Chapter 4

Diversity in aged care

4.1 The Australian population is becoming more diverse and this is reflected in the increasing proportion of aged care service users with special needs and preferences. The *Aged Care Act 1997* defines 10 groups of people as 'people with special needs' for whom there is additional consideration in the planning and delivery of appropriate aged care services.

4.2 'People with special needs' include people from Aboriginal and Torres Strait Islander communities, people from culturally and linguistically diverse (CALD) backgrounds, people who live in rural or remote areas, and lesbian, gay, bisexual, transgender and intersex (LGBTI) people.[1]

4.3 Chapter 1 outlined the diversity of the population accessing aged care services and listed some of the challenges facing the mainstream aged care sector. This chapter will highlight the particular challenges in relation to 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, people living in rural or remote areas, and lesbian, gay, bisexual, transgender and intersex people.

Aboriginal and Torres Strait Islander aged care

> We need to investigate how we provide appropriate aged care for Indigenous older people and in doing so we need to be encouraging Indigenous people to be participating in the aged care workforce. There must be provision for the education, support and a career structure so Indigenous aged care workers can guide and teach non-Indigenous peoples how to be culturally competent in working with Indigenous older people.[2]

4.4 The government funds a number of programs which assist in providing aged care services to Aboriginal and Torres Strait Islander peoples. These programs include the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, which funds organisations to provide flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander peoples close to their home and/or community, primarily in rural and remote areas.[3]

4.5 The National Aboriginal and Torres Strait Islander Flexible Aged Care Program includes a quality framework, which is based on two principles: cultural

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1 Section 11.3 of the *Aged Care Act 1997*.

2 Dr Maree Bernoth, *Submission 249*, p. 3.

3 Department of Social Services, *Residential and Flexible Care Program, National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP), Guidelines Overview*, October 2015, p. 7, accessed 15 February 2016. The program currently funds 29 aged care services, with the majority located in remote or very remote locations. The program is administered outside of the *Aged Care Act 1997*.

safety and continuous quality improvement.[4] The quality framework sets out the requirements to achieve effective staff recruitment and retention to ensure that service user needs are met, including ensuring that services are provided by appropriately skilled staff who have an understanding of the cultural needs of the key stakeholders, including service users.[5]

Changing service delivery

> It has been very difficult for us, in a sense, and I understand why the government has done what they have done and removed it as bucket funding and now it is individual. But for us as a family unit, as a community, if one is sick at the minute then we all chip in to raise them up to get them better, whereas now we are having to say, 'I am sorry, Auntie, but your budget does not allow it.'[6]

4.6 Submitters and witnesses to this inquiry have expressed concern that the national move to consumer directed care (CDC), and the introduction of a centralised access point to aged care services, will adversely impact on the delivery of services to regional and remote predominantly Aboriginal and Torres Strait Islander communities.

4.7 In Townsville, the Northern Regional Aboriginal and Torres Strait Islander Corporation, which delivers aged care and disability services to Aboriginal and Torres Strait Islander peoples in the area, indicated that the move to a centralised portal and phone line for individuals to be assessed for access to aged care services had created a barrier for the service and for their clients. Prior to the introduction of My Aged Care, the Corporation, and clients, could access the one Townsville-based Aboriginal and Torres Strait Islander Aged Care Assessment Team (ACAT) member directly to address issues; now, however, all transactions with the department must go through the centralised portal:

> Now, again, everything has to go through My Aged Care. We have lost that connection between the multidisciplinary team and the consumer. This is all consumer directed, but for us it is actually not working. It is removing that connection that we have all had, and we have built that over a number of years. So it is quite difficult.[7]

4.8 This view has been echoed by service providers in their input to the 2017 performance audit of the Department of Health (department) and the Australian Aged Care Quality Agency by the Australian National Audit Office (ANAO), which found

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4 Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Quality Framework*, 2011, accessed 15 February 2016.

5 Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Quality Framework*, 2011, p. 22.

6 Miss Krys Fischer, Care Coordinator, Northern Regional Aboriginal and Torres Strait Islander Corporation, *Committee Hansard*, 23 February 2017, p. 22.

7 Miss Krys Fischer, Care Coordinator, Northern Regional Aboriginal and Torres Strait Islander Corporation, *Committee Hansard*, 23 February 2017, pp. 22-23.

that the centralised My Aged Care web portal and call centre can be a barrier to accessing aged care services for Aboriginal and Torres Strait Islander peoples, both in terms of cultural appropriateness and, for those living in remote and very remote locations, where access to communication technologies and the internet is limited or unavailable.[8]

4.9 Similarly, a Northern Territory service provider stated that the introduction of My Aged Care and CDC had led to a decline in service levels to aged care clients, as the administrative burden created diverted resources away from direct care:

> To give you an example, previously our programs had one person in Alice Springs overseeing them. We now have four people, which is because of the complexities of budgeting, costings, interacting with My Aged Care—all those sorts of things. That is all money that does not go towards service delivery.[9]

4.10 The Chief Executive Officer of the Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation raised concerns that the CDC model is not compatible with providing services to a small number of people, and particularly when that small group may, for example, need to relocate temporarily to another community, taking the funding with them:

> For example, in Mount Liebig, where there are currently about 10 old people, the staffing for that service is a full-time coordinator who is responsible for everything about that service and a few part-time community employees working a few hours a day...If a few of those old people decide that they need to go to Kintore for sorry business for a month, they take their packages with them. We are concerned that there may be a position where you actually have not got the money to pay the staff on the ground.[10]

4.11 The Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation and the MacDonnell and Central Desert regional councils all indicated that block funding, such as that available, for example, under the Aboriginal and Torres Strait Islander Flexible Aged Care Program, is a more appropriate funding model for remote and geographically-dispersed service delivery, where the costs of

8 Australian National Audit Office, *Indigenous Aged Care*, ANAO Report No. 53 of 201617, pp.27-28.

9 Ms Katie Snell, Manager, Aged and Disability Services, Central Desert Regional Council, *Committee Hansard*, 26 October 2016, p. 16.

