Australian Government

Department of Health

2 March 2017

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Ms Radcliffe

Additional information from the Commonwealth for the Senate inquiry into the future of the aged care sector workforce

I am writing to provide information on a number of matters that arose at the Committee hearings during late 2016.

This is in addition to responses to Questions on Notice that have already been provided to the Committee by the Commonwealth (identified by the Committee as Questions on Notice documents 16, 18, 20, 22 and 23).

The Department of Health has grouped the additional information as individual papers under eight topics for ease of reference.

Some specific matters were raised in the October 2016 Northern Territory hearings relating to aged care services and workforce issues in remote and very remote areas. The attached papers 1 to 3 seek to cover these matters.

During the 3 November 2016 hearings, a wide range of matters were canvassed during the time available. The Committee advised that the Commonwealth would be invited to provide further evidence. Papers 4 to 8 seek to cover a number of matters that arose during the hearing.

In providing this information, the Department of Health wishes to note that as the Department continues its work on aged care programs and activities during 2017, these may touch on aspects of the Committee's Terms of Reference.

In particular, findings from a number of system-wide reviews are due to inform policies and programs that affect providers and their workforces, including the independent Aged Care Legislated Review (due to report in August 2017).

The Department will continue to monitor the implementation of home care and related reforms, notably the significant changes in home care outlined in the Commonwealth's original submission, and scheduled for February 2017. This will include consideration of any additional steps that may be needed to support providers and their workforces in transitioning to and embedding the reforms, particularly in rural, remote and very remote locations.

Government supports for providers and their workforce have taken a variety of forms, and are not limited to direct funding for providers.

Improving the efficiency of Government/provider transactions, linking aged care to wider health reforms and targeting the spread of innovative models of care can all be expected to make a contribution. Examples of this kind of support include adding to the functionality of My Aged Care, strengthening provider supports relating to dementia and targeting seed funding under the Dementia and Aged Care Services Fund to support innovation.

Finally, I should mention that the results of the latest National Aged Care Workforce Census and Survey will be ready for release in the first quarter of 2017. The Department will ensure that the Committee is informed when the final report and related analysis are available.

Yours sincerely

Margot McCarthy
Acting Secretary
Department of Health

SENATE STANDING COMMUNITY AFFAIRS REFERENCES COMMITTEE INQUIRY INTO THE FUTURE OF AUSTRALIA'S AGED CARE SECTOR WORKFORCE

COMMONWEALTH ADDITIONAL INFORMATION PAPERS, FEBRUARY 2017

1 Aged care for Aboriginal and Torres Strait Islander people in remote and very remote locations – services and related support for providers and their workforces

2 Labour markets in remote and very remote areas – context for the aged care sector workforce

3 Home care delivered on a consumer directed care basis for Aboriginal and Torres Strait Islander people in remote and very remote locations

4 Training and supports for aged care workers on palliative care and dementia

5 Quality and consistency of Vocational Education and Training and employer demand

6 Data about the aged care workforce – coverage, types and sources

7 Carers and the aged care workforce

8 Volunteers as part of the aged care workforce

1 AGED CARE FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE IN REMOTE AND VERY REMOTE LOCATIONS − SERVICES AND RELATED SUPPORT FOR PROVIDERS AND THEIR WORKFORCES

During Committee hearings in the Northern Territory (October 2016) matters were raised relating to the labour market in the Northern Territory, how this affects aged care providers and the supports available for aged care services for older Aboriginal and Torres Strait Islander people in remote and very remote locations.

The purpose of this paper is to provide the Committee with information relating to provision of aged care services for Aboriginal and Torres Strait Islander people and the supports available for providers and their workforces.

1.1. Support from mainstream to specialised services

Arrangements through the Department of Health (the department) to meet the needs of older Aboriginal and Torres Strait Islander people support both consumers and the providers and their workforces interacting with them, by:

- Covering their needs, wherever they may be located, in the design, implementation and review of mainstream aged care services.
- Providing supports for providers in locations where there is a high representation of Aboriginal and Torres Strait Islander people which, in turn, supports their workforces.
- Extending training and other supports to improve access to and the provision of culturally safe and respectful care.
- Monitoring the implementation of aged care reforms, and making suitable improvements, including in relation to the needs and experiences of older Aboriginal and Torres Strait Islander people.
- Taking opportunities to work more collaboratively at the local level, particularly in relation to health matters and services.

The Australian Government's policy approach is to have an aged care system that will support people to stay at home, and remain part of their communities, for as long as possible.[1]This feature is of particular significance for Aboriginal and Torres Strait Islander people in remote and very remote areas.

1.2 Provision as part of mainstream aged care services and funding

Aboriginal and Torres Strait Islander people comprise three per cent of Australia's total population.

As health conditions associated with ageing can affect Aboriginal and Torres Strait Islander people earlier than other Australians the aged care target population includes Aboriginal and Torres Strait Islander people aged 50 years or over.

1.2.1 Needs-based planning

The Australian Government's needs-based planning framework aims to ensure sufficient supply of residential and home care places by ensuring that the growth in the number of aged care places matches growth in the aged population. It also seeks to ensure balance in the provision of services among metropolitan, regional, rural and remote areas, as well as among people needing differing levels of care.[2]

1.2.2 Wellness and reablement − support to stay in the community [3]

In the 2015–16 Budget, the Australian Government announced the expansion of flexible aged care initiatives. A new form of flexible care, the Short-Term Restorative Care Programme, aims to reverse and/or slow 'functional decline' in older people and improve their wellbeing. This programme has been established to increase the care

[1] 2015-16 Report on the Operation of the Aged Care Act 1997, Minister's Foreword, page ix.
[2] 2014-15 Report on the Operation of the Aged Care Act 1997, page 14.
[3] A wellness approach in aged care aims to work with individuals and their carers as they seek to maximise their independence and autonomy. Reablement involves time-limited interventions that are more targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities.

options available to older people, through a time-limited, goal-oriented, multi-disciplinary and coordinated package of services. It is designed and approved by the care recipient, and may be delivered in a home setting, a residential setting, or a combination of both.

Under the Short-Term Restorative Care (STRC) Programme, 475 places have been funded and made available for allocation as part of the 2016-17 Aged Care Approvals Round. For this Round, places were allocated across a number of states and territories, including 10 places in the Northern Territory.

STRC places are now included in the aged care system planning ratio: the total number of short-term restorative care places will increase over time in line with population growth.

1.2.3 Dementia and Aged Care Services Research and Innovation Funding Round

The 2016 Dementia and Aged Care Services (DACS) Research and Innovation funding round, which closed on 20 December 2016, provides up to $34 million funding from 2016-17 to 2018-19 to support innovative projects in six priority areas:

- support for existing and emerging challenges in dementia
- better support for services targeting people from diverse backgrounds
- developments that support innovation in aged care
- support for activities focussing on Aboriginal and Torres Strait Islander people
- capital support for activities focussing on Aboriginal and Torres Strait Islander people, and
- seed funding for adaptive technology projects to enable consumers to stay in their own home.

1.3 Additional provision for services in remote and very remote areas

1.3.1 Viability Supplement

As part of the coverage of the Viability Supplement to certain providers[4], the Government provides a Viability Supplement for providers with more than 50 per cent Aboriginal and Torres Strait Islander residents. The Viability Supplement for residential care is a payment made under the *Aged Care Act 1997* to assist aged care services in rural and remote areas with the extra cost of delivering services in those areas.

- As part of the 2014–15 Budget measure *Reprioritising the Aged Care Workforce Supplement*, the Viability Supplement was increased by 20 per cent.

[4] Some aged care services in rural and remote areas receive a Viability Supplement to assist with providing care in those regions. The Viability Supplement aims to improve the ability of small, rural aged care services to offer quality care to residents. Aged care homes may also be eligible if they provide services for people who identify as Aboriginal and/or Torres Strait Islanders or people who have experienced (or who may be at risk of experiencing) homelessness.

- In 2015-16 changes were announced to improve the Viability Supplement by using a more modern methodology for classifying providers in regional, rural and remote areas.[5]
- The change applied from 1 January 2017, increasing the Viability Supplement to $102.3 million over four years.
- The Government announced a further increase in the Viability Supplement for providers of services in rural and remote locations and for homeless older people in the Mid-Year Economic and Fiscal Outlook of 19 December 2016.[6]
    - The Viability Supplement increase will support rural, remote and homeless service providers eligible under the 2017 Scheme to address impacts from changes relating to the Aged Care Funding Instrument.
    - From 1 July 2017, the Viability Supplement will be increased by $19.3 million over four years, through a flat rate increase of an additional $2.12 per resident per day. This will be paid to around 350 eligible services nationally under the Modified Monash Model.

1.3.2 Rural, Regional and Other Special Needs Building Fund

The Australian Government acknowledges that some providers may not be in a position to attract sufficient residents who pay for accommodation costs by lump sum payment (either refundable accommodation deposit or bond). Providers may, for example, be limited in attracting this type of capital for investment in their facilities as a result of their rural or remote location or because the homes target financially disadvantaged people or people from special needs groups as defined in the Act.

The Rural, Regional and Other Special Needs Building Fund provides targeted capital assistance to assist providers who, as a result of such circumstances, are unable to meet all or part of the cost of necessary capital works.

In 2016-17, up to $64 million in capital grants under the Rural, Regional and Other Special Needs Building Fund are available as part of the 2016-17 Aged Care Approvals Round.

1.3.3 Multi-Purpose Services Program delivering some health and aged care services in rural and remote communities

The Multi-Purpose Service (MPS) Program is a joint initiative of the Australian Government and all states and territories, other than the Australian Capital Territory. The MPS Program recognises that the delivery of some health and aged care services may not be viable in rural and remote communities if they are provided separately. By operating an integrated health and aged care service, economies of scale are achieved to support the delivery of a range of health and aged care services.

Multi-Purpose Services operate under the Act and deliver a mix of aged care in a residential or home care setting in rural and remote communities. In general, they are operated by state, territory, and local governments, and are primarily located in hospital settings.

[5] The Modified Monash Model. See 2015-16 Report on the Operation of the Aged Care Act 1997, Page 67.
[6] For details see: http://www.health.gov.au/internet/budget/publishing.nsf/Content/MYEFO-2016

At 30 June 2016, there were 177 operational MPSs, with a total of 3,592 flexible care places.[7] Additionally, in 2015-16, the Australian Government provided Viability Supplement funding of $19.1 million for MPS'.

1.4 Flexible and specialist aged care services for Aboriginal and Torres Strait Islander people − National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP)

This program was described briefly in the Commonwealth's original submission[8]. At hearings of the Committee in the Northern Territory, the Committee explored in more detail certain aspects of the workforce issues arising for NATSIFACP providers. This section provides additional information on these matters.

NATSIFACP operates alongside mainstream services. Aged care services are funded under this program to provide culturally appropriate care to Aboriginal and Torres Strait Islander people close to home and are mainly located in rural and remote locations. As at 30 June 2016, funding of $35.2 million was allocated for 32 services to deliver 820 aged care places through the program.

In addition, a new service is being established in the Northern Territory at Nhulunbuy, this service will be operational in late 2018.

1.4.1 Grants to support improvements in NATSIFACP services

Under the NATSIFACP the department may provide for one-off grants from unsolicited proposals which are essential to the delivery of aged care services. These include but are not limited to:

- the provision of staff accommodation
- equipment
- minor building works;
- staff training;
- Nurse Advisors, and
- Administrators.

[8] See submission no 293, page 31.

Table 1 Example of grants for improvement proposals under the NATSIFACP approved for funding in 2016

Service Provider	Service	Purpose
Australian Regional and Remote Community Services	Pulkapulkka Kari, Tennant Creek Northern Territory	Purchase medical equipment and purchase and install a nurse call bell system
Australian Regional and Remote Community Services	Tjilpi Pampaku Ngura Aged Care Service, Docker River Northern Territory	Purchase equipment, install external security camera and replace internal flooring
Winnam Aboriginal & Torres Strait Islander Corporation	Georgina Margaret Davidson Thompson Hostel, Morningside Queensland	Purchase of medical equipment, pagers, and beside lockers
Palm Island Aboriginal Council	Sandy Boyd Hostel, Palm Island, Queensland	Air conditioning system, kitchen equipment, lighting and hot water system upgrade and lifting hoist

1.5 Remote and Indigenous Aged Care Service Development Assistance Panel

The Australian Government funds a Remote and Indigenous Aged Care Service Development Assistance Panel (the SDAP) to support aged care providers to build capacity and improve the quality of aged care services provided to care recipients.

The SDAP assists aged care providers to develop culturally appropriate local solutions to address the challenges of maintaining and delivering quality aged care services to Aboriginal and Torres Strait Islander communities and people living in the remote and very remote areas of Australia.

