Aged Care and Allied Health Services within the Fitzroy and Central West

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Report by Indigo Gold Pty Limited for

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Glossary

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ACAR	Aged Care Approvals Round
ACAT	Aged Care Assessment Team
ACFA	Aged Care Financing Authority
ACSA	Aged & Community Services Australia
ACSC	Aged Care Sector Committee
ANUHD	Australian Network for Universal Housing Design
ATSIDNQ	Aboriginal and Torres Strait Islander Disability Network of Queensland
BPSD	Behavioural and Psychological Symptoms of Dementia
CALD	Culturally and Linguistically Diverse
CCW	Community Care Worker
CDC	Consumer Directed Care
CEO	Chief Executive Officer
CHRC	Central Highlands Regional Council
CHSP	Commonwealth Home Support Program
COTA	Council of the Ageing
CPD	Continuing and Professional Development
CQ	Central Queensland
CQHHS	Central Queensland Hospital and Health Service
CQPHN	Central Queensland Public Health Network
CWHHS	Central West Hospital and Health Service
DAC	Daily Accommodation Contribution
DVA	Department of Veteran's Affairs
ED	Emergency Department
FCW	Fitzroy and Central West
FTE	Full Time Equivalent
GDP	Gross Domestic Product
GP	General Practitioner
HACC	Home and Community Care (now called Home Care Packages)
HCP	Home Care Packages
ILU	Independent Living Unit
IRSD	Index of Relative Socio-Economic Disadvantage
IT	Information Technology
LGA	Local Government Area
MAC	My Aged Care
MP	Member of Parliament
NACWCS	National Aged Care Workforce Census and Survey
NFP	Not for Profit
NRHA	National Rural Health Alliance Inc
PDF	Portable Document Format
PHN	Public Health Network
RAC	Refundable Accommodation Contribution
RACS	Residential Aged Care Service
RACF	Residential Aged Care Facilities
RDAFCW	RDA Fitzroy & Central West
RFDS	Royal Flying Doctor Service
RN	Registered Nurse
RTO	Registered Training Organisation
SAGE	Sub Acute Geriatric Unit
VET	Vocational Education and Training
WHO	World Health Organization
WQPHN	Western Queensland Primary Health Network

Executive summary

Australia has an ageing population (15% in 2016 were 65 years or older), and by 2055 this proportion will increase to 22.9%. This presents both challenges and opportunities. It increases demand for primary health, aged care services and long-term care, requires a larger and better-trained workforce, and intensifies the need for environments and infrastructure to be age-friendly. It also has implications for the nature and quality of services and will affect economic output and governments' budgets.

A variety of issues are likely to affect older Australians in the future:

- falling rates of home ownership and rising rental prices
- scarcity of community housing and lack of affordable downsizing options
- increasing numbers of older Australians retiring with a mortgage
- housing not suitable for the needs of older people
- inadequate supplies of suitable housing in their current community for older people to downsize.

The five highest types of care for older persons who need assistance are: health care, followed by property maintenance, household chores, mobility and transport. In 2015, 32% of people aged 70 years and older were receiving government subsidised aged care services while living at home and 7% were in residential aged care.

More than 80% of people aged between 85 and 89 live in private housing, which includes self-contained flats in retirement villages. The majority of aged people want to 'age in place' with the main reasons being that they want control over their lives and they enjoy where they live. Most people that move to age-specific housing are forced to do so by declining health, usually very late in their lives. The capacity of a person to age in place can be affected by the appropriateness of the home to their needs, the scope for home modification, availability and cost of home care, or the availability of suitable alternative accommodation within the local community.

The aged care sector is one of Australia's largest and fastest growing service industries, employing over 350,000 people, with the Australian Government expected to spend $17.4 billion in 2016-17. The sector is currently in a phase of substantial transformation and growth. The majority of aged care services is supplied by not-for-profit service providers. The provision of aged care services – particularly residential places – can be costly, and private for-profit providers sometimes regard remote and regional areas as too expensive for them to operate profitably.

With demand increasing as Australia's population ages, the Australian Government has introduced demand-driven service delivery that promotes Consumer Directed Care, to ensure the aged care system is sustainable. As the population of older Australians grows, the pressure on our hospitals will increase.

Consumer preferences include:

- the preference to age at home along with support services, with people only wanting to contemplate residential care when there is no alternative
- the desire for more personalised services by those who move into aged care facilities
- 'baby boomers' generally demanding a higher level and wider choice of living arrangements (better dining, accessible technology), optional outings and art-health activities, and requiring more complex care when entering aged care facilities.
- a simplified and streamlined way to access information on healthy ageing, aged care services available and the quality of these services

- obtaining the selected services in an equally seamless way
- strong views about the need to have as much control as possible over their own death, as well as access to palliative care at home (if required) rather than having to go to hospital.

Chronic diseases and disabilities are increasingly prevalent, particularly among older Australians who often have multiple chronic health issues. This means that the health care aspect of aged care services is an increasingly important consideration for consumers. There is a trend towards more costly and specialised care, particularly as new health technologies are developed that allow for more complex and personalised care.

The Australian Government estimates that the residential care sector will need to build approximately 76,000 additional places over the next decade in order to meet the provision target of 78 operational places per 1,000 people aged 70 and over.

The two Public Health Networks that are charged with improving health care in the Fitzroy and Central West (FCW) region, report a variety of issues:

- Poor access to specialist services, and a high dependence of health care outside the region.
- A heavy reliance on locums, outreach and visiting services.
- Disconnected care / poor communication and collaboration between providers.
- Younger generations moving to cities/regional areas, causing social isolation for older relatives.
- Health barriers: travel costs to access specialist services; limited low cost public transport in many rural areas cause older people difficulty in attending GP or other primary care services.
- Limited culturally appropriate services for Aboriginal and Torres Strait Islander people; insufficient Aboriginal and Torres Strait Islander health workers; overall lack of cultural training and awareness amongst mainstream service workers.
- Supply barriers include: workforce shortages; lack of aged care training.
- Allied health: high turnover of allied health professionals.

The specific needs of Indigenous Australians have to be considered when planning for future aged care needs within our region as the percent of Indigenous people residing in each LGA within the FCW is equal to, or higher than the state average. There is a lack of knowledge among health service providers and planners as to how to meet the unique needs of Aboriginal and Torres Strait Islander people with regards to aged care services. Key factors that relate to this include:

- high rates of chronic diseases, frailty and falls
- life expectancy being 10 years less than the rest of the Australian population
- Aboriginal Elders playing an important role in the health of their communities (cultural rights and responsibilities, caring for extended family members including grandchildren, providing leadership and support within communities)
- alarmingly high prevalence and incidence rates of dementia occurring at a younger age in both urban and rural regions.

Aged care services for the majority of older Australians starts with the Federal Government's My Aged Care. It covers 'short-term help' or 'help at home' via: Commonwealth Home Support Program (CHSP) for entry level home help; Home Care Packages for coordinated services to live at home; and End of life care at home. Providers of these services work in a very competitive environment.

When it is time for someone to move into residential aged care, the Australian Government subsidises aged care homes, with people contributing to the cost of their care if they can afford to. Access to residential aged care in remote and very remote communities is extremely limited.

Private providers are not found in locations that operate on marginally sustainable business models, such as those facilities that operate in remote and very remote communities. The concept of consumer choice is thus more constrained as you progress into more remote locations, and data

strongly suggests that as people in these communities age, they move to regional locations where they are able to access better health and aged care services.

There is a looming challenge of ensuring sufficient residential aged care supply to meet demand arising from the baby boomer generation in 10-15 years' time. To ensure there is a sustainable, high quality aged care system a number of reforms and initiatives are being implemented by Federal and State Government. This includes:

- The Aged Care Roadmap
- Telehealth systems by both levels of Government
- Nurse Navigator Service
- Remote and Aboriginal & Torres Strait Islander Aged Care Service Development Assistance Panel
- Review of aged care quality regulatory processes.

Retirement Villages, a growing sector of the aged care industry, are governed by state government legislation and not connected to the Federal Government reforms. About 42,000 Queenslanders live in 315 retirement villages, 17,000 in 185 residential parks, and 3,000 in aged rental complexes.

In addition to the many service providers, a range of stakeholders are involved in the aged care sector. These include industry and senior's groups, organisations that help with specific health conditions, and alliances to improve services for rural and remote Australians.

In the FCW there are 72 different aged care services delivering aged care services. These provide 671 community care places; 1,643 residential aged care places, and 30 transition care places. For the year to June 2016, these services cost the Federal Government $111M.

Comments/concerns from service provider managers in the region include:

- the difficulty for older people to access information via My Aged Care website
- that some residential aged care places in Rockhampton having wait lists of 100+ people
- lots of enquiries for respite being received that can't be met
- increasing numbers of high-care clients entering aged care facilities requiring more staff time
- sourcing staff with experience in aged care
- the general public being uninformed, naive and unprepared regarding the aged care process and availability; not have insight into the aged person's wishes
- difficulties in meeting the needs of clients with complex needs
- clients who don't have Advanced Health Directive and/or Enduring Power of Attorney documents in place
- the need to increase staffing and money for recreational activities
- a requirement for more Avoidance and Substitution Models
- the need for more secure beds to appropriately deal with clients with dementia
- services that can't be delivered in rural areas due to distance and costs
- the need for targeted education programs.

The workforce for aged care encompasses direct care workers, non-direct care workers, and ancillary workers. To meet growth in the sector, the aged care workforce will be required to: quadruple by 2050; compete for labour; keep pace with the diversity of skills required to care for the ageing population. According to the Primary Health Network Western Queensland, every area within Western Queensland is currently classified as a district of workforce shortage.

An inquiry on the aged care sector workforce, completed in mid-2017 provided many recommendations including:

- Review of existing programs and resources available for: workforce development and support; addressing skills shortages; training/accreditation standards; minimum nursing requirements; remuneration, job security and working conditions; scholarships.
- Consideration of the role of informal carers.
- Requirement for service providers to publish their staff to client ratios.
- Immediate action regarding eligible service providers working in remote and very remote locations to access block funding.
- Implementation of consistent workforce/workplace regulation.

Current and future issues and trends that need to be considered are:

- Meeting the needs of an ageing population: including matching workforce growth and skills requirements, and attracting and retaining staff; Nurse Practitioner services.
- Patients with complex needs.
- The financial impact and/or stress of arranging residential aged care.
- Alternate views on who should be involved in care decisions.
- Issues highlighted by Aged & Community Services Australia.
- New models of providing care.
- Problems faced by the elderly in rural and remote areas.
- Challenges in attracting and retaining staff.
- Responses to Aged Care Legislated Review.
- Investment and sustainability of growth.
- Provide appropriate accommodation for an ageing population.
- Alternative residential options.
- Age-friendly Community Plans.
- Technological changes
- Nurse Practitioner services to deliver care.

Recommendations for consideration by levels of Government, service providers, businesses and organisations are to:

- Implement best practice retention and recruiting.
- Create Age-Friendly Community Plans.
- Invest in technology that improves quality of life for those who chose to age in place.
- Create/investigate appropriate accommodation options.
- Meet the needs of Aboriginal and Torres Strait Islander people.
- Encourage skill development in rural and regional areas.
- Prevent unnecessary and costly hospitalisations.
- Improve communication, information and collaboration.
- Plan for the future.

1. Introduction

The Fitzroy & Central West RDA Committee has recognised that a number of issues and opportunities exist in the Fitzroy & Central West (FCW) region that relate to aged care and allied health services. Specifically, these are:

- Aged persons are relocating from regional and remote FCW locations to other areas.
- A need to attract allied health services to various FCW areas to increase liveability.
- A requirement to adapt services to meet changing needs and standards.
- A need to meet the needs of an increasing aged population.
- Ensure the sustainability of community and infrastructure.
- The importance of ensuring that necessary support measures are available for family and friends of aged persons.

In this context, RDA Fitzroy & Central West (RDAFCW) has commissioned Indigo Gold to examine existing information, undertake stakeholder discussions, and consider broader industry trends, policy issues, existing challenges and future implications. The purpose of this report is to highlight all the aged care and allied health services relevant to the Fitzroy & Central West region to allow further decisions and planning to occur. The region covered by RDAFCW is shown in Figure 1.

Figure 1: Map of the area covered by RDA Fitzroy and Central West

The report collates information from a range of sources including phone and direct conversations with stakeholders, and desktop research. In some instances, the views and opinions of organisations and industry groups have been summarised to provide insight into the issues facing these groups. It is to be noted that research was limited in a number of ways:

- The amount of one-on-one conversations, meetings and document review that could occur within the allocated budget for the investigation.
- Predominantly being desktop research due to large geographical area that the report covers, time and budget constraints.
- In some instances, information provided by Local Government personnel following a formal request.
- The report has information gaps due to organisational personnel not replying to phone and email requests.

The remainder of this report is structured as follows:

- Chapter 2 overviews the characteristics and demographics of aged persons in the world and Australia.
- Chapter 3 reviews the demographics of aged persons in the Fitzroy and Central West.
- Chapter 4 outlines the aged care system in Australia including the services provided by the Federal and State Governments, the recipients of those services, an overview of provider numbers, locations and capital investment, and the reform and policy environment. This is followed by information on the retirement village sector, informal care, and the needs of/services for Indigenous Australians. The variety of stakeholders that work in the aged care sector are also covered within this chapter.
- Chapter 5 covers the aged care sector and system in the Fitzroy and Central West including the numbers and details of aged care services and information from each Local Government Area.
- Chapter 6 profiles the care workforce and allied health including recommendations and opinions from workforce industry organisations and a workforce inquiry. This is followed by data on health employment and vacancy rates in the FCW.
- Chapter 7 looks at a range of current and future issues facing the aged care industry.
- Chapter 8 provides recommendations for consideration.

2. Context: aged persons in Australia and the world

Like many other developed countries, Australia has an ageing population. In 2015, there were around 3.5 million older Australians, representing one in every seven people or 15.1% of the population. This proportion has increased from 14.3% in 2012, making it increasingly important to understand the characteristics and needs of older Australians (Australian Bureau of Statistics, 2016).

Definitions

It should be noted that the term healthy ageing is widely used in documentation, but the definition appears to vary considerably. In the 2015 *World Report on Ageing and Health*, World Health Organization (WHO) considered it in a holistic sense as being “the process of developing and maintaining the functional ability that enables well-being in older age” (World Health Organization, 2015). The following WHO definitions may also be helpful when reading this report.

Aged - The state of being old. A person may be defined as aged on a number of criteria including chronological age, functional assessment, legislation or cultural considerations.

Aged care - Services provided to people deemed to be aged or elderly.

Ageing - The lifelong process of growing older at cellular, organ or whole-body level throughout the life span.

Ageing in place - Meeting the desire and ability of people, through the provision of appropriate services and assistance, to remain living relatively independently in the community in his or her current home or an appropriate level of housing. Ageing in place is designed to prevent or delay more traumatic moves to a dependent facility, such as a nursing home.

Population ageing - The increase over time in the proportion of the population of a specified older age (World Health Organization, 2004).

The Global strategy and action plan on ageing and health

With populations around the world rapidly ageing, the situation presents both challenges and opportunities. It will increase demand for primary health care and long-term care, require a larger and better trained workforce and intensify the need for environments to be made more age-friendly.

In 2014, the World Health Assembly developed a comprehensive Global strategy and action plan on ageing and health. After consideration by the Executive Board in January 2016 and by the Sixty-Ninth World Health Assembly, *“Multisectoral action for a life course approach to healthy ageing: global strategy and plan of action on ageing and health”* was adopted in May 2016.

The Strategy (2016 – 2020) has two goals:

- Five years of evidence-based action to maximize functional ability that reaches every person.
- By 2020, establish evidence and partnerships necessary to support a Decade of *Healthy Ageing* from 2020 to 2030 (World Health Organization, 2017).

Specifically, the Strategy focuses on five strategic objectives:

- commitment to action on *Healthy Ageing* in every country
- developing age-friendly environments

- aligning health systems to the needs of older populations
- developing sustainable and equitable systems for providing long-term care (home, communities, institutions)
- improving measurement, monitoring and research on *Healthy Ageing*.

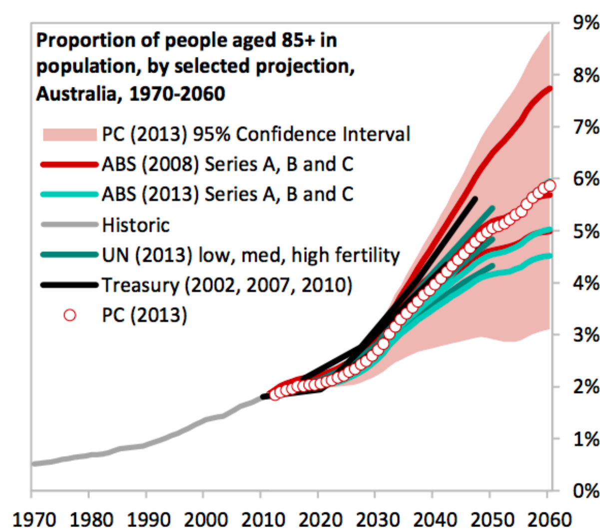
Uncertainties around the magnitudes of population ageing

It should be noted that competing official projections differ according to the agency releasing them, the series offered by each agency, and the year of release. Figure 2 presents projections from the United Nations, the Australian Treasury's Intergenerational Reports (IGR), and the Australian Bureau of Statistics (ABS) for over-85-years-olds. It also features the Productivity Commission's projections, which include confidence intervals. The age group makes up just under 2% of the Australian population currently, but their share is projected to increase to between 3% and 9%.

For the purposes of this report, the ABS data has been used, as this source tends to be referenced most often by Local and State Government.

It is also unclear if increases in life expectancy will be accompanied by more years in good or poor health. Research indicates that Australians could experience longer, healthier and productive lives – some older people may retain the ability to look after more impeded partners into their later years – but it also indicates that a longer overall life may yield longer spells of disability (CEPAR, 2014).

Figure 2: The varying projections of aged population in Australia: 1970-2060 Source: (CEPAR, 2014)



Latest figures on disability rates show the total proportion of Australians with disability has remained relatively stable over time with 18.3% of people reporting a disability in 2015 (Australian Bureau of Statistics, 2016).

Housing issues to effect older Australians

A media release in June this year outlined issues that will impact older Australian in the next two decades (Council Of The Ageing, 2017):

- falling rates of home ownership
- rising rental prices and a hostile private rental property market
- scarcity in social and community housing
- increasing number of older Australians retiring with a mortgage
- rental housing not fit for, or secure enough to meet the physical needs of older people

- inadequate supply of suitable housing for older people to downsize, while remaining in or close to their pre-existing community.