10 Ms Sarah Brown, Chief Executive Officer, Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation, *Committee Hansard*, 7 March 2017, pp. 7-8.

service provision, and attracting and providing professional development for staff, are higher than in less remote locations.[11]

4.12 The MacDonnell Regional Council, which has attempted to apply for funding under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, recommended that

> the funding model for remote Indigenous services needs to reflect the operating environment. Allocations to the NATSI Flexi program need to be sufficient to allow many providers that are currently operating within this context, and under CDC, to transition over to the NATSI Flexi program, to ensure these providers do not exit the sector, which is a real risk at the moment.[12]

4.13 The ANAO performance audit of Indigenous aged care examined the National Aboriginal and Torres Strait Islander Flexible Aged Care Program in the broader context of aged care service delivery to Aboriginal and Torres Strait Islander peoples, finding that the program is a more cost effective and viable model for residential aged care service delivery in remote and very remote locations, however, 'the majority of Flexible Program recurrent funding for residential aged care is allocated to services in major cities and inner regional areas'.[13]

4.14 The ANAO recommended that the Department of Health:

> (a) provide an opportunity for eligible existing Indigenous-focused aged care service providers, which are not currently funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, to access the available funding under this scheme; and
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> (b) apply a consistent assessment process to ensure that places allocated through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program align with service provider capacity and are targeted to those service providers who will generate the greatest community benefit.[14]

4.15 The National Foundation for Australian Women (NFAW) and Catholic Healthcare Wollongong also expressed concern that additional costs associated with

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11 Ms Sarah Brown, Chief Executive Officer, Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation, *Committee Hansard*, 7 March 2017, pp. 8; Mr Rohan Marks, Director, Community Services, MacDonnell Regional Council, *Committee Hansard*, 26 October 2016, p. 3; Ms Katie Snell, Manager, Aged and Disability Services, Central Desert Regional Council, *Committee Hansard*, 26 October 2016.

12 Mr Rohan Marks, Director, Community Services, MacDonnell Regional Council, *Committee Hansard*, 26 October 2016, p. 2.

13 Australian National Audit Office, *Indigenous Aged Care*, ANAO Report No. 53 of 201617, p. 29.

14 Australian National Audit Office, *Indigenous Aged Care*, ANAO Report No. 53 of 201617, p. 35.

service provision in a regional or remote area, for example, the cost of transport and travel, are not accounted for in the CDC model.[15]

4.16 The department indicated that some remote and/or Aboriginal and Torres Strait Islander service providers have successfully implemented CDC. The department stated that it has established the Service Development Assistance Panel (SDAP) to assist service providers who may be experiencing difficulties, in relation to:

- clinical care;
- quality standards;
- governance models; and
- business systems or business planning.[16]

4.17 The ANAO performance audit found that aged care service providers were not necessarily aware of the SDAP service and further commented that:

> there would be benefit in Health better ensuring funding was targeted towards building financial management and governance capacity within organisations, rather than supplementing financial losses that are likely to persist unless changes in organisational culture and skills are made. Raising awareness of the availability of SDAP funding, and ensuring that funding was conditional on entities building financial management and governance capacity, could result in a more equitable and targeted allocation of SDAP funding.[17]

Committee view

4.18 The committee considers that the Government should review the implementation of CDC and consider alternative models where it is clear that CDC is not working, particularly in remote and very remote locations. The committee further notes the challenges to access presented by the implementation of a centralised access point to aged care services, which equally need to be addressed. Alternative models of funding and other support to services operating in remote and very remote locations also need to encompass attracting, maintaining and supporting aged care workers.

4.19 The committee notes the ANAO performance audit findings that the Aboriginal and Torres Strait Islander Flexible Aged Care Program has been effective in delivering culturally appropriate access to aged care services for Aboriginal and Torres Strait Islander peoples. The committee considers that this program should be expanded, and greater opportunities made available for eligible Indigenous-focused services to access the program.

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15 National Foundation for Australian Women, *Submission 105*, p. 22; Mrs Deanna Maunsell, Manager, Ageing and Disability, Catholic Healthcare Wollongong, Committee Hansard, 6 March 2017, p. 14.

16 Ms Rachel Balmanno, First Assistant Secretary, Department of Health, *Committee Hansard*, 3 November 2016, p. 65.

17 Australian National Audit Office, *Indigenous Aged Care*, ANAO Report No. 53 of 201617, p. 37.

4.20 The committee considers it essential to ensure that services delivered to Aboriginal and Torres Strait Islander peoples are accessible, do not present barriers to access, and are culturally appropriate and appropriately resourced, and take into account the specific challenges for service providers and aged care workers operating in remote and very remote locations.

Aboriginal and Torres Strait Islander workforce

4.21 The 2016 Aged Care Workforce Survey found that about one per cent of workers in residential direct care are Aboriginal and Torres Strait Islander people, a proportion which has not changed since the previous survey in 2012.[18]

4.22 The survey found that of these, 81 per cent were personal care attendants (PCAs), about 10 per cent were registered nurses, 7 per cent were enrolled nurses and 2 per cent were allied health workers. The survey noted that Aboriginal and Torres Strait Islander workers are more likely than the overall residential direct care workforce to be PCAs, rather than enrolled or registered nurses, or allied health professionals.[19]

4.23 The survey did not cover the reasons for this difference; however, it did note that the proportion of Aboriginal and Torres Strait Islander nurses had increased from 12 per cent in 2012 to 17 per cent in 2016, and the proportion of Aboriginal and Torres Strait Islander PCAs had fallen from 85 per cent to 81 per cent.[20]

4.24 There are challenges in finding and retaining Aboriginal and Torres Strait Islander workers in the aged care industry. The 2015 *Stocktake and Analysis of Commonwealth-funded Aged Care Workforce Activities* report indicated that consultations undertaken as part of the stocktake revealed that a lack of culturally appropriate training specifically targeted to Aboriginal and Torres Strait Islander peoples wishing to enter or remain in the aged care sector was reported to be a 'significant impediment to the attraction, recruitment and retention of this workforce group'.[21]

4.25 Some issues relate to circumstances which disproportionately affect Aboriginal and Torres Strait Islander peoples' capacity to engage in the workforce. For example, a representative of the aged care service provider, Australian Unity, stated

18 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. 19.

19 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. 19.

20 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. 19.