Eligible aged care service providers are one of the following:

- funded under the NATSIFAC
- residential aged care services operating under the Aged Care Act
- delivering Home Care Packages incorporating the Consumer Directed Care (CDC) model under the *Aged Care Legislation Amendment (Increasing Consumer Choice) Act 2016*
- Commonwealth Home Support Programme (CHSP) providers may be eligible, at the department's discretion.

SDAP panel members provide expert advice on quality care, governance, financial and business management and can also advise on staff recruitment, retention, mentoring and training.

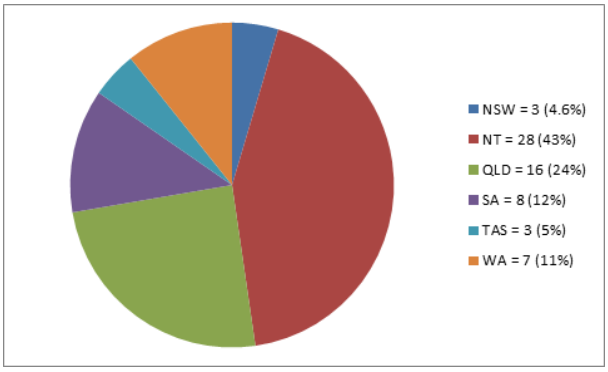
The Panel was first established in 2010. As at 30 June 2016, 20 SDAP contractors have been engaged by the department to deliver 65 projects nationally.

Around half of the SDAP projects are being delivered in the Northern Territory.

Projects can deliver support to aged care providers under the following categories:

- Care Delivery – providing quality care to care recipients
- Quality Delivery – meeting the required regulatory requirements and quality standards and promoting a continuous improvement framework
- Governance – meeting organisational responsibilities
- Business Management – ensuring the organisation is well managed and staff and management capability is enhanced
- Financial Management – effective financial management
- Project Management – developing, managing and delivering a project (includes scoping activities for building and infrastructure projects).

Figure 1 Remote and Indigenous Aged Care Service Development Assistance Panel − Distribution of 65 projects, at 30 June 2016



The current Panel was established in 2013 and is due to expire in June 2017. A procurement process is underway to establish the new Panel to support service providers faced with challenges in delivering timely and quality aged care services in remote and very remote locations from 1 July 2017.

The eligibility criteria and the service categories provided by the existing Panel have been reviewed to ensure that the Panel will be renewed in line with contemporary aged care business management practices and changes to the aged care system.

The Panel will continue to support workforce-related activities such as recruitment, retention and rostering procedures. Panel members will also assess training needs for clinical, quality, business practices and develop training activities, training materials and deliver training. The requirement for training in cultural awareness has been strengthened to ensure service providers and their staff are appropriately skilled to address the needs of Aboriginal and Torres Strait Islander people and people living in remote communities.

1.6 Targeted workforce measures

1.6.1 Supporting employment of Aboriginal and Torres Strait Islander people

Under the Indigenous Employment Initiatives (IEIs) program, the department provides funding for the employment of Aboriginal and Torres Strait Islander people in aged care services. Funding is provided in salary units for wages and on costs for permanent and part-time equivalent positions.

The program provides aged care jobs across Australia to more than 750 Aboriginal and Torres Strait Islander people in permanent and part-time positions in Indigenous-specific aged care services in rural and remote locations.[9]

In recognition of individual service needs and workforce requirements, each salary unit can be combined or split to allow for flexibility in employment. The number of hours required to be worked for each position should be determined in line with service delivery needs.

The organisation is required to ensure that persons employed under the IEIs are provided with standard employment conditions (including superannuation and leave entitlements). They are paid at the relevant award rate, at a minimum, or in line with equivalent hourly rates paid by the organisation, where this amount is greater.

The IEIs have $20.4 million (GST exclusive) funding for 2016-17.

1.6.2 Education and training programs

The department provides training funding for participants under the IEIs via two approaches:

- *Funding registered training organisations (RTOs) to provide training*:
  - This approach was used for the states and territories with the highest number of funded organisations – Western Australia, South Australia, Northern Territory and Queensland.
  - The RTOs were sourced via a tender process. There have been several extensions to contracts since the initial engagement of the RTOs.
- *Providing direct funding to aged care providers:* This approach was used for the states and territories with a smaller number of funded organisations – New South Wales, Tasmania, Victoria and the Australian Capital Territory.

The Northern Territory Training Program (NTTP) and the Rural and Remote Training Program (RRTP) fund training via RTOs in rural and remote locations in Western Australia, South Australia, Northern Territory and Queensland by the following training providers:

NTTP providers:

- Charles Darwin University

[9] Information about the overall program was provided in the Department of Health's response to Questions on Notice taken at the 3 November 2016 (number 18 in the Committee's Questions on Notice page at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareWorkforce45/Additional_Documents).

- HK Training & Consultancy
- Fox Education & Consultancy
- STEPS Group Australia.

RTTP providers:

- North Regional TAFE (Western Australia)
- Queensland TAFE North
- TAFE South Australia.

The RRTP has $3 million (GST exclusive) funding for 2016-17 and the NTTP has $2.9 million (GST exclusive) funding.

The RTOs are funded to provide culturally appropriate, targeted and accredited aged care training to Aboriginal and Torres Strait Islander people.

This approach has helped to alleviate some difficulties Aboriginal and Torres Strait Islander aged care workers in remote areas faced in accessing mainstream training opportunities, such as the cost of travel and accommodation and the lack of culturally appropriate training courses.

Performance of RTOs in the NT

The department notes that there have been some concerns raised at Committee hearings in the Northern Territory about the provision of training to the Northern Territory McDonnell Regional Council aged care services.

The RTO for the region has changed over the past few years and more recently the department is working with both the aged care provider and the training provider to improve access to beneficial training for both employees and the aged care service providers.

Table 2 sets out training provided for McDonnell Regional Council (NT) aged care services since November 2014.

Table 2 Training provided for McDonnell Regional Council (NT) aged care services since November 2014

		TRAINING DAYS DELIVERED					PLANNED Training
Training Period	Community	Nov 2014 – Apr 2015	May – Sep 2015	Oct 2015-Mar 2016	April – June 2016	July-Dec 2016	Jan-June 2017
McDonnell Regional Council	Aputula (Finke)	17	25	10	1	16	15
	Imanpa	7	13	0	10	13	15
	Titjikala	23	16	20	0	16	15
	Amoonguna	12	8	7	0	4	15
	Areyonga	0	0	0	5	5	15
	Hermannsburg	34	19	7	0	20	16
	Ikuntji (Haasts Bluff)	9	11	0	15	21	16
	Papunya	14	10	0	8	15	15
	total	116	102	44	39	110	122

Indigenous Remote Service Delivery Traineeship program

The Indigenous Remote Service Delivery Traineeship (IRSDT) program funds employment and training opportunities in business-focused roles in Aboriginal and Torres Strait Islander-specific aged care and primary health care services.

The IRSDT has operated since 2009 and aims to build the business and management capacity of the aged care service.

Sixteen Aboriginal and Torres Strait Islander aged care services receive funding to meet award wages, compulsory superannuation contributions and leave entitlements.

The IRSDT mainly operates in NSW. A limited number of aged care services in the Northern territory, Queensland, South Australia and Western Australia also receive funding through the IRSDT program.

All training is provided by one RTO, the BCA National Training Group. BCA provides training towards six specific qualifications:

- BSB10115 Certificate I in Business
- BSB20115 Certificate II in Business
- BSB30115 Certificate III in Business
- BSB40215 Certificate IV in Business;
- BSB51915 Diploma of Leadership and Management, and
- BSB61015 Advanced Diploma of Leadership and Management.

The IRSDT program has $4.8 million (GST exclusive) funding for 2016-17.

1.7 Aboriginal and Torres Strait Islander people in the aged care workforce nationally

1.7.1 Context − labour force participation rates for Aboriginal and Torres Strait Islander people

Nationally, the labour force participation rate for Aboriginal and Torres Strait Islander people was 61.1 per cent for people aged 15-64 years in 2014-15.

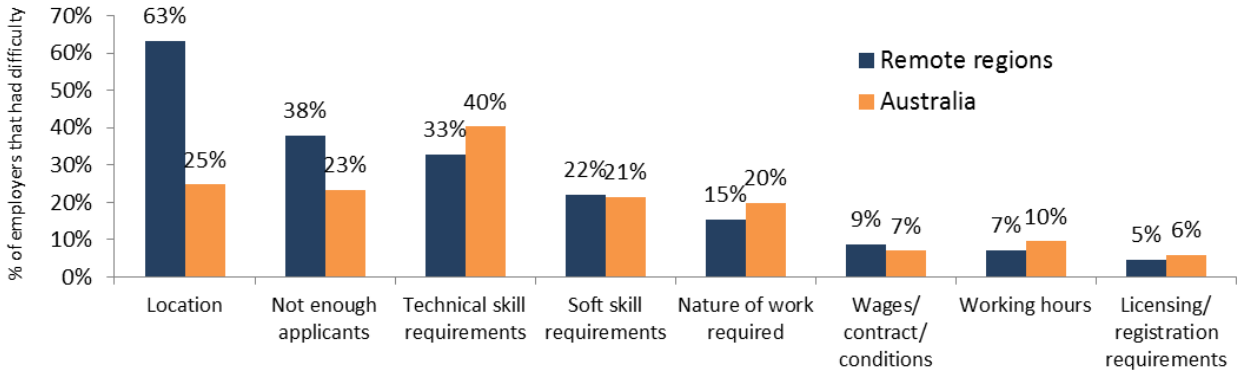
The highest overall labour force participation rates for Aboriginal and Torres Strait Islander peoples are in the Australian Capital Territory (at 67 per cent) and Queensland (at 63 per cent) while the Northern Territory (at 47 per cent) and Western Australia (at 53 per cent) have the lowest participation rates.[10]

1.7.2 Employer difficulties filling vacancies in remote regions

In June 2016, the Department of Employment, as part of its Survey of Employers' Recruitment Experiences, interviewed just under 900 employers in remote regions[11] across Australia. Employers were asked what difficulties they had filling their vacancies in their most recent round of recruitment.

The reasons for employers' recruitment difficulty in remote regions varied markedly compared to the overall results for Australia. As shown in Figure 2, employers in remote regions more commonly had recruitment difficulty due to their location (63 per cent of employers had difficulty) compared with Australia (25 per cent). Remote employers also more frequently mentioned not receiving enough applicants (38 per cent) compared with Australia (23 per cent).

Figure 2 Filling vacancies in remote regions − reasons for recruitment difficulty



[10] ABS *National Aboriginal and Torres Strait Islander Social Survey 2014-15*. See: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4714.0~2014-15~Main%20Features~Labour%20force%20characteristics~6

[11] Regions in which the Community Development Programme (CDP) operates. The CDP is the Australian Government's employment service for job seekers in remote regions. A map of CDP regions is available on the CDP webpage of the Department of the Prime Minister and Cabinet's website.

1.7.3 Indigenous employment in the residential aged care workforce[12]

Introduction

Data in this entry are preliminary data from the draft report from the 2016 National Aged Care Workforce Census and Survey (NACWCS).[13] Estimates may be changed when the final report is published in the first quarter of 2017.

Estimates of the Aboriginal and Torres Strait Islander direct care workforce are derived from a small sample and are therefore imprecise. Caution should be used in the interpretation of these results.

The overall proportion of Aboriginal and Torres Strait Islander people in the total direct care residential aged care workforce in 2016 was 1.2 per cent.

For purpose of comparison, ABS population estimates for 2011 for the 15-64 year age group show that Aboriginal and Torres Strait Islander people make up 2.7 per cent of the total population in this age group.[14]

Of the Aboriginal and Torres Strait Islander residential direct care workers, 81 per cent were in a personal care attendant role. In comparison, 70 per cent of the total direct care residential workforce were personal care attendants. Aboriginal and Torres Strait Islander residential direct care workers were therefore correspondingly less likely to be in nursing or allied health roles than other residential direct care workers.

1.7.4 Indigenous employment in the Home Care and Home Support aged care workforce[15]

Data in this entry are preliminary data from the draft report from the 2016 NACWCS. Estimates may be changed when the final report is published in the first quarter of 2017.

Estimates of the Aboriginal and Torres Strait Islander direct care workforce are derived from a small sample and are therefore imprecise. Caution should be used in the interpretation of these results.

The overall proportion of Aboriginal and Torres Strait Islander people in the total direct care Home care and Home support aged care workforce in 2016 was 2.1 per cent.

