

Chapter One

Introduction

1.1 The aged care sector has experienced the impacts of significant changes in recent years. These changes range from the ageing of the Australian population and the corresponding ageing of the workforce, the increased use of technology in service delivery, the increased complexity of health needs of individuals entering aged care, and the shift in policy approaches to aged care, with much service delivery now occurring at home to allow people to 'age in place' for longer rather than enter institutions at the first sign of age-related frailty. All of these developments are placing significant pressure on the aged care workforce.

1.2 At the same time, the funding model for aged care has shifted from a model where service delivery organisations were directly funded by government through 'block funding', to a market-based model, where consumers of services exercise greater control over how funding is spent. In this new approach, eligible individuals are largely able to choose for themselves what services they need and the organisations or individuals they wish to deliver those services, via the new Consumer Directed Care (CDC) model of service delivery.

1.3 A similar change to disability service funding, via the introduction of the National Disability Insurance Scheme (NDIS), has also seen impacts in the disability sector. In addition, the rollout of the NDIS adds to pressures on the aged care workforce as the need for more staff grows across both the disability and aged care sectors.

1.4 The focus of this inquiry has been to ensure scrutiny is also placed on the aged care service sector, which, like the disability service sector, is responsible for the direct care of vulnerable Australians. This inquiry was undertaken to review the current frameworks under which aged care providers recruit, train and retain their workforce, and to anticipate the impact of current and expected changes to the aged care service sector, and the workforce which will be needed to deliver those services in the years to come.

Terms of reference

1.5 The terms of reference for this 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.

Report structure

1.6 This report is divided into five chapters:

- **Chapter 1** provides a background to the committee's inquiry and an overview of the changing Australian aged care sector and the composition of the workforce. The chapter also reviews the role of government in developing workforce strategies.
- **Chapter 2** examines the changing environment in which the aged care workforce operates, including new service delivery models, increasing use of technology and the increasingly complex needs of people entering the aged care system.
- **Chapter 3** examines the challenges in attracting, training and retaining aged care workers.
- **Chapter 4** examines the increasing diversity of aged care users, and the associated challenges in regional and remote community service delivery, and the challenges faced by organisations in delivering a culturally competent service both in regional and urban locations.
- **Chapter 5** concludes the committee's consideration and makes recommendations for further consideration.

The changing aged care sector

1.7 The aged care sector is undergoing significant changes. The Australian population is ageing, and at the same time the aged care user cohort is becoming more diverse, with greater disparity in health status, disability, location, cultural and language needs, sexual orientation and gender identification. These changes are placing increasing pressure on the workforce not only to meet the overall increased numbers of aged care recipients, but to have the specialised skills needed to meet the increasing diversity of service needs. This following section will outline the key changes occurring in the aged care sector by overall population, and the diversity of specialised service needs.

Increasing aged care service users

1.8 As at 30 June 2016, 15 per cent of Australia's population was aged 65 years and over (3.7 million people) and 2 per cent were aged 85 years and over (488,000 people). By 2026, it is estimated that 18 per cent of the population will be aged 65 years and over (5.0 million people) and 2.3 per cent (644,000 people) will be 85 years and over.¹

1.9 By 2055, the proportion of Australians over 65 will increase to 22.9 per cent (8.9 million) of the total population.² The number of Australians receiving aged care is projected to increase by around 150 per cent over the next 40 years.³

1.10 In 2009-10, around 616 000 people aged 70 years or older received home and community care services (HACC).⁴

1.11 Between 1999 and 2011, the number of people moving into residential aged care in Australia increased by 25 per cent, with the largest growing group being those over 85 years of age. In 2014, 82 per cent of permanent aged care residents required high-level care.⁵

1.12 Department of Health data shows that in 2015-16:

- Over 1.3 million older people received some form of aged care:
 - More than 640,000 older people received home support through the Commonwealth Home Support Programme (CHSP);
 - 285,432 older people received support through the Commonwealth-State HACC program (Victoria and WA);
 - 56,852 people received residential respite care;

1 Department of Health, *2015-16 Report on the Operation of the Aged Care Act 1997*, 2016, p. 6.

2 Australian Government, *2015 Intergenerational Report*, March 2015, pp vii–viii.

3 Productivity Commission, *Caring for Older Australians*, Report No. 53, v.2, 2011, p. 2.

4 Productivity Commission, *Caring for Older Australians*, Report No. 53, v.1, 2011, p. xxvi.

5 Dr Deirdre Marie Anne Fetherstonhaugh, Director, Australian Centre for Evidence Based Aged Care, La Trobe University, *Committee Hansard*, 28 April 2016, p. 26.

- 88,875 people received care through a home care package;
- 234,931 people received permanent residential aged care.
- the average age on entry for new admissions to permanent residential aged care was 82.0 years for men and 84.5 years for women; and
- around 50 per cent of all residential aged care residents had a diagnosis of dementia.⁶

Aged care in rural and remote communities

1.13 The committee notes that there are particular challenges for the delivery of aged care in rural and remote areas. Thirty one per cent of older Australians live in inner and outer regional areas, and approximately 1.5 per cent of all Australians aged 65 years or older live in remote or very remote areas.⁷

1.14 The proportion of older Australians in aged care in rural and remote areas varies across the states and territories. In 2013–14, 30 per cent of people in permanent residential aged care were located in rural or remote areas: fewer than one per cent (0.7 per cent) in remote or very remote areas and 30 per cent in inner and outer regional areas.⁸ In New South Wales, Victoria, South Australia and Western Australia, fewer than 30 per cent of permanent aged care residents were in facilities in rural or remote areas; in Queensland the proportion was 35 per cent.⁹ In the Northern Territory and Tasmania, all people in permanent residential aged care were located in areas categorised by the Australian Bureau of Statistics as regional or remote areas.¹⁰

1.15 In remote and very remote areas, aged care service provision may be delivered by a very limited number of organisations, and in some cases by just one provider. Local government is a key aged care service provider in remote and very remote locations. For example, the MacDonnell Regional Council is the only provider of disability and aged care services in eight remote Aboriginal and Torres Strait Islander communities in Central Australia.¹¹

1.16 The Australian Institute of Health and Welfare (AIHW) has noted:

6 Department of Health, 2015-16 [Report on the Operation of the Aged Care Act 1997](#), 2016, pp. xiii-xiv.

7 Australian Institute of Health and Welfare, [Diversity in aged care](#), accessed 31 May 2017.

8 Australian Institute of Health and Welfare, [Diversity in aged care](#), accessed 24 May 2017.

9 30 per cent of people in New South Wales and Victoria; 35 per cent in Queensland, 23 per cent in South Australia and 17 per cent in Western Australia. Australian Institute of Health and Welfare, [Diversity in aged care](#), accessed 24 May 2017.