21 Health Outcomes International, *Stocktake And Analysis Of Commonwealth Funded Aged Care Workforce Activities: Final Report*, Department of Social Services, 2015, [p. 50].

that many aged care workers are required to have a driving licence, as a car and licence are requirements of the roles.[22]

4.26 Leading Age Services Australia stated that key challenges for engaging Aboriginal and Torres Strait Islander workers are at the commencement of employment in the sector:

> It is at the entry point, supporting the completion of initial training and shifts that presents a barrier. The age services industry are looking to other industries to learn from their successes.[23]

4.27 One aged care facility in a remote location initially had an Aboriginal workforce who were replaced by a non-Aboriginal and non-English speaking background workforce upon a change of ownership, which presented significant difficulties for the residents:

> Using this kind of workforce has really skewed being able to care adequately for the clients. The Indigenous workers who were there did not feel safe working there any longer—but now you have the residents, who cannot leave. We need to be asking those workers why they left and what it would take for them to come back. What does this organisation need to have to be safe?[24]

4.28 Situations like these suggest that a cornerstone to ensure continuity in culturally appropriate care for Aboriginal and Torres Strait Islander peoples accessing aged care as users, is to better source, train and support Aboriginal and Torres Strait Islander peoples to enter the aged care workforce:

> If we look at the patterns of ageing and the demographics of our Aboriginal and Torres Strait Islander populations, our workforce needs into the future, to 2030, are really critical now around planning and how we support, resource and invest in models that work for Aboriginal and Torres Strait Islander people as we live longer.[25]

4.29 Australian Unity's Aboriginal Home Care service has developed an Aboriginal workforce strategy. The key objectives of this strategy include:

> …attracting and retaining our Aboriginal workforce, building capabilities and career pathways for our Aboriginal workforce and improving Aboriginal cultural competency across the company. The themes include:

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22 Ms Kelly Chatfield, Manager, Aboriginal Business Development, Australian Unity, *Committee Hansard*, 6 March 2017, p. 39.

23 Leading Age Services Australia, *Submission 222*, p. 16.

24 Ms Annie Farthing, Member, Services for Australian Rural and Remote Allied Health, *Committee Hansard*, 3 November 2016, p. 17.

25 Ms Donna Murray, Chief Executive Officer, Indigenous Allied Health Australia, *Committee Hansard*, 3 November 2016, p. 40.

> working collaboratively with internal and external business partners to create a supportive cultural environment and promoting staff engagement.[26]

4.30 CRANAplus, a peak organisation for professional remote health workers that provides education, support and professional services to workers in health and related sectors, discussed how it addresses the education needs of remote health care workers, particularly those working in Aboriginal and Torres Strait Islander communities:

> One of our things is that we take education out to the remote area workforce. That has been one of our greatest successes—that we acknowledge the context of your practice is different. You cannot try and make a metropolitan model fit out there, so you have to be adaptable and take the education out to the workforce out there. That has been very successful from our organisation's perspective.[27]

4.31 Services specifically available to support the aged care workforce in delivering services to Aboriginal and Torres Strait Islander peoples include:

- Indigenous Remote Service Delivery (IRSD) traineeships—National Partnership on Indigenous Economic Participation.[28]
- Culturally appropriate and targeted training for the Aboriginal and Torres Strait Islander aged care workers employed in eligible aged care services.[29]
- Remote and Aboriginal and Torres Strait Islander Aged Care Service Development Assistance Panel.[30]
- Activities under the Dementia and Aged Care Services Fund, including training and individual support for Aboriginal and Torres Strait Islander service providers in rural and remote Australia.[31]

4.32 While there are a number of options available via the department for service providers to develop the skills and knowledge of aged care workers delivering services to Aboriginal and Torres Strait Islander peoples, the ANAO performance

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26 Ms Kelly Chatfield, Manager, Aboriginal Business Development, Australian Unity, *Committee Hansard,* 6 March 2017, p. 37.

27 Ms Gerardine Marie Malone, Director, Professional Services, CRANAplus, *Committee Hansard,* 7 March 2017, p. 37.

28 Under this program, up to 80 traineeships are offered annually in business management for Aboriginal and Torres Strait Islander people in aged and primary health care facilities.

29 Under this program, Northern Territory based Registered Training Organisations were funded to deliver culturally appropriate, skills-based aged care training on-site in 59 communities across the Northern Territory and two communities in Western Australia.

30 The Panel provides expert assistance and advice to providers across care delivery, quality delivery, governance, business management, financial management and project management to eligible aged care services.

31 Department of Health, *Submission 293,* p. 31.

audit of Indigenous aged care found that providers are not necessarily aware that such programs and supports exist.[32]

Committee view

4.33 The committee notes that there are specific challenges in providing appropriate training, professional development and secure employment opportunities in the aged care sector in regional and remote locations, including in Aboriginal and Torres Strait Islander communities.

4.34 There is a need to ensure that ongoing challenges in providing appropriate professional development and employment opportunities to Aboriginal and Torres Strait Islander aged care workers, and to those workers providing services to Aboriginal and Torres Strait Islander communities, are addressed.

4.35 The committee considers that these issues cannot be addressed in isolation, and cannot be addressed by the aged care industry alone, but as part of a broader re-examination of aged care service delivery in remote and very remote locations and to Aboriginal and Torres Strait Islander peoples.

CALD aged care sector

4.36 As discussed in chapter 1, the population of Australia is becoming more diverse in cultural and linguistic background, and as the CALD community age, are taking up aged care services in greater numbers, and their differing needs are placing new challenges on the workforce.

National Ageing and Aged Care Strategy for People CALD Backgrounds

4.37 The 2012 *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds* supports the aged care sector to deliver care that is appropriate and sensitive to the needs of older Australians from CALD backgrounds.[33]

4.38 The Strategy is based on five principles and sets out six broad goals and associated actions to be achieved by the Department of Health and Ageing (now the Department of Health) in the period 2012–2017, including:

- CALD input positively affects the development of ageing and aged care policies and programs that are appropriate and responsive (Goal 1);
- monitor and evaluate the delivery of ageing and aged care services to ensure that they meet the care needs of older people from CALD backgrounds, their families and carers (Goal 4); and

32 Australian National Audit Office, *Indigenous Aged Care*, ANAO Report No. 53 of 201617, p. 9.

33 Department of Health and Ageing, *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*, 2012, p. 3, accessed 15 February 2016.