Other factors affecting Australian's ageing population

Sub-groups of Australia's ageing population are affected by specific responsibilities, preferences, influences or conditions. These are not detailed in this report, but may be important when planning or considering the challenges and future implications for aged persons. These sub-groups and factors include:

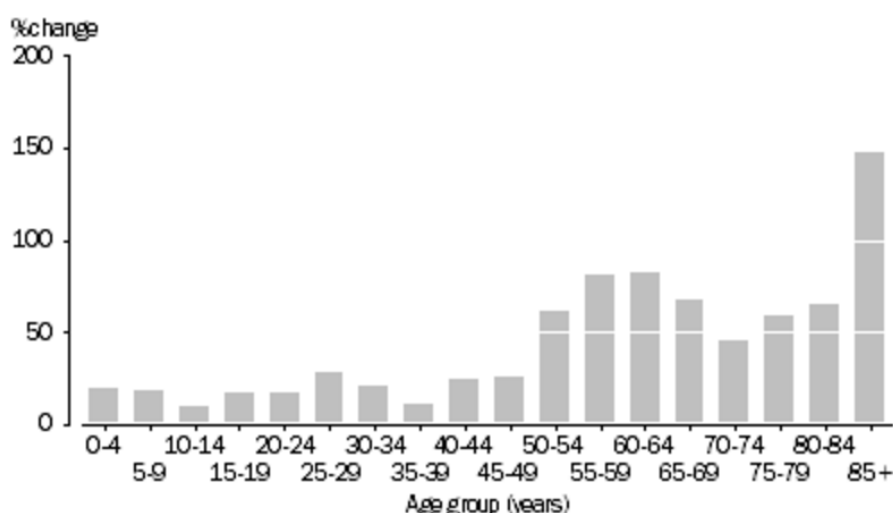
- ageing carers looking after children with disabilities (refer to Carers Australia on page 51)
- people ageing in regional, rural and remote areas – there are many references to this topic throughout the report
- climate change influence that disproportionately affects older people and those living in rural and remote areas
- unique and special needs of Lesbian, Gay, Bisexual, Transgender and Intersex older Australians (refer to Australian Journal on Ageing LGBTI Ageing and Aged Care 2015 Special Issue http://onlinelibrary.wiley.com/doi/10.1111/ajag.12283/full)
- elder abuse (refer to https://aifs.gov.au/publications/family-matters/issue-98/elder-abuse)
- needs of Culturally and Linguistically Diverse people (refer to 2015 National Ageing and Aged Care Strategy For people from Culturally and Linguistically Diverse (CALD) backgrounds https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/07_2015/dss1582_aged_care_strategy_cald_a4_vaccessible.pdf

Demographic trends of Australia's ageing population

Australia's population will grow strongly and become older. There are two aspects to this demographic trend: first, the structure of Australia's population is changing; and secondly, the longevity of Australia's elderly has increased. Combined, these two demographic trends will lead to a strong increase in demand for aged care services. They also have implications for the nature and quality of services demanded (Deloitte, 2016) and will affect labour supply, economic output, infrastructure requirements and governments' budgets (Productivity Commission, 2013).

Figure 3 illustrates that older age groups have significantly outpaced population growth in younger age groups over the last 10 years.

Figure 3: Population Change, Age group - 1995 to 2015



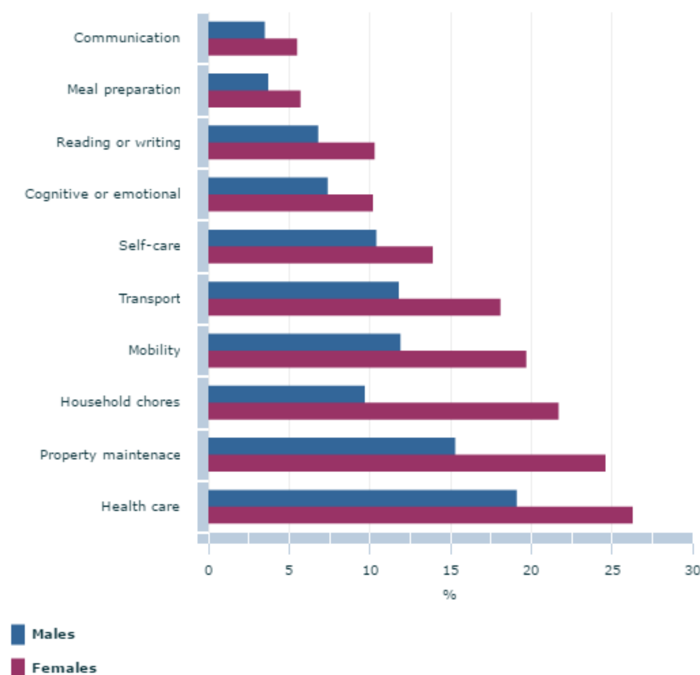
Between 1995 and 2015, the proportion of Australia's population aged 15-64 years remained fairly stable, decreasing from 66.6% to 66.2% of the total population. During the same period, population growth in the 65 years and older age group has averaged around 3% per annum. The proportion of people aged 85 years and over almost doubled from 1.1% of the total population in 1995 to 2% in 2015. Conversely, the proportion aged under 15 years decreased from 21.5% to 18.8% (Australian Bureau of Statistics, 2015).

In 2015:

- Older Australians living in households were more active, with the proportion that participated in physical activities for exercise or recreation increasing from 44.5% in 2012 to 49.2% in 2015.
- The majority of older Australians were living in households (94.8%), while 5.2% or one in twenty lived in cared accommodation such as nursing homes.
- While the proportion of older Australians has increased, the prevalence of disability amongst them has decreased. In 2015, 50.7% of older people were living with disability, down from 52.7% in 2012.
- Two-thirds of older Australians (67.3%) that reported their income lived in a household with an equivalised gross household income that was in the lowest two quintiles. This proportion has decreased from 74.6% in 2012. (Australian Bureau of Statistics, 2016).

The types of care required for persons aged 65 years and older, who need assistance, are shown in Figure 4. For this group, Healthcare is the highest need, followed by Property maintenance.

Figure 4: Persons aged 65 years and over who need assistance by type of assistance required, 2015



Source: (Australian Bureau of Statistics, 2016)

Now vs the future

Current: As at 30 June 2016, 15% of Australia's population was aged 65 years and over (3.7 million people) and 2% were aged 85 years and over (488,000 people).

By 2026: it is estimated that 18% of the population will be aged 65 years and over (5.0 million people) and 2.3% (644,000 people) will be 85 years and over.

By 2055: the proportion of Australians over 65 will increase to 22.9% (8.9 million) of the total population. The number of Australians receiving aged care is projected to increase by around 150% over the next 40 years. (Commonwealth of Australia, 2017). Most notably, the share of Australians aged 85 years and over is expected to be around 5% of the total population by 2054-55, up from only 2% in 2014-15 (Deloitte, 2016).

By 2060: The population aged 75 or more years is expected to rise by 4 million from 2012 to 2060, increasing from about 6.4 to 14.4% of the population. In 2012, there was roughly one person aged 100 years old or more to every 100 babies. By 2060, it is projected there will be around 25 such centenarians.

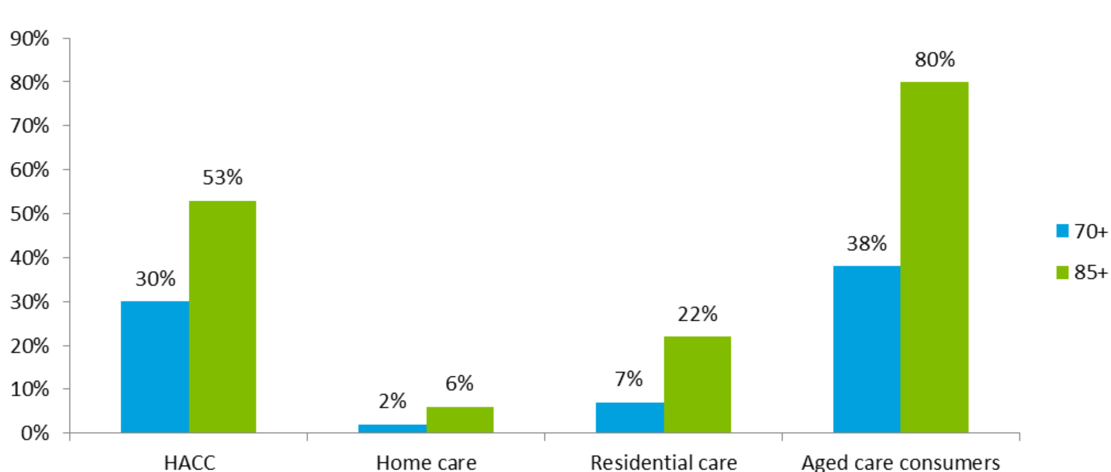
Not only are Australians getting older, they are also living longer due to advances in medicine and technology (Treasury, 2015). The Intergenerational Report suggests that by 2055 Australians aged 60 or 70 can expect to live four to five years longer than 60 or 70-year-olds currently alive (Deloitte, 2016).

Consumers of aged care

The aged care target population definition adopted by the Australian Government in allocating residential and home care places is the population aged 70 years and over. Because of their lower life expectancy and specific care needs, Aboriginal and Torres Strait Islander Australians aged 50-69 years are also included in the target population.

The patterns of use of aged care services change with age. As Figure 5 illustrates, at 30 June 2015, 32% of people aged 70 years and over were receiving Australian Government subsidised aged care services while living at home (Home Care Packages or home care) and 7% were utilising residential aged care. These proportions increase when focused on the 85 and over cohort, particularly for people accessing residential care, where the usage more than triples (Aged Care Financing Authority, 2016).

Figure 5: Proportion of people 70+ and 85+ accessing aged care at 30 June 2015 (Aged Care Financing Authority, 2016)



As Australians are living longer, many with chronic health conditions, this provides significant challenges and opportunities for the aged care system in the years ahead. The composition of this population is also changing as the number of people from CALD backgrounds within this cohort rises. This change has significant implications for the service delivery models adopted by providers to suit the cultural needs of consumers (Aged Care Financing Authority, 2016).

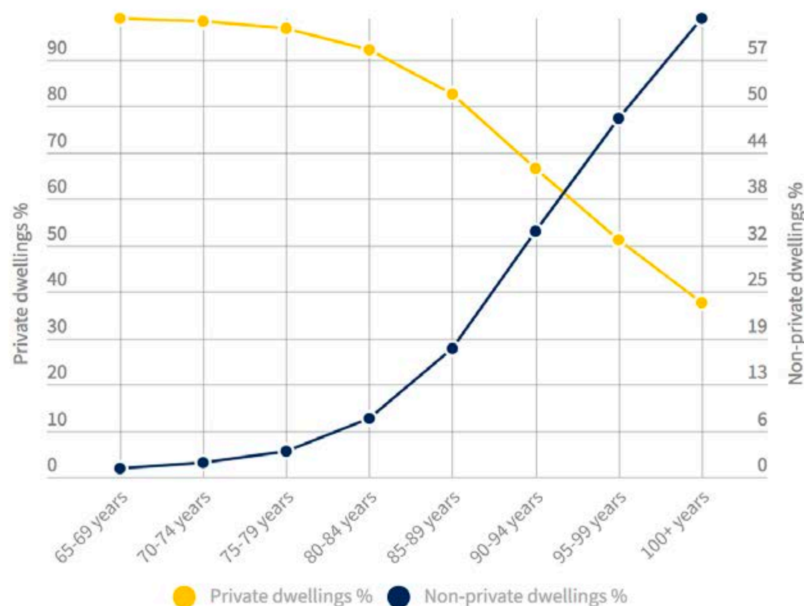
Housing arrangements

More than 80% of people aged between 85 and 89 live in private housing, which includes self-contained flats in retirement villages. Roughly half of the population aged between 95 and 99 occupy private dwellings, according to the ABS (www.domain.com.au, 2017). Domain.com have created a graph (refer Figure 6) from information sourced from the ABS.

Council on the Ageing report that the reasons older Australians want to stay at home are varied, but mostly it's because they want control over their lives and they enjoy where they live.

Most people that make the move to age-specific housing are forced to do so by declining health, but this consideration does not factor prominently until very late in their lives. The capacity of a person to age in place — and their quality of life if they do — can be affected by the appropriateness of the family home to their changing needs, the scope for home modification, the availability and cost of home care, or the availability of suitable alternative accommodation within the local community. For some people, their care and accommodation needs may be better addressed by accessing age-specific housing options, such as a retirement village, mobile home community, or ultimately residential aged care (Productivity Commission, 2015).

Figure 6: Housing arrangement of older Australians



Size of house not necessarily a problem

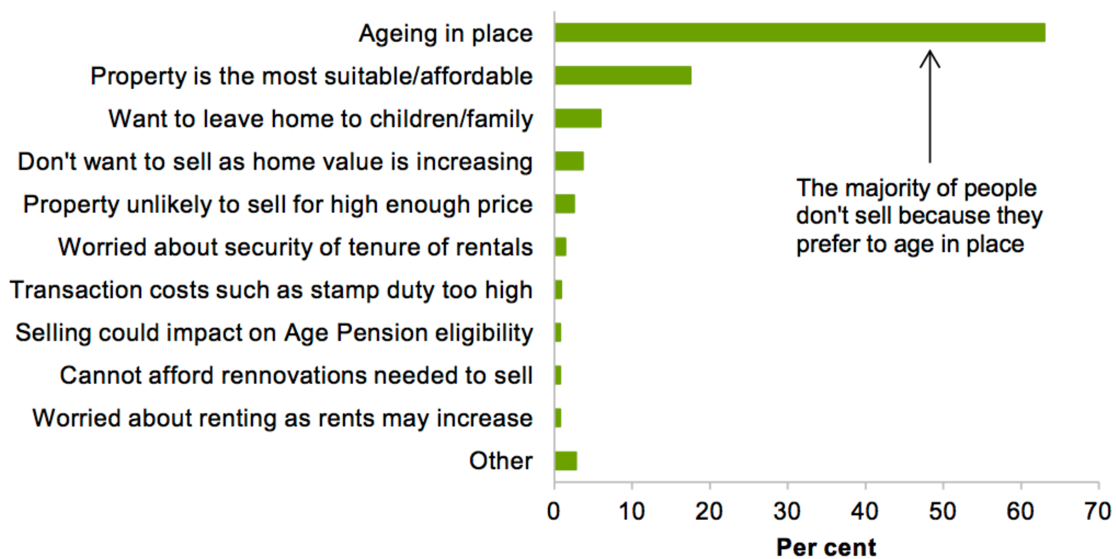
A common presumption is that older people are living in houses that are too big for them. Surveys show that the majority of older people are satisfied with their dwellings and often find other uses for spare rooms. More sophisticated studies show that a large number of bedrooms in the house is less of a concern for older people than the design and layout of the house, or the size of the garden (Productivity Commission, 2015).

Downsizing trends

Downsizing remains a relatively uncommon path for older Australians. According to the Productivity Commission's survey, about one in five older Australians have sold their property and purchased a less expensive home since turning 50. Of the older home owners that have not moved yet, about 15$ had strong intentions to do so at some point in the future. As Figure 7 shows, the primary

reasons for not selling the family home are a very strong desire to age in place and the lack of suitable downsizing options (Productivity Commission, 2015).

*Figure 7: Reasons for older Australians not selling the family home**



* The category for 'Ageing in place' groups three possible answers including those who wanted to stay in their home as long as possible, those who had an emotional attachment to the property, and those who liked or were familiar with their property's location.
Figure source: (Productivity Commission, 2015).

Older renters

A small but significant minority (close to 15%) of older Australian households are renters rather than home owners. Older people are also more reliant on public housing than younger renting households — about half of renters older than 75 are renting publicly. It is expected that renting will increase dramatically, with women to be disproportionately affected.

Renting in older age is associated with a number of potential risks, including poverty, homelessness and adverse impacts upon mental health and wellbeing. Key issues are:

- Housing affordability stress is common, and over the past decade it has grown substantially among older renters.
- Older people as a group are likely to be disproportionately affected by the insecurity of tenure inherent in private rental.
- The supply of social housing has been static, while demand and waiting lists have increased.
- The disadvantages faced by older renters are particularly pertinent to older Indigenous Australians, who are much more likely to be renting than non-Indigenous older Australians. Nearly half of Indigenous Australians aged over 55 are renting, and older Indigenous Australians are also far more likely to be in public housing than other older people.
- For most older Australians who rent, it is a necessity rather than a desirable choice of tenure.

Ageing of the population and falling housing affordability mean that the number of asset-poor older Australians unable to rely on 'wealthfare' – lifetime renters or those who drop out of homeownership – is likely to grow in the future. More information can be found in 'Asset poverty, precarious housing and ontological security in older age: an Australian case study', *International Journal of Housing Policy, 15(2)* which provides qualitative findings from 30 interviews with older Australians.

Social Participation

Many older Australians are active members of their communities with strong social connections. In 2015, almost all older Australians living in households had participated in one or more social activities at home (97.9%) or outside the home (93.6%) in the last 3 months. The majority of older people interacted with their family or friends through telephone calls (93.2%), being visited at home (90.7%) or visiting them (85.8%). Over three-quarters (76.8%) had participated in at least one cultural or physical activity away from home, in the 12 months prior to the survey.

Older Australians were more active in 2015. The proportion of older people living in households who participated in physical activities for exercise or recreation increased, from 44.5% in 2012 to 49.2% in 2015. Almost one-quarter (23.4%) of older men participated in sport in 2015, up from 21.3% in 2012. In contrast, 13.1% of older women participated in sport in 2015, no significant increase from 2012 (12.2%).

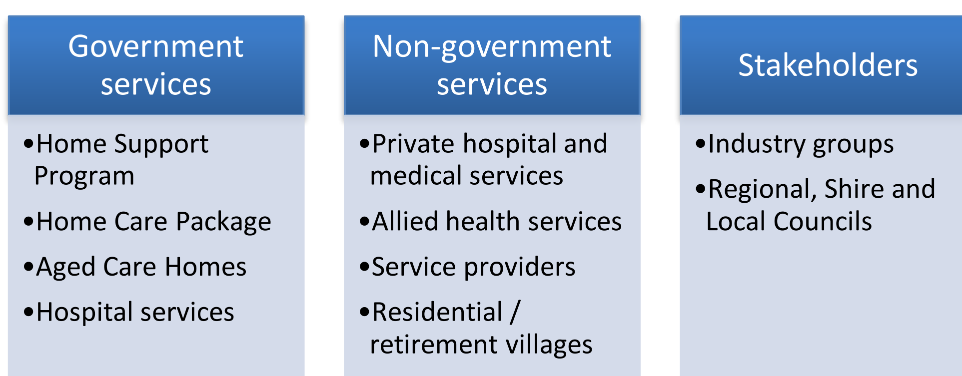
A considerable proportion of older people participated in a range of cultural activities in 2015. Almost half (47.8%) of older people living in households had attended a movie, concert, theatre or performing arts event in the 12 months before the survey, while almost a quarter (23.5%) had visited a museum or art gallery.

Older people make a considerable economic and social contribution to the community through unpaid work. In 2015, almost one in five (18.6%) older Australians living in households were actively involved in voluntary or community service activities outside the home in the previous three months (Australian Bureau of Statistics, 2016).

Aged care sector in Australia

Aged care in Australia consists of a range of Government services, non-Government services from various service providers and residential/retirement villages and stakeholders. It is graphically shown in its simplest form in Figure 8.

Figure 8: Simplified graphical representation of the Aged Care sector in Australia



According to The Aged Care Financing Authority (ACFA), the Aged Care Sector is one of Australia's largest, and fastest growing, service industries:

- services are delivered to 1.3 million older Australians
- delivery involving over 2,000 providers in 2014-15
- employing over 350,000 people.

The Australian Government is the principal funder of the aged care sector. In 2014-15, it contributed $15.2 billion to aged care, up from $14.2 billion in 2013-14. In 2016-17 it is expected to spend $17.4 billion (Aged Care Financing Authority, 2016).

Australian Government expenditure on aged care is projected to nearly double as a share of the economy from 0.9% currently to around 1.7 % of Gross Domestic Product (GDP) by 2055, largely driven by the increasing number of people aged 85 and over. In addition, the costs of care are expected to rise on account of growth in input costs (e.g. wages) and the increasing complexity of chronic health conditions in ageing populations, tempered by improved efficiencies due to advancements in technology and service delivery.

Driven by the ageing of Australia's population and changing attitudes and preferences for the format of aged care, the sector is currently engaged in a phase of substantial transformation and growth. (Aged Care Financing Authority, 2016).

Supply

The majority of aged care services is supplied by not-for-profit service providers across all three types of care, with the market share of these providers ranging from 52% in residential care, 59% in Home Care, to 74% in HACC. The provision of aged care services – particularly residential places – can be costly, and private for-profit providers sometimes regard remote and regional areas as too expensive for them to operate profitably (Deloitte, 2016).

Demand

The demand for aged care is increasing as Australia's population ages. In order to ensure that Australia's aged care system is sustainable, the Australian Government has introduced a demand-driven model of service delivery that promotes Consumer Directed Care (CDC) across the aged care sector (Deloitte, 2016).

