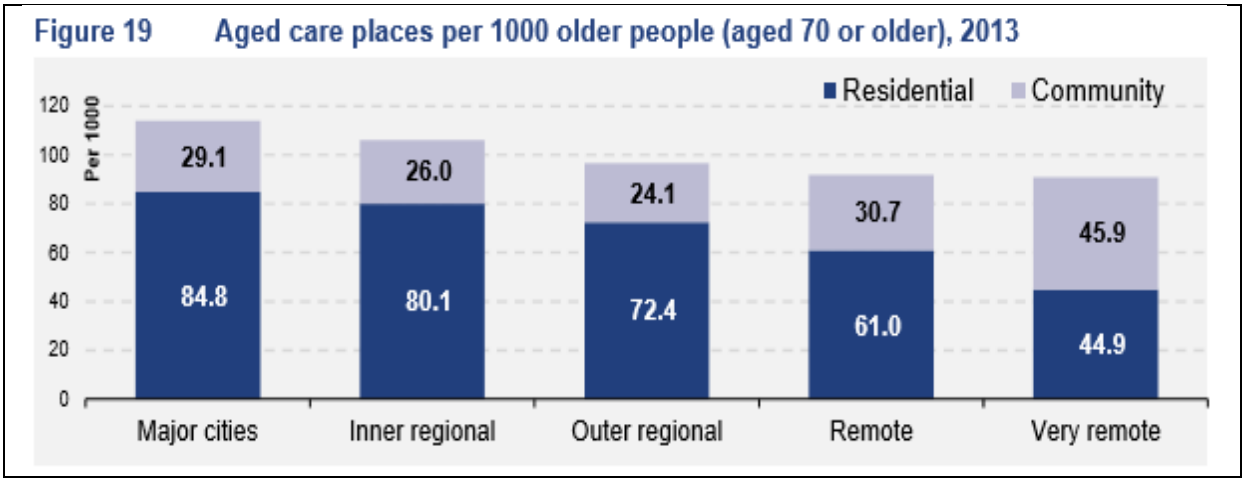
(c) Count is of operational home care places at 30 June 2015 and includes: Home Care Packages 1—4, Transition Care Program, and Multi-Purpose Services and places delivered under the National Aboriginal and Torres Strait Islander Flexible Aged Care and Innovative Care Programs provided in the community. On 1 August 2013 the Home Care Packages Program replaced the former community packaged care programmes – Community Aged Care Packages (CACP), Extended Aged Care at Home (EACH) packages and EACH Dementia packages.

Source http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/community-services/aged-care-services#indigenous-data

Access to residential aged care places decreases with remoteness, from 85 per 1000 older people in Major cities, down to 45 per 1000 older people in Very Remote areas.

Access to community aged care places is lower in regional/rural areas at 5 places per 1000 aged people, compared with 29 places per 1000 older people in Major cities, 31 per 1000 in Remote and 46 per 1000 in Very Remote areas.