Of the Aboriginal and Torres Strait Islander direct care workers in Home care / Home support, 93.9 per cent were in a community care worker role. In comparison, 83.8 per cent of the total direct care Home care / Home support workforce were community

[12] Preliminary data from 2016 National Aged Care Workforce Census and Survey (Census of residential aged care facilities).
[13] The Aged Care Workforce Census and Survey was undertaken for the Department by the National Institute of Labour Studies at Flinders University.
[14] The Department's analysis of ABS 3238.0.55.001 - Estimates of Aboriginal and Torres Strait Islander Australians, June 2011.
[15] Preliminary data from 2016 National Aged Care Workforce Census and Survey (Census of Home care/Home support service outlets).

care workers. Aboriginal and Torres Strait Islander home care/ home support direct care workers were therefore correspondingly slightly less likely to be in nursing or allied health roles than other home care/ home support direct care workers.

1.8 Providers and their workforces and meeting the needs of Aboriginal and Torres Strait Islander people – Looking ahead

1.8.1 Audit findings on Indigenous aged care

During 2016, the Australian National Audit Office (ANAO) undertook a Performance Audit of Indigenous aged care.

The ANAO's report is expected to be tabled in Parliament in the first quarter of 2017. The department will draw on the findings to improve its stewardship of Indigenous aged care.

1.8.2 Extending understanding of wellness and reablement in home care

As part of a review of the current uptake and understanding of wellness and reablement within the home care sector, the review will include service providers delivering home care services under the NATSIFACP. The review is to include a change management strategy, and will be completed by July 2017.

1.8.3 Implementation of the Aboriginal and Torres Strait Islander Health Plan

The Implementation Plan for the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* comprises seven domains that relate to the changes needed to make the health system more comprehensive, culturally safe and effective for Aboriginal and Torres Strait Islander people.

The domains are health systems effectiveness, maternal health and parenting, childhood health and development, adolescent and youth health, healthy adults, healthy ageing, and the social and cultural determinants of health.

Each of the domains includes strategies and corresponding actions and deliverables by 2018 and 2023 respectively, to be achieved by the department and other agencies.

The vision for Domain 6: Healthy Ageing is that 'older Aboriginal and Torres Strait Islander peoples remain active, healthy, independent and comfortable for as long as possible and have access to culturally secure and responsive aged care services.'

Four strategies underpinning this vision deal with:

- access to culturally appropriate residential care and support;
- maintaining independence, good health, and social and cultural connectedness;
- ensuring capability and skills of providers and health workers; and
- local elders and senior community members as champions of culturally appropriate health and wellbeing choices.

Amongst the 15 deliverables covered by the Healthy Ageing Domain is:

- provision for 30 additional places through the NATSIFACP to deliver culturally appropriate health services, and

- the development of an information package for mainstream aged care providers to ensure providers better understand the experiences of the Stolen Generations and the impact on their aged care needs.
  - The package, *Caring for Forgotten Australians, Former Child Migrants and Stolen Generations Information Package for Aged Care Providers* was publicly released on 15 December 2016.[16]
  - The package consists of an information booklet, a video, a training facilitator guide and a PowerPoint presentation to assist providers and their workforces in responding to the specific needs of the forgotten Australians who may use their services.[17]

1.8.4 Aged Care Legislated Review

In addition, the independent Aged Care Legislated Review is to report by August 2017 on the impact of the aged care system changes made to date and where the system may be taken in the future. The matters covered include the effectiveness of arrangements for protecting equity of access to aged care services for different population groups.

1.8.5 Cultural competency and respect

The Minister for Aged Care, The Hon Ken Wyatt AM, MP has emphasised the need to 'embed cultural competency into the way all services are run – so that cultural competency and respect are recognised as fundamental to health outcomes for our mob – that is going to be a big shift, but a critical one, and it has to happen.'[18]

The department considers that more can be done to:

- Tailor information and processes to support consumer choice and decision making in Aboriginal and Torres Strait Islander communities.
- Encourage sharing what works in the sector, for providers and their workforces, in responding to the needs of Aboriginal and Torres Strait Islander people.[19]

[16] See: http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2016-wyatt028.htm. The package was provided for in the Implementation Plan for the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*, page 32.
[17] The package can be accessed on the Department of Health website at: https://agedcare.health.gov.au/careleavers.
[18] Speech by the Assistant Minister for Health and Aged Care, The Hon Ken Wyatt AM, MP presented at the Lowitja Institute International Indigenous Health and Wellbeing Conference on 8 November 2016. See: http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2016-wyatt161108.htm?OpenDocument&yr=2016&mth=11
[19] Indigenous communities establishing innovative care approaches such as Kapululangu Aboriginal Women Law and Culture Centre, in Balgo on the Northern Edge of the Great Sandy Desert in Western Australia – where volunteers and carers run an aged care facility for female Elders along ancient cultural lines. More information can be found on the Kapululangu Aborginal Women Law and Culture Centre website.

- Draw on experience gained, models used and resources developed in other comparable sectors and tap into wider workforce initiatives relating to supporting Aboriginal and Torres Strait Islander workforces in remote and very remote locations.[20]
- Extend training for workforces interacting with older Aboriginal and Torres Strait Islander people and their communities.

[20] For example, the University of Queensland's Centre of Research Excellence in Telehealth has published an evidence-based guide on making best use of telehealth. See: http://cretelehealth.org.au/filething/get/2100/FINAL%20I2I%204%20Telehealth%20%20Nov%202016.pdf

2 LABOUR MARKETS IN REMOTE AND VERY REMOTE AREAS – CONTEXT FOR THE AGED CARE SECTOR WORKFORCE

During Committee hearings in the Northern Territory (October 2016) matters were raised relating to the labour market in the Northern Territory, how this affects aged care providers and the supports available for aged care services for older Aboriginal and Torres Strait Islander people in remote and very remote locations.

This paper provides more information on labour markets in remote and very remote areas to provide the Committee with some contextual information in considering the aged care workforce in these areas.

The information in this paper (except for 2.5) has been assembled from data and analysis provided by the Department of Employment.

2.1 Introduction

Set out below are some data and analysis provided by the Department of Employment on labour market conditions in selected remote and very remote areas. They include data derived from Australian Bureau of Statistics (ABS) datasets.

The Department of Employment undertakes research on an ongoing basis to understand the supply and demand for skilled workers and identify shortages in skilled occupations in the Australian labour market.

2.2. Labour market conditions in selected remote and very remote areas

The Department of Employment hosts the Labour Market Information Portal which brings together data from a range of official sources to help anyone – such as sectors, employers and prospective employees − who need to understand individual or multiple local labour markets. [1]

2.2.1 Considerations

The data provided below focuses on overall labour market conditions in remote and very remote Northern Territory, Queensland and Western Australia (Statistical Area Level 4 (SA4) regions) and skills shortages in regional locations.

It should be noted that ABS data for Statistical Area Level 4 (SA4) regions exhibit considerable volatility and should be viewed with caution. In addition, as some SA4s are quite large, considerable disparity can exist within the regions.

2.2.2 Northern Territory – Outback

Labour market conditions in the Statistical Area 4 of 'Northern Territory – Outback' have weakened over the year to November 2016. For instance, the level of employment has contracted by 400 (or 0.8 per cent) over the last 12 months, to 51,600 in November 2016.

While the unemployment rate in Northern Territory – Outback has decreased over the period, from 6.0 per cent in November 2015, to 4.6 per cent in November 2016 (well below the national rate of 5.7 per cent), the decline has been driven by a 1.4 percentage point fall in the region's participation rate, which declined to 69.7 per cent in November 2016, although it remains well above the national rate of 64.6 per cent.

The largest employing industries in Northern Territory - Outback as at November 2016 (latest available industry employment data) were public administration and safety (employing 11,200 or 21.7 per cent of total employment in the region), health care and social assistance (7500 or 14.5 per cent), education and training (4,800 or 9.3 per cent) and construction (4,000 or 7.8 per cent).

Over the five years to November 2020, the largest growth in employment in the region is projected for public administration and safety (up by 1100), health care and social assistance (900), accommodation and food services (300) and construction (300). By contrast, falls in employment are expected in mining (down by 400), manufacturing (100), and other services (100).

2.2.3 Queensland – Outback

[1] The Portal is at http://lmip.gov.au/.

Labour market conditions in the SA4 of Queensland – Outback have deteriorated over the year to November 2016. For instance, the level of employment in the region has contracted by 9,900 (or 21.2 per cent) over the last 12 months, to 36,800 in November 2016.

The unemployment rate has increased over the period, from 6.0 per cent in November 2015, to 11.7 per cent in November 2016, the highest unemployment rate recorded of any region in Australia. Moreover, the participation rate in Queensland – Outback has fallen by 12.3 percentage points over the year, to stand at 60.1 per cent in November 2016, well below the national rate, of 64.6 per cent.

The largest employing industries in Queensland - Outback as at November 2016 (latest available industry employment data) were mining (employing 7,500 or 19.6 per cent of total employment in the region), public administration and safety (6,400 or 16.8 per cent), agriculture, forestry and fishing (3,600 or 9.4 per cent) and accommodation and food services (3,500 or 9.3 per cent).

Over the five years to November 2020, the largest growth in employment in the region is projected for the industries of health care and social assistance (up by 500) and public administration and safety (200). By contrast, a fall in employment is expected in the mining industry (down by 1,200), while the level of employment in the majority of industries is expected to remain steady.

2.2.4 Western Australia – Outback

Labour market conditions have improved somewhat in the Western Australia – Outback SA4 over the last year, with the level of employment increasing by 2,100 (or 1.5 per cent) over the period, to 138,500 in November 2016.

The unemployment rate has decreased over the period, from 6.5 per cent in November 2015, to 5.9 per cent in November 2016, but remains above the national rate, of 5.7 per cent. That said, the participation rate in Western Australia – Outback has also fallen over the year, from 75.7 per cent in November 2015 to 75.5 per cent in November 2016, although it remains well above the national rate, of 64.6 per cent.

The largest employing industries in Western Australia - Outback as at November 2016 (latest available industry employment data) were mining (employing 30,900 or 22.2 per cent of total employment in the region), retail trade (13,600 or 9.8 per cent), public administration and safety (12,800 or 9.2 per cent) and construction (11,800 or 8.5 per cent).

Over the five years to November 2020, the largest growth in employment in the region is projected for the industries of education and training (up by 1,400), public administration and safety (1,300), accommodation and food services (700) and retail trade (600). By contrast, the largest falls in employment are expected in mining (down by 4,000), wholesale trade (200) and electricity, gas, water and waste services (100).

2.3 Skills shortage research

2.3.1 Recruitment of nurses and allied health professionals

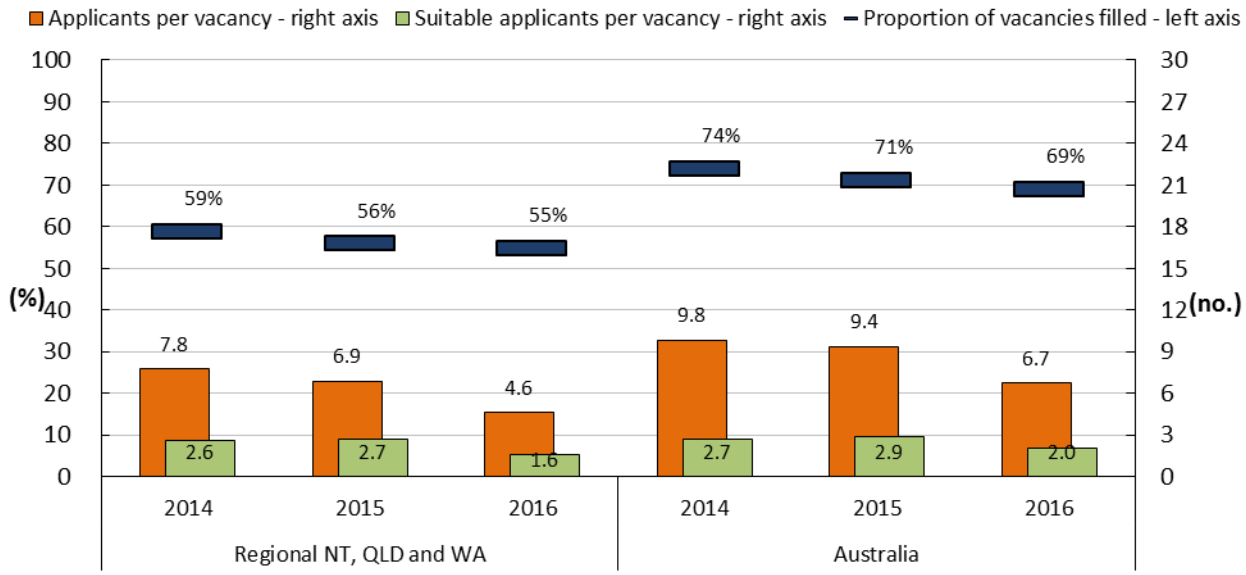
Although the Department of Employment's skill shortage research does not provide data specifically for remote and very remote areas, it is clear from this work that

employers recruiting for allied health professionals in regional locations of Queensland, Western Australia and the Northern Territory (a proxy for remote) generally experience greater difficulty than other employers recruiting for these professionals. The same is true for nurses.