Increasing hospitalisations of aged people

As the population of older Australians grows, the pressure on our hospitals will increase. Between 2011–12 and 2015–16:

- hospitalisations for people aged 65 to 74 increased by an average of 5.9% each year, faster than the population growth for this age group (4.3% each year over the same period)
- hospitalisations for people aged 85 and over increased by an average of 5.1% each year, faster than the population growth for this age group (3.9% each year) (Australian Institute of Health and Welfare, 2017).

What do older Australians want?

Consumer preferences will become increasingly important in determining the types of aged care services provided. Over recent years, these preferences have been:

- to age at home
- a more personalised services for those who move into aged care facilities
- a clear preference for support to be provided at home, with people only wanting to contemplate residential care when there is no alternative
- a desire for simplified and streamlined ways to access information on healthy ageing, aged care services available and the quality of these services
- obtaining their selected services in an equally seamless way
- a higher level and wider choice of living arrangements by new residents entering into residential aged reflecting their pre-care lifestyles. This includes better dining, accessible technology e.g. Foxtel, and Wi-Fi availability) and optional outings and art-health activities

- the need to have as much control as possible over their own death, as well as access to palliative care at home (where it is required) rather than having to go to hospital
- more complex care for 'Baby boomers' entering aged care. This group differs from previous generations with respect to their economic, social and cultural attitudes (Hugo, 2014), (Council of the Ageing, 2013), (Deloitte, 2016).

Chronic diseases and disabilities are increasingly prevalent in the Australian population, particularly among older Australians who often have multiple chronic health issues (comorbidity). This means that the health care aspect of aged care services is an increasingly important consideration for consumers. There is a trend towards more costly and specialised care, particularly as new health technologies are developed that allow for more complex and personalised care (Deloitte, 2016).

In investigating issues relating to the ageing of Australia's population, the Productivity Commission have published three research papers since 2013. Their most recent, *Housing Decisions of Older Australians*, highlights the following key points in regard to the housing choices made by older Australians (Productivity Commission, 2015):

- For many older people home ownership provides security and independence in retirement.
- With Australians preferring to age in place, most people are happy staying in their family home, despite a common perception that such homes are too big for them.
- For others, age-specific housing options provide more integrated accommodation and care, offer a way to release home equity, and may delay entry into residential aged care. Growth in retirement villages and manufactured home estates has been strong, despite planning restrictions.
- About 15% of older Australians are renters, and these people are generally a highly vulnerable and economically disadvantaged group.
- There is a general lack of affordable downsizing options for older Australians, due in large part to the red tape and inconsistencies within state and territory land planning regimes.
- Residential aged care is effectively transforming into an end of life care service. The age of admission is increasing (now 83 years on average), average tenure is about 2 to 3 years, and care needs are higher.
- Many older people are reluctant to plan or get advice for possible future care and end of life needs. Decisions can be prompted by crisis, and made when the person is vulnerable.
- There are positive signs from the recent reforms in aged care, including improved financial viability, transparency, and consumer sovereignty. However, further reform is needed.
- About 800 000 older Australians receive home care. Older people's desire to age in place aligns with governments' fiscal goals — in most cases, assistance for home care is considerably less costly than for residential aged care. Nevertheless, there may be merit in increasing co-contributions for both home and residential aged care.
- Most of older Australians' wealth is in the family home, but it remains an untapped source of retirement income. Many older Australians, including some of the poorest retirees, continue to save (spending less than their Age Pension) even very late in life. The main reasons for such behaviour are precautionary saving, and a strong aversion to debt in old age. This precautionary saving is driven by uncertainty around longevity, health and residential aged care needs, and is a potentially expensive form of 'self-insurance' that can lower living standards in old age.
- Most older Australian home owners on low incomes could achieve a modest retirement living standard over the remainder of their lives by drawing on their home equity.
- Financial equity release products could facilitate withdrawal of home equity to fund retirement needs. However, this market is small and unlikely to grow in the near term
  - Most providers are diffident due to small market size and the risk of reputational damage.

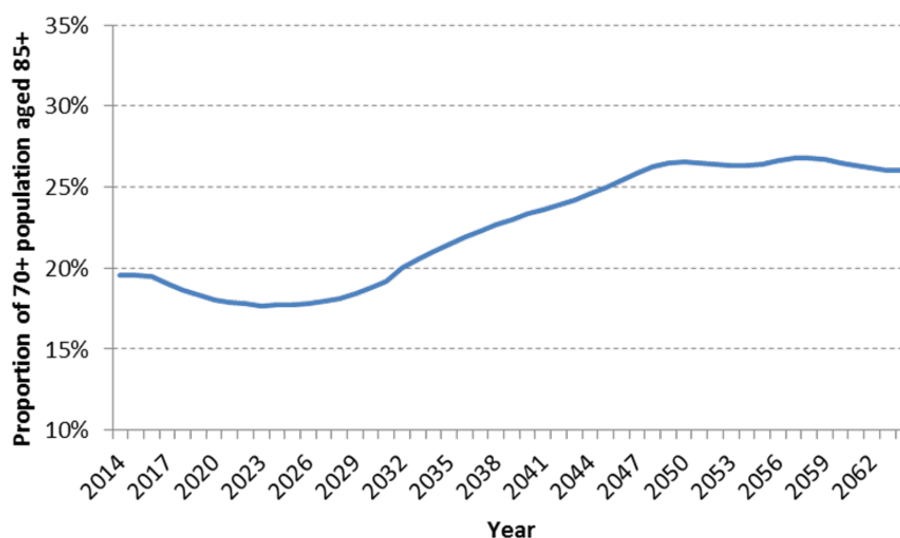
- Broader reluctance by older people to tap into home wealth and strong aversion to debt, coupled with the high cost of such products are impeding demand. The tax and transfer treatment of the family home further reinforces this.

Residential aged care capital investment challenges and trends

The residential aged care target ratio of 78 places per 1,000 people aged 70 years and over by 2021-22 means the Australian Government is aiming to achieve one operational residential care place for every 13 people, aged 70 years and over. If the sector is to meet this target, there will need to be significant growth in the supply of places as the baby boomer cohort reaches 70 years old.

Because the baby boomers are such a large group compared with the pre-war generation, the proportion of the 70 and over population that are aged 85 and over will reduce over the next decade then subsequently increase (Figure 9). This implies that the challenge of ensuring there is sufficient residential aged care supply to meet demand arising from the baby boomer generation is likely to be more significant in 10-15 years' time than over the next decade (Aged Care Financing Authority, 2016).

Figure 9: Proportion of 70+ age group who are aged 85+ (Aged Care Financing Authority, 2016)

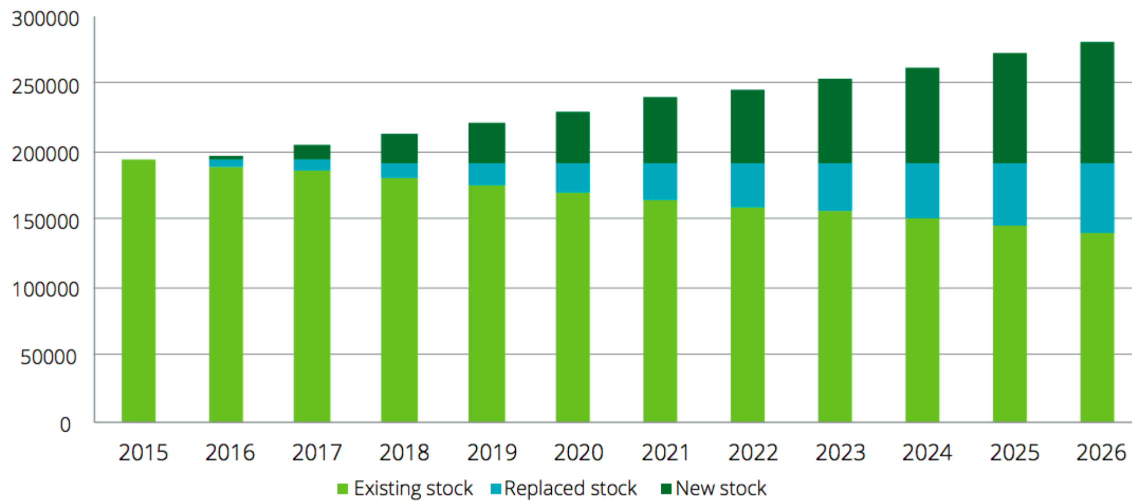


The Federal Government has provided its updated estimates of the sector's annual investment requirement for residential care each year over the next decade, in terms of the amount of required investment and the number of places that will need to be built. These estimates are based on several key assumptions:

- the current service provision targets continue
- the cost of construction continues to grow at about 2.8% each year
- the average lifetime of an aged care building is about 40 years, so that the current stock will need to be replaced over the next four decades.

The Government estimates that the residential care sector will need to build an additional 76,000 places that the over the next decade in order to meet the provision target of 78 operational places per 1,000 people aged 70 and over. This compares with 34,788 new places that came online over the previous decade (Figure 10).

Figure 10: Number of operational Residential Aged Care Places required in the next decade - 2015 - 20126



At the same time, the sector will need to knock down and rebuild a substantial proportion of its current stock. Assuming that a quarter of the current stock of buildings is rebuilt at an even rate over the next decade, the Department estimates that the investment requirement of the sector over the next decade to be in the order of $33 billion. It should be noted that this is almost equal to the total asset value of the industry as at 30 June 2015 ($36.6 billion) (Aged Care Financing Authority, 2016).

This increase in investment will require several inputs in order to be met, including:

- subsidised operational funding from the Commonwealth on behalf of supported residents
- consumer contributions to operational funding
- capital financing from residents, providers, investors and financiers and the Commonwealth
- industry wide access to detailed medium term demographic forecasts to ensure correct siting of future facilities
- availability of greenfield sites for the construction of new aged care homes in the areas needed.

Increased investment activity now and in future years is necessary to meet this challenge given the lead time in building and commissioning homes (Aged Care Financing Authority, 2016).

3. Aged persons in the Fitzroy & Central West region

Data from Primary Health Networks

A summary of information from 2016 Health Needs Assessments from the two Primary Health Networks (PHN) that cover the region: Western Queensland PHN (WQPHN) and Central Queensland, Wide Bay, Sunshine Coast PHN (CQPHN) are listed below:

- The median age of death is lower in Central West Hospital and Health Service (CWHHS) (78 years) than for Queensland (80 years).
- CWHHS - high proportions of: daily smokers (15th worst out of 16 Hospital and Health Services); adults who are overweight/obese (9th out of 16); adults classified as having a lifetime of risky alcohol consumption (13th worst out of 16).
- Central Queensland: 15% of people are daily smokers; substantially high rates of obesity (29.2%) and overweight residents (39%).
- Central Highlands, Livingstone and Banana Local Government Authorities (LGAs) have the highest lifetime alcohol risk.
- High dependence of health care outside the region: 48% patient transfers out of the region for CWHHS.
- Poor access to specialist services – out of all PHNs in Australia, WQPHN was ranked 2nd worst for seeing a specialist (0.41 specialist attendances); in CQPHN, the limited availability of specialists often makes the management of complex medical issues difficult to address.
- There are lower numbers of General Practitioners (GPs) in Western Queensland, a heavy reliance on locums, a low proportion of residents who have a preferred GP, and a lower number of GP attendances per person (3.9) compared to other PHNs in Australia. The Royal Flying Doctor Service provides GP clinics in the Western corridor and has difficulty maintaining reliable GP clinics and providing proactive chronic care management.
- There is a heavy reliance on outreach and visiting services. Some visiting specialists are not linked into local referral processes, general practices and hospital services, and there is an absence of information back the local medical practitioners.
- Care is disconnected and there is poor communication and collaboration between providers. Issues include: multiple information systems; a need for referrals to be electronic and compatible with GP software; poor awareness of available services by provider and patient and the need for collaborative planning, design and delivery; a lack of integration of GP services with other services resulting in poorly coordinated and duplicated care; and multiple funding streams/sources resulting in duplicating services.
- There are gaps in aged care services and in many rural communities, younger generations are moving to cities and regional areas, leading to greater social isolation for their older relatives.
- With limited low cost or public transport in many rural areas, many older people face difficulties in attending GP or other primary care services.
- An increasing number of elderly people have limited family support in coastal areas. Reduced availability of family networks along with limited respite care options, can also place family carers at a higher risk of mental illness and other health issues.
- Health barriers in the Central Queensland region include: the cost of travel to access specialist services (e.g. in Brisbane) compound issues of accessibility; 12% of adults delayed or avoided filling a script due to associated costs.

- Limited culturally appropriate services were preventing Aboriginal and/or Torres Strait Islander people from accessing key mental health and primary care services. Insufficient Aboriginal and/or Torres Strait Islander health workers, as well as an overall lack of cultural training and awareness amongst mainstream service workers.
- Supply barriers highlighted by stakeholders included: workforce shortages, particularly in allied health; lack of training services locally available, such as those related to aged care; long wait times for public hospital specialist clinics; restrictions on government funding for non-face-to--face care for chronically ill patients; overall lack of integration and coordination of services.
- Allied health is an issue for both PHNs: the turnover of allied health professionals can be as high as 65%; a loss of two or three staff in a small team has a significant impact on service capacity. Short term or uncertainty of funding has led to difficulties recruiting; lack of availability and continuity issues; restrictions on the number of allied health services funded through Medicare, as part of the Chronic Disease Management Plan, were often highlighted as inadequate.
- There is no culturally appropriate health service for Indigenous Australians in the CWHHS.
- Stakeholders in a number of areas also commented on the lack of availability of COPD (long-term diseases of the lungs) and cardiac rehabilitation services, especially in rural settings. They stressed the need to manage complex chronic conditions locally as much as possible.
- The context of the number of aged care residential and home care places compared with Queensland: many of the residential care places are located in Multi-purpose Health Services and these facilities are challenged to provide dementia care, from the perspective of a secure environment and appropriately skilled staff. The provision of home care packages in small remote communities is challenged by the viability of providing home care services to several residents.

Sources: (Western Queensland Primary Health Network, 2016) and (Central Queensland, Health Needs Assessment Summary, 2016)

The percentage of people 65 years or older in the FCW region are shown in Table 1. Those LGAs with the proportion of people 65 years or older that are higher than the state average has been shaded blue. Data for 2016 shows that in Barcaldine, Barcoo, Blackall-Tambo, Livingstone, and Winton, the proportion of people 65 year or older is higher than the state average of 14.7%.

Table 1: Age proportions/numbers of people over 65: various LGSs in Central West region and Queensland

LGA Region	% 65+ 2015	% 65+ 2016	Number 65+ 2015	Number 65+ 2016
Banana	13.2	13.4	2014	1,956
Barcaldine	16.5	17.8	553	517
Barcoo	12.6	21	45	57
Blackall-Tambo	17.0	20.8	380	401
Central Highlands	6.9	7.3	2,176	2,087
Diamantina	9.0	4	26	12
Gladstone	9.7	10.1	6,530	6,370
Livingstone	16.2	17.0	5,982	6,306
Longreach	12.2	14.7	498	548
Rockhampton	14.3	14.4	11,941	11,775
Winton	18.0	21.1	245	244
Woorabinda	4.6	4.1	46	41
Central West region total	12.3	12.8	30,191	30,314
Queensland	14.4	14.7	686,214	713,653
Source: Australian Bureau of Statistics, Population by Age and Sex, Regions of Australia 2015 / 2016				

The following 12 diagrams show the 2016 figures from Table 1 as age pyramids for the Estimated Resident Population by Age and Sex in the various LGA regions, compared to Queensland.