Figure 1: Aged care places per 1000 older people, 2013

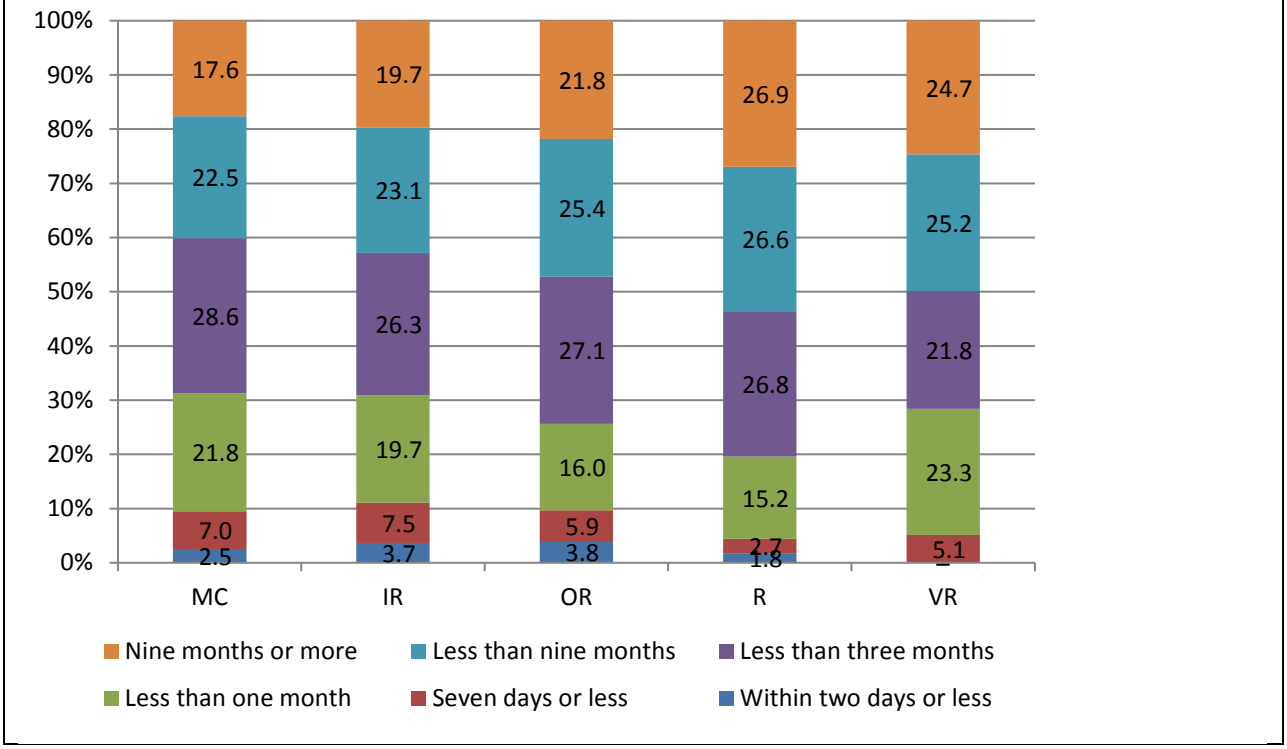


Source: snipped from http://pandora.nla.gov.au/pan/146265/20140703-0935/www.coagreformcouncil.gov.au/sites/default/files/files/Healthcare%20in%20Australia%202012-13%20-%20Comparing%20outcomes%20by%20remoteness.pdf
Note: "aged 70 or older" includes Indigenous people 50+

Rural and remote aged care – a longer wait

> ***"People living outside major cities are more likely to wait 9 months or more to entre high residential care and have a higher rate of using hospital days for patients approved and waiting for residential care."***
>
> ***Healthcare in Australia 2012-13: Comparing outcomes by remoteness***
> ***COAG Reform Council (26 June 2014) – page 5***

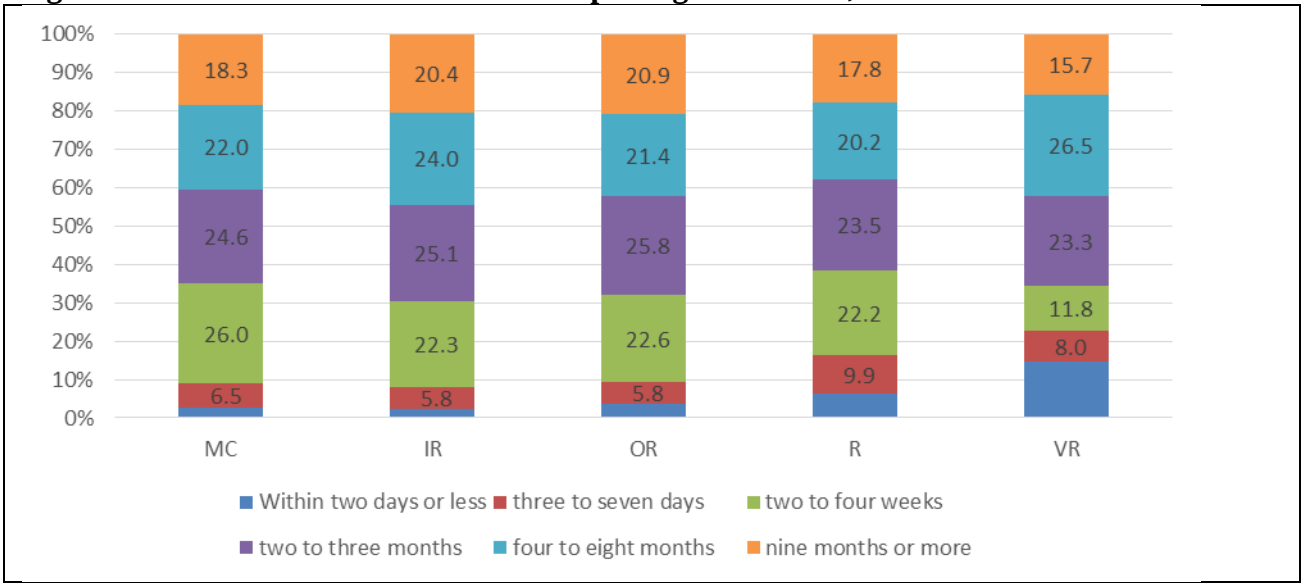
Figure 2: Time taken to enter residential aged care, 2014-15



Source http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/community-services/aged-care-services#indigenous-data Table 13A.36

People in rural/regional and remote areas more likely to have to wait longer than 9 months for residential aged care compared with those in major cities.

Figure 3: Time taken to access home care packages levels 1-4, 2014-15



Source http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/community-services/aged-care-services#indigenous-data Table 13A.36

People in rural/regional areas are slightly more likely to have to wait more than 3 months for community care than those in major cities (and those in remote areas), and are slightly less likely than these other groups to get a place within a month. More detailed figures on the breakdown of time taken for different care packages is provided at Appendix 1.

Rural Elapsed waiting times for aged care

The absence of available aged care services has flow-on impacts for other high demand services.