Figures 1 and 2 below show the markedly lower numbers of applicants and vacancies filled in these regional areas compared with the results for Australia.

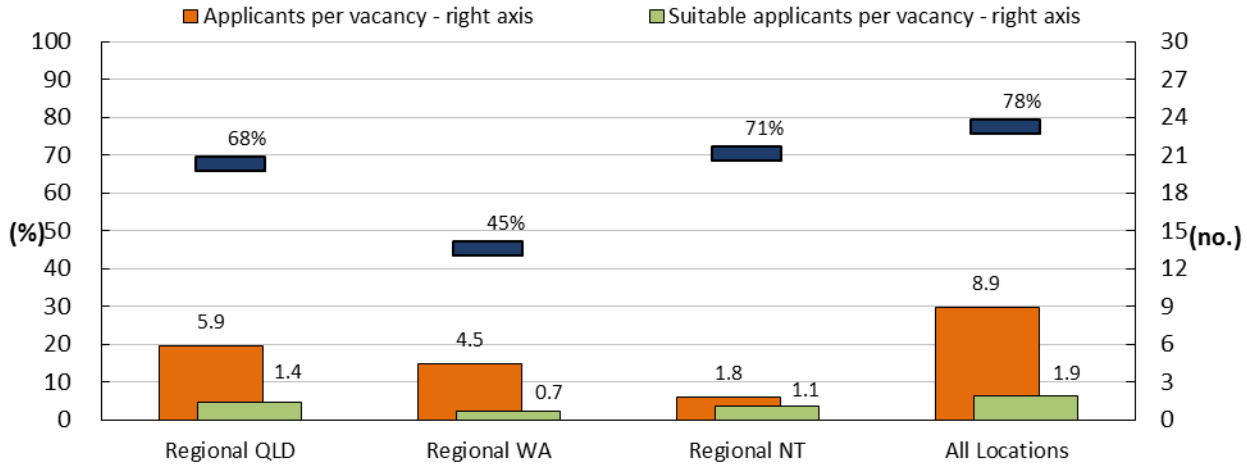
Research undertaken by the Department of Employment in 2014, into the labour market for personal care workers in aged and disability care indicated that regional aged care providers attracted markedly smaller candidate fields than those in metropolitan locations, although they filled a similar proportion of vacancies.

Figure 1 Proportion of vacancies filled, no. of applicants and suitable applicants, Allied health professions, selected location, 2014 to 2016



Source: Department of Employment, Skill Shortage Research 2016 (assessed allied health professions - excludes nurses and medical practitioners).

Figure 2 Proportion of vacancies filled, no. of applicants and suitable applicants, Nurses, selected locations, 2016



Source: Department of Employment, Skill Shortage Research 2016 (registered and enrolled nurses).

Across all skilled occupations, although there are smaller fields of applicants, there are generally larger numbers of suitable applicants per vacancy in regional areas of Queensland, Western Australia and the Northern Territory when compared with all locations (see Table 1). There is only a slight difference in the proportion of vacancies filled in these locations compared with the average across all skilled occupations nationally.

Table 1 Proportion of vacancies filled, no. of applicants and suitable applicants, all assessed occupations, selected location

	All locations			Regional Queensland, Western Australia, Northern Territory		
Year	Proportion of vacancies filled (%)	Av number of applicants per vacancy	Av number of suitable applicants per vacancy	Proportion of vacancies filled (%)	Av number of applicants per vacancy	Av number of suitable applicants per vacancy
2014	75	15.2	2.4	74	13.7	2.5
2015	70	12.4	2.1	69	9.8	2.2
2016	67	12.5	2.0	65	12.6	2.3

Source: Department of Employment, Skill Shortage Research 2016.

2.3.2 Analysis of the Northern Territory labour market for skilled workers

The Department of Employment's research shows that the Northern Territory labour market is tighter in terms of the availability of skilled workers, compared to the national labour market.

There are consistently lower numbers of applicants for skilled vacancies in the Northern Territory. This is especially apparent in the allied health professions for which there is no local training and shortages are long standing.

In 2016, there are current, Northern Territory wide shortages identified for the following allied health professions.

2512-11	Medical Diagnostic Radiographer
2512-14	Sonographer
2514-11	Optometrist
2515-11,13	Hospital and Retail Pharmacists
2524-11	Occupational Therapist
2525-11	Physiotherapist.

The labour market for skilled workers tightened in the Northern Territory in 2015-16, with markedly fewer applicants and suitable applicants than there were the previous year. There was also a ten percentage point drop in the proportion of vacancies filled.

2.3.3 National picture of long standing skill shortages

Nationally, there were significant and widespread shortages of allied health professionals in the decade to 2009, but the labour market has eased (mainly on the back of increased training) and widespread national shortages are no longer evident.

Shortages are now limited to a small number of occupations, although employers in some regional locations and those recruiting for sectors such as aged care, sometimes have difficulty attracting workers who have appropriate skills and experience. Shortages of optometrists, sonographers and audiologists, however, have been persistent and widespread.

Employment of allied health professionals is increasing strongly, but there has also been a large increase in training numbers over recent years, which has boosted the available supply of these workers. There is now some surplus capacity, particularly at the new graduate level.

National shortages of registered nurses were evident almost continuously between 1986 and 2011 and for enrolled nurses between 2008 and 2012, but these have now abated.

The labour market for nurses remains complex. Overall, employers are able to recruit nurses with ease but results at the state and territory level are mixed.

2.4 Labour market for specific skilled occupations important for aged care

Set out below are some analyses prepared by the Department of Employment of the labour markets for specific skilled occupations which are important to aged care.

These provide national pictures across all employing sectors, but specific findings have been drawn out from the research which relate to regional or remote issues, or to the aged care sector.

Detailed statistical tables are available if needed.

2.4.1 Enrolled and Registered Nurses

There is no national shortage of Registered Nurses and Enrolled Nurses however, regional employers find it considerably more difficult than their metropolitan counterparts to recruit these workers.

There are shortages of registered nurses in regional areas of New South Wales and some difficulties recruiting in regional Western Australia.

- In Victoria, employers across the state experience difficulty filling registered nurse roles in residential aged care.

Regional aged care – Registered Nurses

- Western Australia: 50 per cent of regional vacancies for registered nurses were filled, compared with 80 per cent in metropolitan areas.
  - Unfilled vacancies in regional areas were for positions in the aged care and Aboriginal health care sectors, and the main reason these vacancies remained unfilled was applicants' unwillingness to relocate.
  - More generally, Western Australian employers reported that it was more difficult to recruit experienced Registered Nurses and some indicated that they compromised on the level of experience required in order to fill their vacancies.
- Northern Territory: A number of Northern Territory employers stated that the Department of Health funded Rural Health Professionals Program (RHPP) was helpful in providing recruitment, orientation and retention support services to nurses and allied health professionals into rural and remote Australia and Aboriginal and Torres Strait Islander health services.
  - Nursing is one of the priority professions for the RHPP with 68 per cent of the total number of health professionals assisted to go rural in 2014-15 being nurses or physiotherapists.

Regional and aged care – Enrolled Nurses

- Queensland: For enrolled nurses, half the surveyed vacancies in regional Queensland were filled (compared with all filled in metropolitan areas). For Queensland as a whole, around 78 per cent of those applicants who were qualified were considered by employers to be unsuitable. Many applicants, particularly in regional areas, were new graduates without the necessary depth of experience, while others lacked specific experience in areas such as emergency or aged care.

- Western Australia: The majority of surveyed enrolled nurse vacancies were in the aged care sector. Overall, 87 per cent of vacancies were filled.
  - The main reasons vacancies remained unfilled were applicants securing other employment or not being available for the required hours.
  - A small number of employers were unable to fill vacancies due to applicants' lack of experience in the relevant sector (e.g. aged care).
  - Employers in regional areas had more difficulty filling vacancies mainly due to lower numbers of qualified applicants and applicants who were unwilling to relocate
  - Some surveyed employers in the aged care sector commented that one of the reasons they believe it is difficult to attract suitable applicants is that some enrolled nurses consider that wages and working conditions in hospitals are more attractive than in aged care facilities.

2.4.2 Occupational therapists

- There are more than adequate supplies of occupational therapists across most locations and national shortages have not been apparent since 2010. However, there are shortages in the Northern Territory and Tasmania.
- Regional vacancies attract significantly smaller fields of applicants and slightly fewer suitable applicants.

2.4.3 Physiotherapists

General comment

- It is hard to recruit physiotherapists in regional locations.
- Shortages are evident in regional Victoria, Queensland and Tasmania, and across the Northern Territory.
- Although shortages are evident in a number of regional areas, there are marked differences in recruitment experiences between locations and specialisations.

Aged care

- In New South Wales, difficulties filling physiotherapist positions in aged care were no longer apparent in 2016.
- In Victoria, employers suggested that the aged care sector is less attractive to graduating physiotherapists, which makes recruitment into this field particularly difficult. In this state, also, it was noted that the primary factor impacting on the suitability of qualified applicants across both metropolitan and regional areas was a lack of experience in specialised fields, especially aged care.
    - Employers in the aged care sector commented on the personal attributes required to work with the ageing population. These included patience, empathy and an understanding of the demographic. Some employers considered qualified applicants unsuitable if they did not possess all of these characteristics.

2.4.5 Podiatrists

General comment

Employers in hospitals, private practice, community health and other sectors are generally able to fill vacancies for junior to senior podiatrists across a wide range of specialisations including general podiatry, muscoskeletal, biomechanics, acute care/high risk and aged care.

Underlying demand for the profession is increasing due to the growth and ageing of the population and health factors such as the increasing incidence of type 2 diabetes, renal disease and obesity.[2]

Department of Employment projections show a 16.7 per cent increase in employment of podiatrists over the five years to 2020. This is well above the average growth of 8.3 per cent for all occupations.[3]

Vacancies were filled across a range of specialisations including general podiatry, muscoskeletal, biomechanics, acute care/high risk, and aged care.

[2] Health Workforce Australia, *Australia's Health Workforce Series Podiatrists in Focus,* March 2014
[3] Department of Employment, *Occupational Employment Projections to November 2020*

A small number of employers in regional NSW were unable to fill their vacancies. However, all these vacancies attracted more than one suitable applicant. Vacancies remained unfilled because suitable applicants accepted other employment or decided not to relocate to the relevant region.

In addition, some additional data by location (including some unpublished) for specific labour markets are provided below.

Note: More detailed analysis and data on skills shortages, filling of vacancies for speech pathologist, optometrists and audiologists and regional (non-metropolitan) labour market analysis for Northern Territory, Western Australia and Queensland can be provided.

2.5 Nursing and allied health professionals − access to support through the Department of Health funded Rural Health Professionals Programme (RHPP)

RHPP has been designed to attract, recruit and retain nursing and allied health professionals from Australia and approved overseas locations. Successful candidates are provided with retention support to help them stay practising in rural and remote communities for up to two years.

The priority professions for RHPP are:

- Nursing and Midwifery
- Physiotherapy
- Social Work
- Psychology and other mental health professions
- Speech Pathology
- Occupational Therapy, and
- Podiatry

Eligibility is also extended to the following professions:

- Dental Hygienists
- Diabetes Education
- Dietetics, Nutrition
- Medical Imaging (Radiography, Sonography)
- Pharmacy
- Audiology
- Aboriginal and Torres Strait Islander Health Workers
- Exercise Physiology, and
- Orthotics and Prosthetics

RHPP is administered by Rural Health Workforce Australia and delivered via the network of seven state and territory Rural Workforce Agencies. The agencies work with employers to identify eligible vacancies and provide case-managed recruitment services to eligible candidates.[4]

[4] See: http://www.rhwa.org.au/ruralworkforceagencies

3 HOME CARE DELIVERED ON A CONSUMER DIRECTED CARE BASIS FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE IN REMOTE AND VERY REMOTE LOCATIONS

During Committee hearings in the Northern Territory (October 2016) matters were raised relating to the labour market in the Northern Territory, how this affects aged care providers and the supports available for aged care services for older Aboriginal and Torres Strait Islander people in remote and very remote locations.

This paper provides the Committee with additional information relating to the delivery of home care based on a consumer directed care approach, the support available to providers and their workforces, and provision for further review based on experience, including in specialist services for Aboriginal and Torres Strait Islander people.