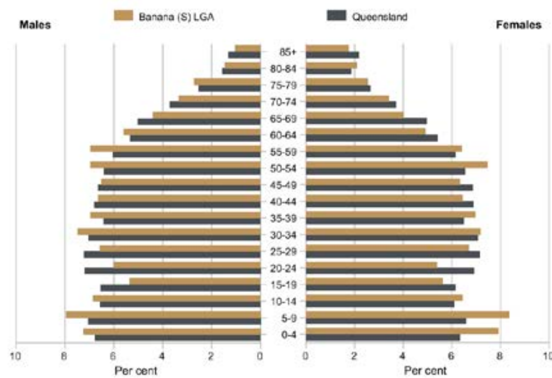


Figure 11: Age pyramid for Banana LGA and Queensland, 30 June 2016pr

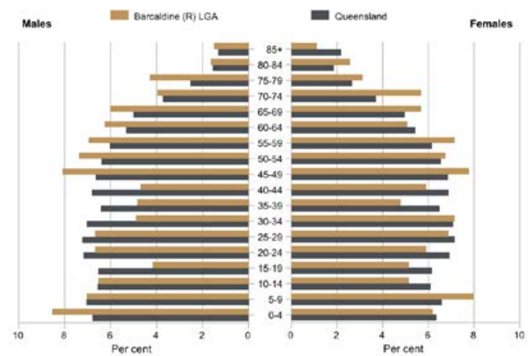


Figure 12: Age pyramid for Barcaldine LGA and Queensland, 30 June 2016pr

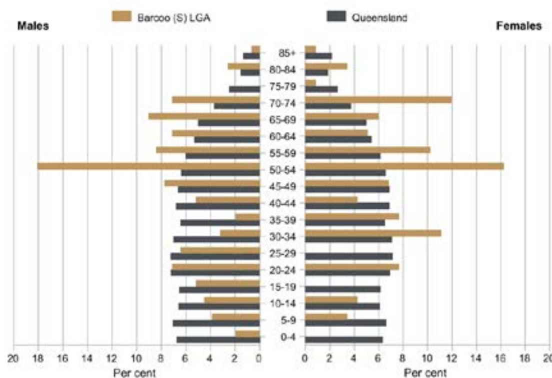


Figure 13: Age pyramid for Barcoo LGA and Queensland, 30 June 2016pr

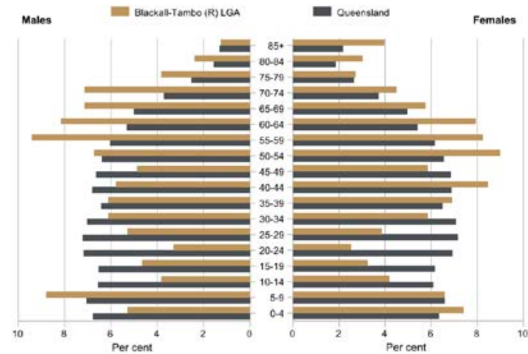


Figure 14: Age pyramid for Blackall-Tambo LGA and Queensland, 30 June 2016pr

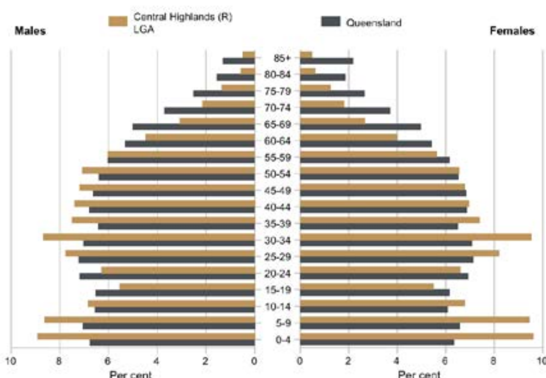


Figure 15: Age pyramid for Central Highlands LGA and Queensland, 30 June 2016pr

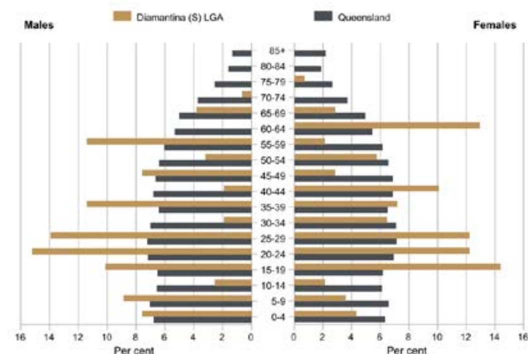


Figure 16: Age pyramid for Diamantina LGA and Queensland, 30 June 2016pr

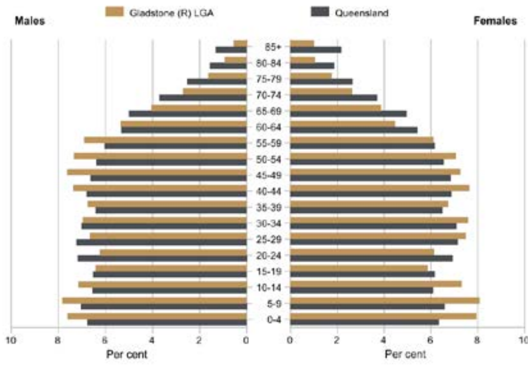


Figure 17: Age pyramid for Gladstone LGA and Queensland, 30 June 2016pr

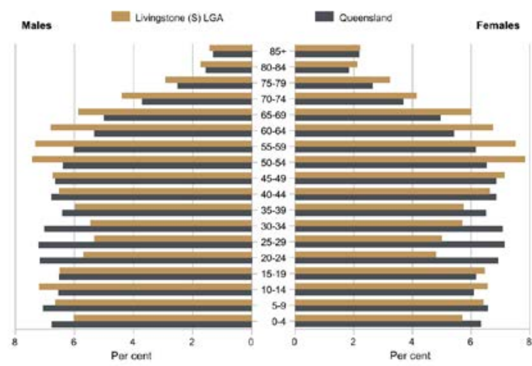


Figure 18: Age pyramid for Livingstone LGA and Queensland, 30 June 2016pr

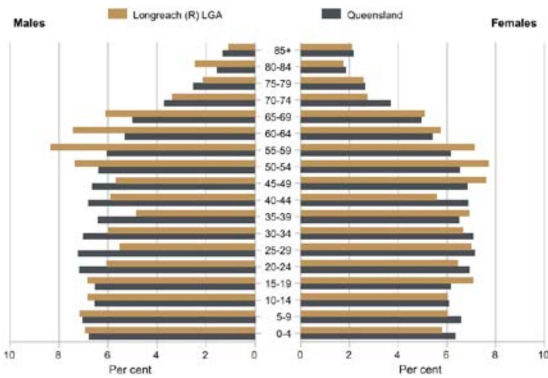


Figure 19: Age pyramid for Longreach LGA and Queensland, 30 June 2016pr

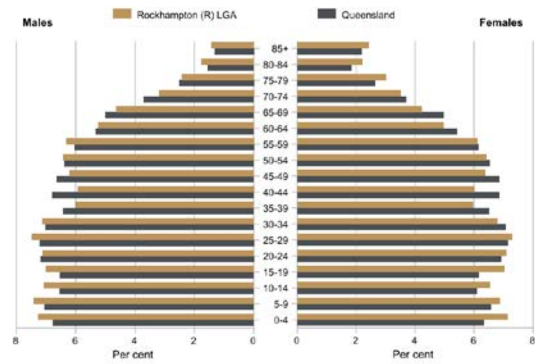


Figure 20: Age pyramid for Rockhampton LGA and Queensland, 30 June 2016pr

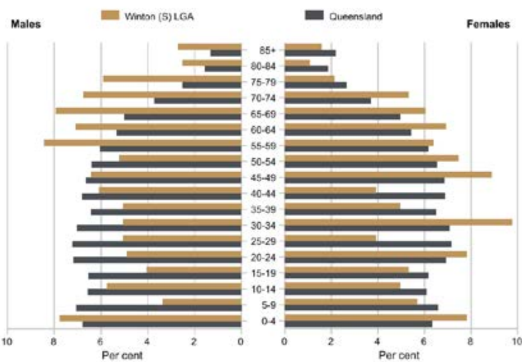


Figure 20: Age pyramid for Winton LGA and Queensland, 30 June 2016pr

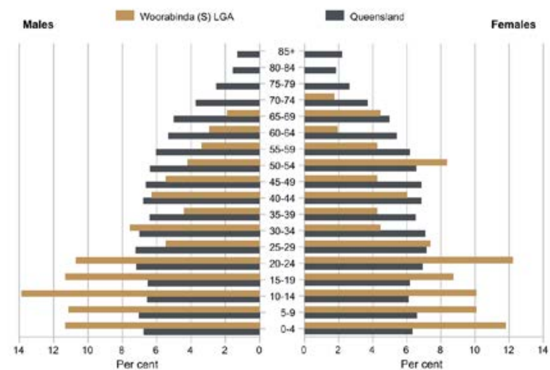


Figure 21: Age pyramid for Woorabinda LGA and Queensland, 30 June 2016pr

The various population projections for persons aged 65 years and above, from 2011 through to 2031, are shown in Table 2.

Table 2: Population projections by LGA for all people and persons aged 65 years and above

LGA	2011		2016/2015		2021		2026		2031	
	total	65+	total	65+	total	65+	total	65+	total	65+
Banana	14,812	1,802	15,188	2,014	15,519	2,386	15,807	2,730	16,064	3,022
Barcaldine	3,292	499	3,234	553	3,347	693	3,362	786	3,378	875
Barcoo	363	51	347	45	337	70	325	75	313	80
Blackall-Tambo	2,257	365	2,176	380	2,346	500	2,371	562	2,397	622
Central Highlands	29,541	1,805	31,083	2,176	34,073	3,074	35,890	3,747	37,630	4,315
Diamantina	292	22	280	26	284	33	277	36	271	39
Gladstone	59,461	5,346	67,426	6,530	78,484	9,579	87,764	12,190	97,315	14,761
Livingstone	33,394	4,919	37,455	5,982	41,427	8,353	45,994	10,470	51,142	12,689
Longreach	4,296	477	4,075	498	4056	556	3,959	594	3,853	623
Rockhampton	78,939	10,637	83,309	11,941	90,013	14,805	94,647	17,264	99,321	19,533
Winton	1,380	235	1,322	245	1314	332	1,276	363	1,240	393
Woorabinda	976	31	1,010	46	1,043	67	1,074	83	1,108	96
Queensland	**4,476,778**	**579,758**	**4,853,048**	**686,214**	**5,250,292**	**851,406**	**5,730,062**	**1,014,266**	**6,240,546**	**1,182,161**
Source - Queensland Government Population Projections, 2015 edition (medium series)										

Unfortunately, Australian Bureau of Statistics was not able to provide Migration statistics by LGA for people aged 65 plus, that were collected as part of the 2017 Census. This would have indicated the movement of residents of various age groups to and from each LGA.

Socio-economic disadvantage

It is important to note the socio-economic disadvantage scores of geographic areas with FCW. The Index of Relative Socio-Economic Disadvantage (IRSD) ranks geographical areas in terms of their relative socio-economic disadvantage in Australia. The index focuses on low-income earners, relatively lower educational attainment, high unemployment and dwellings without motor vehicles. Low index values represent areas of most disadvantage – these are shaded blue in Table 3. The mean score for Australia is 1000. Three of the LGAs in FCW have 100% of their population in the two most disadvantaged quintiles.

Table 3: IRSD score and population by Index of Relative Socio-Economic Disadvantage quintiles by LGA, 2011

LGA (score)	Quintile 1 (most dis-advantaged)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (least dis-advantaged)
			%		
Banana (980)	13.3	35.6	13.2	32.2	5.8
Barcaldine (974)	18.3	44.9	10.2	26.6	0
Barcoo (947)	0	100	0	0	0
Blackall-Tambo (945)	60.3	11.3	0	11.8	16.7
Central Highlands (1024)	8.4	14.5	19.2	26.6	31.3
Diamantina (917)	100	0	0	0	0
Gladstone (1007)	10.9	22.9	19	31.2	16
Livingstone (979)	10	23.7	36.8	17.9	11.6
Longreach (983)	0	54.5	33.8	5.2	6.5
Rockhampton (966)	35.2	24.3	19.1	12.6	8.8
Winton (931)	71.5	0	0	28.5	0
Woorabinda (592)	99.3	0.7	0	0	0
FCW total	**20.2**	**23.9**	**21**	**21.3**	**13.6**
Queensland	**20**	**20**	**20**	**20**	**20**
Source - Queensland Government Statistician's Office, July 2017					

Inconsistency of electronic health records

The inconsistency of electronic health records currently creates significant barriers to the provision of comprehensive primary health care across the Western Queensland Primary Health Network. Barriers include:

- the lack of coordinated care between service providers
- poor follow up of patients
- poor practice level data for efficient and effective management of patients' health
- poor data for local and regional planning.

Source: (Western Queensland Primary Health Network, 2016).

4. Aged Care System / Stakeholders

Aged care system in Australia

A research brief carried out by The ARC Centre of Excellence in Population Ageing Research (CEPAR) in 2014 surveyed aged care in Australia. CEPAR brings together researchers, government and industry to address one of the major social challenges of this century. CEPAR's view of some of the stakeholders and their responsibilities within the aged care sector are presented in Table 4. Please note that some changes have occurred since 2014, however it does provide a good overview.

Table 4: Main aged care industry stakeholders (CEPAR, 2014)

Government departments	Main Public agencies	Stakeholder institutions	Other
Department of Social Services (Overall responsibility)	**Australian Aged Care Quality Agency** (AACQA; former Age Care Standards & Accreditation Agency)	**Sector-wide advocacy** (National Aged Care Alliance)	**Other Sectors / Agencies** (Disability; Health; Workforce – e.g. Health Workforce Aust.; Education – e.g., Aust. Skills Quality Authority)
Department of Veterans' Affairs (Veteran programs)	**Aged Care Financing Authority** (ACFA; Pricing and financing advice to government)	**Consumer Advocacy** (e.g. Alzheimer's Australia, COTA, Carers Australia, National Seniors Australia)	**Research** (e.g., AIHW, Productivity Commission, Productive Ageing Centre, Academia)
Department of Human Services (Processing of subsidies)	**Aged Care Pricing Commissioner** (ACPC, Accommodation pricing)	**Unions** (e.g., Aust. Nursing & Midwifery Federation, United Voice)	**Age Discrimination Commissioner**
Department of Health (formerly overall responsibility; some responsibility via Health Workforce Aust. and accreditation)	**Aged Care Gateway** (Information, assessment, coordination)	**Professional bodies** (e.g., Aust. College of Nursing, Aust. Assoc. of Gerontology)	
Department of Industry (responsibility for workforce skills and training)	**Aged Care Reform Implementation Council** (Monitoring reform progress)	**Provider advocacy** (e.g., ACSA – not for profit, ACIA – home care LASA – industry-wide)	
Governments of Victoria and Western Australia (separate arrangements)	**Aged Care Commissioner** (Complaints)	**Providers** (e.g., Anglicare Australia, Bupa, local councils)	

Summary of CEPAR's research brief

Provider characteristics

The aged care industry is dominated by not-for-profits (58% in residential and 81% in home care) but for-profit provision has grown in importance. Occupancy is higher for not-for profits, high-care providers, and those just outside major cities; but until recently occupancy rates have been declining. The industry has also seen a consolidation into larger facilities.

Provider finances

Provider profitability varies. Four out of five report positive earnings, which are higher among for-profit, high-care, city-based, single-service providers. But these were not the only explanatory factors – management and business practice must play a role.

Staffing is the largest expenditure item, while the main component of income is the basic public subsidy; other subsidies and private fees make up the balance. But funding sources are subject to reform, which may affect providers with low-care, extra-level places negatively. Capital investment is lagging and may affect future supply. New strategies are needed to adapt to these as well as demand changes. Research suggests that 'clinical leadership' can help, as can integrated businesses with a greater range of services.

Workforce characteristics

The sector employs about 350,000 staff and has seen a growth in lower skilled workers in place of nurses. Care workers tend to be older, female, better educated than average, to work part time, and to spend considerable work time not directly caring. There also tends to be lower staff turnover than previously thought and high rates of satisfaction with work but not with pay, which for personal and community care workers averages $600-650 per week.

Future workforce: Projections for the workers that will be needed by 2050 range from 830,000 to 1.3M. There are various recruitment, retention and productivity responses. Action so far includes fragmented funding for staffing innovations and training. But proposed funding of wage increases has been scrapped, leaving the existing wage gap – which is also a gender pay gap – unaddressed.

Access

Data suggests access issues in the form of high stated unmet need (for home based services); under-representation of disadvantaged groups in residential care; declining average waiting times for care admission when leaving hospital but no declines for some groups; and potentially long times between approval for and admission to care. Increasing supply may improve access, as may cultural awareness training programs and a new information gateway.

Quality

Improvements in quality will depend on better measurement. In addition to regulating standards from the top, greater customer choice is expected to raise quality via market discipline. But some people may find choice difficult and will require guidance and information (CEPAR, 2014).

Federal Government's aged care services

My Aged Care: short-term help | help at home

All aged-care services for the majority of older Australians starts with the Federal Government's My Aged Care. A client registers via the website or their phone, and the contact staff help work out the support needed and whether an assessment to access services is required.

My Aged Care oversees services in two areas: 'Short-term help' and 'Help at home'. Help at home covers:

Commonwealth Home Support Program (CHSP)

This is an entry level (subsidised) home help program for older people who need some assistance with daily tasks to live independently at home. The aim of the CHSP is to help older people live as independently as possible. Following an assessment (called a RAS), an assessor works with the client to develop a support plan that reflects their aged care needs, goals and preferences. A client may be approved for a variety of services that can be from several different providers. If additional services are needed, they can be purchased through the existing provider, following negotiation.

People find service providers in their local area that meet their needs with help from the assessor, by using the service finder on the My Aged Care website or calling My Aged Care on 1800 200 422.

Home Care Packages

These packages help people who need coordinated services to live independently in their own home for as long as they can. The Australian Government provides a subsidy to an approved home care provider towards a package of care, services and case management to meet the individual's needs. A member of the My Aged Care team determines if the person needs an assessment by an Aged Care Assessment Team (ACAT) member who then visits to determine the stay-at-home needs.

The person is then approved for one of four levels of Home Care Packages (HCP), prioritised, based on the assessed need. The various HCPs are:

- Level 1 – basic care needs
- Level 2 – low-level care needs
- Level 3 – intermediate care needs
- Level 4 – high-level care needs.

Each level of home care package provides a different subsidy amount. This amount is paid directly to the provider the person has chosen. If the person is eligible, they are expected to contribute to the cost of the care where their personal circumstances allow.

This process changed in February, when before that time, the client had less control of the funds, so it can be assumed that quality of service and value for money will be a critical factor when choosing providers. A problem for clients without family or support people, is that they are less likely to have someone they can trust. They are more likely to experience a decline in social connections and health and problems accessing information. Furthermore, they are less inclined to question providers on contract elements and care issues, so may be more prone to elder abuse.

Services that can be accessed include, but are not limited to:

- **Personal services:** assistance with personal activities such as bathing, showering, toileting, dressing and undressing, mobility and communication.
- **Nutrition, hydration, meal preparation and diet:** assistance with preparing meals, including special diets for health, religious, cultural or other reasons; assistance with using eating utensils and assistance with feeding.
- **Continence management:** assistance in using continence aids and appliances such as disposable pads and absorbent aids, commode chairs, bedpans and urinals, catheter and urinary drainage appliances, and enemas.
- **Mobility and dexterity:** providing crutches, quadruped walkers, walking frames, walking sticks, mechanical devices for lifting, bed rails, slide sheets, sheepskins, tri-pillows, pressure-relieving mattresses and assistance with the use of these aids.
- **Nursing, allied health and other clinical services:** speech therapy, podiatry, occupational or physiotherapy services, hearing and vision services. Home care level 1 and 2 packages are not intended to provide comprehensive clinical or health services. Home care level 3 and 4 packages have a greater emphasis on delivering complex care in the home, including more clinical care where needed.
- **Transport and personal assistance:** assistance with shopping, visiting health practitioners and attending social activities.
- **Management of skin integrity:** assistance with bandages, dressings and skin emollients.

A home care package may also be used to support the use of:

- **Telehealth:** video conferencing and digital technology (including remote monitoring) to increase access to timely and appropriate care
- **assistive technology:** such as aids and equipment (particularly those that assist a person to perform daily living tasks), as well as devices that assist mobility, communication and personal safety
- **aids and equipment:** some aids and equipment that are directly associated with your care needs can be purchased using funds from your package budget.

End of life care at home

If someone is caring for a person who is nearing the end of their life, there is a range of help and support available during this difficult time.

My Aged Care: aged care homes

Once it is time for someone to move into residential aged care, financial calculations are required to determine costs. The Australian Government subsidises aged care homes to keep costs reasonable and affordable. People are expected to contribute to the cost of their care if they can afford to.

Application forms are made to each Residential Care Home and people can apply to as many homes as they wish. Wait lists apply to many facilities. An assessment with a member of an ACAT is required before you can apply. The costs can include one or more of the following:

- A basic daily fee which covers living costs such as meals, power and laundry. For some people (those with no or minimal assets) this is the only fee they are required to pay.
- A means-tested care fee. This is an additional contribution towards the cost of care that some people may be required to pay. The Department of Human Services (Centrelink) or Department of Veterans' Affairs (DVA) will work out if clients are required to pay this fee based on an assessment of income and assets, and advise the amount.
- An accommodation payment. Some people will have their accommodation costs met in full or part by the Australian Government, while others will need to pay the accommodation price agreed with the aged care home. Centrelink will advise which applies to each client based on an assessment of income and assets. If costs are required, this can be paid by a refundable accommodation contribution (RAC), daily accommodation contribution (DAC) or a combination of both. RACs can range (some are around $300,000 per client), depending on the client's assets, and the price set by the Residential Care Home. The Aged Care Pricing Commissioner's website states that "the maximum amount that a provider may charge a care recipient without approval from the Aged Care Pricing Commissioner is $550,000". Accommodation providers can apply to the Aged Care Pricing Commissioner to increase this.
- Fees for extra or additional optional services. Additional fees may apply if people choose a higher standard of accommodation or additional services. These vary from home to home. Each aged care provider can provide details of these services and the fees that apply.

Supply of residential aged care

Residential aged care provides personal and nursing care for those who choose to have their care provided within a residential aged care setting. It is provided on a permanent or respite basis.

The Australian Government regulates the supply of residential aged care places and home care packages by specifying national and regional targets for the provision of subsidised aged care places. These targets – termed the 'aged care provision ratio' – are based on the number of people aged 70 and over for every 1,000 people in the Australian population. By 2021-22, the aged care provision ratio is set to grow from 113 to 125 operational places for every 1000 people aged 70 and over.

In addition to setting an overall target ratio for care places, the Commonwealth has maintained ratio-based targets for residential care places and home care packages. Over the coming years, the mix of home care and residential care will be substantially altered. The target for home care packages will increase from 27 to 45, while the residential target is to reduce from 88 to 78 with an additional 2 places in the overall ratio reserved for the new Short-Term Restorative Care Programme places.

Aged care providers

In 2014-15 there were over 2,000 providers supplying aged care in Australia. There is a large number of providers in each service sector, but relatively few operate across all three settings of HCP, home care and residential care. There were around 1600 HCP providers, 500 home care providers and nearly a thousand residential care providers. Home care providers are the most likely to also operate in other service types. However, across aged care, four out of five providers operate only one type of

care, and only 2% of providers operate all three service types. ACFA notes this may change as aged care moves toward a more market-based system with some providers likely to expand their operations to other service types (Aged Care Financing Authority, 2016).

Table 5 provides an overview of the aged care sector in 2014-15. Note that the aged care system has changed and program names have altered, however the information provides a good overview of the numbers of services and providers, along with information on revenues and profits.

Table 5: Aged care in Australia, 2014-15 (Aged Care Financing Authority, 2016)

	HACC	Home care	Residential care
Number of providers	1,628	504	972
Number of services	N/A	2,292	2,681
Number of places	N/A	72,702	192,370[1]
Total revenue	$2.1 b	$1.4 b	$15.8 b
Commonwealth contribution to total revenue	$1.9 b	$1.28 b	$10.6 b
Consumer contribution to total revenue	$190 m	$147 m	$4.2 b
Other contribution to total revenue[2]	N/A	$14 m	$1.2 b
Total expenditure	N/A[3]	$1.2 b	$14.9 b
Total net profit before tax	N/A[4]	$150 m	$907 m

[1]Number of places does not include Multi-Purpose Services or Aboriginal and Torres Strait Islander places
[2] 'Other' revenue includes interest income, asset revaluations and trust distributions
[3]Analysis of expenditure for HACC providers is not possible as they are funded on a grants and acquittal basis
[4]Analysis of profit for HACC providers is not possible as they are funded on a grants and acquittal basis

Residential care providers

In 2014-15, there were 972 providers down from 1,016 in 2013-14, reflecting consolidation in the industry. There were 2,681 services operated in 2014-15 with 192,370 places. While the number of services remained relatively stable, the number of places increased from 189,283 in 2013-14 (1.6%). The 2015 ACAR allocated 10,940 new residential aged care places.