- enhance the CALD sector's capacity to provide ageing and aged care services (Goal 5).[34]

4.39 The Department of Health has submitted that the strategy includes coverage for workforce issues, including 'resources to support consumers and providers'.[35]

Partners in Culturally Appropriate Care

4.40 An organisation in each state and territory is funded to assist aged care providers to deliver culturally appropriate care to older people from CALD backgrounds (Partners in Culturally Appropriate Care (PICAC) organisations). The PICAC organisations conduct a range of activities—such as training, information sessions, workshops and resource development—to achieve three primary outcomes:

- more aged care services delivering culturally appropriate care to older persons from CALD communities;
- older people from CALD communities having increased access to culturally appropriate residential and community based aged care services; and
- older people from CALD communities having greater capacity to make informed decisions about residential and community based aged care.[36]

4.41 The Department of Health has submitted that PICAC organisations:

> provide culturally appropriate training to staff of aged care services, disseminate information on high quality aged care practices and support the aged care service providers to develop new culturally appropriate services including clusters, ethno-specific and multicultural aged care services.[37]

Building capacity for the aged care needs of CALD communities

4.42 The Department of Social Services has developed a number of resources to support CALD communities with emerging aged care needs to establish aged care services.[38]

4.43 In the 2014 Budget, the Government announced $20 million funding to support the provision of culturally appropriate aged care services in Western Sydney: $10 million over three years to the Lebanese Muslim Association; and $10 million over two years to the Maronite and other Arabic speaking Christian communities.[39]

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34 Department of Health and Ageing, *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*, 2012, pp 12–17, (accessed 23 December 2015).

35 Department of Health, *Submission 293*, p. 29.

36 Department of Health, *Ageing and Aged Care, People from diverse backgrounds* webpage, https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/older-people-their-families-and-carers/people-from-diverse-backgrounds (accessed 16 December 2015).

37 Department of Health, *Submission 293*, p. 29.

38 Department of Social Services, People from diverse backgrounds, accessed 15 February 2016.

39 Australian Government, *Budget measures: budget paper no. 2: 2014–15*, 2014, p. 190, (accessed 3 December 2015).

4.44 Mr Christopher Lacey, General Manager, Multicultural Communities Council of Illawarra (MCCI), emphasised the diversity of people accessing aged care:

> In our region at the time of the 2011 census there were about 8,039 people who were aged 70-plus and were born overseas. Of these, around 2,400 people needed assistance with core activities, 1,800 of those people were living alone and about 2,300 of those people spoke English 'not well or not at all'.[40]

4.45 To address the needs of these people, of the 52 staff (approximately 30 FTE positions) employed by MCCI, around 70 per cent are bilingual:

> For us, this is a very significant capability requirement. To be able to deliver culturally-appropriate care to CALD communities, we need workers who can speak a range of different languages. It is a key component of who we are as a business.[41]

4.46 The Ethnic Communities' Council of Victoria (ECCV) stated that the feedback they had received from members indicated that:

> Bilingual aged-care workers trained in ethno-specific and multicultural agencies have invaluable expertise in facilitating the access of seniors from non-English-speaking backgrounds to the service systems.[42]

4.47 The ECCV expressed particular concern about the lack of availability of culturally appropriate services and resources in rural and regional towns and areas.[43]

4.48 Another concern raised, in relation to aged care workers from CALD backgrounds, was the assumption that these workers do not need training in culturally appropriate aged care services:

> For instance, here in Melbourne we know that all aged-care facilities in the western and southern regions have residents who prefer to speak a language other than English. We also know that staff are not provided with initial training or professional development, as was outlined, in how to carry out the work that provides the services in a culturally inclusive way.[44]

4.49 Further, the Centre for Cultural Diversity and Ageing referred to the lack of bilingualism in Australia as an additional factor impacting on the ability to provide culturally appropriate aged care services:

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40 Mr Christopher Lacey, General Manager, Multicultural Communities Council of Illawarra, Committee Hansard, 6 March 2017, p. 10.

41 Mr Christopher Lacey, General Manager, Multicultural Communities Council of Illawarra, Committee Hansard, 6 March 2017, p. 10.

42 Mrs Marion Lau, Deputy Chairperson, Ethnic Communities' Council of Victoria, *Committee Hansard*, 28 April 2016, p. 57.

43 Mrs Marion Lau, Deputy Chairperson, Ethnic Communities' Council of Victoria, *Committee Hansard*, 28 April 2016, p. 57.

44 Ms Ljubica Petrov, Manager, Centre for Cultural Diversity in Ageing, *Committee Hansard*, 28 April 2016, p. 62.

> That is something that I think needs to be explored in the future, because we need more bilingual people who will meet the diversity of language needs in the aged-care sector.[45]

4.50 To this end, the Federation of Ethnic Communities' Councils of Australia (FECCA) has recommended, given the evidence available on the increasing cultural diversity of the aged population requiring care, the development of an Aged Care Workforce Cultural Diversity Management Strategy.[46]

4.51 FECCA submitted that this strategy should address the following areas:

- ways to attract CALD workers to employment in aged care services; methods for improving the retention of culturally competent aged care workers, including but not limited to workers from CALD backgrounds;
- attracting aged care workers to rural and regional areas;
- implications for interface between the National Disability Insurance Scheme (NDIS) and aged care system; and
- strategies to enhance cultural competency of the aged care workforce, as part of increasing the capability of the sector to meet the needs of older people from CALD backgrounds.[47]

4.52 The call for a specific strategy was echoed by a number of submitters and witnesses.[48]

CALD people in the aged care workforce

4.53 The 2016 Aged Care Workforce Survey found that 32 per cent of the total residential care workforce were born overseas, and 40 per cent of recent hires in residential care were migrant workers; and 23 per cent of the PAYG home care and home support direct care workforce were born overseas.[49]

4.54 The 2016 survey asked residential aged care facilities to identify the benefits of engaging people from CALD backgrounds. Responses indicated that 84 per cent found a benefit in the opportunity to enhance cross-cultural understandings and activities; and 37 per cent indicated that employing people from CALD backgrounds was important for developing networks into particular communities.[50]

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45 Ms Ljubica Petrov, Manager, Centre for Cultural Diversity in Ageing, *Committee Hansard*, 28 April 2016, p. 62.

46 FECCA, *Submission 205*, p. 2.

47 FECCA, *Submission 205*, p. 2.

48 See for example: National Foundation for Australian Women, *Submission 105*; Resthaven Incorporated, *Submission 140*; Alzheimer's Australia, *Submission 180*; Brightwater Care Group, *Submission 213*; Aged Care Guild, *Submission 220*; Aged & Community Services Australia, *Submission 229*.

49 National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, pp. xvi, 10.

50 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. 45.

Committee view

4.55 The ageing population is clearly culturally diverse, and so too is the workforce providing care to those in need of either in home or residential aged care services.

4.56 The committee acknowledges the challenges and opportunities in delivering culturally aware aged care and the need for the aged care workforce to be prepared effectively to deliver culturally appropriate care.