10 This reflects these jurisdictions' overall remoteness status, with no areas classified as *Major cities*. Australian Institute of Health and Welfare, [Diversity in aged care](#), accessed 24 May 2017.

11 Mr Rohan Marks, Director, Community Services, MacDonnell Regional Council, *Committee Hansard*, 26 October 2016, p. 1.

People who live in rural or remote areas face additional difficulties in accessing health and ageing related services. Rural and remote areas have fewer services available, particularly in close proximity to where people live, and the services that do exist may not be attainable, for example, due to cost or lack of transport. In addition, service providers in rural or remote areas face challenges in service provision: the costs of building and operating facilities are higher, and there are fewer skilled workers available.¹²

Aboriginal and Torres Strait Islander peoples in aged care

1.17 Aged care service delivery to Aboriginal and Torres Strait Islander peoples has differing challenges from mainstream service delivery, not only based on the need to deliver a culturally competent service, but also because the demographics, health profiles and locations of these service users differ significantly from the non-Indigenous population.

1.18 In 2014-15, 34 283 Aboriginal and Torres Strait Islander people accessed residential aged care (2 279), Home Care (2 214) and Home and Community Care (29 552), and 800 people accessed services through the Aboriginal and Torres Strait Islander Flexible Aged Care program. In 2015-16, Aboriginal and Torres Strait Islander peoples accessed the majority of residential places and home care packages in remote and very remote locations.¹³

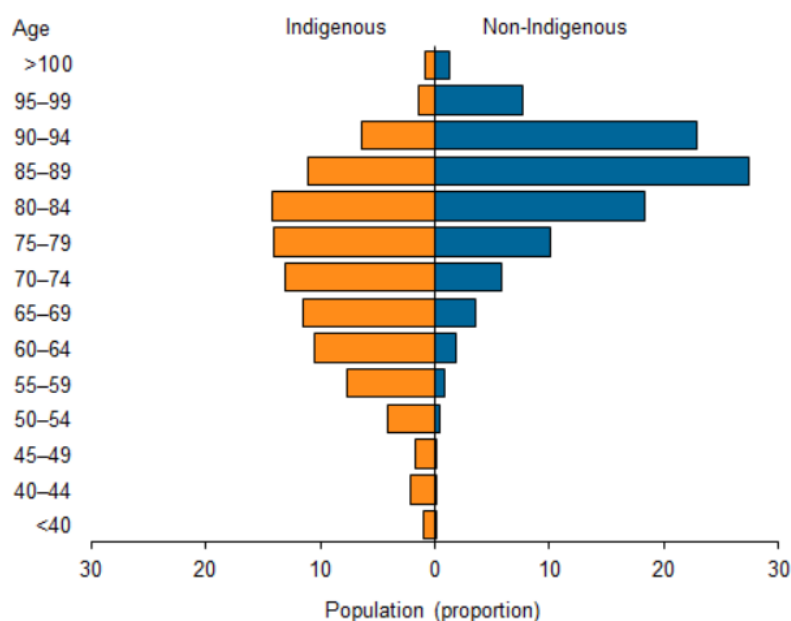
1.19 The committee notes that the age distribution of Aboriginal and Torres Strait Islander peoples in aged care differs from the non-Indigenous population, with a younger age structure and shorter life expectancy. The average life expectancy of the general population is about 73 years for women and 69 years for men. Due to generally poorer health, conditions associated with ageing may affect Aboriginal and Torres Strait Islander peoples earlier than non-Indigenous people. Owing to these factors, aged care planning includes the Aboriginal and Torres Strait Islander population aged 50 and over, rather than 70 and over as with the non-Indigenous population.

1.20 In general, the age profile of Aboriginal and Torres Strait Islander peoples in residential facilities was substantially younger than that of non-Indigenous people (Figure 1.1).

12 Australian Institute of Health and Welfare, [Diversity in aged care](#), (accessed 24 May 2017).

13 Australian National Audit Office, [Indigenous Aged Care](#), ANAO Report No. 53 of 2016/17, p 23.

Figure 1.1: People in residential aged care, by age group as a proportion of population by Indigenous status, at 30 June 2014.



Source: AIHW National Aged Care Data Clearinghouse. [Data table \(386KB XLS\)](#).

Source: Australian Institute of Health and Welfare, [Indigenous people in aged care](#) webpage, (accessed 23 December 2015).

1.21 In all groups aged under 85 years, Aboriginal and Torres Strait Islander peoples used residential aged care at higher rates than non-Indigenous people of the same age (Table 1.1).

Table 1.1: Age and sex specific usage rates for people in residential aged care by Indigenous status, at 30 June 2014 (per 1,000 population)

Age group	Indigenous Males	Indigenous Females	Indigenous Persons	Non-Indigenous Males	Non-Indigenous Females	Non-Indigenous Persons
<50	0.2	0.1	0.1	0.0	0.0	0.0
50-54	2.3	1.4	1.8	0.5	0.6	0.5
55-59	4.0	4.6	4.3	1.2	0.9	1.1
60-64	9.1	7.2	8.1	2.7	2.2	2.5
65-69	14.2	13.1	13.6	5.8	5.1	5.4
70-74	27.3	23.6	25.3	12.0	12.3	12.2
75-79	36.9	56.6	47.9	24.7	31.5	28.3
80-84	69.7	95.5	84.8	55.0	82.9	70.7
≥ 85	155.3	235.5	207.6	149.6	264.2	222.8
Total	1.7	2.3	2.0	4.7	10.3	7.5

Sources: AIHW National Aged Care Data Clearinghouse; ABS 2014 [1]. [Data table \(386KB XLS\)](#).

Source: Australian Institute of Health and Welfare, [Indigenous people in aged care webpage](#), (accessed 23 December 2015).