3.1 Delivery of home care through consumer directed care

3.2 Ongoing monitoring of implementation of changes in home care and identifying issues for attention

3.3 Accessing the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) as an alternative to mainstream home care

3.1 Delivery of home care through consumer directed care

Through a consumer directed care approach, consumers who receive home care services have more control over the types of care and services they access and the delivery of those services, including who delivers the services and when. The essential relationship is that between the provider (and individual workers providing care) and the consumer.

In developing those relationships, providers are to have regard for consumer diversity, taking into account a consumer's individual interests, customs, beliefs and backgrounds.

The Home Care Packages Program is established under Section 45 of the *Aged Care Act 1997*. However, it is the Act's subsidiary legislation that sets out the rights and responsibilities of Home Care Package providers and recipients. These are:

- The *Quality of Care Principles 2014* set out the services that may comprise a Home Care Package and the standards to which providers must deliver those services; and
- The *User Rights Principles 2014* establish the concept of consumer directed care as a model of Home Care Package delivery in Schedule 2, *Charter of care recipients' rights and responsibilities – home care*.

The key elements set out in the Charter relating to consumer direct care are:

- choice and flexibility
- care and services, and
- individualised budget and monthly statement of available funds and expenditure.[1]

Further changes are to apply from 27 February 2017 in home care, with greater choice for the consumers as to who provides their care. Home Care package funding will follow the consumer, allowing them to choose and direct package funding to the provider that best meets their needs, and giving home care providers the opportunity to expand their businesses to meet local demand and consumer expectations. A consumer can choose the provider that is to provide home care to him or her, and to have the flexibility to change that approved provider if he or she wishes.[2]

3.1.1 Supporting providers and their workforces

The department uses a number of vehicles through which to disseminate and extend the reach of information, tools and resources needed to support these changes. These are designed to assist providers, staff and consumers, their families and carers.

[1] User Rights Amendment (Consumer Directed Care) Principles 2015 amended the User Rights Principles to require all providers to deliver home care packages on a CDC basis. *Aged Care Act 1997*, Schedule 2 User Rights Principles 2014. The rights and responsibilities of consumers are set out in the Charter of care recipients' rights and responsibilities – Home Care (the Charter). The Charter is contained in Schedule 2 to the User Rights Principles 2014. See: https://agedcare.health.gov.au/publications-and-articles/guides-advice-and-policies/charter-of-care-recipients-rights-and-responsibilities-home-care

[2] From: Overview of Increasing Choice in Home Care Legislative Framework (see: https://agedcare.govcms.gov.au/sites/g/files/net1426/f/documents/10_2016/overview_of_legislative_framework_-_increasing_choice_in_home_care.pdf

The department, together with aged care provider peaks, consumer organisations, providers and their workforces all have a part to play in contributing to effective information sharing and communication activities to support home care reform.

In addition to updating information on the department and My Aged Care websites, the department regularly communicates via email to the aged care sector, and aged care stakeholders. Subscribers also receive information in an Aged Care Providers newsletter, which provides a snapshot of advice on current key issues.

The department hosts webinars on a range of topics relevant to the aged care sector. This platform allows for deep engagement in an accessible format and provides opportunities to ask questions or raise issues as the topic is presented. Since October 2015, eight Webinars for providers on various features of home care reform have been made available for viewing.

The department also administers the Remote and Indigenous Aged Care Service Development Assistance Panel (SDAP). SDAP assists aged care providers to develop culturally appropriate local solutions to address the challenges of maintaining and delivering quality aged care services to Aboriginal and Torres Strait Islander communities and people living in the remote and very remote areas of Australia.

SDAP members provide expert advice on quality care, governance, financial and business management and can assist providers to align their business practices and service delivery with the consumer directed care model and broader aged care reforms.

3.1.2 Challenges in delivery on a consumer directed care basis in remote and very remote locations

From within the required legislative framework for the Home Care Package Program it is acknowledged that there may be a range of issues impacting the implementation of reforms to the Home Care Package Program in remote areas, including:

- the capacity of remote providers to meet the Home Care Common Standards;
- their capacity to ensure care recipients receive reliable, coordinated safe, quality care and services which are appropriate to meeting his or her goals and assessed needs; and
- ensuring each care recipient receives an individualised budget for the care and services to be provided as a monthly statement of the funds available and the expenditure in respect of the care and services provided during the month.

In recognising these challenges, in April 2016, the department noted that several remote indigenous Home Care Package providers had embraced service delivery on a consumer directed care basis, but also identified a number of providers across remote areas who had not commenced transitioning to consumer directed care or had only partially transitioned. The department actively worked with these providers providing education and training to assist them in transitioning to delivering services on a consumer directed care basis.

The department used the SDAP to provide onsite education and support, telephone support and workshops.

In August 2016, further education and support was provided to remote Home Care Package providers across the three jurisdictions to maximise the number of remote provider's transitioning to a consumer directed care basis prior to the Increasing Choice reforms and gain a stronger understanding of the factors impacting upon their transition.

Significant progress was made with this additional support with the majority transitioning to consumer directed care in a more seamless way. It is worth noting the additional support was not necessarily based on a consumer directed care delivery model, but targeted more generally on operational issues such as governance and reporting issues for indigenous providers.

3.2. Ongoing monitoring of implementation of changes to home care and identifying issues for attention

The department uses a variety of ways to monitor and assess access to services and any emerging issues around the use of the new arrangements.

The Aged Care Sector Committee[3] provides advice to the Government on aged care policy development and implementation and helps to guide the future reform of the aged care system. The Committee membership comprises senior representatives from across the aged care sector, including, peak bodies, large for-profit and not-for-profit providers, consumers, workforce, the National Aged Care Alliance (NACA)[4] and the department.

The Committee also acts as the mechanism for consultation between the Australian Government and the aged care sector.

The committee members consult broadly within their own memberships and constituencies to ensure that stakeholder views inform the policy development process.

A Home Care Reforms Advisory Group has been established under the NACA to provide ongoing advice to the Minister and the department on policy, implementation, communication and monitoring issues. The Advisory Group comprises representatives from providers, consumers and carers, unions, health professionals, and state and territory governments.

As part of its role in aged care system development, the department takes a co-design approach and issues discussion papers for public consultation in order to obtain feedback on implementation arrangements, such as for major changes like the home care changes.

[3] For more details see: https://agedcare.health.gov.au/aged-care-reform/aged-care-sector-committee.
[4] NACA is a representative body of 48 peak national organisations in aged care, including consumer groups, providers, unions and health professionals, working together to determine a more positive future for aged care in Australia. For more details see: http://www.naca.asn.au/.

The feedback provided is used to inform additional steps that might be taken to support effective implementation. For example, feedback was provided on a discussion paper on the *Increasing Choice in Home Care – Stage 1* that was made available for public consultation in September/October 2015.[5]

The Aged Care Legislated Review sought public submissions in late 2016 and is due to report in August 2017. The Review provides an opportunity for reflection on progress with the changes in home care through assessing the issue of 'whether further steps could be taken to change key aged care services from a supply driven model to a consumer demand driven model.'[6]

Feedback like this is drawn on over time as changes are implemented, and in light of monitoring of implementation that is undertaken by the department.

The department monitors the implementation of home care reforms in collaboration with the Australian Aged Care Quality Agency (the Quality Agency) and the Aged Care Complaints Commissioner. For example, as a result of feedback received, the Quality Agency and Home Care Today[7] have joined to develop and deliver a national roadshow of one-day practical forums 'Consumer Directed Care and the Home Care Standards - Where can it take you?'.

The department's review of the uptake and understanding of wellness and reablement within the home care sector will include service providers delivering home care services under the National Aboriginal and Torres Strait Islander Flexible Aged Care program (NATSIFACP). An additional consideration is that in mainstream services or non-flexible aged care services, Aboriginal and Torres Strait Islander people have a proportionately higher representation in home care and a proportionately lower representation in residential aged care. [8] The department expects the project to start in January 2017, with a final report due by July 2017.

The department draws on its network of state and territory offices for jurisdiction level feedback on where providers are experiencing implementation challenges, including in rural, remote or very remote locations. Through this process, the offices may identify where additional support may be needed or where additional consumer supports may be required to assist consumers in exercising choice.

[5] Increasing Choice in Home Care – Stage 1 Discussion Paper Feedback Summary Report January 2016. See: https://agedcare.health.gov.au/programs-services/home-care/home-care-packages-reform/increasing-choice-in-home-care-stage-1-discussion-paper-feedback .
[6] See: https://agedcare.health.gov.au/reform/aged-care-legislated-review.
[7] Home Care Today (https://homecaretoday.org.au/) is a national service managed by COTA that aims to support both consumers and home care providers to work together to implement Consumer Directed Care in Home Care Packages. Home Care Today is funded by the Department of Health.
[8] 2015-16 Report on the Operation of the Aged Care Act 1997, page 64.

3.3 Accessing the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) as an alternative to mainstream home care

There are some providers that suggest that the home care consumer directed care model is not appropriate in some remote locations and that providers should be able to transition these services to the NATSIFACP.

An underlying and important feature of NATSIFACP is that the program operates specifically and solely for the purpose of providing appropriate care based on the cultural needs of the Aboriginal and Torres Strait Islander communities they service.

3.3.1 Growth in the NATSIFACP

The Australian Government provides funding of approximately $37 million annually for the NATSIFACP. The NATSIFACP has grown in recent years with a number of new services established in Western Australia and the Northern Territory over the past three years.

The Program is fully committed to 2019-20, with remaining funding allocated to establish a new service in Nhulunbuy in the Northern Territory which is expected to be operational in late 2018.

The department also expects that there may be further opportunities for existing flexible aged care services to increase service delivery.

3.3.2 Pathway to NATSIFACP

NATSIFACP service providers must satisfy a number of requirements including: a culturally competent workforce; appropriate facilities for cultural activities; and inclusion of Aboriginal and Torres Strait Islander community members in planning and providing the aged care services.

The NATSIFACP Guidelines outline the factors that are to be taken into consideration in establishing a new service, these include:

- the overall capacity of the service provider to ensure that the objective/s and outcomes of the activity will be met;
- community commitment and engagement;
- the geographical location where the services will be delivered, that is, remote or very remote locations or a location where there is market failure;
- the location of other mainstream health/aged care services, such as Primary Health Care, the Commonwealth Home Support Program, Home Care Packages Program and/or respite services;
- the capacity of the service provider to deliver services that are sensitive to the needs of the local Indigenous communities;
- the ability of the service provider to meet regulatory and legislative requirements;
- the capacity of the service provider to deliver care over a sustained period; and

- whether the service provider will be located in a community with one or more of the following features:
    - the community is identified as a priority community by [the department] that is, having a critical unmet aged care need and for current services which are not meeting these needs;
    - the community is highly populated by care recipients in the targeted group; and/or
    - the community is experiencing high population growth within the target population or is anticipating high population growth within the target population.

Priority will be given to:

- those communities where the demand for aged care services exceeds the availability of services;
- locations that are assessed as being able to support and operate aged care services to Aboriginal and Torres Strait Islander people; and
- remote and very remote locations.'[9]

When a provider funded under mainstream aged care programs, approaches the department to discuss transitioning to the NATSIFACP, the department works with them to identify the reasons why they are of the view that this is a preferable model.

The department has found that, in many cases, transitioning to the NATSIFACP does not necessarily address the challenges that the aged care provider is facing.

[9] The National Aboriginal and Torres Strait Islander Flexible Aged Care Program Guidelines, page 17 (see: https://agedcare.health.gov.au/national-aboriginal-and-torres-strait-islander-flexible-aged-care-program-natsifacp-guidelines)

4 TRAINING AND SUPPORTS FOR AGED CARE WORKERS ON PALLIATIVE CARE AND DEMENTIA

At the Committee hearing of 3 November 2016, more detailed information was sought on whether training and support were available for the aged care workforce on palliative care matters and dementia.

This paper provides information on education, training and supports available to aged care providers and their workforces in the areas of palliative care and dementia. This adds to the information provided in the Commonwealth's original submission (no. 293).

4.1 Provision in Vocational Education and Training (VET) qualifications

4.2 Education for nurses

4.3 Commonwealth funding to extend supports for providers and their workforces in relation to palliative care and dementia

4.1 Provision in Vocational Education and Training (VET) qualifications

4.1.1 New VET qualifications – inclusion of palliative care and dementia units

New qualifications started in 2016 for Certificate III Individual Support qualification and Certificate IV in Ageing Support.

There are seven core units for the Certificate III Individual Support that students must complete. These are:

- Provide individualised support
- Support independence and well-being
- Communicate and work in health or community services
- Work with diverse people
- Work legally and ethically
- Recognise healthy body systems
- Follow safe work practices for direct client care.