National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy

4.57 The 2012 *National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy* is designed to enable better education, care and support for older LGBTI Australians in aged care. The strategy is intended also to help workers to understand any differences between their personal values or beliefs and appropriate and inclusive workplace behaviour and practice.[51]

4.58 The strategy has six strategic goals and associated actions that are the outcomes to be achieved by the Department of Health and Ageing (now the Department of Health) from 2012 to 2017, including:

- LGBTI people will experience equitable access to appropriate ageing and aged care services (Goal 1);
- the aged care and LGBTI sectors will be supported and resourced to proactively address the needs of older LGBTI people (Goal 2);
- ageing and aged care services will be supported to deliver LGBTI-inclusive services (Goal 3);
- LGBTI-inclusive ageing and aged care services will be delivered by a skilled and competent paid and volunteer workforce (Goal 4);
- LGBTI communities, including older LGBTI people, will be actively engaged in the planning, delivery and evaluation of ageing and aged care policies, programs and services (Goal 5); and
- LGBTI people, their families and carers will be a priority for ageing and aged care research (Goal 6).[52]

4.59 The Department of Health submitted that the strategy includes coverage of workforce issues, including 'resources to support consumers and providers'.[53]

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51 Department of Health and Ageing, *National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy*, 2012, p. 3, accessed 15 February 2016.

52 Department of Health and Ageing, *National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy*, 2012, pp 12–17, (accessed 21 December 2015).

53 Department of Health, *Submission 293*, p. 31.

Review of strategy implementation

4.60 In 2013, the National LGBTI Health Alliance convened the Second National LGBTI Ageing and Aged Care Roundtable, to review implementation of the strategy. Four recommendations were made:

- update VET qualifications with LGBTI competencies;
- include LGBTI with special needs/diversity outcomes in all aged care standards and linked to accreditation;
- include LGBTI within the Survey of Ageing, Disability and Carers and in all government research; and
- ensure workplace inclusion strategies for aged care organisations.[54]

LGBTI workers in the aged care workforce

4.61 There is no data available on the number or proportion of people working in the aged care sector who identify as LGBTI, which makes it challenging to obtain information about LGBTI people working, or seeking employment in, the aged care workforce.

4.62 The National LGBTI Health Alliance has submitted that a significant issue affecting LGBTI people who wish to work in the aged care sector is the ability of faith-based organisations providing aged care services to discriminate in the hiring of workers under Section 37 of the *Sex Discrimination Act 1984*:

> The exemption to the SDA undermines the ability of faith-based organisations to create an LGBTI-inclusive service and decreases the confidence that LGBTI consumers have in these organisations to deliver inclusive care. Furthermore, the blanket nature of the exemption disadvantages faith-based providers that do not want to be exempted from anti-discrimination laws.[55]

4.63 The National LGBTI Health Alliance argues that this is a significant issue, given that '[in] 2015-16 faith-based organisations provided 24.4% of residential care places and 31.9 % of operational home care places in Australia'.[56]

4.64 A member of the Legislative Council of New South Wales, Ms Jan Barham MLC, also indicated in her submission the inconsistency introduced through amendments to the *Sex Discrimination Act* in 2013 that prohibit discrimination against LGBTI people seeking aged care services, but which allows discrimination against LGBTI aged care workers.[57]

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54 National LGBTI Health Alliance, *2nd National Lesbian, Gay, Bisexual, Transgender and Intersex Ageing and Aged Care Roundtable*, August 2014, (accessed 21 December 2015).

55 National LGBTI Health Alliance, *Submission 308*, p. [2].

56 National LGBTI Health Alliance, *Submission 308*, p. [3].

57 Ms Jan Barham MLC, *Submission 245*, p. [6].

4.65 The Alliance has argued that this matter should be addressed either through repeal of the relevant section enabling the discrimination to occur, or to narrow the definition of what kinds of occupation and work the exemption can apply to:

> Under this option, a faith-based provider would be able to lawfully discriminate when hiring a chaplain but it would not allow discrimination against other staff (e.g. cleaners).[58]

Committee view

4.66 The committee has heard evidence that indicates that aged care providers and other stakeholders including the government have worked to help accommodate and cater for LGBTI people accessing aged care services. This includes more services specifically catering for LGBTI people.

4.67 The committee is concerned, however, that more could be done to address discrimination faced by LGBTI workers in the aged care industry and seeking to enter the industry. While aged care facilities are no longer able to exclude potential residents and clients because of their LGBTI status, the same does not apply to LGBTI workers.

Regional and remote aged care sector

4.68 Earlier in this report, it was noted that about a third of the population of Australia aged 65 and over live in regional and remote locations, and that there is considerable diversity amongst this population.

The aged care workforce in regional and remote Australia

4.69 Recent data shows that just over one third of the residential aged care workforce, and 40 per cent of the community care aged care workforce, is employed in regional and remote areas. For both groups of aged care workers, the majority of those working outside major cities are located in regional areas, with fewer than two per cent of residential care workers, and just over four per cent of community care workers, located in remote or very remote areas.

58 National LGBTI Health Alliance, *Submission 308*, p. [4].

Table 4.1: Distribution of residential direct care workforce and home support direct care workforce (per cent) by location, 2016.

Location*	Residential care[1]	Community Care[2]
Major cities	64.6	59.7
Inner regional	23.4	18.9
Outer regional	10.3	17.0
Remote	1.2	3.5
Very remote	0.5	0.6

Source: 1. 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.50; 2. 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. 112.

*Australian Bureau of Statistics remoteness area categories.

4.70 The data from the recently released *2016 National Aged Care Workforce Census and Survey* indicates that there has been little change in the geographical distribution of workers in residential aged care over the past 5 years. Due to changes in the method of defining categories, data on community care workers cannot be compared with previous surveys.

4.71 Geographical location was nominated by aged care service providers who completed the survey as the second highest factor causing skills shortages, with lack of available suitable applicants being the leading cause of skills shortages.[59] The *2016 National Aged Care Workforce Census and Survey* also found that vacancies, especially for registered nurses in residential care facilities, take longer to fill in remote and very remote areas.[60]

Aged care workforce challenges in regional and remote communities

> Being in a semi-regional area we have the issue of trained staff – that is probably our biggest problem – and the cost of training, and also the availability of young people coming through[61]

4.72 Delivering aged care services is particularly challenging in regional and remote communities.[62]The *2016 National Aged Care Workforce Census and Survey*

59 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. 55.