1.22 A higher proportion of Aboriginal and Torres Strait Islander aged care residents are located in remote or very remote facilities across Australia than non-Indigenous aged care residents. In New South Wales and Victoria, however, where

there are no aged care facilities in remote or very remote areas, all aged care residents are in urban or regional aged care facilities.¹⁴

Culturally and linguistically diverse (CALD) community in aged care

1.23 A key diversity challenge for the aged care sector is service delivery to CALD communities. As outlined below, the proportion of older Australians from CALD backgrounds is increasing, and, like Aboriginal and Torres Strait Islander peoples, they utilise aged care services differently to Australian-born aged care service users.

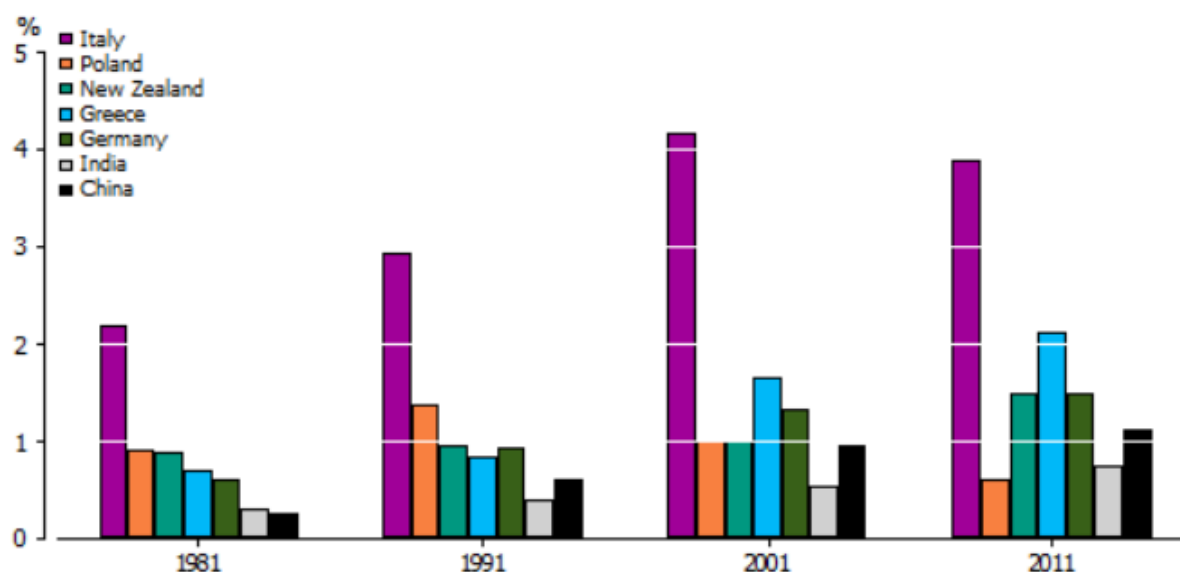
1.24 In 2011, 36 per cent of older Australians were born overseas, with 22 per cent from 'non-main English speaking countries'.¹⁵ The older population of Australia comes from a diverse range of countries, which is expected to continue into the future (Table 1.2). The Australian Bureau of Statistics examined the birthplace of the 0–64 age group in the 2011 Census and reported: older Australians are more likely to be born in Australia, many as second generation Australians the United Kingdom and Europe are becoming much less dominant sources of immigrants, with strengthening proportions from India and Sri Lanka, Lebanon, Vietnam, the Philippines, Malaysia, China, Hong Kong, South Africa, New Zealand and other countries in the region.¹⁶

14 Australian Institute of Health and Welfare, [Indigenous people in aged care](#) (accessed 23 December 2015).

15 Australian Bureau of Statistics, [Who are Australia's Older People?, Reflecting a Nation: Stories from the 2011 Census](#), 2012, (accessed 22 December 2015).

16 Australian Bureau of Statistics, [Who are Australia's Older People?, Reflecting a Nation: Stories from the 2011 Census](#), 2012, (accessed 22 December 2015).

Table 1.2: Older persons born overseas, countries of birth, 1981, 1991, 2001 and 2011(a)(b)



(a) Leading countries of birth, excluding Australia and the UK.

(b) Calculated as a proportion of the total population aged 65 years and over.

Source: Australian Bureau of Statistics, [Who are Australia's Older People?, Reflecting a Nation: Stories from the 2011 Census](#), 2012, (accessed 22 December 2015).

1.25 The number of older Australians from CALD backgrounds is expected to increase in future decades, in line with the overall increase in the older population. In a 2001 study, the Australian Institute of Health and Welfare forecast:

Between 2011 and 2026 the number of people aged 65 and over from culturally and linguistically diverse backgrounds is projected to increase from 653,800 to 939,800, a growth rate of 44% over the 15-year period. At the same time, the number of Australian-born people aged 65 and over is projected to increase by 59%. Older persons from culturally and linguistically diverse backgrounds are projected to account for 22.5% of the older Australian population at the beginning of the period, and 21.2% at the end.

Between 2011 and 2026 the proportion of the culturally and linguistically diverse background population that is aged 80 and over is projected to increase from 25.9% (compared with 27.5% for the Australian-born) to 28.7% (compared with 22.4% for the Australian-born). The older population from culturally and linguistically diverse backgrounds thus ends the projection period with a considerably older population profile than the Australian-born, having begun it with a considerably younger one.

The numbers for those aged 80 and over are projected to increase from 169,500 to 269,600 (a 59% increase compared with 29% in the Australian-born population). The proportion of people aged 80 and over who are from culturally and linguistically diverse backgrounds is projected to change

from 21.8% to 25.2%. By 2026, then, one in every four people aged 80 and over will be from culturally and linguistically diverse backgrounds.¹⁷

1.26 The cultural and linguistic diversity of older Australians is an important consideration in the planning and delivery of appropriate aged care services. Diversity may be reflected in a number of ways, such as:

- attitudes to the elderly, expectations of family care giving, roles of women and support groups, and beliefs about health and disability;
- beliefs, practices, religions, behaviours and preferences which can affect the propensity to use formal care services; and
- English language proficiency, which can affect access to information and services, communication of needs and participation in the wider community.¹⁸

1.27 As a result, the use of aged care services by older Australians from CALD backgrounds is different than that for many other older Australians, with variation across programs, age groups and countries of birth (Table 1.3). In general, people born in 'non-main English speaking countries' have higher usage rates of non-residential care.¹⁹

17 Australian Institute of Health and Welfare, [*Projections of Immigrants, People from culturally and linguistically diverse backgrounds, 1996–2026, Australia*](#), Department of Health and Aged Care, May 2001, p. xviii, (accessed 22 December 2015).