The majority of residential aged care places are operated by not-for-profit providers (54% of providers and 57% of places). For-profit providers account for 36% of providers and 38% of places, with state and territory and local government owned providers accounting for 11% of providers and 5% of places. There continues to be a significant number of single home providers (64% of all residential providers) though they only account for 23% of places. Conversely, providers with more than 20 homes account for only 2% of all providers, however, they account for 25% of operational places.

The majority of providers continue to be located in metropolitan regions only, however, the number who exclusively serve metropolitan regions has dropped (52% compared with 58% in 2013-14). The number of providers serving both metropolitan and regional areas has risen from 4% in 2013-14 to 9% in 2014-15 (Aged Care Financing Authority, 2016).

Residents

The number of residents who received permanent residential care during 2014-15 was 231,255 (compared with 231,515 in 2013-14). However, the number of people who accessed residential respite care increased by almost 10% over the same period, to 53,021.

The residential aged care population is getting older over time as people live longer and have more opportunity to stay in their own homes longer with the help of home care packages. The proportion of residents aged 85 years and over has increased from 55% in 2009 to 59% in 2015, while the proportion of those aged between 70 and 84 has decreased from 37% to 34%. The average age of permanent residents in 2015 was 84.6 years. This has been steadily increasing since 2009 when it was 84.0 years (Aged Care Financing Authority, 2016). Figure 23 shows the changes in the target provision ratio since 2004 and Figure 24 shows the achieved ratio over the last 10 years (Aged Care Financing Authority, 2016).

Figure 23: Increase in provision ratio, 2004-2022 (per 1,000 people aged 70 and over)

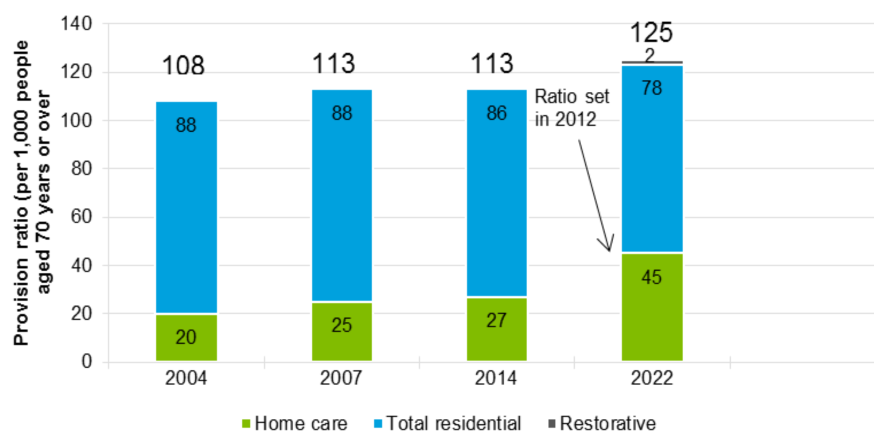
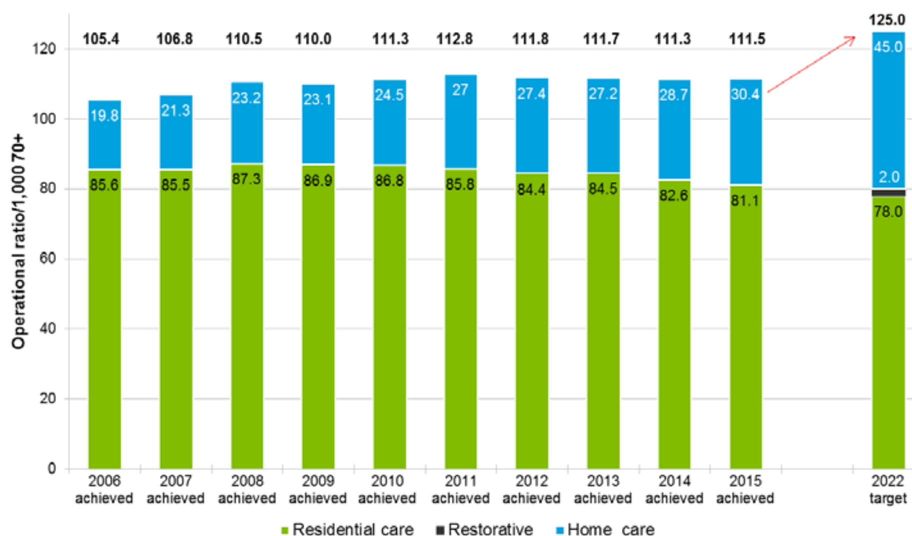


Figure 24: Aged care operational ratios achieved since 2006, compared with the target ratio to be achieved by 2022

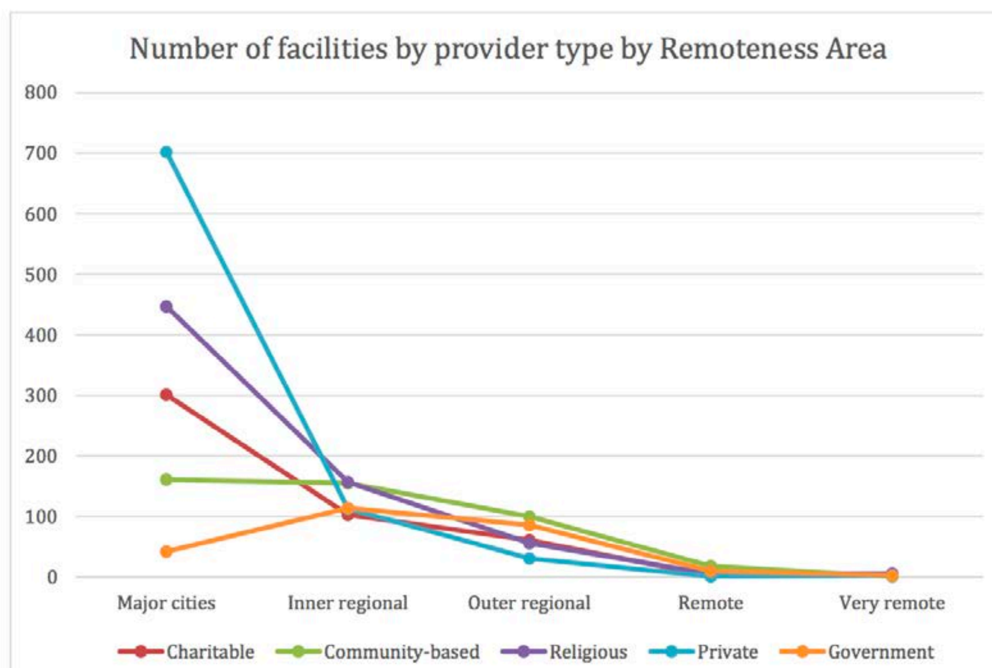


Traditionally each year, new aged care places for residential and home care have been made available for allocation through the Aged Care Approvals Rounds (ACAR).

Facilities by provider type by remoteness area

The data below (Figure 25) shows that access to residential aged care in remote and very remote communities is extremely limited. The type of provider of residential aged care in rural and remote Australia differs from major cities substantially. The largest provider type in major cities is the private provider, but their market share outside major cities is extremely limited – particularly once you leave inner regional locations (National Rural Health Alliance Inc, 2016).

Figure 25: Number of facilities by provider type and remoteness. Source (National Rural Health Alliance Inc, 2016)



Private providers are not found in locations that operate on marginally sustainable business models, such as those facilities that operate in remote and very remote communities. The concept of consumer choice is thus more constrained as you progress into more remote locations. In these locations, the need for legislated requirements and regulation is vital to guarantee both access to residential and community based aged care and to an acceptable quality of care (National Rural Health Alliance Inc, 2016).

For every ten working age adults aged 25-54 years, there are:

- three elderly (65+) people in major cities
- four elderly people in regional areas
- two elderly people in remote areas.

This data strongly suggests that as people in remote and very remote communities age, they move to regional locations where they are able to access better health and aged care services (National Rural Health Alliance Inc, 2016).

Summary: Report on Issues Affecting the Financial Performance of Rural and Remote Providers
ACFA's report 'Financial Issues Affecting Rural and Remote Aged Care Providers' was delivered to the Minister in January 2016. The analysis – which considered 2014-15 service level financial data – showed that services in rural and remote areas were more likely to experience high cost pressures that lowered their financial results. Lower financial performance became more pronounced with remoteness and lower bed numbers. Results were also generally lower for state and territory government providers who have higher costs, particularly wages, though many also receive additional state and territory government funding.

Notably, the Report did confirm that location alone was not the sole determinant of financial performance. There were a number of providers in rural and remote settings reporting strong financial results. Factors driving these pockets of strong performance were found to include:

- The quality, skills and range of organisation leadership;
- The adoption of innovative approaches (including Information Technology) to service delivery; and
- Overall organisational structure and approaches to facility/service management, covering care, administration and financial management.

Source: (Aged Care Financing Authority, 2016)

Policy and reform environment

The current aged care system is at a transitional point on a longer pathway to ensure there is a sustainable, high quality aged care system that meets the needs of all older Australians. This pathway includes reforms to home care announced in 2015, which is being implemented in 2017 and 2018; and a longer-term reform program that is being developed by the Commonwealth and the sector. The reforms announced in 2015 include funds following the consumer in home care from February 2017, which will give consumers choice of service provider. Also announced was the intention to combine the Home Care Program and CHSP into a single care at home program in 2018 (Aged Care Financing Authority, 2016).

ACFA has noted some uncertainty in the sector regarding these changes to home care. The market to provide home care services will develop alongside the open market for services to consumers under the National Disability Insurance Scheme. ACFA anticipates that the sector will evolve to respond to this consumer-driven market. Some rationalisation of providers could occur as the sector moves to a more competitive environment. A portion of that rationalisation is likely to involve strategic alliances and mergers between not-for-profit providers who will continue to pursue their missions in the communities that they currently serve. These reforms are also expected to result in increased involvement by the for-profit sector in home care.

Beyond these planned changes to home care, the Commonwealth and the sector are planning for further change, and ACFA recognises that the current configuration of aged care represents an intermediate stage in that longer reform process.

Likely directions for change are evident in the consensus expressed by stakeholders and reflected in that Aged Care Roadmap developed by the Minister’s Aged Care Sector Committee (ACSC), and informed by the Productivity Commission’s 2011 report, as well as the work of the National Aged Care Alliance.

On care and support, there would be less regulation of prices and choices, with consumers able to choose service types and how much they pay. The Commonwealth would however place some limits on the kinds of things on which its contribution to costs of care could be spent. ACFA agrees with the ACSC that critical to achieving reform is a deep understanding of consumer behaviour and the economics of the sector.

ACFA considers that the success of further reforms will be dependent on the readiness of key stakeholders. ACFA considers that key areas in which stakeholders need to prepare are:

- The Commonwealth needs to provide sufficient certainty to allow informed and effective business planning, and have infrastructure and support systems in place that have the capacity to underpin intended reforms.
- Consumers need to be aware of, and ready to accept, their rights and obligations.
- Providers need to implement appropriate systems and practices to reflect the new arrangements and have the necessary culture and capacity to adapt.
- Investors need to have sufficient certainty to have the confidence to respond to the growing demand (Aged Care Financing Authority, 2016).

In July 2017, a Discussion Paper was released by The Hon Key Wyatt (Minister for Aged Care and Minister for Indigenous Health): Future reform – an integrated care at home program to support older Australians. Submissions closed on 21 August 2017. The discussion paper invited stakeholder views on how future reform can best support older Australians to remain living at home and in their communities. The feedback was to inform government decisions on an integrated 'care at home' program. As part of the Discussion Paper, responses to the item (shown in Table 5) were requested:

Table 5: Discussion item 6.1.3 from the July 2017 Discussion Paper released by the Minister for Aged Care

6.1.3. Rural and remote areas

There are unique considerations for service delivery in rural and remote areas, which have implications for service availability. Services located in these areas are also sometimes less viable. The Aged Care Financing Authority has found that such services are more likely to experience high cost pressures (e.g. workforce costs, travel/freight costs), among other challenges including access to appropriately skilled staff, limited internet coverage, and smaller consumer bases (resulting in smaller scale services)[14].

Questions

How can we address the unique challenges associated with service delivery in rural and remote areas?

What other service delivery and funding models could we consider for providing care at home services to consumers living in rural and remote areas, including examples of innovative local community models?

In a Media Release on 24 January 2017, Minister Wyatt, stated:
"Australia's population is ageing rapidly so it's imperative that we structure our aged care system so it is flexible, provides greater choice, is people-centred and sustainable. "No matter where people live, aged care services must be available to communities across the nation and in all its diversity. "It's important that older people with increasing or complex care needs are able to stay close to loved ones and where they have established community ties" (Wyatt, $8.5 Million in Additional Funding for Aged Ca re Services in Regional, Rural and Remote Australia, 2017).

Australian Digital Health Agency: Telehealth

Telehealth consultations are now available within some Aged Care Facilities. During the Telehealth consultations, clients are able to see, hear and talk to specialists via the computer, via the comfort of their Aged Care Facility. A member of the nursing staff, or another healthcare professional is with the client during the appointment, along with any additional support people that the client would like.

The Aged Care Sector Committee

The Aged Care Sector Committee (the Committee) 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 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.

Their work includes:

- Aged Care Legislated Review
- Aged Care Roadmap
- Aged Care Sector Statement of Principles
- Red Tape Reduction Action Plan.

Aged Care Roadmap

The Aged Care Roadmap (2016) sets out a future path for a sustainable, consumer-driven and market-based aged care system in Australia. It represents a considered view by industry and key stakeholders on the broad future directions that the aged care sector should work towards in the long run. The Roadmap recognises that substantial change is affecting the sector as a whole, with factors such as the sustainability of future investment in industry growth, changing consumer preferences and funding arrangements within the sector having important implications for the broader industry landscape.

In relation to how aged care is financed, the Roadmap suggests that increasing demand for, and cost of, aged care means that the system should change to ensure that consumers contribute consistent with their capacity to do so. The Roadmap suggests different reforms and policies for accommodation and living costs on the one hand, and care and support on the other. The Roadmap proposes that consumers remain responsible for accommodation and everyday living costs, as they have been throughout their lives, with the Commonwealth providing a safety net, and to intervene to assist where the market does not respond to consumer needs (Aged Care Financing Authority, 2016).

Achieving the market-based and consumer-centric aged care system that has been envisioned in the Aged Care Roadmap is dependent on action by both industry and government. The Aged Care Roadmap (2016) highlights important recommendations for the aged care industry to implement over the next seven years. One important recommendation is to provide a single aged care support system that is market-based and consumer-driven (Table 6).

Table 6: 'Consumer centricity': a part of the Aged Care Roadmap

Short term (within 2 years)	Medium term (3-5 years)	Long term (5-7 years)	Destination
• Minimised government restrictions • Greater consumer choice in delivery of Home Care Packages	• Cease the allocation process for residential care places • Individualised funding that follows the consumer in home care	• True consumer choice of care and provider across the system • Remove distinction between home and residential care	A single aged care and support system that is market based and consumer driven, with access based on assessed need.

Department of Health

Review of aged care quality regulatory processes

The Australian Government (Federal Aged Care Minister / The Department of Health and the Australian Aged Care Quality Agency) is commissioning an independent review of the Commonwealth's aged care quality regulatory processes to determine why they did not identify the extent of the failures of care at a South Australian Older Persons Mental Health Service. While the review will primarily examine the Commonwealth Government's accreditation, monitoring, review, investigation, complaints and compliance processes in relation to the incident, the recommendations are to assure the community that the regulatory system in residential aged care works effectively. "This review is a crucial step in ensuring that older Australians are cared for properly, with safety and respect and so I want this review to report to me by 31 August 2017 (Wyatt, Media Release, 2017).

Residential aged care resource utilization and classification study

Ageing and Aged Care Group (part of Department of Health) announced on 15 August 2017 the commencement of the Resource Utilisation and Classification Study into residential aged care.

The Department has engaged the Australian Health Services Research Institute, University of Wollongong to undertake the study, which aims to examine the relative costs of providing care to residents with different care needs and use that data to design a case mix style classification system. The purpose of the study is to determine the characteristics of residents that drive residential care costs, and use this information to inform the Government's consideration of future reform options, which may include a new resident classification tool.

The results will help guide long-term reform in residential aged care funding. The Institute has already developed options and recommendations to help inform the design of future residential aged care funding models. Seminars were held in 10 national locations to present the options to stakeholders. No decisions have been made on options. The Department is in the process of establishing a Sector Reference Group to provide advice on the design and implementation of the study.

Remote and Aboriginal and Torres Strait Islander Aged Care Service Development Assistance Panel

The Remote and Aboriginal and Torres Strait Islander Aged Care Service Development Assistance Panel has been established to address the challenges in maintaining and delivering culturally appropriate and quality aged care services in remote and very remote areas and/or those providing aged care to a significant number of Aboriginal and Torres Strait Islander people located anywhere in Australia.

Queensland Government

Nurse Navigator service

Launched in June 2017, Nurse Navigators are a team of registered nurses who provide a service for patients who have complex health conditions and require a high degree of comprehensive, clinical care. This may include patients with multiple chronic illnesses, those with a high need for health services, or those who have complicated health conditions.

These nurses are highly experienced and have an in-depth understanding of the health system. The Nurse Navigator services at Central Queensland Hospital and Health Service (CQHHS) are to:

- Coordinate patient centred care - providing support, advocacy and care coordination across the patient's health care journey, from community, GP, hospital and home again.
- Create partnerships - working closely with patients, their GP, Medical Specialists, Allied Health Specialists (such as Physiotherapists and Occupational Therapists), Aboriginal and Torres Strait Islander Health Workers, and other organisations or Care Providers involved in patient care to support the patient in their health care journey.
- Improve patient outcomes - providing education to the patient and their family to support them to make informed decisions about their health care and advanced care planning. Working closely with the patient and their family to develop health care goals and care plans to assist them to better manage their own health and to promote independence. Assisting the patient navigate support services so they can access the care support they need.
- Facilitate systems improvement - help the patient and their family access appropriate treatment with effective communication of referral pathways, reduce fragmentation, duplication, time delays, inappropriate treatment and other barriers to support patient centred care.

In the CQHHS region, services include:

- A Nurse Navigator Older Persons who is part of the Subacute Ambulatory and Community Services, Rockhampton. The nurse has clients in Rockhampton, with the possibility of also covering Capricorn Coast and Mt Morgan.

- An additional Nurse Navigator Older Persons in Banana Shire (Chronic and Complex) and one covering Mental Health.
- 15 Nurse Navigators to be in CQHHS by end of 2017, covering key gaps. Generalists most suitable for rural areas and their expertise. To link services, rather than provide hands-on care. More holistic approach.
- Referrals tend to come from hospital doctors, nurses and allied health workers such as social workers.

Residential Acute Care Service (RACS)

Residential Acute Care Service (RACS) is a hospital avoidance strategy. RACS provides a clinical consultancy service to the 10 Residential Aged Care Facilities (RACF) within the Rockhampton and Gracemere area.

The service is based on the principles of Hospital in the Nursing Home. RACS provides a timely triage assessment and treatment plan to residents with an acute illness and/or exacerbation of a chronic condition within the RACF. This service works in collaboration with the residents' GP and facility staff. The medical governance regarding the clinical treatment remains with the resident's GP. RACS staffing includes two Nurse Practitioners who are able to facilitate timely diagnosis and treatment of complex conditions.