In 2013-14, 0.73% of hospital patient days in Major cities were used for caring for people eligible for residential aged care, compared with 0.9%, 2.2%, 3.0% and 3.1% of hospital patient days in Inner regional, Outer regional, Remote and Very Remote areas[13].

[13] Source http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/community-services/aged-care-services#indigenous-data (see Table 13A.42 Hospital patient days used by those eligible and waiting for residential aged care).

Section 2: Recent Government Decisions – direction and rationale?

Government rhetoric continues to suggest a high level of support for the development of the aged care sector and an appropriately skilled workforce. However, recent funding decisions indicate that development of the aged care workforce is a relatively low and waning priority for the Australian Government.

The Government flagged concerns about the effectiveness of Australian Government aged care workforce programs on 11 December 2015. That day, a joint media release entitled *"Questions raised over aged care workforce programmes: Stocktake"*[14] was released by Minister for Health, Sussan Ley, and Assistant Minister for Health, Ken Wyatt. The concerns raised focussed on issues such as the lack of program evaluation that has occurred and concerns about gaps and overlaps in the purpose of programs[15].

Also on 11 December 2015, Ministers Ley and Wyatt announced funding of $5.79 million to increase aged care places in rural and remote communities across Australia, through 17 Multi-Purpose Services (MPS) in Queensland, NSW and Victoria. The MPS Program is jointly funded by the Australian and State and Territory Governments and provides integrated health and aged care services to small rural and remote communities. It is a valuable program, which enables economies to be achieved in delivering crucial services to people living in smaller communities, and as Ministers explained *"…makes it easier for older Australians to stay connected in their communities and close to loved ones". …*[16]

The Ministers' media release *Questions raised over aged care workforce programmes: Stocktake* makes the point that over half of Commonwealth aged care workforce programs have never had their performance reviewed or evaluated. This is a significant concern, especially at a time when governments appear to be finding it more and more difficult to fund services, such as health and aged care. Of course, governments set the conditions for funding such services and determine the focus and extent to which such programs are effective in having a positive impact for the community.

Subsequently, on 15 December 2015, the Government announced its decision to reduce funding support for health and aged care workforce development by almost $600 million[17] as part of the Mid-Year Economic and Fiscal Outlook (MYEFO). MYEFO included a substantial number of savings measures in health and aged care, including a measure entitled *Streamlining Health and Aged Care Workforce Programme Funding*[18]. The government streamlined $595.1m away from health and aged care workforce support over the 4 years 2015-16 through 2018-19 inclusive. The official description of the measure as it appears in the Budget paper follows.

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[14] https://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2014-ley151211.htm?OpenDocument&yr=2015&mth=12

[15] https://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2014-ley151211.htm?OpenDocument&yr=2015&mth=12

[16] https://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley148.htm?OpenDocument&yr=2015&mth=12

[17] http://www.budget.gov.au/2015-16/content/myefo/download/MYEFO_2015-16_Final.pdf (see page 184)

[18] http://www.budget.gov.au/2015-16/content/myefo/download/MYEFO_2015-16_Final.pdf (see page 184)

Mid-Year Economic and Fiscal Outlook – December 2015 – decisions and impact?

Excerpt from the Mid-Year Economic and Fiscal Outlook – December 2015
Appendix A: Policy decisions taken since the 2015-16 Budget – Expense Measures

Streamlining Health and Aged Care Workforce Programme Funding
Expense ($M)

	2014-15	*2015-16*	*2016-17*	*2017-18*	*2018-19*
Department of Health	-	-178.2	-157.1	-130.4	-129.5

The Government will achieve savings of $595.1 million over four years by streamlining funding across a range of health workforce programmes, including ceasing the operations of:

- the Clinical Training Fund;
- the *Rural Health Continuing Education Programme*;
- the Aged Care Education and Training Initiative; and
- the Aged Care Vocational Education and Training professional development programmes.

The Government will redirect a further $225.0 million from these measures to support current health workforce priorities, including:

- $131.2 million over four years to expand the Rural Health Multidisciplinary Training Programme and establish grants to private healthcare providers to support undergraduate medical places; and
- $93.8 million over four years to develop an integrated prevocational, postgraduate medical training pathway in rural and regional areas.

The savings from this measure will be redirected by the Government to repair the Budget and fund policy priorities.

Source: http://www.budget.gov.au/2015-16/content/myefo/html/11_appendix_a_expense.htm

Little evidence or justification was offered publicly to explain the reduction in aged care workforce funding other than the concerns raised on 11 December 2015. The decision also seems at odds with the available evidence – much of it produced by and/or for Australian Government agencies – which appear to argue for continuing support for aged care workforce development programs.