Added to the core units, students must complete three elective units, which have been identified for the 'Ageing specialisation' as:

- Facilitate the empowerment of older people
- Provide support to people living with dementia
- Meet personal support needs.

The Certificate IV in Ageing Support has 15 Core units that students must complete. These include:

- Implement interventions with older people at risk
- Provide support to people living with dementia
- Work with diverse people
- Deliver care services using a palliative approach.

In addition, students must take up three elective units, and the electives chosen must contribute to a valid, industry-supported vocational outcome. They can choose from a list of 59 Electives units, and these units include, for example:

- Implement interventions for older persons at risk
- Deliver care services using a palliative approach
- Address the needs of people with chronic disease.

4.2 Education for nurses

4.2.1 Undergraduate education for nurses

To work as a nurse in Australia, individuals must complete an approved course in nursing and register with the Nursing and Midwifery Board of Australia (as part of the National Registration and Accreditation Scheme for health professions).

The type of course that needs to be completed will vary according to whether the work is as an enrolled nurse, a registered nurse or a nurse practitioner.

Nursing and Midwifery Board Approved Programs of Study, together with the relevant education providers − are listed on the Board's website

(at http://www.nursingmidwiferyboard.gov.au/Accreditation/Approved-programs-of-study.aspx).

Approved programs of study must provide content which incorporates existing and emerging national and regional health priorities.

4.2.2 Post Graduate Education for Nurses

The Australian College of Nursing provides access to education packages. For example:

- For Registered Nurses: a Graduate Certificate in Aged Care Nursing studies (12 months) is available to meet the complex needs of the older person being cared for within diverse health care environments, including clinical decision-making within aged care environments.
- For Enrolled Nurses: Assessment of the older person. This is a six months unit of study which includes methods of clinical assessment for older people, evaluation of a variety of assessment tools and the interpretation and integration of assessment findings relevant to care.
- Various Continuing Professional Development (CPD) courses for nurses.

Gerontology specialisation and geriatric nursing

The Australian Association of Gerontology has Collaborating Research Centres based at 17 universities and institutes across Australia which engage in discussions on issues affecting ageing and aged care research.

Leaders in gerontological nursing drawn from the nursing schools of nine universities have established an Australian consortium in May 2016 to build the profile and capacity of the speciality.[1]

The initial focus will be on building academic and teaching capacity in gerontological and psychogeriatric nursing. The combination of nursing schools in this way may provide an opportunity to influence curriculum in nursing schools, including for undergraduate nursing programs.

4.3 Commonwealth funding to extend supports for providers and their workforces in relation to palliative care and dementia

The Australian Government's contribution to education, training and skills development has taken a variety of forms, and has not been confined to direct funding of educational qualifications for individuals.

4.3.1 Palliative care

Palliative care is provided in almost all settings where health care is provided, including neonatal units, paediatric services, acute hospitals, general practices, residential and community aged care services, and generalist community services.

[1] It will be part of the US Hartford Centre of Gerontological Nursing Excellence, the role of which is to enhance and sustain the capacity and competency of nurses to provide quality care to older adults through: faculty development, advancing gerontological nursing science, facilitating adoption of best practices, fostering leadership, and designing and shaping policy.

The Commonwealth's submission outlined the additional supports and resources for palliative care that are available to providers and their workforces (submission no. 293, pages 61-63), noting the wider context provided by the *National Palliative Care Strategy 2010 – Supporting Australians to Live Well at the End of Life.*

Funding is to be extended from 2017-18 for three years, for the Specialist Palliative Care and Advance Care Planning Advisory Services (SPCACPAS). These fund activities that support innovative specialist palliative care and advance care planning advisory services for aged care providers and GPs providing health care for recipients of aged care services to improve the linkages between aged care and palliative care services.

The SPCACPAS includes development of content and delivery of targeted advice, education and training to aged care providers and GPs providing health care to recipients of aged care services.

The advice, education and training must be appropriate for all population groups, including veterans, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, people identifying as lesbian, gay, bisexual, transgender and/or intersex, and people in rural and regional Australia.

Funding of $45.4 million for the National Palliative Care Projects 2017-2020 was approved in late 2016. Outcomes from an open competitive grants round for these projects will be finalised mid-2017.

4.3.2 Workforce education, training and supports on dementia

The Commonwealth's submission covered the action being taken in relation to care of people living with dementia (pages 32-34) in the context of the *National Framework for Action on Dementia 2015–2019*.

In addition, since 2014, the department convenes an annual Ministerial Dementia Forum of a wide range of organisations and individuals with an interest in improving aged care services for people with dementia.[2]

One of the major areas covered at these forums is the re-design of consumer and provider supports, and consideration of additional steps that can be taken to support providers and their workforce in their interactions with people living with dementia, and their families and carers.

Dementia Training Program

Experience has shown that advisory networks, well-targeted specific education initiatives (such as on dementia) and support for specific changes in care service delivery are of sustained and practical value to providers and their workforces.

As part of a re-design of aged care dementia programs, a new national Dementia Training Program (DTP) began on 1 October 2016 to provide training to the

[2] See: https://agedcare.health.gov.au/older-people-their-families-and-carers/dementia

workforce that care for people with dementia. National training options are available, incorporating latest research on best practice, as well as optional tailored onsite training.

Delivered by a consortium of leading dementia educators led by the University of Wollongong, the DTP offers a national approach to accredited education, up-skilling, and professional development in dementia care.

Services include:

- Continuing Professional Development training on dementia assessment, diagnosis and management to GPs, nurses, pharmacists, psychologists, specialists, allied health and other relevant professionals as appropriate.
- Accredited dementia care vocational level training courses – this is provided free to eligible care workers in residential, respite, community care or the wider health services.
- An online training portal allowing staff to undertake web-based training.
- Tailored onsite training to aged care providers who request assistance, including a dementia skills and environment audit, followed by a tailored training package.

Supporting innovation in caring for people living with dementia

Through the Dementia and Aged Care Services Fund, projects are being funded to support innovation in caring for people living with dementia. Learning outcomes from these research translation projects are to be systematically made available through the following Commonwealth-funded supports available for providers, their workforces and consumers and carers:

- The Dementia Behaviour Management Advisory Service: this delivers episodic support services to service providers in the primary, acute and aged care settings
- Severe Behaviour Response Teams: these are specialised teams of clinical experts which work with providers to respond quickly to the more severe cases of behaviour management concerns.
- Specialised units: work is commencing on establishing Specialist Dementia Care Units, for people for people who experience very severe behavioural and psychological symptoms and who are unable to be effectively cared for in a mainstream residential aged care facility.

In addition, the National Health and Medical Research Council National Institute for Dementia Research[3] is using Commonwealth funding to prioritise and boost dementia research in Australia and provide the focus to rapidly translate evidence into policy and practice.

The Institute approach is to ensure integration with international research and draw on the expertise of researchers, consumers, health professionals, industry and policy makers to improve dementia prevention, treatment and care outcomes.

[3] For details see: https://www.nhmrc.gov.au/research/boosting-dementia-research-initiative/nhmrc-national-institute-dementia-research-nnidr.

5 QUALITY AND CONSISTENCY OF VOCATIONAL EDUCATION AND TRAINING AND EMPLOYER DEMAND

At the Committee hearing of 3 November 2016, the quality of the Vocational Education and Training (VET) system was raised in relation to meeting the needs of the aged care sector.

This paper provides additional information on avenues for improving the quality and consistency of VET for aged care, and adds to the information provided in the Commonwealth's original submission to the Committee (no. 293).

5.1 Introduction

5.2 Industry leadership in developing training packages

5.3 Commonwealth-funded support for new aged care sector training packages

5.4 Driving the performance of Registered Training Organisations (RTOs) in meeting employer demand

5.5 Role of work placements in aged care settings to improve job readiness

5.6 Using partnerships to improve education and training

5.1 Introduction

The Commonwealth has outlined the action being taken as a result of Vocational Education and Training (VET) reform priorities agreed by the Council of Australian Governments (COAG) in April 2014, which aim to support the current and future skills needs of Australian businesses.[1]

5.2 Industry leadership in developing training packages

One of the underpinning features of the VET reforms that are being overseen by the Industry and Skills Council, is industry leadership of training package development so that training better aligns with jobs in the economy.

Nationally recognised qualifications and statements of attainment are issued in accordance with industry-defined and nationally consistent competency standards, which are set out in training packages.

Registered Training Organisations (RTOs) are authorised to issue a nationally recognised qualification only where the requirements of the training package have been met.

The operation of RTOs is overseen by the VET system regulators.[2]

5.3 Commonwealth-funded support for new aged care sector training packages

For aged care, training packages within the Health training package were developed during 2015 through extensive national consultations with the aged care sector on employer needs. RTOs use training packages to help design curriculum, and or learning and assessment methodologies.

The department provided funding for this comprehensive review of Certificate III and Certificate IV qualifications that had been sought by the sector.

New qualifications were designed in collaboration between the aged care sector and other relevant care sectors in recognition of their changing skill needs.

The new Certificate III and IV qualifications better reflect industry needs as they draw on the connections and common features shared across aged care, health, disability and community assistance. As a result, it better supports movement within the care sector by allowing individuals to undertake the new qualification and move easily from one care-related occupation to another.

5.4 Driving the performance of Registered Training Organisations (RTOs) in meeting employer demand

There are two dimensions to driving a better performing VET system:

- The machinery established to improve the national standards expected of RTOs and the role of VET regulators (this machinery was outlined in the Commonwealth's original submission, at pages 70-72).

[1] Commonwealth's Submission (number 293)
[2] Industry Reference Committees Operating Framework for the Development of Training Packages, May 2016, Version 1.0. See: www.aisc.net.au

- The active participation of industries or sectors in ensuring that industry requirements are reflected in training and skills development.

Industry Reference Committees (IRCs) drive priorities for the review and development of training packages. The IRCs are supported by a Skills Service Organisation (SSO). The SSOs are funded by the Australian Government to serve as independent professional bodies which work with their industry or industries to develop training packages.

The interests of the aged care sector are currently spread across several IRCs, based on the industry stake in the development and review of training packages:

- Direct Client Care and Support
  - This covers a wide range of sectors (aged and home care, disability, mental health, alcohol and other drugs, leisure and health, allied health assistance, health services assistance, and health support services).
  - The proposed structure for the IRC was opened for public consultation and comment by 6 January 2016, with industry being asked to comment on the proposed structure.
- Enrolled Nurses.
- Community Sector and Development: this includes specialist services in case management to clients with complex and diverse needs across health and community services. It also includes coverage of volunteers.
- Aboriginal and Torres Strait Islander Health Workers.

(these four IRCs are supported by SkillsIQ as their SSO)

The scope and membership of IRCs are to be reviewed in early 2017 and decisions about membership are subject to approval by the Australian Industry and Skills Committee.

The variability in the quality of VET education and training has featured in provider concerns, and there are various ways this has been addresses by the sector. For example:

- Aged Care Services Australia (ACSA) Tasmania has provided evidence to the Committee of how providers have worked in a concerted, collaborative way in Tasmania to improve the quality of VET services and responsiveness to employer needs.

5.5 Role of work placements in aged care settings to improve job readiness

In response to broader economy-wide employer demand for more job ready employees with VET qualifications, the number of mandatory hours of workforce placement increased from 80 hours to 120 hours in 2015.

This opens up opportunities for aged care providers to engineer well-structured and supported placements that can make working in aged care an attractive proposition after training is completed.

In addition, parts of the sector have taken a ‘growing our own’ approach, building on basic qualifications through on-the-job training or specialisations.

5.6 Using partnerships to improve education and training

In addition to action by individual providers to support education and training of their staff, the sector has used partnerships and innovative approaches to improve opportunities to extend the knowledge and skills of the workforce. Examples include:

- Improving the interaction between the education and training sectors and employers – for example, the Juniper partnership with the Curtin University Simulation Centre in Western Australia to support work experience in a simulated environment.
- The University of Newcastle has been working with the aged care sector to develop a new education pathway for direct care workers through an Associate Degree of Integrated Care in Ageing. This is due to start from 2017. It offers further training as part of a two-year degree program.
- Organisations in several locations have built on seed funding that had been provided by the Commonwealth for consortia of aged care providers and universities to operate as learning environments by combining teaching, research, clinical care, and service delivery in one location (the concept of Teaching and Research Aged Care Services (TRACS)).[3]

- Tapping into alternative ways of providing evidence-based online education and training. . The University of Tasmania's Understanding Dementia Massive Open Online Course (MOOC) is an example.

[3] An example is the Illawarra services, ITRACS. See: http://itracs.uow.edu.au/index.html .