RACS objectives are to:

- provide early mobile triage and assessment of the resident's condition
- foster timely GP consultation to enable early intervention and treatment plan
- provide a safe and appropriate alternative to hospitalisation
- avoid unnecessary Emergency Department (ED) presentation and subsequent hospitalisation
- provide the communication link between acute care and aged care settings
- provision of care within the convenience of their home in partnership with the GP, RACF and other health professionals
- advocate residents' health care preferences and decisions related to ongoing care
- identify and monitor Residents who have presented to ED and/or admitted to Rockhampton Hospital to facilitate early intervention strategies. Strategies include referral to Hospital in the Home or RACS and early transition back to the RACF with RACS support
- mentor RACF staff through opportunistic learning to develop their assessment skills promoting early identification and management of common conditions.

Telehealth Portal

The Queensland Health Telehealth Portal provides easy, safe and secure video access to a health professional via a web browser on a computer or through an app on smart phones or tablet.

Queensland Health employees send the client an email with a link to the meeting and details on how to use the system for an arranged Telehealth appointment. People click on the link at the time nominated and the health employee will be waiting to meet them. People can also send images or documentation to the clinician, during the meeting by uploading PDF (portable document format) files into the app.

Sub-Acute Geriatric Unit (SAGE)

Located at the Rockhampton Base Hospital, SAGE caters for patients with age-related conditions (non-Indigenous persons over 65 years; Indigenous persons over 50 years) who are not sick enough for an acute hospital bed, but not well enough to go home.

The team consists of: nursing staff and doctors; two occupational therapists, physiotherapists, and social workers; a speech pathologist, dietician, psychologist, pharmacist and assistant, recreational officer; allied health personnel; and operational and administrative staff.

The team provide elderly residents with the care and support they need, whether that be in hospital, or to keep them healthy and well enough to live independently at home. The team work closely with other units within Central Queensland (CQ) hospitals and the Community Health team, as well as aged-care facilities and other existing support agencies to ensure the right person gets the right treatment at the right time.

SAGE has 27 beds and is always at full capacity, with a waiting list of approximately 8-10 patients at any time. There is no limit to the length of time a patient can be in SAGE, but the average stay is 11 days. Many patients go through a 2 to 3-week Geriatric Rehabilitation Program. Patients come from the entire Fitzroy and Central Health region. It is the only Sub Acute Geriatric Unit of its type in Central Queensland. The Unit tends to hold 25% of clients from outside the Rockhampton region.

The process from intake to discharge is:

- an event occurs, requiring hospitalisation from previous 'home' (this can be house, supported living, aged care facility etc)
- assessment at Emergency Department
- admitted to hospital Ward
- referral process by hospital team
- admission to SAGE for
    - geriatric evaluation and management (funded by Government), or
    - interim care ($58 per day paid by patient)
- Advanced Care Planning including family conference
- return to the previous 'home' or to appropriate aged card facility
- the aim for patients to be returned to a location as close to their home as possible.

The retirement village sector

Retirement villages

Retirement Villages are a growing sector of the aged care industry. *The Courier Mail* reported in June 2017 that "today, about 200,000 people over 65 live in villages and that number is expected to double by 2025 (Scott, 2017). Just like living in a regular residential home, aged people can access Government home care packages while living in this type of accommodation. Some villages offer their own fee-based services to provide additional services for their residents.

The retirement village industry is governed by state government legislation and is not connected to the Federal Government reforms. About 42,000 Queenslanders live in 315 retirement villages, 17,000 in 185 residential parks, and 3,000 in aged rental complexes (Mick de Brenni MP, 2017).

In the last few months, there have been various media reports about retirement villages:

- 9 July 2017 – ABC News: *Retirement village fees, contract reform proposed in Queensland to better protect seniors' rights*
- July 2017 - Four Corners report on financial methods of retirement village company Aveo (one of the biggest retirement village operators in the country): *Exploitation of the elderly rife in retirement villages*
- June 2017 – Four Corners report: *Retirement village regulation lacking, leaving residents open to exploitation*
- August 2017 - Sydney Morning Herald: *The price of freedom.*

Key points to note from the articles were:

- Retirement village residents are not in any federal minister's portfolio.
- Several people claiming they've had trouble selling property.
- Concerns raised over dense contracts, high fees and lack of resources to instigate change.
- Retirement villages collect an exit fee when a resident dies or leaves – this is unique to the retirement village industry.

Retirement Living Council

The Retirement Living Council seeks to play a critical role in the ongoing growth and sustainability of the retirement living industry. It is the only national organisation solely focused on advocating on the critical issues facing housing and services for older people, supporting and promoting members and the retirement living industry at large.

Following a 2017 meeting to hear resident feedback and work on common issues, retirement village owners and operators agreed to deliver higher standards, clearer and simpler information about costs and contracts, and an independent umpire to resolve disputes. The retirement village industry has committed to an 8-point plan that is designed to lead to greater transparency and higher standards across the industry. This will be achieved by supporting mandatory accreditation for retirement village operators, ensuring contracts are clearer and more understandable and providing better dispute resolution mechanisms (Retirement Living Council, 2017).

Information on their site provides the following facts:

- Over 184,000 older Australians live in retirement villages.
- The Action Plan will form the basis of future discussions with politicians and regulators about enhancing the industry so that residents are reassured that their interests remain paramount to retirement village operators across Australia.
- Independent surveys and resident feedback indicates that the clear majority of village residents enjoy the retirement village lifestyle and the advantages it provides.
- Industry surveys have found most residents believe the financial agreement they reached with their retirement village is fair: 83% regard their fees as reasonable and 70% said the cost of living was the same or less than when they lived in their family home.
- If they had their time over to make the same choice to move into a retirement village, 98% of residents said they would move again.
- Village accommodation prices are significantly less than median house prices (with average entry level prices still below $400,000). The entry price for an average two-bedroom retirement village unit is one third less than the median house price in the same postcode.
- The deferred management fee (DMF) model used by most retirement village operators enables residents – of which the vast majority access an age pension – to effectively part-pay for their villa or apartment at the end of their tenure when their place is resold. This means a lower entry price that makes village living more accessible and affordable.
- In most states, regulations ensure that each prospective resident is given a fact sheet and/or disclosure statement, to help them compare villages, inspect documents such as the village accounts, and understand the costs of moving in and out. A cooling off period ensures residents who sign the contract can change their mind.

The 2016, Price Waterhouse Coopers/Property Council Retirement Census delivered the following data in November 2016, based on 53,000 retirement units (Property Council of Australia, 2016). A snapshot of the data is shown in Figure 26.

- Average current tenure of Queensland residents is 8 years.
- Average resident age on entry into a Queensland village is 75 years.
- Village occupancy remains relatively high across the various regions – in Queensland it is 89%, the lowest of all regions; highest is 93% in NSW/ACT.
- There has been moderate year-on-year average price growth for two-bedroom Independent Living Units (ILU) over the past 3 years: $375,000 in 2014; $385,000 in 2015; $398,000 in 2016.
- The 2-bedroom/1-bathroom configuration remains the most commonly available product – 72%.
- Newer villages established in the last ten years provide a variety of facilities including gyms, cinemas, pools and communal gardens which can attract a more active and independent demographic: 74% have a gym; 47% have a cinema; 71% have a pool; 76% have a resident communal garden; 82% allow pets.
- Monthly service fees (such as common area cleaning and insurance, which a resident in private strata accommodation would also typically incur) for a single resident: $405 NFP; $431 For Profit Group Private; $381 For Profit Group Public.
- 70% of villages have a Buy Back requirement (gives residents confidence that on departure, the operator will purchase back the ILU within a certain period of time if a buyer is not found.
- In Queensland, 34% of villages have aged care within 500m (the mean is 26% for Australia).

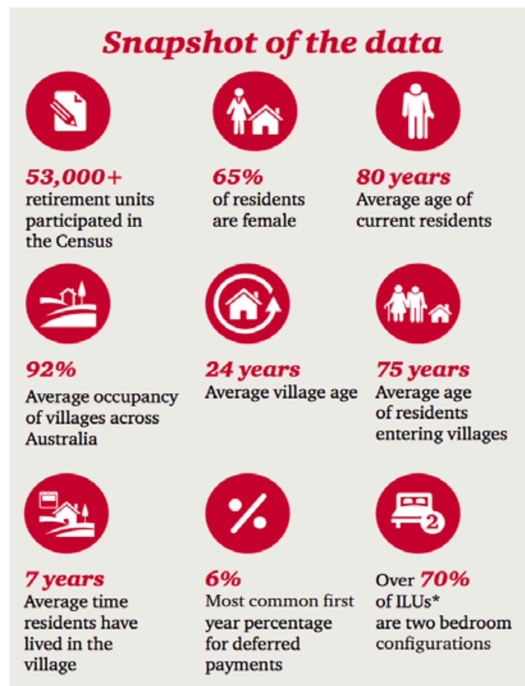
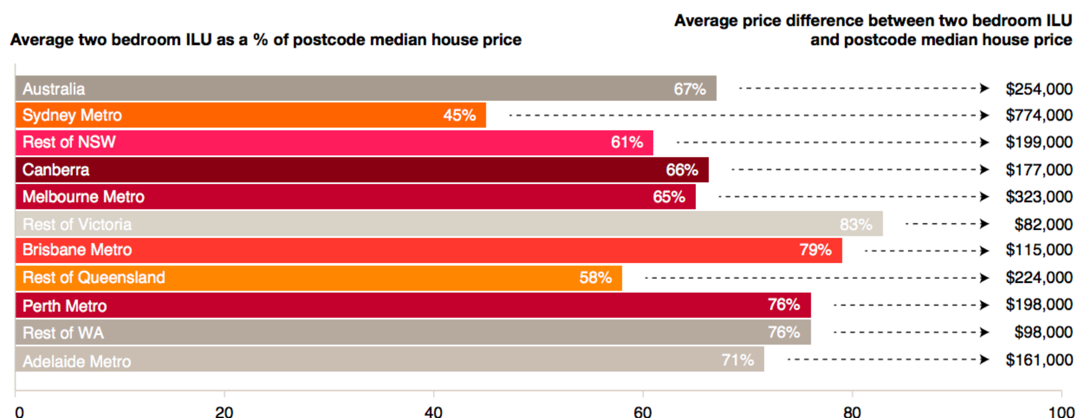


Figure 26: Snapshot of the 2016 data from a retirement census by Price Waterhouse Coopers

Information in the report included the average two-bedroom Independent Living Unit price compared to medium house prices in the same postcode. Figure 27 shows the various prices.

Figure 27: Average 2-bedroom ILU price compared to median house price in the same postcode1



[1] Postcode median data provided by CoreLogic.

Informal care

Informal care determines the level, composition, and cost of formal care. It is provided by family, friends and neighbours and is assumed to make up the majority of all care for older people.

In 2015, almost 2.7 million Australians were carers (11.6%), with 856,100 people (3.7%) aged 15 years and over identified as primary carers. These patterns were similar to those in 2009 and 2012. In 2015:

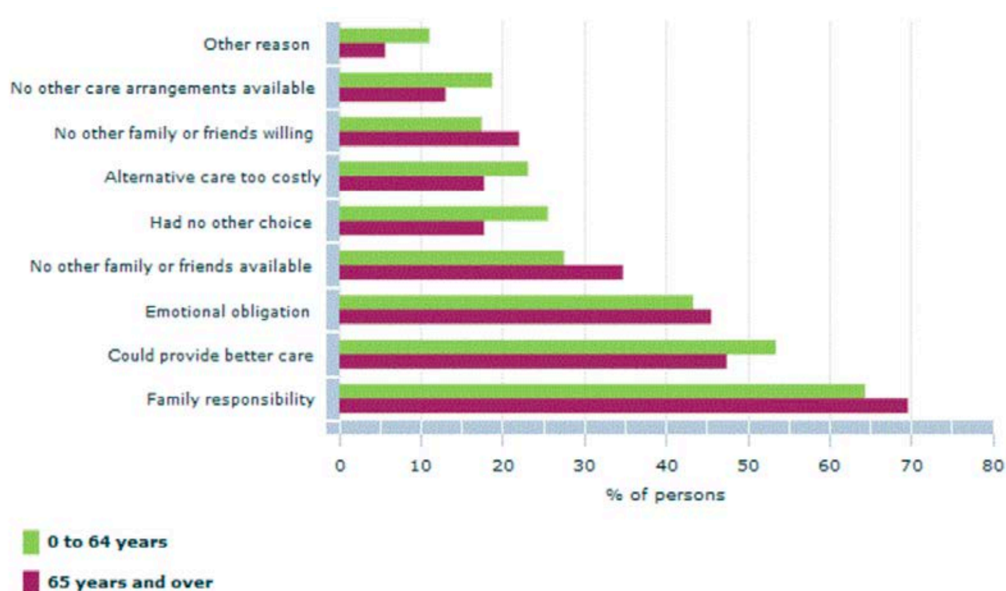
- the average age of a primary carer was 55 years
- over one-third of primary carers (37.8%) were living with disability themselves
- females made up the majority of carers, representing 68.1% of primary carers and 55.5% of all carers
- for people aged 15 to 64 years, the labour force participation rate for primary carers (56.3%) and other carers (77.2%) was lower than for non–carers (80.3%) (Australian Bureau of Statistics, 2016).

The future supply of informal carers will depend not only on the relative size of age groups who have traditionally been carers but also on cohabitation and family formation patterns, labour force participation, particularly of women, and general willingness to take on the role (CEPAR, 2014). Informal carers are often older and mostly women; the majority care fewer than ten hours per week; and the recipients of their care tend to be partners or parents (ABS 2013).

Reasons for taking on a carer's role

There are many reasons for taking on a caring role and these are shown in Figure 28. Similar to 2012, the 2015 Survey of Disability Ageing and Carers found that primary carers reported that the most common reason was a sense of family responsibility (66.9%). The next most common reason was a feeling they could provide better care than anybody else (50.3%), followed by a feeling of emotional obligation to undertake the role (44.2%). When the person being cared for was an older person (aged 65 years and over) it was more likely that no other friends or family were available to take on the caring role (34.7% compared with 27.5% for recipients aged under 65 years).

Figure 28: Primary carers – Reasons for taking on caring role, by age of main recipient of care, 2015. Source (Australian Bureau of Statistics, 2016)



The value of unpaid care was estimated to be worth $40 billion in Australia in 2010 (Access Economics, 2010). It comes at a cost, as carers work less and are more likely to be in poverty (due to lower income, not necessarily lower wages) and are more likely to suffer mental health problems (CEPAR, 2014).

The need to support informal care is not lost on policy makers. Responses from CEPAR's research have included:

- recognising carers – including National Carer Strategy and Carer Recognition Act 2010
- ensuring employment protections - changes to Australia's *Fair Work Act 2009*
- providing a number of in-kind support services – respite; social and emotional help; education/information
- cash benefits to cover costs or absence from work – Australian Government's Carer Allowance and Carer Payment (CEPAR, 2014).

Services for / needs of Australia's First Nation's Peoples

The specific needs of Aboriginal and Torres Strait Islander people have to be considered when planning for future aged care needs within our region. This is especially important, as the percent of Indigenous Australian people residing in each LGA within the FCW is equal to, or higher than the state average of 4.0%, shown in Table 7. LGAs with more than 10% of the population being people of Aboriginal and/or Torres Strait Islander descent are: Barcoo (12.4%), Diamantina (14.8%) and Woorabinda (94.4%).

Table 7: Indigenous status by LGA, Fitzroy Central West region and Queensland, 2016

Custom region / LGA / State	Indigenous persons					Non-Indigenous persons		Total persons[b]
	Aboriginal	Torres Strait Islander	Both[a]	Total				
	— number —			number	%	number	%	number
Fitzroy Central West region	**11,773**	**639**	**891**	**13,335**	**5.8**	**199,007**	**86.1**	**231,038**
Banana (S)	519	17	44	579	4.0	12,576	87.8	14,319
Barcaldine (R)	154	6	4	169	5.9	2,478	86.5	2,865
Barcoo (S)	25	0	3	33	12.4	227	85.0	267
Blackall-Tambo (R)	92	3	3	106	5.6	1,703	89.5	1,903
Central Highlands (R)	1,108	40	61	1,210	4.3	23,344	83.4	27,999
Diamantina (S)	43	0	0	43	14.8	205	70.4	291
Gladstone (R)	2,205	82	209	2,503	4.1	54,607	88.6	61,640
Livingstone (S)	1,388	94	126	1,607	4.4	31,690	87.4	36,272
Longreach (R)	170	22	9	195	5.3	3,135	85.7	3,660
Rockhampton (R)	5,140	357	375	5,874	7.4	68,077	85.4	79,726
Winton (S)	78	15	6	108	9.5	925	81.6	1,134
Woorabinda (S)	851	3	51	908	94.4	40	4.2	962
Queensland	**148,943**	**21,053**	**16,493**	**186,482**	**4.0**	**4,211,020**	**89.5**	**4,703,193**

(a) Applicable to persons who are of 'both Aboriginal and Torres Strait Islander origin'.
(b) Includes Indigenous status not stated.

The Lowitja Institute (Australia's national institute for Aboriginal and Torres Strait Islander health research) has a current research program – 'A health workforce to address Aboriginal and Torres Strait Islander health'. It has three goals:

- To develop knowledge, tools and resources that will enable end-users (policymakers, health services and community) to enhance the capability of the health workforce to be effective in the delivery of all aspects of health care for Aboriginal and Torres Strait Islander people.
- To develop knowledge, tools and resources that will enable end-users (policymakers, health services and community) to provide culturally competent and safe working environments that facilitate entry and career pathways for Aboriginal and Torres Strait Islander people in the health and health research workforce.
- To build and strengthen the Aboriginal and Torres Strait Islander health research workforce.

A number of reports have been published by Australian Association of Gerontology's Aboriginal and Torres Strait Islander Ageing Advisory Group. These include:

- Closing remote communities: effects on ageing in place – 2015
- Aboriginal ageing: growing old in Aboriginal communities | Linking services and research – 2010
- Growing old well: a life cycle approach for Aboriginal and Torres Strait Islander People – 2008.

Health of older Aboriginal and Torres Strait Islander peoples

In 2016, Dina LoGiudice wrote about the health of older Aboriginal and Torres Strait Islander peoples (published in the Australasian Journal on Ageing). Important detail from the work appears below.

Despite the Aboriginal population having a younger age structure than the wider Australian community, the young–old (45–64 years) group are rapidly growing. The number of Aboriginal people is projected to treble in those aged 65 years and over from 22,700 to 61,900 by 2026. Aboriginal and Torres Strait Islander people have a unique pattern of need for aged care services. Discrepancy in poor health status and rates of chronic diseases continues, and life expectancy remains 10 years less than the rest of the Australian population. Aboriginal older people play a key role in the health of their communities, including holding cultural rights and responsibilities for the maintenance of connections to country, caring for extended family members including grandchildren, and providing leadership and support within communities (LoGiudice, 2016).

Yet there remains a lack of awareness of what it means to 'age well' within an Aboriginal context. The World Health Organization definition of ageing well includes 'optimising opportunities for good health, so that older people can take an active part in society and enjoy an independent and high quality of life', yet the many biopsychosocial factors that might contribute to this are likely to be substantially different for Aboriginal older people living in their communities**.** In addition, there is a lack of knowledge among health service providers and planners as to how to meet the unique needs of this group (LoGiudice, 2016).

Australia and New Zealand have undertaken significant landmark studies that have demonstrated alarmingly high prevalence and incidence rates of dementia of up to 3–4 times those of the wider community of Australians, occurring at a younger age (typically 10–15 years earlier) in both urban and rural regions. In addition, frailty and falls appear common (LoGiudice, 2016).

The importance of the older person remaining in their community close to family and country is well documented. The need to investigate effective approaches to ageing well in Aboriginal communities (both urban and rural) have largely been ignored, although with improvement in chronic health outcomes, an emerging understanding of the complexities of ageing and service provision for this population is increasing. There are a number of Government-funded programs that assist with provision of care to Aboriginal older people, including National ATSI Flexible Aged Care program, and quality standards and indicators are under current review and development to support community care services (LoGiudice, 2016).