The Final Report of the Department of Social Services *Stocktake and Analysis of Commonwealth Funded Aged Care Workforce Activities* – the basis of the December 11 media release - is dated 11 August 2015. The opening paragraph the Executive Summary of the Report reads:

> Aged care workforce activities allow the Australian Government to support initiatives that promote training and knowledge transfer; capacity building; and innovation and reform to improve the quality of aged care by expanding the skills of the aged care workforce. The increasing demand and competition among industries (such as the disability, child care and health workforces) with comparable or related skill sets creates a competitive environment for attracting and retaining workers. [19]

Allowing that some programs may not have been delivering as well as they could, the Government opted to substantially reduce funding for aged care workforce programs. It would have been possible, instead, to modify programs and optimise efficiency and effectiveness. The lack of public consideration of this point is concerning - as is the apparent intention of

[19] https://www.dss.gov.au/ageing-and-aged-care/workforce-development-programs/stocktake-and-analysis-of-commonwealth-funded-aged-care-workforce-activities-final-report

Government to withdraw from this area, despite the evidence – as offered in this and other submissions - of need and certain, substantial increasing demand for aged care services.

The argument, put by officials during Senate Additional Estimates Hearings in February 2016, is that Government has a lesser role to play in aged care workforce development than may have been assumed. The position put by officials responding to questioning by Senators emphasised that (paraphrasing the Hansard transcript):

- providers have legislated responsibilities in relation to having the appropriate sized workforce in relation to their services and the right type of people with the right qualifications;
- government has responsibilities that it exercises through a range of policy and funding levers, both within the health portfolio but also well beyond the health portfolio; and
- while government wants to assist industry to develop a workforce strategy it is essentially their responsibility and should lead development of a workforce strategy.[20]

The 2016-17 Budget

Over coming weeks the Government will be finalising details of the 2016-17 Budget. In January 2016, the Alliance wrote to the Treasurer noting, in particular, its concerns about changes in health and aged care policy and programs and the way in which budget changes may impact on people living in rural and remote Australia. The Alliance emphasised priority be given in the 2016-17 Budget to three key areas:

- ***Health and health care workforce*** – noting the substantial reduction in health workforce funding overall as a result of the 2015 MYEFO decisions, the NRHA welcomed the increased targeting on the rural and remote sector workforce development and support, which is crucial to addressing the persistent health workforce shortages and maldistribution;
- ***Primary care and prevention*** - noting that evidence from around the world shows the highest returns on health investment are from resources devoted to primary care and prevention, which assumes special importance at a time when health budgets are subject to significant pressure; and
- ***Aged care –*** noting that aged care has been subject of significant reform and cost cutting and that this is a particular concern to the Alliance with the age profile of people living in rural and remote Australia tipped towards the older end and average incomes are lower than in the major cities. Having to move away from family, friends and familiar environments to access aged care services is a significant, potentially detrimental, life decision for frail, older people in rural and remote Australia.

[20] pages 96-98 inclusive
http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;adv=yes;db=COMMITTEES;id=committees%2Festimate%2Fd4e63ac2-46c0-4422-955d-4b7db9b3b72d%2F0001;orderBy=customrank;page=0;query=Dataset%3AcomSen,estimate%20Decade%3A%222010s%22%20Year%3A%222016%22%20Month%3A%2202%22%20Dataset_Phrase%3A%22estimate%22%20SearchCategory_Phrase%3A%22committees%22%20CommitteeName_Phrase%3A%22community%20affairs%20legislation%20committee%22%20Day%3A%2210%22;rec=0;resCount=Default

The Alliance further noted its concern at recent reports of closures of aged care services in rural areas despite high demand; residential aged care facilities being unable to meet the needs of their residents, who are among the most vulnerable Australians; and the need to grow the aged care workforce in rural and remote communities to ensure the ongoing viability of services. The Alliance urged the Treasurer not to make further cuts to the health budget until the Government is able to consider, as a whole, the findings and recommendations of the several policy review processes underway, including the Review of the Medicare Benefits Schedule, the work of the Primary Health Care Advisory Group (PHCAG), consideration of reform of the Federation and reform of the taxation system – all of which have the potential to direct existing resources to better effect, and to reduce long-term pressure on the health and aged care systems.

https://www.dss.gov.au/sites/default/files/documents/02_2016/11415_acfa_financial_report.pdf

Section 3: Aged care workforce – emerging evidence and contemporary challenges

"The aged care and services industry in Australia needs to grow significantly in the coming years and decades. According to government projections, there is a need for an additional 75,000 residential aged care places and a further 85,000 home care packages over the 10 years from 2013 to 2023. As aged care is, at its essence, human work this increase in the number of care places means the need for a significant increase in the number of workers. Numerous attempts have been made to determine the number of aged care staff, particularly in those providing direct care, that will be needed in the future. The Australian Government estimated that the number of aged care workers will grow by an average of 2.5% every year for the 40 years to 2050, peaking at 3.6% in the current decade. This projection is supported by the Australian Workforce and Productivity Agency, which has predicted that the number of 'aged and disabled carers' will grow at a rate of between 2.2 and 4.4% each year from 2013-2025 with a growth rate of 1.4-3.8% for registered nurses. Based on the projections for service growth to 2023, it is estimated that there will need to be an additional 55,770 FTE care workers (37,620 in residential aged care and 18,150 in community aged care) over the decade from 2013 to 2023. While this data provides some indication of future workforce needs, it also has serious shortfalls. Although the composition of the aged care workforce is set to change significantly, these estimates are based on projecting current models into the future. It is unlikely that this will occur."