60 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. 58.

61 Ms Julie Cooper, Executive Officer, Bess Home and Community Care Inc, *Committee Hansard*, 28 September 2016, p. 1.

shows that there are difficulties in both attracting and retaining aged care workers in the sector, and that there are also skills shortages which aged care providers struggle to address. The survey also shows that these difficulties are more pronounced in regional and remote areas.[63]

4.73 A lack of community level coordination of services across related health, disability and aged care services and agencies also impacts on peoples' access to services in remote locations. Dr Kate Smith, a Research Fellow at the University of Western Australia who has been conducting research into ageing in the Kimberley region for around 15 years, suggested that greater collaboration across sectors at a local level may be of use in addressing access to services, including allied health care workers.[64]

4.74 There is concern that where there currently is coordination of services, the introduction of CDC and the move to introduce greater competition between service providers may result in a 'weakening of that kind of collaborative, coordinated delivery of services'.[65] This is particularly critical when, due to limited service availability in remote and very remote locations, aged care service providers often deliver services for young people who have a disability. This places an additional requirement on those services, and their staff, to possess an appropriate level of training and skills to meet the differing needs of a broad client base. Finding and retaining staff to meet this additional need adds to the challenges facing service providers in regional and remote locations. [66]

4.75 The Aged Care Funding Agency (ACFA) has found that aged care providers in regional and remote areas generally have higher cost pressures and lower financial results and 'face a high level of workforce 'churn' and challenges in recruiting and retaining staff'.[67] In discussing these issues, Aged and Community Services Australia noted that there are additional challenges for the aged care workforce in rural and remote communities:

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62 See: Yass Valley Aged Cares, *Submission 59*; CRANAplus, *Submission 1*; Rural Health Workforce Australia, *Submission 133*; Services for Australian Rural and Remote Allied Health (SARRAH), *Submission 238*; Australian College of Rural and Remote Medicine, *Submission 251*; National Rural Health Alliance, *Submission 296*.

63 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. xvii.

64 Dr Kate Smith, Research Fellow, University of Western Australia, *Proof Committee Hansard*, 9 June 2017, p. 32.

65 Mr Robert McPhee, Deputy Chief Executive Officer, Kimberley Aboriginal Medical Services, *Proof Committee Hansard,* 9 June 2017, p. 15.

66 Mr Robert McPhee, Deputy Chief Executive Officer, Kimberley Aboriginal Medical Services, *Proof Committee Hansard,* 9 June 2017, p. 15.

67 Aged Care Funding Agency (ACFA), *Financial Issues Affecting Rural and Remote Care Providers*, February 2016, p. 57.

> Aged care services in rural and remote Australia are experiencing particular challenges in accessing the necessary workforce to provide services to older Australians living in these areas.[68]

4.76 Further, aged care service providers can also struggle to maintain consistent funding in order to engage staff. This is particularly an issue for remote and very remote services with a small client base. One example raised during this inquiry is that of the limitation on 'social leave' of up to 52 nights per year for aged care residents, after which government funding for the aged care place ceases. This can impact on aged care service providers in remote locations where Aboriginal or Torres Strait Islander residents may need to visit their home communities for cultural purposes, and who may exceed the 52 day limit.[69]

4.77 Health Workforce Australia explained that these extra and well-documented challenges include:

- distance from family and friends;
- feelings of professional and/or personal isolation;
- lack of employment opportunities for partners;
- lack of preferred schooling opportunities for children;
- lack of professional development opportunities;
- lack of local community amenities (eg. theatre, restaurants, etc.);
- higher workloads and on-call hours; and
- poor workplace infrastructure.[70]

4.78 The section below will look at two key challenges particularly relevant to regional and remote aged care workforce: attracting and retaining workers and lack of training.

Attracting and retaining workers

4.79 There are two distinct forms of challenges facing aged care providers in attracting and retaining aged care workers in regional and remote areas. The first are challenges that are specific to rural and regional areas, and the second are general challenges faced by the industry that are made more acute by the regional and remote location. For example, workers in regional and remote areas may face challenges in finding and being able to afford adequate housing and transport close to work, a challenge raised by Bess Home and Community Care Inc.[71]

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68 Aged and Community Services Australia, *Submission 229*, p. 2.

69 Dr Kate Smith, Research Fellow, University of Western Australia, *Proof Committee Hansard*, 9 June 2017, pp. 31-32.

70 Health Workforce Australia, *Submission 133*, p. 23.

71 Ms Julie Cooper, Executive Officer, Bess Home and Community Care Inc, *Committee Hansard*, 28 September 2016, p. 9.

4.80 The issue of attracting particularly professional staff to regional and remote locations was highlighted by aged care service providers, including Bethanie Care:

> Where we find it difficult currently – and I can only see it getting worse in the future – is when you are looking at professional staff, such as registered nurses and in particular allied health: physiotherapists, OTs and those sorts of people. They are very hard to attract to regional areas.[72]

4.81 Some submitters suggest that due to the difficulties in attracting staff, regional and remote providers rely on agency (temporary) staff to fill vacancies, which can adversely impact on the costs of running services (including where temporary staff must be brought in to cover a vacancy), the quality of care provided and cohesiveness of workplace culture.[73]

4.82 Some aged care providers stated the difficulty of attracting or retaining workers related to the lack of opportunities in regional and remote areas.[74]

4.83 It is clear that while there are challenges in attracting suitably skilled and qualified staff to work in the aged care sector in regional and remote areas, there are also challenges in making use of the existing potential workforce in regional areas. Ms Nicky Sloan, Chief Executive Officer, Illawarra Forum Inc., informed the committee that, '[d]espite unemployment in our region – we do have significant unemployment across the region – we struggle to attract the workforce that we need.'[75]

4.84 While the aged care sector, along with the health sector in general, is expanding in the Illawarra region of New South Wales, stakeholders are also trying to find ways to 'broaden the profile of the aged care sector,' to attract younger people and also men into the sector.[76]

4.85 The available workforce in the Wollongong and Illawarra region of New South Wales has in recent times been affected by the loss of job opportunities in other industries, but aged care providers have found that the sector is not seen, and in many cases is not, an attractive industry for many workers moving out of other, higher paid, industries, a point raised by Catholic Care:

> Especially in Wollongong, we did a lot of work with members leaving BHP and looking for a new place to work, and there was just not the

72 Ms Joanne Christie, Chief, People and Culture, The Bethanie Group Inc, *Committee Hansard*, 28 September 2016, pp. 1-2.