18 Productivity Commission, [*Caring for Older Australians*](#), Inquiry Report No. 53, 28 June 2011, Vol 2 p. 246, (accessed 21 December 2015).

19 Australian Institute of Health and Welfare, [*Cultural and linguistic diversity measures in aged care, Working Paper*](#), 2014, p. 8, (accessed 22 December 2015).

Table 1.3: Use of selected aged care programs, by country of birth^(a) and age, 2010–11 (clients per 1,000 population)

Program	Overseas-born								
	Main English-speaking countries ^(b)			Non-main English-speaking countries			Australian-born		
	65–74	75–84	85+	65–74	75–84	85+	65–74	75–84	85+
HACC	73.5	266.9	469.7	101.5	296.2	511.1	111.8	322.9	482.5
ACAP	9.7	59.1	168.3	10.7	56.6	147.0	3.1	65.4	164.6
CACP ^(c)	2.3	13.8	43.6	3.3	18.0	49.9	3.9	15.7	39.6
EACH & EACHD ^(c)	1.1	3.6	10.3	1.1	4.6	12.7	1.1	3.5	7.4
Permanent residential care ^(c)	6.3	44.8	232.9	6.6	41.2	191.8	10.2	53.8	233.5

(a) Country of birth population data used for the calculation of rates are based on ABS data for 2010. The data were pro-rated from 2010 by 5-year age groups using 2011 total estimated resident population.

(b) Main English-speaking countries are the United Kingdom, Ireland, New Zealand, Canada, the United States of America and South Africa.

(c) Data for CACP, EACH, EACHD and permanent residential aged care are at 30 June 2011.

Note: Packaged care provided under CACP, EACH and EACHD was replaced with the Home Care Packages Program on 1 August 2013, for which data are not yet available.

Source: AIHW 2013c (AIHW analysis of unpublished data from the then DoHA Ageing and Aged Care data warehouse (October 2012); AIHW analysis of unpublished Aged Care Assessment Program data from then DoHA; AIHW analysis of the NSW HACC State Data Repository and the HACC MDS National Data Repository).

Source: Australian Institute of Health and Welfare, [Cultural and linguistic diversity measures in aged care](#), Working Paper, 2014, p. 8, (accessed 22 December 2015).

1.28 Some CALD communities receive aged care services from providers, who have tailored services to particular groups. However, the majority of older Australians from CALD backgrounds access mainstream aged care services.²⁰

Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) community in aged care

1.29 Many older LGBTI people have experienced discrimination over the course of their lives on account of their sexual orientation and/or gender identity. This discrimination can continue in aged care services, if older LGBTI Australians are not recognised and supported in policy and practice.

1.30 At present, there is no data on the number and distribution of older LGBTI Australians. However, it has been estimated that, in line with Australia's growing ageing population, the number of older LGBTI Australians aged 65 years and over is expected to reach 500 000 people by 2051.²¹

20 Productivity Commission, [Caring for Older Australians](#), Inquiry Report No. 53, 28 June 2011, Vol 2 p. 247, (accessed 21 December 2015).

21 GLBTI Retirement Association Incorporated and Curtin Health Innovation Research Institute, [Best practice guidelines, Accommodating older gay, lesbian, bisexual, trans and intersex \(GLBTI\) people](#), p. 2, (accessed 21 December 2015).

1.31 The 2016 Aged Care Workforce Survey found that:

- 11 per cent of residential aged care facilities cater for LGBTI residents; and
- of the 25 per cent of residential aged care facilities that cater for a specific ethnic or cultural group, 44 per cent cater for LGBTI residents.²²

1.32 There has been a significant increase in the proportion of home care and home support service providers providing specialised services who now also cater for LGBTI clients: in 2012, just one per cent of this group catered for LGBTI clients; in 2016, this had risen to almost 41 per cent.²³

Current composition of the aged care workforce

1.33 Just as the ageing population has changed in size and diversity, the demographics of the workforce have also been shifting.

1.34 The aged care workforce consists of a variety of employment types, including:

- paid direct care workers, including personal care workers and health care professionals;
- paid non-direct care workers, including managers and ancillary staff;
- agency, brokered or self-employed staff; and
- unpaid volunteers and informal carers.²⁴

1.35 Latest research shows that the aged care workforce is predominately female, has a higher than average median age, is largely employed on a permanent part-time basis, and is disproportionality represented by Personal Care Attendants (PCAs).²⁵

1.36 The main source of data on the aged care workforce is the National Aged Care Workforce Census and Survey (NACWCS), conducted by the National Institute of Labour Studies (NILS) at Flinders University, on behalf of the Australian Department of Health. The NACWCS is conducted every four years and collects comprehensive data on the profile of, and identifies prevailing trends in, the aged care workforce.²⁶

22 National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, p. 53.

23 National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, p. 119.

24 The Department of Health defines the aged care workforce as 'the formal workforce of the providers and services that offer Australian Government subsidised aged care through Home Support, Home Care Packages, residential aged care, veterans' home care and flexible care'. See: Department of Health, *Submission 293*, p. 5.

25 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, pp. xviii; 160 .