Source: Aged and Community Services Australia (ACSA) position paper the Aged Care Workforce in Australia (February 2015). Page 10.
http://www.agedcare.org.au/news/copy_of_2014-news/acsa-position-paper-the-aged-care-workforce-in-australia

It appears to be universally accepted that the aged care workforce will and must continue to grow significantly.

There is also a view that, in order to provide the care needed to the aged population and to ensure that care is both high quality and sustainable, productivity based workforce development and reform is part of the answer. Notwithstanding inevitable contention around aspects of workforce development (such as delegation and scope of practice), workforce reform and evolution is a live discussion point. The challenge of improving the match between aged care workforce capacity and demand for care will be best addressed by engaging in active, collaborative workforce planning and development. Government has a major role in promoting the development of a long-term, well-informed workforce development strategy in aged care. It will not occur if the Australian government withdraws. The cost to the nation and to individuals will be high.

Workforce development needs a viable sector

The development of a strong aged care workforce in rural and remote Australia depends on having service providers able to employ that workforce. It is, undoubtedly, in the interest of providers to contribute to developing that workforce, not least because the availability of a skilled workforce is one of the key factors that underpins service viability. However, this is also something of a 'chicken and egg' argument, as current workforce shortages mean services have to commit additional resources from limited funds to deal with immediate, and often expensive, staffing issues. In practice this can limit their capacity to contribute to more systemic workforce development. These issues are examined in the Report by Aged and Community Services Australia (ACSA), *Issues facing aged care services in rural and remote Australia* (December 2013). The Executive Summary of the ACSA report reads, in part:

"Residential aged care facilities in outer regional, remote and very remote areas are generally small in size. The facilities lack the economies of scale and economies of scope which are found in more urban areas. Aged care costs more per patient in these settings on a 'like for like' basis while the aged care system provides only minor opportunities for operators to recoup these above average costs. There is little evidence to suggest that extra funding such as the viability supplement is an effective offset against these increased costs. Many aged care facilities in rural and remote areas operate on the cusp of viability. These facilities will, from 1 July 2014, be particularly sensitive to the changing payment settings of residential care. Residents will pay for accommodation costs through a refundable accommodation deposit or a nonrefundable daily accommodation payment or a combination of both." [21]

Importantly the Report does deal with issues of concern, raised in their media release of 11 December 2015. For instance, under the heading *Areas of duplication, overlaps and inefficiencies in current activity*, the Report states:

"Programme objectives identified through the Stocktake do appear to have some duplication at a thematic level (i.e. workforce upskilling or recruitment) but the design varies quite significantly between these initiatives. ….Through consultations, ***inefficiencies described largely referred to programme or funding administration and processes****. This included burdensome reporting requirements and inflexible timing and eligibility criteria. In addition comment was made on the ineffective collection, management and utilisation of workforce activity, training, education, recruitment and retention data."* (page 14)

The Report also notes: "A*nalysis of the information captured within the Matrix indicates that a small proportion (approximately 3.7%) of Commonwealth Funded Aged Care Workforce Activities was directed toward, or involved aspects specific to regional, rural and remote service provision. Of the total reported funding across all Stocktake activity, approximately 7.9% was attributed to this theme."*(Page 17)

The Stocktake also reported that of the 109 Regional Training Organisations (RTOs) responding to a survey question *"Do you anticipate there to be a training or skills gap in the future?"*[22] , 86.2 per cent thought there would be. The survey pre-dates the Government's announced reduction in funding for aged care workforce support in MYEFO.

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[21] http://www.agedcare.org.au/publications/issues-facing-aged-care-in-rural-and-remote-australia Page 1.

[22] Appendix D, stocktake

Aged care and Aboriginal and Torres Strait Islanders – rural and remote Australia

The shortage of appropriate and accessible aged care options in rural and remote Australia is particularly acute for Aboriginal and Torres Strait Islander people. Tragically, the main reason that shortage is not worse is that the average life expectancy of Aboriginal and Torres Strait Islanders people remains so far below that of the broader population: 10.6 years less for males and 9.5 years less for females.[23] Fortunately, projections suggest the number of older Aboriginal people (55 and over) will more than double between 2006 and 2012 – from 40,000 to over 82,000. A substantially higher proportion of Aboriginal and Torres Strait Islander Australians live in rural and (particularly) remote Australia, meaning that finding appropriate care options can be especially difficult. These population trends - together with important issues of access, cultural safety, patient-centred care, connectedness to country and family and affordability - emphasise the need for urgent, concerted action to improve access, quality and capacity in this area. Ideally, this should occur in conjunction with effective developments in health care policy and services that are preventive and enable health ageing among Aboriginal and Torres Strait Islander people.