TOPIC 6 DATA ABOUT THE AGED CARE WORKFORCE – COVERAGE, TYPES AND SOURCES

On 3 November 2016 the Committee received evidence from the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW) and the Department of Health on various statistical data collections about or that can be related to the aged care workforce.

This paper provides an overview of the data sources available on the aged care workforce and the different perspectives that these data can provide on the workforce.

6.1 Coverage of the aged care sector − industry and occupations

6.2 The National Aged Care Workforce Census and Survey (NACWCS)

6.3 Department of Health National Health Workforce Dataset

6.4 Australian Institute of Health and Welfare (AIHW) analyses

6.5 Australian Bureau of Census and Statistics (ABS)

6.6 Department of Employment labour market and skills data

6.7 National Centre for Vocational Education Research (NCVER)

6.1 Coverage of the aged care sector − industry and occupations

6.1.1 Aged care in the Australian and New Zealand Standard Industry Classification (ANZSIC) structure

The aged care workforce is drawn from two separate industries in the standard Australian and New Zealand Standard Industry Classification (ANZSIC) structure.

'Aged care' is not represented as a separate category in ANZSIC. The activities involved are classified as part of 'Health Care and Social Assistance.'

- 'Aged care residential services' (8601) is part of sub-division Code 86 Residential Care Services.[1]
- Other Social Assistance Services (8790) is part of sub-division Code 87 Social Assistance Services.[2]

This can mean that data for aged care purposes can only be represented as part of a broad industry − for example:

- Department of Immigration and Border Protection information on the number of temporary and permanent work visas granted to primary applicants are at Health Care and Social Assistance industry level.
- The Department of Employment's Workplace Agreements Database that uniquely provides data on developments in coverage, wage increases and conditions of employment included in collective agreements, is organised at broad industry level.

6.1.2 The aged care workforce in the Australian and New Zealand Standard Classification of Occupations (ANZSCO)

Data about the various occupations represented in the aged care sector workforce are collected and analysed from a number of differing perspectives. This is due to a number of factors:

- The range of settings for aged care and the workforce engaged in care:
  - Various service types are represented in the sector, covering residential, home care or community-based care and services.
  - Within community-based care and services, Commonwealth Home Support Program workers are part of a wide pool or community services, where aged care work can be intermingled with other community-based work.
- Parts of the aged care workforce are grouped within wider community services occupations:
  - ANZSCO Major Group 4 covers Community and Personal Service Workers[3], and includes under Minor Group 423 Personal Carers and Assistants, within which appears 'Aged or Disabled Carer'(423111).

[1] Division Q Health Care and Social Assistance Subdivision 86 Residential Care Services Group 860 Residential Care Services Class 8601 Aged Care Residential Services

[2] Division Q Health Care and Social Assistance Subdivision 87 Social Assistance Services Group 879 Other Social Assistance Services Class 8790 Other Social Assistance Services.

[3] Described as assisting ' Health Professionals in the provision of patient care, provide information and support on a range of social welfare matters, and provide other services in the areas of aged care and childcare, education support, hospitality, defence, policing and emergency services, security, travel and tourism, fitness, sports and personal services.'

- Occupations represented in aged care can be part of national health professional groups with recognised standing as part of the health system or as part of broader categories − for example:
    - Nurses (Nurse Practitioners, Registered Nurses and Enrolled Nurses) are part of Australia's 326,669 national nursing workforce population.[4]
    - Allied health professionals.
    - In addition to the range of health-related work involved, some non-health occupations in the aged care workforce may be in a profession or line of work that is not unique to or solely related to aged care – for example accountants, kitchen hands or gardeners.
    - Aged care workers can be classified or grouped into wider categories for specific purposes – for example:
        - The AIHW includes aged care workers as 'welfare workers' in Australia's welfare system.[5]
        - For the purposes of managing the VET qualifications framework.

As a result, significant parts of the aged care workforce are sub-sets of or overlap with other sectors, and the labour markets tapped by those sectors. Therefore, aged care providers and organisations face competition for employees. For example:

- the ABS grouped 'aged or disabled carers' as one classification for the 2011 Census — the number of people employed in this category has been reported to have risen by 30,800 or 40 per cent from 2006 to 2011, reaching 108,000[6].
- Commonwealth Home Support Program workers are part of a wide pool or community services, where aged care work can be intermingled with other community-based work.[7]

6.2 National Aged Care Workforce Census and Survey (NACWCS)

6.2.1 Coverage of NACWCS

The NACWCS is currently the most detailed and complete collection of Aged care workforce data, and is the only data collection that covers the workforce for both the residential and community-based aged care programs.

[4] In 2011, aged care was the clinical area of nursing and midwifery with the largest number of workers (AIHW Nursing and midwifery workforce 2011, p viii). Aged care also had the highest proportion of enrolled nurses (41.5 per cent).

[5] Described as 'the set of supports, services and payments that Australian society—in part through their elected governments—has chosen as acceptable investments to improve the wellbeing of Australians in need, largely by enhancing capabilities and opportunities for people to participate economically and socially' From: AIHW Australia's welfare 2015, page 345.(see: http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129555153)

[6] Bernard Salt, *The Australian*, 31/01/13, page 6.

[7] The services are diverse: nursing care; allied health services like podiatry, physiotherapy and speech pathology; domestic assistance, including help with cleaning, washing and shopping ; personal care, such as help with bathing, dressing, grooming and eating; social support; home maintenance; home modifications; assistance with food preparation in the home; delivery of meals ; transport; assessment, client care coordination and case management; counselling, information and advocacy services; centre-based day care; support for carers including respite services.

Time period
The NACWCS is undertaken on a roughly four-yearly basis. The current iteration (the 2016 NACWCS) is the fourth of the series: previous iterations were run in 2003, 2007, and 2012 (2003 was for residential care only). Each NACWCS has been outsourced to the National Institute of Labour Studies (NILS) at Flinders University, under contract to the department.

Value for workforce planning
Aged care providers and services contribute the data that is then assembled and analysed through the NACWCS. This process enables providers to profile their own workforces in a systematic way, and assess the data as part of their workforce planning.

Scope of topics covered
The national analyses and reports produced provide a benchmark and point in time picture of workforce matters, sector–wide, and in relation to service types and occupational groups.

The NACWCS includes a census of residential aged care facilities and a survey of their employees, together with a census of community aged care outlets and a survey of their employees.

Census question topics include: Direct care workforce employment and characteristics – age, gender, qualifications; skill shortages; vacancies; setting of employment conditions; agency, brokered and self-employed workers; volunteers.

Worker survey topics include: characteristics − age, gender, qualifications; cultural and linguistic diversity; employment arrangements and hours; wages; training; career paths into aged care; experiences of working in aged care; job satisfaction; job demands; work related injury and wellbeing; work and non-work responsibilities.

Most questions in NACWCS 2016 remain unchanged, allowing comparison of the 2007, 2012 and 2016 collections.

6.2.2 New features in the 2016 NACWCS
NACWCS 2016 collects data on the extent to which aged care skills are interchangeable with those used in disability support, and the particular role that agency workers, self-employed, brokered workers, and volunteers play in meeting aged care workforce requirements.

Data is also collected about the methods used to monitor the quality of the aged care services or supports provided by their facility or service outlet.

A report on the results from the 2016 NACWCS is expected to be released in the first quarter of 2017.

6.3 Department of Health National Health Workforce Dataset

The Australian Health Practitioner Regulation Agency (AHPRA), in conjunction with the national boards, is responsible for the national registration process for 14 health professions.

The data from this annual registration process, together with data from a workforce survey that is voluntarily completed at the time of registration, forms the National Health Workforce Dataset (NHWDS). Data in the NHWDS includes demographic and employment information for registered health professionals.

This dataset can provide estimates of the number of registered nurses, enrolled nurses, GPs and selected allied health professionals that are employed in aged care.

However, this data is only a subset of the total aged care workforce, because it only includes occupations that require registration by AHPRA.

6.4 Australian Institute of Health and Welfare (AIHW) analyses

The AIHW manages a National Aged Care Data Clearinghouse (NACDC) which is a central, independent repository of national aged care data. It coordinates data collection from various agencies and departments and creates data sets from the information that is collected.[8]

In addition, as part of its role in analysing health and welfare issues, the AIHW produces the 'Australia's welfare' series, which provides an overview of the wellbeing of Australians, and examines a wide range of relevant topics.

The AIHW's 12th report included a summary of the aged care workforce in *Australia's Welfare 2015* in a feature article on 'The changing face of the welfare workforce'. (see: Australia's welfare 2015)

AIHW also produces publications using the data from the National Health Workforce Dataset. (see: http://www.aihw.gov.au/workforce/).

6.5 Australian Bureau of Census and Statistics (ABS)

6.5.1 ABS Census data (5 yearly)

Detailed 2011 Census data is available for workers in residential aged care (e.g. age, sex, place of work, education and qualifications, labour force status and income, hours of work, cultural and language diversity etc.). These data can be cross-classified by occupation.

However, there is no ABS Census data available specifically for Home care / Home support aged care (previously referred to as 'community aged care').

[8] See: http://www.aihw.gov.au/national-aged-care-data-clearinghouse/

- Industry of employment in the ABS 2011 Census is coded using the Australian and New Zealand Standard Industrial Classification (ANZSIC), 2006 (Revision 1.0).
- As outlined above, there is a large Industry category (Division Q) labelled 'Health care and Social Assistance' which includes, for example, hospital, medical, pathology, imaging and allied health services.
- The sub-category (Class 8790) named 'Other Social Assistance services' includes 'aged care assistance service' together with a number of non-aged care services.

Therefore, specific data for the 'community aged care' workforce and for the whole aged care sector workforce are not available from the ABS Census.

Census data is, however, available by occupation.

ABS 2016 Census data on occupation and industry of employment will be released in late 2017.

6.5.2 ABS Labour Force survey (quarterly)

High level data on the broad category of 'residential care services' is published in *ABS 6291.0.55.003 Labour Force, Australia, Detailed, Quarter*ly (Table 06).

This category includes, but is not limited to residential aged care. From ABS 2011 Census data on Industry of Employment, about 90 per cent of people in 'residential care services' (ANZSIC code 860) have 'aged care residential service' (code 8601) as their industry. The remaining 10 per cent have 'Other Residential care services' (code 8609) or 'Residential care services [not further defined].' (code 8600) as their industry.

This suggests that the broad category 'residential care services' can provide useful trend information for the workforce in aged care residential services, even though it is not entirely specific to aged care.

However, data for the whole aged care sector workforce (residential and community) are not available from the ABS Labour Force Survey.

Labour Force data is also available by occupation.

6.5.3 ABS Survey of Disability Ageing and Carers (SDAC)

Data on informal (unpaid) carers is available from the SDAC. Of the almost 2.7 million Australians that were identified as carers in 2015, around 856,100 were identified as primary carers. The SDAC covers all people who are informal carers, not just those caring for older people.

Latest data are available at this link:
ABS 4430.0 Disability, Ageing and carers, Australia: Summary of Findings 2015

The SDAC does not have data on the paid (i.e. formal) aged care workforce.

6.6 Department of Employment labour market and skills data

The Department of Employment hosts the Labour Market Information Portal which brings together data from a range of official sources to help anyone – such as sectors, employers and prospective employees − who need to understand individual or multiple local labour markets. [9]

Each year, the Department of Employment produces employment projections by industry, occupation, skill level and region for the following five-year period. These employment projections are designed to provide a guide to the future direction of the labour market, however, like all such exercises, they are subject to an inherent degree of uncertainty.

These projections as they relate to the aged care sector (as part of the broad Healthcare and Social Assistance industry) and occupations represented in aged care (such as Aged and Disabled Carers) were provided in the Commonwealth's original submission, and then updated in November 2016.

The Department of Employment conducts ongoing research to identify skill shortages in the labour market. The focus is on skilled occupations. The core of the research is a survey of employers who have recently advertised vacancies for selected skilled occupations and discussing whether they are able to fill their vacancies with suitable workers. Industry intelligence is considered in tandem with statistical information on demand and supply trends, such as industry activity indicators, training data, wastage and vacancy trends. [10]

From time to time, additional specific purpose surveys may be undertaken. A mail-based survey[11] on personal care workers across all industries (including but not limited to aged care) was undertaken in 2014 by the Department of Employment. [12] This was also referred to in the Commonwealth's original submission.

6.7 National Centre for Vocational Education Research (NCVER)

NCVER has data available on completion of various Vocational Education Training courses for aged care. It should be noted that this is data on qualifications only and has no information on whether award recipients actually work in aged care.