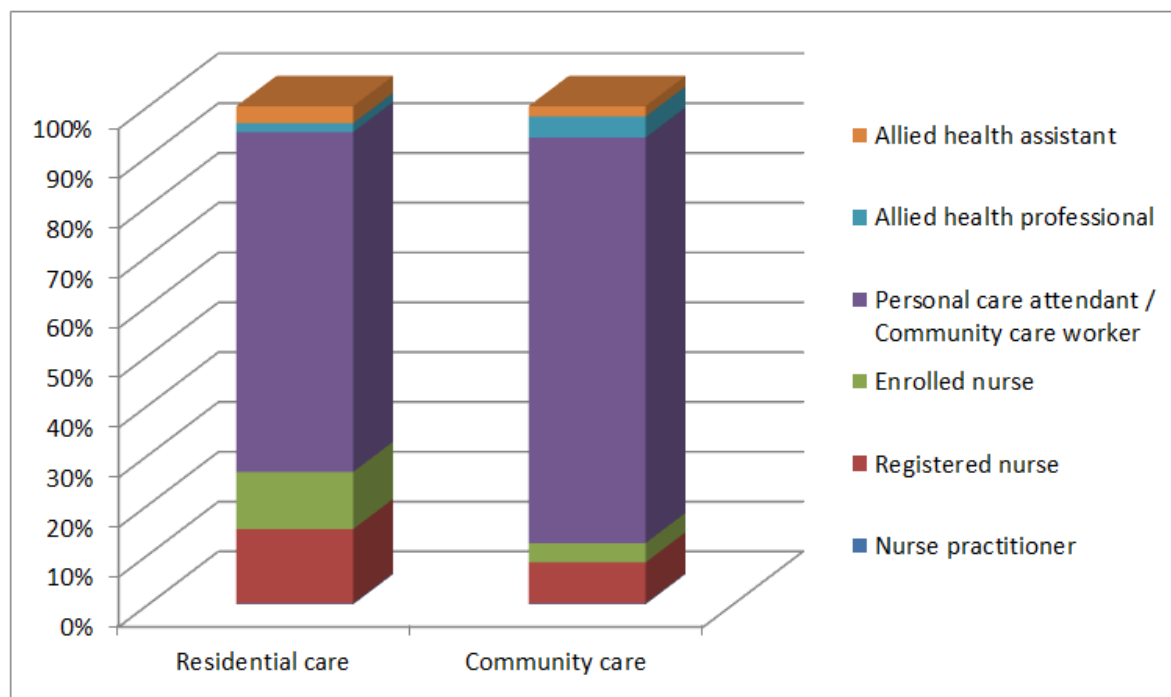
26 Previous reports were published in 2003, 2007 and 2012.

The Aged Care Workforce, 2016, published in March 2017, contains the most recent information and data.²⁷

Direct care workers

1.37 In 2016, there were an estimated 235 764 workers in residential care and 130 263 workers in home care and home support.²⁸ The majority of these workers were employed in direct care roles.²⁹

Figure 1.2: Direct care workforce, residential and community care, by occupational group, 2016



Source: National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, Department of Health, Table 3.2, Table 5.2.

1.38 Figure 1.2 shows that personal care attendants (PCAs)/community care workers (CCWs) are the largest occupational group in the home care and home support sector, representing nearly 84 per cent of workers.

1.39 Figure 1.2 also shows that, in 2016, PCAs constituted the majority of the residential direct care workforce, whereas Registered Nurses (RNs) and Enrolled

27 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health.

28 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 160.

29 The National Institute of Labour Studies defines the direct care workforce to include 'Nurse Practitioners (NP), Registered Nurses (RN), Enrolled Nurses (EN), Personal Care Attendants (PCA)/Community Care Workers (CCW), Allied Health Professionals (AHP) and Allied Health Assistants (AHA)'. See National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 158.

Nurses (ENs) constituted a comparatively small proportion. Since 2012, PCAs working in aged care have continued to increase both numerically and proportionally. In contrast, the proportion of nurses in residential aged care has declined.

1.40 Several submitters expressed concern that the number of qualified staff, particularly nurses, working in aged care is declining.³⁰ However, latest research appears to show that while the proportion of qualified nursing staff in residential direct care roles has remained relatively steady, their numbers (with the exception of ENs) have increased since 2012.³¹ The same trends have not been observed in the home care and home support sector however, with latest data showing that qualified nursing staff has declined numerically and proportionally since 2012.³²

Volunteers

1.41 Volunteers are significant contributors to the aged care workforce, with 83 per cent of residential facilities and 51 per cent of home care and home support outlets utilising volunteer staff. Several submitters argued that volunteers have a crucial role in the workforce, and that future challenges cannot be faced without their continued and increasing support.³³ The role, services provided by, and future challenges impacting volunteers is discussed in greater detail in chapter 2.

Allied Health Professionals

1.42 Allied Health Professionals (AHPs) represent a comparatively small proportion of the workforce (particularly in residential care).³⁴ Some submitters argued that AHPs are currently being underutilised, but will increasingly be required to meet the complex needs of older people in care.³⁵ The role of AHPs in helping to meet future workforce demands is discussed further in chapter 2.

30 See, for example: Australian Medical Association, *Committee Hansard*, 3 November 2016, p. 17; Palliative Care Nurses Australia, *Committee Hansard*, 3 November 2016, p. 27; Alzheimer's Australia, *Committee Hansard*, 3 November 2016, p. 28; NSW Nurses and Midwives' Association, *Committee Hansard*, 3 November 2016, p. 48.

31 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016, 2017*, Department of Health, Table 3.2, p. 13.

32 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016, 2017*, Department of Health, Tables 5.2, 5.3, p. 70.

33 See for example: Volunteering Tasmania, *Committee Hansard*, 31 October 2016, pp. 3-4, 6; Volunteering SA and NT Inc, *Committee Hansard*, 7 March 2017, p.34; Carers Australia, *Submission 269*, p. 3; Volunteering Victoria, *Submission 272*, p. 3; Australian Association of Gerontology, *Submission 217*, p.2.

34 See: Services for Australian and Remote Allied Health, *Submission 238*, p. 4-5.

35 See for example: Exercise and Sports Science Australia, *Submission 35*, p. [1]; Allied Health Professions Australia, *Submission 208*, p. 1; Occupational Therapy Australia, *Submission 282*; Services for Australian and Remote Allied Health, *Submission 238*, p. 4-5.

Characteristics of the aged care workforce

1.43 The average aged care worker is likely to be:

- female (88 per cent);
- older (49 years old); and
- located in a major city (around 2/3 of all workers).

1.44 Females represent the highest proportion of workers, accounting for 87 per cent in the residential care sector, and 89 per cent in the home care and home support sector in 2016. However, the proportion of males in the residential aged care workforce has grown from 7 per cent in 2007 to 13 per cent in 2016. The proportion of males in the home care and home support sector has not changed significantly since the collection of data began in 2007.³⁶

1.45 The latest iteration of the NACWCS found that the median age of the residential direct care age workforce has decreased from 48 years in 2012 to 46 years in 2016. However, the median age of home care and home support workers continues to grow, increasing from 50 years in 2012, to 52 years in 2016. Similar trends have also been observed for recently hired employees in both sectors.³⁷

1.46 Consistent with evidence received by the committee, the majority of the workforce is located in major cities, with about one third located in regional areas.³⁸

1.47 A substantial proportion of aged care workers are overseas-born. However, the overall proportion of the workforce born overseas has reduced since 2012 to 32 per cent and 23 per cent in residential and home care respectively. Despite this latest trend, the proportion of recently hired employees in the residential sector that are overseas-born has continued to increase.³⁹

1.48 By comparison, Aboriginal and Torres Strait Islander people account for a very small proportion of the workforce, representing around one to two per cent of the total workforce.⁴⁰

36 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 160.