The Alliance is pleased to understand that initiatives relating to Aboriginal and Torres Strait Islander aged care workforce (as well as for dementia care) will not be affected by the decision to cut aged care workforce funding. The Alliance also notes and refers the Committee to the joint Submission to the Inquiry by the Australian Indigenous Doctors Association (AIDA), the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), Indigenous Allied Health Australian (IAHA) and the National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA) – Submission Number 104.

Nonetheless, broader cuts in aged care workforce funding will remove resources from areas of need where there continues to be high and growing unmet. This is likely to impact on Aboriginal and Torres Strait islander people directly and indirectly. A more considered approach would deliver greater coherence with other policy objectives – addressing workforce shortages in areas of need, improving skills and employment outcomes, and related benefits in terms of income, housing and health - to which governments profess a commitment.

However, for this to occur the government will need to consider advice from their Stocktake that "*Access to culturally appropriate and relevant Aboriginal and Torres Strait Islander workforce training, particularly in regional, remote and rural areas, was reported to be a significant impediment to attracting this group into aged and community care*". [24]

A Global, National and Local Issue

The challenges associate with structural population ageing and delivering aged care services into the future is not uniquely Australian. It is global. In fact, Australia has a relatively young population compared with many of the more developed nations, notably Europe and parts of Asia. This means there is real potential to prepare for and manage future demand and issues of sustainability in Australia comparatively well, notwithstanding the reality of the challenges we face.

As international aged care expert, Dr Robyn Stone, told the Aged and Community Services Australia (ACSA) Conference in September 2015 "*we are a very labour-intensive sector and*

[23] http://www.aihw.gov.au/indigenous-observatory/reports/health-and-welfare-2015/life-expectancy-and-mortality/
[24] https://www.dss.gov.au/ageing-and-aged-care/workforce-development-programs/stocktake-and-analysis-of-commonwealth-funded-aged-care-workforce-activities-final-report (page 21)

our workforce – our human capital- is what will make or break us, and make or break many countries over the next 25 to 30 years" [25]. Dr Stone also pointed to the tension between quality and cost – and suggested that attracting, retaining and improving the productivity of the workforce – through mechanisms such as increased task delegation and scope of practice among aged care workers - will be crucial to this. That suggestion, and the debates around it, are not new to Australia. Prior to being abolished in 2014 Health Workforce Australia was undertaking a stream of work to progress these issues[26]. As indicated previously, these are complex and serious issues, including the safe management of medications and the care of vulnerable people with complex multiple conditions. Quality of care and ensuring appropriate skills levels are very important considerations. With these in mind, it is difficult to reconcile the importance of workforce development and support to the future quality and sustainability of our aged care system and the magnitude of reductions in funding for that purpose.

Local 'evidence' – the impacts in communities

Statistical information and analysis is crucial, but *must* be complemented by a reasonably broad understanding of the impact of policy decisions and prevailing circumstances on the ground. Both are needed – and provide different, but equally valid, information.

The risks and shortcomings of considering one and not the other were made evident in the criticisms and protests – to go to another area of policy for illustrative purposes - around the proposed Murray-Darling Basin Plan in 2010. Chief among the concerns of many people living in Murray-Darling Basin communities was that the macro-analysis and oriented consultation process failed to take adequate account of what the impacts would be at a local level, where people and their families had lived and worked for generations. Macro-level considerations, often expressed in terms of 'averages', 'swings and roundabouts' and the like provided little comfort for people concerned about the loss of local employment and services even if it pointed to gains in both for communities many hundreds of kilometres away.

This is not to suggest that major change can or should be prevented, or that people living in rural and remote Australia are reluctant to embrace or cope with change. The challenges of industry change, weather and climate, global markets, demographic shifts attest to the resilience of people living in rural and remote Australia. It is of more concern when the very real impacts of change on communities are disregarded or 'lost' in the way data is 'cut' or in the process of budget preparations and trade-offs.

There are many local examples, and we encourage the Committee to seek these out and to give them proper attention in deliberating and preparing Recommendations from this Inquiry. The following example may help to demonstrate the local impacts of decisions made at a national level.

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[25] http://www.australianageingagenda.com.au/2015/09/04/aged-care-workforce-an-international-challenge-us-expert/

[26] http://www.hwa.gov.au/our-work/boost-productivity/aged-care-workforce-reform-program

Stanthorpe – Queensland

Stanthorpe is a town of just over 4,200 people situated in south east Queensland, around 220 kilometres south west of Brisbane. The Stanthorpe Nursing Home, with 35-40 beds, closed in December 2015. Local media[27] reported concerns about the closure, including that advice on the closure was only provided in late 2015 leaving little time for people to find alternative care arrangements for residents, make transitions and deal with nursing home job losses. The Alliance understands that other local aged care providers have assisted but not been able to fully cover the loss in places. As with all examples, there are complexities and local issues that need to be dealt with should be considered. While the Alliance is not in a position to understand the specific complexities or to relay them, there are some fundamental issues that suggest the circumstances of this rural community, the vulnerable residents of the aged care facility affected and others waiting to gain access; and to much-needed services that appear to have not been dealt with well. For instance:

- Supply and demand – the loss of over 35 residential aged care places in a town of around 4,200 is significant.
    - Stanthorpe has a relatively elderly population compared with the national population – over a third being 60 or older[28];
- Such disruption to vulnerable residents entails serious risks, especially when the timeframe between announcement and closure is tight, limiting options and adding stress to the transition process; and
- Local concern about the lack of notice suggests the adjustment timeframe was too short and/or the communication process was inadequate – something that presumably could be guarded against through regulation.
- The immediate impact in terms of aged care workforce includes personal disruption associated with the loss of a job, and the flow-on impacts to families and communities. More broadly, as evidence cited elsewhere in this submission indicates, it is often difficult to attract and retain staff in aged care facilities, especially in rural and remote Australia. Processes that are more disruptive than they need to be – for residents or staff – do little to attract or retain capable people in a sector[29].

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[27] For examples of local media coverage prior to the closure see: http://www.gattonstar.com.au/news/elderly-kicked-out-for-christmas/2823122/ and http://www.acsaqld.org.au/news/the-queensland-report/issue-46-24th-november-2015/churches-of-christ-care-expand-services-on-the-southern-downs

[28] According to (http://myboot.com.au/4380/Stanthorpe/demographics.aspx) 37.2% of Stanthorpe's residents are 60 or older; while (noting difference in age group) only 15% (of the population Australia-wide is aged 65 or older http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3235.0Main%20Features252014?opendocument&tabname=Summary&prodno=3235.0&issue=2014&num=&view

[29] For an elaboration of these issues please refer to the Submission by the Rural Health Workforce Agency to this Inquiry – Submission 133, available at http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Aged_Care_Workforce/Submissions

Concluding comments

Over 1000 delegates attended the 12th National Rural Health Conference in April 2013. The *Living Longer Living Better* legislation was being developed. The priority recommendations from the Conference included:

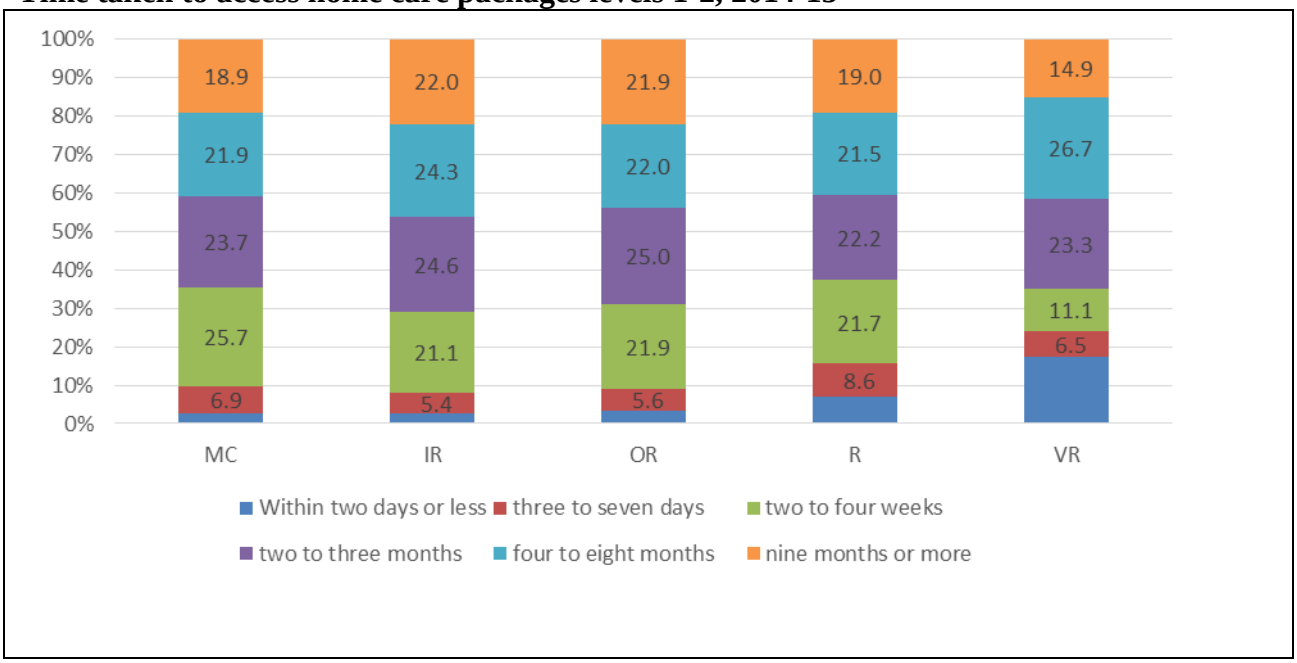
> *"Conference calls on the Living Longer Living Better legislation, with its focus on greater support for older people to live in their own homes and communities, to be adapted to closely address the particular vulnerabilities of older people living in rural and remote communities. These include higher costs of living, a higher proportion with low incomes, greater isolation, and greater exposure to adverse weather events (eg heat waves, fires and floods). Measures should include:*
>
> > *• rural seniors' fuel vouchers to compensate for poor access to public transport; and*
> >
> > *• 'safe at home' modifications that include timely access to falls prevention modifications, air conditioning, and reflective roofing.*
>
> *Pooled Commonwealth and State investment in aged and disability services should be considered in order to increase the potential for viable home services in under-served rural communities."*

The Alliance continues to advocate for policy and programs that address the particular challenges to healthy ageing and aged care in rural areas: higher costs; and the availability of staff. The Alliance continues to have concerns about the extent to which the existing system accommodates the particular cost challenges of providing aged care services in rural and remote areas.