[9] The Portal is at http://lmip.gov.au/.
[10] See: https://www.employment.gov.au/skill-shortages
[11] "The focus of the research was personal care workers, that is, non-nursing staff who provide personal care, general assistance, emotional support and companionship for the elderly and those with disability (or long-term health conditions). This coverage loosely aligns to ANZSCO codes 4231 Aged and Disabled Carers and 4233 Nursing Support and Personal Care Workers (excluding Hospital Orderlies and Therapy Aides)."… "The sample was selected from the Department of Social Services' Aged Care Services List of providers who are subsidised by the Australian Government and providers registered with the National Disability Insurance Agency as providing personal assistance support services. Responses were received from 125 providers whose personal care employees represented around 10 per cent of the personal care workforce."
[12] See: Department of Employment. See: https://docs.employment.gov.au/node/5304

7 CARERS AND THE AGED CARE WORKFORCE

At the Committee hearing of 3 November 2016, additional information was sought on the contribution to care made by carers, how they are supported and their interactions with the formal aged care workforce.

This paper provides additional information about informal carers and the steps being taken by the Commonwealth to further improvements in the supports available to them.

7.1 Informal carers – partners in aged care

7.2 Carer numbers in the future

7.3 Supports for carers − developing a new Service Delivery Model

7.1 Informal carers – partners in aged care

The original Commonwealth submission provided information on how the Commonwealth supports informal carers which, in turn, assists carer interactions with the aged care workforce.

The submission (no. 293, pages 57-60) outlined the role that carers play in working in partnership with the formal workforce in providing access to appropriate care for older people.

In 2015, almost 2.7 million Australians were carers (11.6 per cent), with 856,100 (3.7 per cent) identified as informal primary carers aged 15 years and over. These patterns were similar to those in 2009 and 2012. Of all informal primary carers 359,500 provided less than 20 hours of care per week, 162,500 provided 20 to 30 hours of care per week, and 284,400 (40 per cent) provided 40 hours or more of care per week.

In the context of aged care, in 2015 there were 233,100 informal primary carers themselves aged 65 years or over (133,400 female, and 99,700 male primary carers aged 65 years or over). Of all informal primary carers, including those aged 65 years or over, over one-third (37.8 per cent) were living with disability themselves and may be in need of their own services and supports.[1]

The position of informal carers is distinct and separate from the formal aged care workforce. Informal carers are defined as people who provide unpaid personal care, support and assistance to family members or friends with a disability, medical condition (including terminal or chronic illness), mental illness, dementia or frailty due to age.

There is variation in the extent, form or duration of a caring role and this is mostly based on the needs of the care recipient. For example, some informal carers look after another person 24 hours a day and help with daily living activities. Other informal carers look after people who are mostly independent but need help with some everyday tasks.

Informal carers are an integral part of Australia's health system and are the foundation of the aged, disability and community care system. Without the support of their informal carers, and access to support services, many Australians would not be able to remain living in their own homes, placing additional pressure on the formal aged care workforce.[2]

The *Commonwealth Carer Recognition Act 2010* includes a Statement for Australia's Carers that contains ten key principles including the principle that:

> 'Carers should be considered as partners with other care providers in the provision of care, acknowledging the unique knowledge and experience of carers.'[3]

[1] ABS Survey of Disability, Ageing and Carers 2015
[2] *Department of Social Services. 2016. Designing the new integrated carer support service: A draft Service Concept for the delivery of interventions to improve carer outcomes*'
[3] *Commonwealth Carer Recognition Act 2010* Section 6, Schedule 1 – Principle 7.

7.2 Carer numbers in the future

In its report *Caring for Older Australians*, the Productivity Commission suggested that, for a variety of reasons, there are likely to be fewer informal carers relative to the growing older population, leading to the prospect of greater reliance on the formal workforce.[4]

The Australian Institute of Health and Welfare has also referred to this development in its report *Australia's Welfare 2015*, as follows: [5]

> 'Changing demographics and current health trends are increasing the demand for informal carers. These include the ageing of the population, increased longevity, and the increasing incidence of dementia and mental health conditions. At the same time, the supply of carers is diminishing. Reasons include: the changing roles of women, who were traditionally carers, but now are typically re-entering the workforce after childbearing; pressure on carers to remain in the workforce later into life, thereby reducing the time available for caring; and complex family structures. The end result has been that fewer people are willing and able to provide informal care.'

The *Department of Social Service, 2016, Designing the new integrated carer support service: A draft Service Concept for the delivery of interventions to improve carer outcomes*, refers to the decline in the number of informal carers in the future. Caring responsibilities have a significant impact on carers' physical and emotional welfare and employment status and their ability to sustain their caring role. By preventing breakdown of the valuable support that carers provide, not only is the financial cost of repairing carers' own health avoided, but the additional cost of providing alternative care for the people they are supporting is avoided too.

The extent to which home care services are used, and the demands on informal carers, may be influenced by a number of factors including:

- the extent to which in-home technology or online supports may assist consumers and carers
- how access to other care support can improve connectedness with health services, such as the Health Care Home model (currently being trialled by the Commonwealth)
- improvements in supports available for people living with dementia at home or in the community.[6]

Given the above mentioned, it may be difficult to suggest a reliable figure on future numbers of informal carers.

[4] See submission 293 and Carers Australia's submission number 269.
[5] In a feature article on Informal Carers.
See:http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129552261
[6] The Report for the 2015 Ministerial Dementia Forum reported that there is evidence that the carer role is a major component of the quality of life for people living with dementia. See: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/11_2016/kpmg_2015_ministerial_dementia_forum_final_report.pdf

7.3 Supports for carers – developing a new Service Delivery Model

The Commonwealth's original submission included an entry on support for informal carers, including recognising the importance of their relationship with the formal aged care workforce.

Informal carers are supported through a range of Commonwealth and state and territory government funded programs, services and payments appropriate to carers' needs and circumstances. This includes access to information, respite care, carer-specific counselling and advice, training and education and payments and allowances to financially assist eligible carers.

As part of the 2015-16 Budget the Australian Government committed to the development of an Integrated Plan for Carer Support Services (the Plan) in recognition of the need to support and sustain the vital work of unpaid carers[7].

The Plan is intended to complement the investments being made in aged care and disability reform. The Plan includes two key stages.

The first stage of the Plan was the design and implementation of Carer Gateway. Carer Gateway was established to provide a recognisable source of clear, consistent and reliable information to help carers navigate the system of support and services. Carer Gateway was established in December 2015 and includes a national website providing carer-specific information and a national contact centre.

The second stage of the Plan involves the design of a new integrated carer support service system. The purpose of the new service is to deliver supports that reduce caregiver strain (based on a model of social, psychological, physical and financial outcomes) with the twofold objective of increasing a carer's well-being and reducing the risk of the caring role ending.

The aim would be to reach carers earlier in their caring journey in order to sustain them by providing supports that build their capacity, reduce strain, enable increased participation in education and employment and ultimately improve their wellbeing.

A draft Service Concept for the delivery of interventions to improve outcomes for carers was made available by DSS for consultation from 2 May 2016 to 16 June 2016.

Feedback from the submission process and further co-design activities has informed the development of a draft Service Delivery Model, which was made available for public consultation from 6 November to 16 December 2016.

[7] https://www.dss.gov.au/disability-and-carers/programmes-services/for-carers/integrated-plan-for-carer-support-services.

8 VOLUNTEERS AS PART OF THE AGED CARE WORKFORCE

At the Committee hearing of 3 November 2016, additional information was sought on the participation of volunteers as part of the aged care workforce.

This paper provides additional information on this topic.

Tables

8.1 Context − volunteering in Australia

According to Australian Bureau of Statistics (ABS) figures, in 2010, 6.1 million people (36 per cent of the Australian population aged 18 years and over) participated in voluntary work. Women (38 per cent were more likely to volunteer than men (34 per cent).

The Prime Minister's Community Business Partnership cites a figure of 31 per cent of the Australian population volunteering in 2014, that is 5.8 million people aged 15 years and over.[1]

The Principles of Volunteering identified by the Prime Minister's Community Business Partnership include:

- volunteering benefits the community and the volunteer;
- volunteer work is unpaid; and
- volunteering is always a matter of choice.[2]

Volunteering Australia uses a definition endorsed by its Board in 2015: Volunteering is time willingly given for the common good and without financial gain.[3]

8.2 Defining 'volunteer' in the aged care system

Under Part 1, Section 4 of the *Aged Care Act Accountability Principles 2014*, a volunteer is defined as a person who:

- is not a staff member of the provider; and
- offers his or her services to the provider; and
- provides care or other services on the invitation of the provider and not solely on the express or implied invitation of a consumer; and
- has, or is reasonably likely to have, unsupervised access to consumers; and
- is at least 16 years old or, if the person is a full-time student, is at least 18 years old.

8.3 Numbers, roles and contribution made by volunteers as part of the aged care workforce

8.3.1 Role of volunteers

The Commonwealth's submission (number 293 at page 15) covered the role of volunteers in aged care.

Volunteers play an important role in aged care services, in both residential aged care and in the home based care segment of the sector through the Commonwealth Home Support Programme (formerly Home and Community Care (HACC)).

[1] Figures drawn from the Prime Minister's Community Business Partnership information – see: http://www.communitybusinesspartnership.gov.au/volunteering/
[2] See: http://www.communitybusinesspartnership.gov.au/volunteering/
[3] See: http://www.volunteeringaustralia.org/wp-content/uploads/Definition-of-Volunteering-27-July-20151.pdf

My Aged Care[4] highlights the role played by volunteers in the following terms:

> 'Volunteers play an important part in Australia's healthcare system, especially in rural areas. These volunteers form the community's most valuable hidden asset. Volunteers can assist older people by:
>
> - social visits
> - helping with food shopping
> - providing transport to medical, dental and hospital appointments
> - assisting with a wide range of other services.'

The use of volunteers, as identified and reported by providers, is covered in the National Aged Care Workforce Census and Survey (NACWCS) undertaken for the Department of Health by the National Institute of Labour Studies. Data in this entry are preliminary data from the draft report from the 2016 NACWCS. Estimates may be changed when the final report is published in the first quarter of 2017.

Table 1 shows the roles that were undertaken by volunteers in residential aged care and in Home care and Home support aged care. The percentages shown are of the facilities/outlets which use volunteers.

Table 1 Roles undertaken by volunteer workers in aged care (per cent): 2016

	% of residential facilities using volunteers	**% of Home care/Home support outlets using volunteers**
Domestic activity assistance	8.9	4.8
Respite care assistance	1.8	10.4
Social activity support assistance	81.7	52.7
Planned group activity assistance	67.7	45.7
Home maintenance assistance	2.3	3.8
Gardening assistance	14.6	8.1
Transport assistance	22.9	44.0
Shopping/appointment assistance	15.7	20.6
Meal/preparation assistance	6.4	32.5
Companionship/befriending	63.8	33.2
Other	7.6	18.2

Source: Preliminary data from 2016 National Aged care Workforce Census and Survey (Census of residential aged care facilities and Census of Home care / Home support service outlets).
Note: Multiple responses were allowed, so column percentages will not add to 100.

[4] My Aged Care is a website and a contact centre designed to provide information on aged care for consumers, and their family members, friends or informal carers.

Volunteers in Residential aged care[5]

- 83 per cent of residential aged care services used one or more volunteers.
- Facilities using volunteers indicate they had an average of 10 volunteers per facility with each volunteer contributing an average of 4.9 hours per fortnight
- Over 23,500 volunteers provided 114,900 hours of services to residential aged clients in the designated fortnight, corresponding to an estimated 3 million hours of volunteer service in a year.
- Facilities in Major Cities / Inner Regional / Outer Regional locations were more likely to use volunteers than those in Remote or Very Remote areas.
- 91 per cent of not-for-profit facilities used volunteers. Not-for-profit facilities were more likely to use volunteers than for-profit or government facilities.

Volunteers in Home care and Home Support[6]

- 51 per cent of Home care and Home support service outlets used one or more volunteers.
- Responses from outlets using volunteers indicate an average of 29 volunteers per outlet. Each volunteer contributed an average of 4.6 hours per fortnight.
- Over 44,800 volunteers provided 206,500 hours of service to clients in the designated fortnight, corresponding to an estimated 5.4 million hours of volunteer service to Home care and Home support clients in a year.
- Outlets in Major Cities / Inner Regional / Outer Regional locations were more likely to use volunteers than those in Remote or Very Remote areas.
- 55 per cent of not-for-profit outlets used volunteers. Not-for-profit outlets were more likely to use volunteers than for-profit or government outlets.

[5] Preliminary data from 2016 National Aged Care Workforce Census and Survey (Census of residential aged care facilities).
[6] Preliminary data from 2016 National Aged Care Workforce Census and Survey (Census of Home care/Home support service outlets).