37 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 160.

38 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 158.

39 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 160.

40 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 160.

The role of governments in aged care

1.49 The Australian Government's role in the provision of aged care services in Australia is in setting the regulatory framework and providing the majority of funding to support aged care providers.⁴¹

1.50 At the federal level, aged care is administered by the department and governed by the *Aged Care Act 1997* and associated *Aged Care Principles*.⁴² Aged care services in Australia are delivered by a range of not-for-profit (religious, charitable, and community) and for-profit organisations, and state/local government providers. The department provides funding to a large number of these providers through various funding packages.⁴³

1.51 The main programs funded by the department in the residential and community based care sector include:

- Residential aged care:
 - Permanent care: ongoing care in a residential aged care facility.
 - Respite care: temporary short-term care in a residential aged care facility.
- Community based care:
 - Commonwealth Home Support Program (CHSP): entry-level home-based support services.
 - Home Care Packages Programme: for more complex, coordinated and personalised home-based care.⁴⁴

1.52 Australian Government funding represents the highest proportion of revenue for aged care providers. In 2014-15, the Australian Government spent 15.2 billion on aged care.⁴⁵ In 2015-16, Australian Government expenditure on aged care was \$16.2 billion, of which \$11.4 billion was for residential aged care.⁴⁶

41 Department of Health, *Submission 293*, p. 10.

42 Department of Health, *Submission 293*, p. 7.

43 In 2014-15, the Australian Government's contribution to total revenue for aged care providers was: 65 per cent for residential aged care, 92 per cent for home care and 95 per cent for home support. See: Department of Health, *Submission 293*, p. 10.

44 Australian Institute of Health and Welfare, [Aged Care](#), (accessed 11 May 2017).

45 Department of Health, *Submission 293*, p. 10.

46 Department of Health, 2015-16 [Report on the Operation of the Aged Care Act 1997](#), 2016, p. xiii.

1.53 The majority of aged care providers across all types of care are not-for-profit organisations, with smaller proportions delivered by for-profit and state, territory and local governments.⁴⁷

1.54 In its 2017-18 Budget the Government announced that it will extend funding arrangements for the CHSP and Regional Assessment Services for a further two years.⁴⁸ More recently, the Government announced increased funding of \$649 million per year to provide an additional 9911 new aged care places in the 2016-17 Aged Care Approvals Round, with 2719 places reserved for services outside metropolitan areas. Of the total places being made available 75% are reserved for the development of new aged care services, including existing service providers establishing new dementia specific units. An additional \$64 million funding for capital grants is available to assist organisations establish new, or upgrade existing, facilities required to deliver their new aged care services.⁴⁹

Role of State and Territory governments

1.55 Under the 2011 Council of Australian Government's (COAG) *National Health Reform Agreement*, the Australian Government agreed to assume 'full funding, policy, management and delivery responsibility' for aged care services.⁵⁰ Separate agreements were negotiated with Victoria and Western Australia, where some home support services continue to be funded under the joint state/Commonwealth Home and Community Care (HACC) program, with plans to transition to the Commonwealth program at a later date.⁵¹

1.56 However despite the transition to full Commonwealth funding, it is clear from evidence received by the committee that state and territory governments continue to play an important role in the funding and delivery of aged care services.⁵²

1.57 For example, Queensland Health submitted that it provides 'about five per cent of residential aged care places, the majority of flexible community and residential aged care places...and a limited number of Home Care Packages and Commonwealth Home Support program services'.⁵³

47 In 2013-14, not-for-profit organisations accounted for 52 per cent of residential care, 69 per cent of home care and 74 per cent of home support aged care providers. See: Aged Care Financing Authority, [Report on the Funding and Financing of the Aged Care Industry](#), July 2015, p. xi.

48 Commonwealth of Australia, *budget Measures: Budget Paper No. 2 2017-18*, p. 123.

49 The Hon Ken Wyatt AM, Minister for Aged Care, [Media Release](#), 26 May 2017, (accessed 29 May 2015).

50 Council of Australian Governments, [National Health Reform Agreement](#), (accessed 12 May 2017).

51 See: Department of Health, [Commonwealth HACC Program](#), (accessed 12 May 2017).

52 See, for example: Queensland Government, *Submission 227*, p. 2.

53 Queensland Health, *Submission 227*, p. 2.

Role of local government

1.58 The committee received evidence that local governments play an important role in the delivery of aged care services, particularly in regional and remote areas.

1.59 The Local Government Association of the Northern Territory (LGANT) submitted that aged care services in remote Indigenous communities in the Northern Territory (NT) are provided under contract by a number of regional councils, which are 'cost sensitive' and rely on flexible funding arrangements to support their workforce.⁵⁴ LGANT noted that 'regional councils are well placed to provide a long term and accountable option for the delivery of Commonwealth programs and currently do so...'⁵⁵ At the committee's hearing in Darwin, LGANT suggested that regional councils, rather than for-profit providers are better placed to deliver aged care services in remote areas of the NT, as it is not generally viable for for-profit providers to deliver such services.⁵⁶

1.60 In Victoria, local government also has an important role as the main provider of community care through the HACC program.⁵⁷ Some Victorian local government agencies suggested that greater funding will be needed to assist with the transition of the HACC program to the Commonwealth from 2019.⁵⁸

Australian Government funded aged care workforce measures

1.61 This section examines the role government currently plays in funding and developing aged care workforce measures, and the role it should have in developing any future national strategy.

1.62 The Australian Government funds a range of measures to support the aged care workforce.⁵⁹

1.63 In 2015, the Australian Government commissioned the *Stocktake and analysis of Commonwealth funded aged care workforce activities*, which examined 54 workforce specific activities that received funding between 2011-12 and 2013-14. The stocktake found:

- the majority of Commonwealth funding was directed toward workforce training, education and upskilling;

54 Local Government Association of the Northern Territory, *Submission 241*, p. 1.

55 Local Government Association of the Northern Territory, *Submission 241*, p. 1.

56 Local Government Association of the Northern Territory, *Committee Hansard*, 25 October 2016, p. 18.

57 Municipal Association of Victoria, *Submission 268*, p. 1.

58 See, for example: Australian Services Union, *Submission 255*, p. 8; Municipal Association of Victoria, *Submission 268*, p. 3.