APPENDIX 1

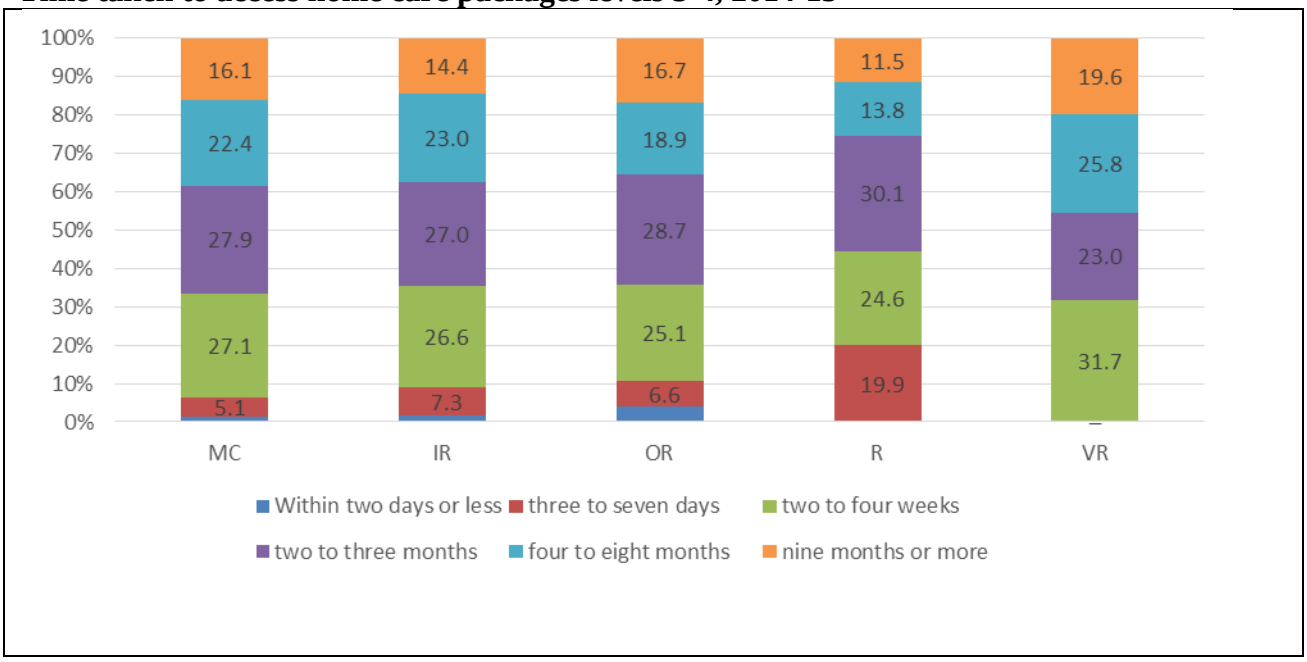
TIME TAKEN TO ACCESS HOME CARE PACKAGES – LEVELS 1-2 & 3-4

Time taken to access home care packages levels 1-2, 2014-15



Source http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/community-services/aged-care-services#indigenous-data Table 13A.36

Time taken to access home care packages levels 3-4, 2014-15



Source http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/community-services/aged-care-services#indigenous-data Table 13A.36

APPENDIX 2

Member Bodies of the National Rural Health Alliance

ACEM (RRRC)	Australasian College of Emergency Medicine (Rural, Regional and Remote Committee)
ACHSM	Australasian College of Health Service Management
ACM (RRAC)	Australian College of Midwives (Rural and Remote Advisory Committee)
ACN (RNMCI)	Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANMF	Australian Nursing and Midwifery Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRPIG)	Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CRANAplus	CRANAplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
ESSA (RRIG)	Exercise and Sports Science Australia (Rural and Remote Interest Group)
FRAME	Federation of Rural Australian Medical Educators
HCRRA	Health Consumers of Rural and Remote Australia
IAHA	Indigenous Allied Health Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group
PSA (RSIG)	Rural Special Interest Group of the Pharmaceutical Society of Australia
RACGP - Rural	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Royal Flying Doctor Service
RHWA	Rural Health Workforce Australia
RIHG of CAA	Rural Indigenous and Health interest Group of Chiropractors' Association of Australia
ROG of OA	Rural Optometry Group of Optometry Australia
RPA	Rural Pharmacists Australia
SARRAH	Services for Australian Rural and Remote Allied Health
SPA (RRMC)	Speech Pathology Australia (Rural and Remote Member Community)