73 Illawarra Forum, *Submission 212*, p. 8.

74 See for example: Mrs Hazel Gordon, Facility Manager, Wattle Hill Lodge Inc, *Committee Hansard*, 28 September 2016, p. 28.

75 Ms Nicky Sloan, Chief Executive Officer, Illawarra Forum Inc, *Committee Hansard*, 6 March 2017, p. 2.

76 Mr David Muscio, Project Officer, RDA Illawarra, *Committee Hansard*, 6 March 2017, p. 1.

> competitiveness in wages for that to sustain them to work full time in the aged-care industry.[77]

4.86 In Port Augusta, South Australia, the Port Augusta City Council is a provider of two residential aged care facilities and provided evidence to the inquiry that a key issue in relation to attracting and retaining registered and enrolled nurses, is the competition with other services, including the local hospital and the Port Augusta prison. This is because '[p]ublic sector employees are paid at higher pay rates and also have the benefit of more attractive salary-sacrificing options here in Port Augusta.'[78]

4.87 Competition with other sectors was raised by a number of submitters, as there are often more attractive conditions available in the acute health sector, services associated with the National Disability Insurance Scheme, and other services, including those provided through Multi-Purpose Services (MPS). The MPS Program, a joint Commonwealth-state/territory initiative, provides 'integrated health and aged care services to small regional, rural and remote communities,' and was recently provided with additional funding of $8.5 million.[79]

4.88 The Multi-Purpose Services Programme (MPS) is a joint initiative of commonwealth, state and territory governments to provide integrated health and aged care services for some small rural and remote communities: 'It allows services to exist in regions that could not viably support stand-alone hospitals or aged care homes'.[80]

4.89 MPSs receive funding from the Commonwealth for the delivery of aged care services, with the relevant state or territory government providing funding for a range of health services.

4.90 The National Foundation for Australian Women is supportive of the collaborative approach underpinning the MPS program:

> The development of Multi-Purpose Services in rural and remote areas has demonstrated a model that has supported multi-disciplinary workforces in many MPS that would not be viable in separate services in small communities. These approaches are critical to supporting employment of women in rural and remote communities and achieving benefits to the wider community by way of the social stability this can bring.[81]

4.91 Another key issue for Port Augusta is the challenge of finding suitably qualified staff, particularly personal care attendants. The committee heard that the use

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77 Mrs Deanna Maunsell, Manager, Aged and Disability, Catholic Care Wollongong, *Committee Hansard*, 6 March 2017, p. 9.

78 Mrs Anne O'Reilly, Director, Community Services, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 1.

79 The Hon. Ken Wyatt, MP, Assistant Minister for Health and Aged Care, '$8.5 Million in Additional Funding for Aged Care Services in Regional, Rural and Remote Australia', *Media Release*, 24 January 2017.

80 Department of Social Services, *Ageing and Aged Care, Multi-Purpose Services Programme*, accessed 16 February 2016.

81 National Foundation for Australian Women, *Submission 105*, p. 22.

of agency staff presented challenges, especially covering additional costs such as travel and accommodation for staff brought in from other locations, for which no additional funding is available, as the City is not eligible for any supplementation. The City of Port Augusta indicated that 'being a regional centre there is no acknowledgement of those higher costs in relation to staffing'.[82]

4.92 To address these issues, the City of Port Augusta established a training program in partnership with a local training provider (TAFE SA), and accessed funding through the Regional Development Australia Far North program funding.[83]

4.93 The Illawarra Regional Workforce Planning Strategy for the Aged Care Sector recommended a strategy to 'enhance community awareness about the Aged Care sector and improve its visibility in the community'. It does this by producing promotional material, conducting Career Expos, promoting government programs such as Young at Heart with TAFE and using social media platforms to advance aged care and the broader community and disability services sectors.[84]

4.94 The committee heard that another issue aged care service providers is the move to CDC, which presents a challenge for regional but particularly remote and very remote aged care providers and workers alike:

> The thing is: a marketised model is probably not going to work very well in regional and remote areas where you do not have the demand. It just does not work. Maybe the goal in these regional areas is not to have a choice of multiple, different providers but to have real and meaningful control over your care and the way it is delivered.[85]

Lack of training

4.95 Further to the training issues considered in chapter three, the committee notes that there are several training related challenges specific to regional and remote aged care providers and workers.

4.96 The quality of training was raised on a number of occasions throughout the inquiry, with a number of submitters and witnesses identifying inconsistencies in the quality of training available as contributing to the challenges of maintaining an appropriately qualified and skilled aged care workforce.

4.97 In particular, submitters stated that service providers in regional or remote locations can find it difficult to source good quality local training providers to cover the full range of training required by staff working in the aged care sector. For

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82 Mrs Anne O'Reilly, Director, Community Services, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 1.

83 Mrs Anne O'Reilly, Director, Community Services, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 1.

84 Aged Care Illawarra Workforce Action Group, *Submission 148*, p. [2].

85 Ms Ellis Blaikie, Senior Policy Adviser, Combined Pensioners and Superannuants Association, *Committee Hansard*, 3 November 2016, p. 39.

example, in the Illawarra region, Catholic Care Wollongong indicated that 'there is a vast difference between different RTOs in the Illawarra.'[86]

4.98 The prohibitive costs of either bringing trainers on-site or sending staff to a major centre to undertake training is another key issue affecting the aged care workforce in regional and remote areas. Port Augusta City Council stated that:

> We also experience difficulties in relation to training of staff in that it costs more to hold training on site here in Port Augusta due to travel and accommodation for trainers and the increased cost of sending staff to Adelaide for training purposes. What we found previously was that not all certificate III qualified staff were job ready on employment.[87]

4.99 Ms Sarah Brown, Chief Executive Officer, Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation, submitted that services should have flexibility to provide their own training:

> In my experience, giving aged-care coordinators of staff on the ground some skills to train the support staff is much more sustainable. It means that education and training support is happening all the time and it is not from a for-profit company, where they are coming in for a couple of days and they have got no real idea of the culture of the place or the cultural priorities.[88]

4.100 Where training is not available locally, there can be considerable costs involved in getting staff to the location of training and covering their shifts while they are away. This was highlighted by Bess Home and Community Care Inc., an organisation which operates in regional Western Australia:

> The main bulk – I would say 99.9 per cent – of the training that is offered is always around the Perth area. If you want to put some staff through, say, medication training, half of your workforce goes up to Perth. So you have to pay for the course and their accommodation and we do not have the staff backup to cover them.[89]

4.101 Some aged care providers have developed innovative solutions to the challenge of providing appropriate training to aged care workers, or people seeking to enter the industry, through partnerships with training providers. Hall and Prior Health and Aged Care Group implemented a training program in Albany, Western Australia, in partnership with the Chamber of Commerce and Industry and what is now called the Great Southern Institute of Technology. This training program:

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86 Mrs Deanna Maunsell, Manager, Aged and Disability, Catholic Care Wollongong, *Committee Hansard*, 6 March 2017, p. 11.