59 Since 2004, successive Australian governments have introduced a range of measures to develop the aged care workforce. Some of the major initiatives include the Living Longer, Living Better initiative, Aged Care Workforce Fund and the National Aged Care Workforce Strategy.

- consideration should be given to supporting workforce planning strategies, leadership development, regional and remote services, carers and volunteers; and
- program effectiveness needs to be better designed, measured, demonstrated and shared through evaluation with input from the aged care sector.⁶⁰

1.64 Some submitters expressed concerns about recent changes to the funding and structure measures for aged care, particularly the Aged Care Workforce Fund (ACWF).⁶¹

1.65 The ACWF was introduced in 2011 to provide a flexible funding pool for initiatives aimed at improving the quality of aged care, by developing the skills of the aged care workforce. The ACWF:

- provides access to training, education and other supports (such as scholarships for nurses and financial support for aged care providers to provide training places); and
- provides targeted training and development strategies for priority groups, including for Aboriginal and Torres Strait Islander peoples.

1.66 In 2015, the government announced that the ACWF would be combined with the Rural Health Outreach Fund and the Health Workforce Fund into a single Health Workforce Programme.

1.67 The department submitted that:

The merging of funds will enable the Government to develop and drive workforce change across the health and aged care sectors that will in turn benefit ageing Australians.

As part of the integration, Government support for aged care-specific workforce activities will be integrated into health workforce programs already available. In line with the Government's high prioritisation of Indigenous employment issues, it will continue to provide significant support and funding for workforce activities to provide access to health and aged care services for Australians in hard to reach areas, such as for Indigenous communities and in rural and remote areas.⁶²

1.68 The Aged Care Financing Authority (ACFA) noted that this change 'reflected an overall reduction in funding for these programmes across the forward estimates.'⁶³

60 Department of Health, [Stocktake and analysis of Commonwealth-funded aged care workforce activities](#), (accessed 12 May 2017).

61 Following announcements in the 2015-16 Budget the Aged Care Workforce Development Fund was redesigned to bring in 40.2 million dollars of savings over four years.

62 Department of Health, *Submission 293*, p. 23.

63 Aged Care Financing Authority, [Annual Report on the Funding and Financing of the Aged Care Sector](#), July 2016, pp. 52-3.

1.69 The committee received evidence from a wide range of groups across the sector, including local government, not-for-profit and for-profit aged care providers, and nurses and nursing unions concerning these changes. Many of these submitters expressed concerns about the reduction in funding for the ACWF, submitting that the ACWF has enabled them to provide education and training that they may not have been otherwise able to provide.⁶⁴

1.70 For example, the Local Government Association of the Northern Territory (LGANT) indicated that further reductions to the ACWF would have the following implications for remote and very remote aged care services and their workers:

- the ability to continue to provide services at a high level would be compromised;
- the ability to employ qualified staff would be further compromised;
- the ability for aged care clients to remain on country would be reduced, placing further pressures on residential facilities in regional centres; and
- services within communities would be compromised and potentially reduced, and clients' dependent on services which provide regular nutritious meals, water and personal care would be impacted.⁶⁵

1.71 Not-for-profit providers also expressed concerns regarding the streamlining and reduction of funding for the ACWF, and its impact on:

- ability of providers to support training for workers;⁶⁶
- development of palliative care and dementia care skills;⁶⁷
- support for workers in regional and remote areas.⁶⁸

1.72 Not-for-profit providers also noted the cap on fringe benefits tax exemptions and its impact on their ability to attract and retain workers.⁶⁹

1.73 In contrast, for-profit providers' main concern was the removal of the payroll tax subsidy and its impact on the ability of private providers to compete with not-for-profit providers.⁷⁰

64 See, for example: DutchCare, *Submission 179*, pp. 3 and 8.

65 Local Government Association of the Northern Territory, *Submission 241*, pp. 4-5.

66 See, for example: Leading Age Services Australia, *Submission 222*, p. 17; JewishCare Victoria, *Submission 109*, p. 6; Presbyterian National Aged Care Network, *Submission 190*, p. 7; DutchCare, *Submission 179*, p. 8; Baptist Care Australia, *Submission 219*, p. 9.

67 See, for example: Brightwater Care Group, *Submission 213*, p. 7; Palliative Care Nurses Australia, *Submission 188*, p. 9; Palliative Care Australia, *Submission 139*, pp. 2-3; Alzheimer's Australia, *Submission 180*, p. 3.

68 See, for example: LGANT, *Submission 241*, p. 4; Yass Valley Aged Care, *Submission 59*, p. 9.

69 See, for example: Health Workers' Union, *Submission 248*, p. 77.

70 See, for example: Aged Care Guild, *Submission 290*, p. 7.

1.74 Nurses and nursing unions expressed concern that the removal of the high/low care distinction for residential facilities may result in providers cutting RN staff.⁷¹ This change is expected to be particularly acute in NSW, where it is currently legislated that all high care facilities must have a RN on site at all times.⁷² This issue is discussed further in chapter 3.

Role of the Australian government in developing an aged care workforce strategy

1.75 During the inquiry the committee heard evidence that suggested the need for a national aged care workforce strategy to plan for and respond to future challenges facing the aged care sector.

1.76 The committee heard overwhelming support for a collaborative, strategic and targeted approach to the funding and design of a national aged care workforce strategy.

1.77 The committee received a vast array of evidence from groups across the aged care sector including not-for-profit and for-profit aged care providers, unions, nurses, medical professionals and allied health practitioners who considered that the Australian Government should:

- take responsibility and leadership for development of an aged care workforce strategy;⁷³ or
- work in consultation with the aged care sector to 'co-design' a strategy.⁷⁴

1.78 The National Aged Care Alliance (NACA), a national peak body of those in the aged care sector, were particularly supportive of a co-design approach to the development of a strategy. NACA recommended that the Australian Government:

...work with stakeholders to co-design a definitive workforce development strategy to ensure a sufficient future workforce to meet the service needs of health, aged care, disability and community service sectors (including in regional and remote areas). This strategy should work towards greater coordination across the social services sectors and should focus on recruitment, retention, education, development and remuneration to ensure the workforce needs of each of the sectors are met.⁷⁵

71 For example, the NSW Nursing and Midwives' Association expressed concern that the removal of the high/low care distinction 'will provide a window of opportunity for some aged care providers to reduce their overheads by removing RNs from their workforce'. See: NSW Nurses and Midwives' Association, *Submission 134*, pp. 30-31.