Yet despite many programs available, the contributing issues of social and economic disadvantage, geographic challenges and cultural differences may impede the adequate provision of care at all stages of ageing (including preventative management to end of life care). It is documented that Aboriginal people have less access and use of specialist care after an event requiring hospitalisation and residential care, although high relative use of home care assistance. Adherence to medical advice may be compromised by different belief systems and barriers in communication barriers and less understanding of the broader health-care system. In turn, service providers often do not fully understand either the needs of the older person or the needs of Indigenous people who experience cultural and service barriers in accessing services (LoGiudice, 2016).

Best principles for provision of culturally responsive care are documented and include adequate funding, genuine consultation, participation, leadership and quality assurance, with the aim to enhance cultural resiliency, empowerment and assistance with education and advocacy. In addition, encouraging the importance of local workforce engagement should be supported by appropriate education and training. The few examples of successful service development include these principles, but in each instance, have not been replicated in other settings to test for reproducibility, assessed for cost-effectiveness, or for outcomes including quality of life (LoGiudice, 2016).

The conditions of dementia, chronic pain, falls, incontinence and others are common in older Aboriginal Australians. Cultural, social and environmental factors play a role in the prevalence, assessment and management of these conditions and need to be acknowledged if we are to improve the quality of life of older Aboriginal Australians already greatly affected by many disabling and costly conditions (LoGiudice, 2016).

Prevention or delay of onset of many of these common conditions of the aged require increasing engagement and education by local health service providers, where traditionally the primary focus has been on children and chronic diseases. There is a shortage of Aboriginal people employed in health and aged care at all levels, including aged-care policy development and decision-making. Aboriginal-specific aged-care training and best practice guidelines are required for all health professionals that work with this population. Discussions about advance care planning and end of life care need to begin within the primary care setting (LoGiudice, 2016).

Poor health means that Aboriginal and Torres Strait Islander people are affected by conditions of ageing, and require services, much earlier. Add to this a proportionately high regional and remote based population and high levels of poverty and large demographic differences in the needs for aged care emerges. Aboriginal and Torres Strait Islander people have a very strong connection to country and to ‘their place’. Leaving the community to access appropriate aged care services can be very upsetting and difficult for individuals, their families and communities. Further, accessing culturally safe and appropriate services can be difficult and can add to the distress and upheaval during this time of transition (National Rural Health Alliance Inc, 2016).

Information from National Rural Health Alliance Inc

Participants in the My Aged Care discovery workshops reported that self-referral does not work for Indigenous Elders who need someone they know and feel comfortable with to guide them through the process, both because relationships are valued and access to technology, including landline or mobile phones, can be limited. Indigenous language services are not available on the Telephone Interpreter Service (TIS National) utilised by My Aged Care (National Aged Care Alliance, 2017).

Indigenous Elders often fall through the cracks, if they fail to answer the prescribed number of calls they are categorised as ‘declining services,’ require their cultural needs and context to be understood with reference not just to the rights of the individual but rights of the collective, i.e. what is good for the community is good for all. This is commonly not understood by people working with Elders from indigenous backgrounds. In a cultural context, it is not effective to work with people as individual units, it is too problematic and is a white man’s perspective/approach to solving problems/finding solutions (National Aged Care Alliance, 2017).

As part of their submission to Aged Care Legislated Review December 2016, the Association of Gerontology provided the following Case Study:

CASE STUDY: In around 2014, my relative was the first Aboriginal recipient of a consumer directed care package in a particular regional area in South Australia. Even with my help and the help of the local Elders program it was still very confusing for her and (although discounted by the provider) it was also very expensive. Since that time, the introduction of My Aged Care has increased the

difficulty Aboriginal people have in accessing the Regional Assessment Service teams. All contact ends up being through a service provider as individuals find the system far too confusing. The rate of change in the system means that sometimes service staff are not up to date and this causes longer delays and more frustration. However, most Aboriginal Community Controlled Health Organisations and Aboriginal service groups are not funded to provide this assistance. They don't get access to quality information and training around the aged care system but they provide this service because they are the only ones who seem to care enough about our older people, and they realise that if they don't do it our Elders are the ones to suffer.

Leaving the community to access appropriate aged care services can be very upsetting and difficult for individuals, their families and communities. Further, accessing culturally safe and appropriate services can be difficult and can add to the distress and upheaval during this time of transition (National Rural Health Alliance Inc, 2016).

Only 35% of Aboriginal and Torres Strait Islander people live in major cities - representing only 1% of the population in major cities. However, Aboriginal and Torres Strait Islander people are 45% of the population in very remote communities. The delivery of aged care services in remote and very remote Australia that meet cultural needs and allow Aboriginal people to maintain their links to country and family means a very different, flexible and responsive approach is necessary. This is a requirement to deliver both home based and residential aged care employing and supporting a culturally appropriate and culturally safe workforce (National Rural Health Alliance Inc, 2016).

The cultural safety and responsiveness of services as well as the cost and location are factors that impact on Aboriginal and Torres Strait Islander peoples' ability and confidence in accessing aged care services. While it is well known that Aboriginal and Torres Strait Islander people are more likely to access, and experience better outcomes from, services that are culturally safe and responsive, approaches to education, training and quality assurance for health professionals in these areas remains inconsistent. In summary, cultural safety is the final step on a continuum in which systemic change occurs within an organisation or service, and individual health professionals develop awareness of their own identity and how this impacts on the care provision for Aboriginal and Torres Strait Islander peoples. It is an ongoing process, requiring regular self-reflection and proactive response, both at the organisation and health professional level, to the person, family or community with whom the interaction is occurring (National Rural Health Alliance Inc, 2016).

Aboriginal & Torres Strait Islander Disability Network of Queensland (ATSIDNQ)

The ATSIDNQ is a growing network of over 500 Aboriginal and Torres Strait Islander (A&TSI) people with disability, their families, carers and supporters. The ATSIDNQ has identified the following as barriers Aboriginal and Torres Strait Islander people face in accessing aged care services:

Awareness

There is a general lack of awareness about what types of aged care services are available, what the eligibility criteria is and how to go about accessing these services. This lack of awareness partly stems from the methods and resources used to promote and communicate information about aged care services amongst Aboriginal and Torres Strait Islander communities.

Communication

Navigating the aged care system can be difficult and communication strategies adopted by MAC, the gateway to the aged care industry, are not always appropriate. Most information is disseminated on the internet or over the phone and access to the internet, language barriers and low literacy levels present as challenges for many Aboriginal and Torres Strait Islander people. Letters from MAC, government departments and service providers are also often difficult to understand making the

process of accessing aged care confusing and stressful. This ongoing issue will only be increased with the implementation of the February 2017 reforms which introduce added layers to an already complex process. The ATSIDNQ recommends that a culturally appropriate awareness campaign be developed to better inform Aboriginal and Torres Strait Islander communities about the range of aged care services and how to access them. The ATSIDNQ also suggests that increased access to face to face supports for those with low literacy levels would help address communication barriers and increase access to aged care services.

Historical influences

A number of the Aboriginal and Torres Strait Islander Elders who are eligible to access residential aged care are people from the "Stolen Generation", the generation of children who were forcibly removed from their families by government, churches and welfare groups and placed into institutions. The child removal policies of the past have undeniably resulted in intergenerational trauma which can deter some Aboriginal and Torres Strait Islander Elders and their families from accessing care in the institutional setting of a mainstream residential aged care facility.

The ATSIDNQ recommend that all aged care services be required to demonstrate an understanding of the history that has significantly impacted on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. Having the capability to identify disparities that Aboriginal and Torres Strait Islander people still continue to face, will enable services to provide a quality of care that is culturally appropriate.

Documentation

Some Elders, especially those who are members of the Stolen Generation, have incomplete, disjointed or no access to official records such as birth certificates and adoption papers. A lack of official identification has been known to slow down or stop the process of accessing aged care services. The ATSIDNQ recommends that systems be put in place to allow people to access care whilst they are supported to locate any necessary documentation. ATSIDNQ suggests that local and trusted supports such as Local Area Coordinators, Health Centres, Land Councils are the most appropriate to assist with the recovery and ongoing storage of documentation.

Culturally appropriate services

The importance of connection to Country cannot be under estimated amongst Aboriginal and Torres Strait Islander communities. In rural areas, there is often only one community care provider or residential care facility to choose from and these services are not always culturally appropriate. Many Elders do not want to travel off Country to access aged care supports and in some instances, will forgo care when appropriate options are not available on Country. It is therefore essential that all aged care services practice cultural sensitivity, follow cultural protocol and adopt a collaborative and coordinated community approach to delivering services. Understanding the intricacies of cultural protocol is of particular importance.

For example, a male Elder may not want to access personal care supports from a young woman. The ATSIDNQ recommends that Aboriginal and Torres Strait Islander cultural awareness training be a requirement for all mainstream aged care services. An acknowledgment that there is diversity within Aboriginal and Torres Strait Islander culture should be an essential component of any training program delivered. The ATSIDNQ also suggests that aged care services be required to demonstrate that cultural sensitivities have been embedded into their policies and practice.

Workforce issues

Targeted strategies aimed at increasing the Aboriginal and Torres Strait Islander workforce within the aged care industry would assist in ensuring that aged care services are more culturally responsive and accessible. It is acknowledged that confidentiality and professional boundary

concerns can discourage some Elders from accessing supports from services where kinship and blood ties exist. Formal training around confidentiality and professional boundaries may assist in eliminating these concerns.

Other stakeholders

A range of stakeholders are involved in the aged care sector. Some of these are detailed below.

Aged & Community Services Australia

Aged & Community Services Australia (ACSA) (www.acsa.asn.au) is the leading national peak body for aged and community care providers. It represents church, charitable and community-based organisations providing housing, residential care, community care and home support services to older people, younger people with a disability and their carers. ACSA members provide care and support in metropolitan, regional, rural and remote regions across Australia.

Aged and Disability Advocacy Australia

Aged and Disability Advocacy Australia (ADA Australia) (www.adaaustralia.com.au) is a not-for-profit, independent, community based advocacy and education service with more than 25 years' experience in supporting and improving the wellbeing of older people and people with disability.

Their advocacy services are free, confidential and client focused. ADA Australia also offers a range of education and training options. Their website includes information on events, as well as resources and a newsletter.

Australian Association of Gerontology

Australian Association of Gerontology's (www.aag.asn.au) purpose is to improve the experience of ageing through connecting research, policy and practice. Since 1964, AAG has been Australia's peak body linking professionals working across the fields of ageing.

They have a range of special interest groups that include:

- Aboriginal and Torres Strait Islander Ageing Advisory Group
- Ageing, Workforce and Education
- Culturally and Linguistically Diverse
- Elder Abuse
- Housing and Built Environment
- Lesbian, Gay, Bisexual, Transgender and Intersex
- Regional Remote and Rural.

Carers Australia

Carers Australia (www.carersaustralia.com.au) is the national peak body representing Australia's carers, advocating on behalf of Australia's carers to influence policies and services at a national level. It works collaboratively with partners and its member organisations, the Network of state and territory Carers Associations, to deliver a range of essential national carer services.

The organisation's website has a range of recommendations and information in relation to ageing and carers including:

- The need for flexible working conditions - With an ageing population, becoming a carer-friendly workplace makes business sense. Providing flexible and supportive working conditions to enable employees to combine paid work with an unpaid caring role will ensure employers are able to hold onto experienced workers.

- A *Work & Care* Initiative aimed at improving the capacity of carers to combine paid employment with their caring responsibilities. Many of the carers are mature aged workers.
- 2012 article - Carers caught in the 'sandwich generation'. The sandwich generation (a term coined in the 80's) is a recognisable and growing sub-group of the baby boomers who had children later and as a result 'have become the first generation to be 'sandwiched' between the care of adult children, even grandchildren, and their parents' (Carers Australia, 2012).

Council of the Ageing

Council of the Ageing (COTA Australia) (www.cota.org.au/australia) is the peak national organisation representing the rights, needs and interests of older Australians. COTA Australia is the national policy and advocacy arm of the COTA Federation which comprises COTAs in each State and Territory. COTA Australia focuses on policy issues from the perspective of older people as citizens and consumers. The organisation presents comments and submissions on national policy issues.

Dementia Australia (previously known as Alzheimer's Australia)

Dementia Australia (www.dementia.org.au) represents the 413,106 Australians living with dementia and the estimated 291,163 Australians involved in their care. The organisation is a unified, national peak body for people, of all ages, living with all forms of dementia, their families and carers.

It reports that by 2050 there will be nearly 900,000 people with dementia (Australian Institute of Health and Welfare, 2012).

Each week there are 1,800 new cases of dementia in Australia, and this is expected to increase to 7,400 new cases each week by 2050 (Access Economics, 2009).

National Aged Care Alliance

The National Aged Care Alliance (www.naca.asn.au) is a representative body of peak national organisations in aged care (approximately 50), including consumer groups, providers, unions, and health professionals, working together to determine a more positive future for aged care in Australia. Their united policy agenda looks at the following issues:

- consumer rights
- quality of care
- workforce planning
- short and long term financing of aged care.

National Rural Health Alliance Inc

The National Rural Health Alliance Inc (NRHA) (www.ruralhealth.org.au) is comprised of 37 national organisations. They are committed to improving the health and wellbeing of the 7 million people in rural and remote Australia. Their members include consumer groups (such as the Country Women's Association of Australia), representation from the Aboriginal and Torres Strait Islander health sector, health professional organisations (representing doctors, nurses and midwives, allied health professionals, dentists, pharmacists, optometrists, paramedics, health students, chiropractors and health service managers) and service providers (such as the Royal Flying Doctor Service).

Its large and diverse membership gives the NRHA a broad and authentic view of the interests of the people of rural and remote Australia. It works with a range of stakeholders to improve the health and wellbeing of those people by developing well-targeted, cost-effective, evidence-based solutions. The NRHA is a rich source of credible information and expertise, and stands ready to work with Government and Opposition on responses to current and emerging rural health issues.

The NRHA produces a range of communication materials, including Fact sheets and infographics, media releases, its flagship magazine *Partyline* - which has more than 11,000 subscribers, - and a monthly online newsletter *The BushWire*.

National Seniors Australia

National Seniors Australia (www.nationalseniors.com.au) was established in 1976. Now, 40 years on, with over 200,000 members, 140 branches, and 70 employees, it is the consumer lobby for older Australians and the fourth largest organisation of its type in the world. Providing access to policy-makers, a raft of commercial benefits, world-class research and top-notch publications, National Seniors is everything the over 50s need to navigate the second half of their lives.

The group:

- Believes there is a need to strengthen processes used to provide information to consumers to enable choice. There is also a strong desire to retain government protections, such as those in place to maintain equitable access and to guarantee bonds.
- Wants to see ongoing improvement in service quality and assurances from government that aged care services will be available when they are needed.

Survey data indicates that National Seniors members are concerned about a range of issues:

- Some members are particularly sceptical about the availability of aged care services in regional and rural areas. They suggested that information could be made publicly available to enable providers to better plan for the delivery of services in particular locations. Needs assessments could be undertaken in specific locations to deliver information that providers could use to make rational planning decisions to ensure that supply better matched demand. Competition could still occur within local areas based on quality but in the context of more certainty about supply and demand dynamics.
- Members are keenly aware that aged care services are not always available when and where they are needed.
- 19% of members responding to the survey did not feel confident in being able to choose a home care provider that best meets their needs, regardless of whether they had used My Aged Care or not. There are a range of reasons why their members are not confident in choosing a provider. Most notable among these is the fact that many are confused by the current system. For example, members made the following comments in response to choosing a home care provider
  - Can be a complex system as you do not know what you may need in the future and if this can be provided under that home care provider
  - I am very alert for my age but found the paper work confusing
  - The area is so complex and mind boggling. It needs to be simplified
  - You have to do too much research on pricing, complaints, unsuitable choices etc
  - We need help to understand paper work. It is hard to understand what it is all about.
- Members commented specifically that the current system does not deliver sufficient and clear information to help them make informed decisions about providers
  - I can't get straight answers - everyone tells a different story
  - Providers do not advertise what they can offer and you don't know unless you ask
  - The My Aged Care database is only alphabetically listed. My Aged Care staff do not have the knowledge of knowing which service provider is good or not so they cannot advise the client. The client is not well equipped to ask important questions like: does the service provider pass ISO standards, are they regularly accredited, are the care workers subcontracted and many more questions that will safe guard the client
  - The trouble with greater competition is that the consumer does not have adequate information to make an "informed" choice

- Confidence is based on two things: my own ability, but then also whether or not I receive accurate and trustworthy information. That's the bigger challenge!

- A central theme emerging from members' comments was that people have limited confidence in exercising choice because of the significant difficulties they face in comparing between the providers in terms of price, quality and service offering
- Members were very conscious of the impact of physical and mental capacity on the decision - making process and were cautious about their confidence to choose a provider if capacity
- was diminished. In this regard, some survey responses highlighted the importance of family members helping to make decisions in situations of diminished capacity, while others raised concerns about not having family support
- Members commented that, while it would be ideal to have systems that can enable consumers to share their experience of a provider, it can be difficult for consumers to provide feedback about this experience.
- A significant proportion (37%) of members thought that the My Aged Care gateway did not provide them with adequate information to confidently choose a provider.

5. Aged care sector/system in the Fitzroy & Central West region

Public Health Networks (PHNs)

There are 31 PHNs servicing all the regions of Australia. PHNs replaced Medicare Locals on 1 July 2015. The Fitzroy and Central West region has two PHNs within the geographical region.

Central West PHN

The Central West PHN provides public hospital and health services to the communities of central Western Queensland. These service the LGAs of Diamantina, Winton, Blackall-Tambo, Barcoo, Barcaldine and Longreach. There are community hospitals in Barcaldine and Winton, a rural hospital in Blackall and a District hospital in Longreach. Primary Health Clinics are located at Aramac, Isisford, Jericho, Muttaburra and Tambo, staffed by Remote Area Nurses. Central West Hospital and Health Service (CWHHS) employed GPs deliver services to these clinics under a hub and spoke model. Primary Health Clinics are also located in Bedourie, Birdsville, Windorah and Jundah, with visiting GP clinics provided by the RFDS.

Information from CWHHS's *Annual Report 2016-2017* relevant to aged care includes:

- 2367 Telehealth non-admitted patient occasions of service (495 in Barcaldine; 134 in Alpha; 185 in Winton) – reducing travel and delivering health care closer to home
- A partnership with RSL care which enables Central West Health to provide rehabilitation closer to home. Investing to enable a faster and safer return from hospital either in the Central West or from further afield
- 18,930 health service prepared meals on wheels provided to residents across the health service
- As at 30 June 2017, and for the first time in more than 20 years, Central West Health's medical establishment is staffed by permanent doctors. They have implemented highly successful recruitment strategies for permanent doctors, nurses, allied health professionals and other clinical staff which has dramatically reduced the reliance on rotating locums from outside Central West area.
- $8.5M upgrade to Longreach Hospital – installation of a CT scanner; surgery improvements have commenced (Queensland Health, 2017).

Central Queensland, Wide Bay, Sunshine Coast Public Health Network

The relevant region for FCW covers north of Yeppoon, west beyond Emerald, and encompasses Rockhampton and Gladstone. This includes the LGAs of Livingstone, Rockhampton, Gladstone, Banana and Woorabinda. There is a base hospital in Rockhampton, District hospitals in Gladstone and Emerald, smaller hospitals in Biloela, Moura and Yeppoon, and Multipurpose Health Services in Blackwater, Theodore, Springsure, Woorabinda and Baralaba.

CQHHS is a successful user of Telehealth, which supports individuals to remain at, or close to home. They hosted the second highest number of sessions for any health service in Queensland, up 20% from the previous year. Plans are in place to grow by a further 20% during 2017-2018 including:

- increasing Rockhampton Hospital services: gerontology with Sub-Acute and Geriatric Evaluation outpatient unit; supervised remote chemotherapy clinic; heart failure clinic with Emerald
- an expanded renal service
- a new diabetic and endocrine clinic (Central Queensland Hospital and Health Service, 2017).