87 Mrs Anne O'Reilly, Director, Community Services, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 2.

88 Ms Sarah Brown, Chief Executive Officer, Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation, *Committee Hansard*, 7 March 2017, p. 11.

89 Ms Cara Kekkula, Manager, Bess Home and Community Care Inc, *Committee Hansard*, 28 September 2017, p. 3.

> garner[ed] attention because we won a national award for it, but it was a real solution to a real problem of how to manage older people with high and complex care needs in a regional centre by staff, who, up to then, had not been adequately trained to meet those care needs.[90]

4.102 The impact of changes in policy direction or support by government can be significant. For example, the funding that had supported this successful partnership between Hall and Prior Health and Aged Care Group, Great Southern Institute of Technology and the Chamber of Commerce and Industry in Albany was removed or substantially reduced.[91]

4.103 Submitters highlighted the need for greater cooperation between Commonwealth, state, territory and local governments across health, disability and aged care services in regional and remote areas to take advantage of the economies of scale and scope.[92]

4.104 The Australian College of Rural and Remote Medicine recommends that the committee explore opportunities for 'cooperative management' of Commonwealth, state, territory and local government funded aged care resources in regional and remote communities.[93]

4.105 In 2015, the government undertook an examination of Commonwealth-funded aged care workforce activities. The analysis covered activities implemented over a three year period from 2011–12 to 2013–14.

4.106 A key finding of the government's *Stocktake and Analysis of Commonwealth-Funded Aged Care Workforce Activities* report was that: 'Consideration should be given to developing specific strategies in respect of the workforce in regional and remote areas.'[94] This finding was based on analysis which showed that only around 3.7 per cent of Commonwealth funded aged care workforce activities, and 7.9 per cent of funding, were listed as specifically for regional, rural and remote service provision.[95]

4.107 Recognition of the specific characteristics and challenges of remote service delivery will be needed in developing any strategy to strengthen the aged care workforce in remote locations. For this reason the NFAW recommends that:

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90 Mrs Jennifer Grieve, General Manager Health and Care Services WA, Hall and Prior Health and Aged Care Group, *Committee Hansard*, 28 September 2016, pp. 21-22.

91 Mrs Jennifer Grieve, General Manager Health and Care Services WA, Hall and Prior Health and Aged Care Group, *Committee Hansard*, 28 September 2016, pp. 22.

92 Yass Valley Aged Care, *Submission 59*, p. 11; Australian College of Rural and Remote Medicine, *Submission 251*, p. 4.

93 Australian College of Rural and Remote Medicine, *Submission 251*, p. 4.

94 Health Outcomes International, *Stocktake And Analysis Of Commonwealth Funded Aged Care Workforce Activities: Final Report*, Department of Social Services, 2015, [p. 6].

95 Health Outcomes International, *Stocktake And Analysis Of Commonwealth Funded Aged Care Workforce Activities: Final Report*, Department of Social Services, 2015, [p. 6].

> that the extent to which the impacts of geographic isolation on the aged care workforce can be moderated by organisational integration and outreach be taken into account in the development of service delivery models in rural and remote areas that strengthen and support workers in those areas, and that this strategy consider ways of bringing all services in these areas into such support networks.[96]

4.108 The Greater Northern Australia Regional Training Network (GNARTN), a cross-jurisdictional network funded by the government has been developing an issues paper on the aged care workforce in the Northern Territory. Mr Robert McPhee of the Kimberley Aboriginal Medical Service, a member of the GNARTN, told the committee that the issues paper, part of a series, has identified around 12 recommendations relating to aged-care workforce issues in northern Australia. Mr McPhee informed the committee that the completed issues paper will be submitted to the government for consideration.[97]

Committee view

4.109 The evidence presented during this inquiry confirms the findings of the ACFA report and the *2016 National Aged Care Workforce Census and Survey*. The issues of high turnover and recruitment and retention of staff have been consistent themes for aged care service providers outside of major urban centres.

4.110 There are particular needs for training the aged care workforce for regional and remote areas that will need innovative approaches, most likely across aged and disability care and the health sector.

4.111 The recently announced National Aged Care Workforce Strategy will need to address the particular needs of regional and remote service delivery, particularly in the context of CDC, and work in collaboration with stakeholders to arrive at locally relevant and workable solutions to challenges facing particular regions or communities.

4.112 The taskforce should consider work already undertaken by the Greater Northern Australia Regional Training Network (GNARTN) in its issues paper on aged care workforce issues in the Northern Territory.

Concluding committee view

4.113 The committee acknowledges the particular challenges facing aged care workers and service providers in delivering services to a diverse and geographically dispersed ageing population. As part of this inquiry, the committee has had the opportunity to visit and see first-hand, and to hear compelling evidence from, these service providers, aged care workers and other stakeholders. Their message has been clear: there is a need for a more tailored, flexible approach to aged care service delivery, particularly in remote and very remote areas.

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96 National Foundation for Australian Women, *Submission 105*, p. 22.

97 Mr Robert McPhee, Deputy Chief Executive Officer, Kimberley Aboriginal Medical Services, Proof Committee Hansard, 9 June 2017, p. 7.

4.114 Aged care service providers delivering services to Aboriginal and Torres Strait Islander communities, particularly in more remote locations and often as the sole provider, are struggling to adapt to the CDC model, indicating a need for review and change. The committee notes that the government has programs available to assist workers and service providers. However, the evidence from this inquiry shows that some aged care service providers are either unable to access these programs or are unaware of their existence. In some cases, the available support programs do not address the particular needs of the aged care service providers and/or their workforce.

4.115 Equally, service providers delivering services to CALD and LGBTI people are facing difficulties delivering training to prepare and develop the skills of aged care workers in maintaining culturally appropriate care, and in the case of LGBTI workers, of ensuring equitable access to employment.