72 NSW Nurses and Midwives' Association, *Submission 134*, pp. 30-31.

73 See, for example: Combined Pensioners and Superannuants Association of NSW, *Submission 295*, p. 5; Health Services Union, *Committee Hansard*, 28 April 2016, p.8.

74 See, for example: COTA Australia, *Submission 283*, p. 1; Aged and Community Services Australia, *Submission 229*, p. 13; Leading Aged Care Services, *Submission 222*, p.15; Salvation Army Aged Care Plus, *Submission 183*, p. 8; Benevolent Society, *Submission 240*, p. 3; Catholic Health Australia, *Committee Hansard*, 3 November 2016, pp. 20, 21.

75 National Aged Care Alliance, *Submission 77*, p. 2.

1.79 COTA Australia, the national peak organisation representing older Australians, agreed with this approach, stating that a national strategy will only be effective 'if there is ownership of the development process by all stakeholders', noting:

It is not sufficient, as some in the sector have tended to do, to lay the primary responsibility on the federal government.⁷⁶

1.80 The Department of Health (department) views the Australian Government's role in the development of a workforce strategy as more of a 'facilitator', rather than a leader.⁷⁷ The department explained that the Australian Government's position on a national aged care workforce strategy is that it will support the sector in developing a strategy, but that it is ultimately the sector's responsibility:

Aged care employers are responsible, like any other employer, for assuring that their workforce needs are aligned with their business strategy, as an essential component of organisational governance.⁷⁸

1.81 In its submission, the department further commented that government will assist the sector in the development of a strategy 'by providing funding for a sector-run development process, including provision for consultation with all relevant parties'.⁷⁹

1.82 Consistent with these comments, the Government announced in its 2017-18 Budget that it will:

...provide \$1.9 million over two years from 1 July 2017 to establish and support an industry-led aged care workforce taskforce and contribute to the development of an aged care workforce strategy, including for regional and remote areas.⁸⁰

1.83 The department has explained that the taskforce will explore:

...short, medium and longer term options to boost supply, address demand and improve productivity for the aged care workforce.⁸¹

1.84 The department has also commented that the strategy 'will connect with the National Disability Insurance Scheme (NDIS) Integrated Market, Sector and Workforce Strategy', and that the taskforce will consult within the sector, but 'also engage with other sectors, including disability, education and employment'.⁸²

76 COTA Australia, *Submission 283*, p. 1.

77 Department of Health, *Submission 293*, p. 10.

78 Department of Health, *Submission 293*, p. 22.

79 Department of Health, *Submission 293*, p. 24.

80 Commonwealth of Australia, *Budget Measures: Budget Paper No. 2 2017-18*, p. 123.

81 Department of Health, [Strengthening Aged Care – developing an aged care workforce strategy](#), (accessed 25 May 2017).

82 Department of Health, [Strengthening Aged Care – developing an aged care workforce strategy](#), (accessed 25 May 2017).

1.85 The Government has not committed any additional funding for an aged care workforce strategy, but stated the measure will be funded 'from within the existing resources of the Department of Health'.⁸³

1.86 The funding forms part of a broader \$33 million dollar 'Boosting the Local Care Workforce' workforce initiative to:

...assist providers in rural, regional and outer suburban areas to provide the workforce required to meet the expected growth in the disability and aged care sectors arising from the introduction of the National Disability Insurance Scheme and an ageing population...⁸⁴

1.87 The department has stated that the initiative will create 'regional and specialist coordinators to assist NDIS and aged care providers to grow their businesses and employ more workers'.⁸⁵ The measure will be funded from within the existing resources of the Department of Health, and Department of Social Services, and is discussed in greater detail in chapter 4.

Committee view

1.88 The committee notes that all levels of government have an important role in aged care administration and expenditure, and providing funding and support to the sector.

1.89 The committee considers that federal, state and territory, and local governments have a role in assisting the sector to develop a national aged care workforce strategy.

1.90 The committee is pleased that the Government has announced a commitment to provide funding to assist to establish an industry-led aged care workforce strategy.

1.91 The committee notes it will be important to ensure that stakeholder consultation and engagement is properly organised to enable wide and meaningful input from those who may be affected by any changes included in a national workforce strategy.

Conduct of the inquiry

1.92 This inquiry was first referred by the Senate of the 44th Parliament for inquiry on 1 December 2015, with a reporting date of 30 June 2016. The inquiry lapsed at the dissolution of the Senate on 9 May 2016.

1.93 On 13 September 2016, the Senate of the 45th Parliament agreed to re-adopt the inquiry with a reporting date of 28 April 2017. On 20 March 2017, the Senate granted an extension of time for reporting until 21 June 2017.

83 Commonwealth of Australia, *budget Measures: Budget Paper No. 2 2017-18*, p. 123.

84 Commonwealth of Australia, *budget Measures: Budget Paper No. 2 2017-18*, p. 145.

85 Department of Health, [Strengthening Aged Care – developing an aged care workforce strategy](#), (accessed 25 May 2017).

Handling of submissions

1.94 During the first referral of this inquiry under the 44th Parliament, a total of 296 submissions were received, 98 from organisations and 198 personal accounts from individuals, showing the depth of concern with this issue from the general public.

1.95 In the second referral under the 45th Parliament, the committee resolved not to call for new submissions but to rely on submissions received during the 44th Parliament. All correspondence and evidence previously received for this inquiry has been made available to the new committee. An additional 13 submissions were received and accepted by the committee.

Public hearings

1.96 A total of 12 public hearings were held:

28 April 2016	Melbourne, VIC
27 September 2016	Perth, WA
28 September 2016	Bunbury, WA
25 October 2016	Darwin, NT
26 October 2016	Alice Springs, NT
31 October 2016	Launceston, TAS
3 November 2016	Canberra, ACT
23 February 2016	Townsville, QLD
6 March 2016	Wollongong, NSW
7 March 2017	Adelaide, SA
9 June 2017	Broome, WA
13 June 2017	Canberra, ACT