Relevant strategies listed in CQHH's *Destination 2030: Great Care for Central Queenslanders* include:

- Great care, close to home - a mobile workforce with specialised training will provide skilled outreach care and will utilise technology to support Telehealth and other innovation that connects clinicians with patients without the need for travel.
- Rural and remote clinical schools - partnering with universities to develop rural and remote clinical schools at Emerald and Biloela hospitals to train local medical, nursing, allied health and Indigenous health students to support the skills and sustainability of the future rural workforce.
- Out-of-hospital care - improving community-based patient access, support early discharge and prevent unnecessary admission to their hospitals; partner with general practitioners to ensure an integrated patient-centred approach across all health services and develop integrated pathways for out-of-hospital care for people with complex and chronic conditions.
- Improving mental health and wellbeing - supporting a new step up from community care or down from specialist Brisbane-based inpatient care mental health service at Gladstone; streamline access pathways to support assessments and care delivery as close to home as possible; and provide quality specialist mental health services to the growing ageing population.
- Supporting and improving older person's care - developing an older persons' strategy to support the care and transition of the ageing population. This will include strategies to enable people to live in their own homes for as long as possible and receive compassionate end-of-life care. We will develop and support our aged care services to ensure contemporary aged care models across all settings. The development of relevant partnerships will achieve the delivery of high quality aged care services that help keep our older residents in the best health and provide community-based healthcare to reduce hospital admissions.
- Improving the health of Aboriginal and Torres Strait Islander communities - making further progress to address the health and life expectancy gap for Aboriginal and Torres Strait Islander people living in Central Queensland, which is still unacceptably high; work to incorporate traditional approaches to wellbeing and health, ensuring a service that provides interventions for the whole person, not just medical diagnosis (Queensland Health, 2017).

Aged Care services

The various types of Aged Care services that are subsidised by the Australian Government, are shown in Table 8. The table details the various Community Care, Residential Aged Care, and Transition Care places for each Local Government Area, as at June 2016.

Table 8: Aged Care Services by LGA

LGA	Aged care services	Number of operational placed by care type				Australian funding
		Community Care	Residential aged care	Transition care	Total Places	
	number	number				$m
Banana	12	60	117	0	177	7.5
Barcaldine	4	22	19	0	41	1.2
Barcoo	0	0	0	0	0	0
Blackall-Tambo	2	15	29	0	44	1.6
Central Highlands	7	41	77	0	118	4.2
Diamantina	0	0	0	0	0	0
Gladstone	7	64	220	0	284	15.1
Livingstone	6	58	252	0	310	16
Longreach	4	13	59	0	72	4.1
Rockhampton	26	370	837	30	1237	59.5
Winton	3	22	9	0	31	.9
Woorabinda	1	6	24	0	30	.9
Total FCW	**72**	**671**	**1,643**	**30**	**2,344**	**111.1**
Queensland	954	14,488	35,924	733	51,145	2,369.5
Source - Queensland Government Statistician's Office, June 2016						

Details about the various Residential Aged Care and Independent Living facilities are shown in Table 9. Please note that some LGAs don't have any of these services.

Table 9: Detail of the various Residential Aged Care beds and Independent Living beds in each Local Government Area

Banana Shire Council		
Name	**Residential LC/HC**	**Independent**
Baralaba Hospital Multipurpose Health Service 1 Stopford Street, Baralaba	4 beds	
Leichhardt Villa 1 McCorley Street, Taroom	29 beds Single and shared rooms and serviced apartments Dementia-specific unit	4 x co-located retirement dwellings enable partners who are able to live independently to be near by
Theodore Multipurpose Health Centre 85 The Bouldevard, Theodore	19 beds	
Wahroonga Retirement Village 1 Wahroonga Street, Biloela	65 residential beds 1 and 2-bedroom units	
Barcaldine Regional Council		
Name	**Residential LC/HC**	**Independent**
Barcaldine Multipurpose Health Service 25 Oak Street, Barcaldine	14 beds (89% occupancy for the 2016-17 period)	
Alpha and Jericho Multipurpose Health Service 3 Gordon Street, Alpha	5 beds (85% occupancy for the 2016-17 period)	
Barcoo Shire Council		
No services		
Blackall Tambo Regional Council		
Name	**Residential LC/HC**	**Independent**
Churches of Christ Care Barcoo Living Multi-Purpose Service 2A Coronation Drive, Blackall	McLean Place provides accommodation for 29 residents with both high and low levels of care Respite care also offered	
Central Highlands Regional Council		
Name	**Residential LC/HC**	**Independent**
Blackwater Hospital Multipurpose Health Service 41 Mackenzie Street, Blackwater	4 beds	
Blue Care Emerald Avalon Aged Care Facility 126 Borilla Street, Emerald	Residential aged care including dementia care and respite care 58 Beds	
Central Highlands Regional Council Senior Housing (in partnership with State Government) Various locations		Springsure: 1 and 2 bedroom units Anakie: 1 bedroom units Duaringa: 1 bedroom units Sapphire: 2 bedroom units Capella: 1 and 2 bedroom units Emerald: 1, 2 and 3 bedroom units
Springsure Hospital Multipurpose Health Service 21 Woodbine Street, Springsure	15 beds	
Diamantina Shire Council		
No services		
Gladstone Regional Council		
Name	**Residential LC/HC**	**Independent**
Blue Care Edenvale Aged Care Facility 41 Glen Eden Drive, Gladstone	52 beds High care only including dementia beds Full occupancy as of 8 August	
Bindaree Lodge Care Centre 1 Beacon Avenue, Boyne Island	40 beds including respite	

Eureka Care Communities 8 Wicks Street, New Auckland Phone: 4978 7055		52 dwellings which are 1-bedroom units that can take singles and doubles 4 are disabled 6 vacancies as at 8 August 2017
New Auckland Place Aged Care Residence 18 Wicks Street, New Auckland	128 beds	
Settlers Gladstone 28 Marten Street, South Gladstone		56 townhouses: 1 and 2-bedrooms
Livingstone Shire Council		
Name	**Residential LC/HC**	**Independent**
Blue Care Brolga Court 17-19 Lorikeet Avenue, Yeppoon		4 x 1-bedroom units
Blue Care Capricorn Gardens 26 Magpie Avenue, Yeppoon	66 low and high care beds	3 x 1-bedroom units 4 x 2-bedroom units
Blue Care Archer Court Retirement Living 28 Rockhampton Road, Yeppoon		10 x 1-bedroom units
Bolton Clarke Sunset Ridge 44 Svendsen Road, Zilzie	120 beds: 30 x secure dementia 1 available as at 15 August 2017	29 x 2 & 3 bedroom villas 14 additional to be built in 2018 (7 already sold); Approved for a further 57 dwellings
Capricorn Adventist 150 Rockhampton Road, Yeppoon	66 places, 12 of these dedicated for dementia or memory impairment	Capricorn Adventist Retirement Village 185 x 1,2,3 bedroom units
Oak Tree Retirement Village 3 Kookaburra Drive, Yeppoon		62 dwellings: 1,2 & 3-bedroom villas
Oak Tree Retirement Village 31 Barmaryee Road Yeppoon		34 dwellings: 2 & 3 bedroom homes
New development proposed for Zilzie	Multi-level Residential Aged care	Retirement living
Longreach Regional Council		
Name	**Residential LC/HC**	**Independent**
Bolton Clarke Pioneers 1 Sparrow Street, Longreach	59 beds including respite service	5 dwellings: 2 & 3 bedrooms No vacancies as at 9 August 2017
Rockhampton Regional Council		
Name	**Residential LC/HC**	**Independent**
Alexandra Gardens 20 Withers Street, Kawana	94 beds Single and double rooms available	40 x 2-bedroom units
Benevolent Aged Care 60 West Street, Rockhampton	116 beds Includes dementia and respite beds	
Bethany 75 Ward Street, Rockhampton	115 beds: high and low care	13 units: 1, 2 & 3 bedrooms
Bethesda Aged Care Plus Centre 58 Talford Street, Rockhampton	50 beds Low care and high care No vacancies as at 9 August 2017	
Blue Care Gracemere Gardens Aged Care Facility 27-45 Conaghan Street, Gracemere	71 beds Includes 1 respite bed 1 vacancy as at 15 August 2017	21 dwellings
Carinity Aged Care – Shalom 121 Maloney Street North Rockhampton	65 beds	45 x 1, 2 or 3 bedroom units
Carinity Aged Care, John Cani, 35 Hall Street, Mount Morgan	25 beds	
Eureka Care Communities 341-351 Dean Street, Frenchville		104 dwellings: 1 bedroom
Eventide Home, Cnr North & Campbell Streets, Rockhampton	80 beds	

Gateway Lifestyle, 19 Schuffenhauer Street, Norman Gardens		146 houses: 2 and 3 bedrooms 3 available as at 3 September 2017
Leinster Place 3 Pearce Street, North Rockhampton	79 beds: low and high care Single rooms	
McAuley Place Hostel 263 Agnes Street, Rockhampton	30 low care beds	
Mount Morgan Multipurpose Health Service, Black Street, Mt Morgan	12 beds	
North Rockhampton Nursing Centre, Norman Road, North Rockhampton	100 beds	
Oak Tree Retirement Village 155-157 Glenmore Road, Park Avenue		43 dwellings: 1 and 2 bedroom units Vacancies: 7 units as at 3 September 2017
Oak Tree Retirement Village 40 Foulkes Street, Norman Gardens		8 x 2 or 3 bedroom units A further 42 are approved to be built in stages, as demand requires Vacancies: 6 units as at 3 September 2017
Regis Farris Villas 52 Breakspear Street, Gracemere		12 dwellings
Settlers Rockhampton 14 Pauline Martin Drive, Rockhampton		74 dwellings: 1 and 2 bedroom units
The Range Village Corberry and Gordon Streets, Rockhampton		34 dwellings: 1, 2 & 3 bedroom units
Winton Shire Council		
Winton Multipurpose Health Service 34-77 Blomfield Street, Winton	9 beds (85% occupancy for the 2016-17 period)	
Woorabinda Aboriginal Shire Council		
Woorabinda Multipurpose Health Service 1 Munns Drive, Woorabinda	24 beds	
Source: Phone calls to service providers; (Department of Health, 2016); website research; Central West Hospital and Health Service 2016-17 Community Profiles (Winton, Barcaldine, Alpha)		

When collating information for this report, comments were collated from managers in the region and included:

- The difficulty for older people to access information as My Aged Care does not 'work' for the age group, therefore they are not aware of information until they enter hospital.
- Some residential aged care places in Rockhampton have wait lists of over 100 people, many wait more than 12 months for a place; Wait list have been getting longer over the past few years; Wait list can contain clients who regularly decline a spot (as they aren't ready to take up the place).
- Lots of enquiries for respite, but can't meet the demand as the beds are used for long term clients; Respite needed for carers (often partners) who need a break, especially if they are requiring medical care themselves (such as a hospitalisation).
- A lot more high-care clients are entering aged care facilities – requires more demands on staff time.
- Always having problems getting staff with experience in aged care (Rockhampton). Sometime running a bit low, so staff are required to work overtime.
- Some Independent Living Unit places state that they have services to 'assist' but many don't.

- General public are uninformed, naive and unprepared regarding aged care process and availability etc. do not have insight into their loved ones wishes so that these can be carried out at the appropriate time.
- There are some very complex clients (estranged from loved ones; mental health issues; no Advanced Health Directives/Enduring Power of Attorney; many health issues).
- GPs possibly need extra funding to do Advanced Care Planning.
- Need to increase staffing.
- Need to increase money for recreational activities in the hospital setting.
- Need more Avoidance and Substitution Models to be in place
  - Avoidance element example – Victoria has mobile/portable X-ray machines that can be taken to Residential Aged Care – cost less than $50,000
  - Substitution – need more allied health – keep people in their homes longer.
- Need more secure beds for people with dementia – growing need due to issues such as drug use earlier in lives; dementia overtaking diabetes.
- As people are delaying the aged they have children, when they are needing assistance in later years, the children are busy with their own children, so can't help.
- Issues between Miriamvale and Agnes Water rural areas – many enquiries, but services unable to be delivered due to distance and costs.
- Services in Gladstone region needed for respite and home maintenance can't be delivered by some services with the staff and roster availability.
- Need a targeted education program – including donating brains to brain research.

Other service providers

A range of organisations provide Home Care and other services for aged persons. The numbers of them in each LGA vary, depending on the size of the client base and services required. The database on the My Aged Care website can be used by clients to locate services.

As mentioned elsewhere in the report, some services who have their details listed within the My Aged Care database tool, do not necessarily have an office in the region. Some are more 'national' in nature and have generic information on their websites.

Information from Local Government Areas

Local Members of Parliament, Mayors and Chief Executive Officers were invited to provide relevant information for this report including information on: age-friendly planning; public transport; existing services and training providers in the aged care and allied health sector; regional specific research on the sector. The following information was provided from various Councils and stakeholders.

Banana LGA

The Banana Shire Council arranged a group meeting so that relevant service providers and community personnel could provide information for this report. The information below was provided at a meeting in May 2017.

Moura Hospital Survey

In 2014, Moura Hospital surveyed community members on the demand for aged care, respite and palliative care services, receiving 58 responses from the 70 years+ age group. Key issues were:

- There was a consistency that survey participants knew a number of family or friends (average of at least 12 people) that had left the Moura region to receive aged care placement. Relocation was to aged care facilities in Taroom, Emerald, Gracemere, Biloela, Yeppoon, Theodore, Calliope, and Gladstone. The average distance of travel for loved ones to visit is approximately 200 km

- Negative impacts on the separated resident and on their loved ones: creating difficulties for family and friends to travel long distances to visit; putting strain on the family unit to cope with the separation of their family member from their community; not knowing the wellbeing of a loved one on a daily basis and unfortunately family often miss out on seeing them before their passing.
- Spouses and some children of their relocated loved one are usually of a similar age and more than likely have their own medical conditions which impacts on being able to travel and visit with the family member.
- All recipients of the Aged Care Survey were very concerned about their future and community security if the Moura Hospital were to be closed or downgraded.
- Residents who have decided to live out their final years in Moura, and who have bought homes would have to decide whether or not to stay if services were not available to them at Moura Hospital.

Community Care

- In Biloela, Bluecare and one other provider provide services, working closely with the client to work what is best for them.
- A weekend service commenced in Moura prior to June 2017 to meet demand.
- Education is important to aged people as they need to accept care. The perception is that family will look after them, so there has to be a willingness to accept that it is time to change.
- Many elderly persons don’t have computers, so often have difficulties accessing information to make choices.
- It is difficult for some to admit that they are getting old.
- Bluecare take clients into social settings.
- Various community groups (such as Men’s Shed) work together to provide solutions.

Residential Care

- Baralaba - have four beds with 16 on the waiting list.
- Biloela – have 65 beds (16 dementia); 3 on wait list for dementia; vacancies in the hostel section
- Theodore – four beds.
- Taroom – 20 low care bed facility and 6 high care and dementia; 2 x 1-bed individual living; 2 x 2-bed individual living; 6 empty beds and 1 respite bed. They take people from other areas such as Moura and Theodore.
- Wandoan – independent living units x 4 + 2DVA units.
- Moura – 14-unit independent living complex managed by volunteers and Bluecare.
- Wowan – 4 independent living units.

Key issues

Moura

- Need an aged care centre. There is a brand-new hospital, but no palliative care. 6-8 beds would be ideal for ‘end of life’ care. There is no waiting list as there is nothing to offer.
- Getting information to elderly people is an issue. An advocate service could be the way to make this better.
- There is no public transport. Bluecare can do this for clients only. Needs to be a better process so that everyone could collaborate to share a vehicle for appointments in Rockhampton. The way appointments are currently set up would have to change so that collaboration could occur.
- Physio is a problem – not viable (due to funding).

Taroom

- Local residents needing aged care, have to go through the Public Health System until a bed is available. If they have dementia they have to look further afield as there is nowhere local to go. If aged and needing residential care, need to move to the hospital.
- Transport – Council provides a car; however, volunteer drivers are hard to get (this is provided via HACC).
- Meals delivered 7 days a week.
- Staffing is an issue. Recruitment retention is challenging.
- Need to train senior staff to educate others.

Baralaba

- Need to access to specialists – gerontologists don't come at all and we don't have access to Telehealth. In-house WIFI is not good in the area. The majority of services for Telehealth are delivery by QHealth, so it can't be accessed easily unless you are a Qld Health worker.
- Access for training is not provided under PHN, so have to source own training. Particularly need dementia and behaviour management training.

Barcaldine LGA

Information on Jericho and Alpha

Please note: This information was from community consultation carried out in 2014, so could be out of date.

- An overall district health workforce shortage: GPs and specialists; retention of health professionals, particularly allied health.
- Need for affordable and appropriate transport and accommodation services.
- High reliance on outreach and visiting services.
- Poor access to GP services.
- Heavy reliance on locums.
- Poor chronic care management.
- Cost barriers to prescribed medications.
- Inefficient and fragmented care.
- Limited access to culturally appropriate health services for Indigenous Australians
- Limited health information.

Alpha community feedback:

- Hospital is not a suitable facility for long term residential care.
- Good utilisation of hospital aged care facility would be 2 aged care beds and 1 respite as a minimum – now a new facility.
- Potential use of a 'Companion House' concept for aged care.
- Allied health services could be expanded to include physiotherapist, podiatrist, speech therapist and occupational therapist.
- No resident doctor – GP attends 2 days at the end of week; is often booked out so availability very limited and sometimes non-existent; late from Jericho clinic on Thursdays.
- Dental services limited to visiting van with very limited services and long waiting times.
- Slow pathology results.
- There is an over reliance on Ambulance volunteer driver services – very high risk.
- Need to increase community information and interagency collaboration.
- Could explore the potential use of a nurse practitioner.
- Increase collaboration with allied non-government service providers in the region, explore partnership models.

- Develop a skills-mix of staff; don't need only RNs to look after aged care patients - could use AIN and qualified carers.
- Allow Alpha HACC to run Meals on Wheels.
- Better access to Telehealth service to support service delivery.
- Increased need for Health Service Awareness e.g. need to let community know what services are currently available locally and visiting.
- Better collaboration with ALPHA HACC and other aged care service providers in the region.

Jericho community feedback:

- Improvements could include
  - access to medical services, half-day clinic is always booked out
  - availability of allied health services including physiotherapist and podiatrist
  - telecommunications infrastructure, including reception for mobile phones and internet – risk to health in emergencies
  - Make available Telehealth equipment and provide access to Telehealth service.
- No resident doctor - GP comes for one half-day per week – needs to increase to 1 day a week.

Barcoo LGA

Stonehenge Community Centre

- They have one acute 'without care' person who but by choice does not want formal assistance, so community members help out in various ways.
- 4 aged people could do with help of various sorts including yard (mowing, weeding), general help, and handyman assistance.
- 3 aged people who need help with personal care and/or household help.

Items of interest / concern:

- Very interested in digital health options.
- Internet connection will be available to the Community Centre once Fibre-optic connection has been completed.
- Internet to private homes is via satellite.
- Keen to have the Health Bus with cardiac team come to the town.
- Very interested in digital health/tablet idea.
- No regular social activities for aged people, only community social events 3 times a year
- People who are currently in their 60s are unsure what they will do when they age – only option at present is to move to Longreach.
- Community would like a small supported accommodation facility – interested in a 'pod' option.

Allied health visits from North West Primary Health:

- Team (paid by Government) comes three times a year for a morning clinic (this is adequate for their needs) with: physio; exercise physiologist; podiatrist; dietician, and diabetic educator if required who use the Community Centre's clinic rooms.
- RFDS comes every two weeks from Charleville.
- For specialist visits, residents have to either drive to:
  - hospital at Jundah (63km away)
  - Longreach (165 km away)
  - Longreach and fly to Townsville (plane twice a week)
  - Longreach and fly/bus/train to Rockhampton.

Windorah Primary Health Clinic

The town has seven residents who would fit into the category of seniors. There are two residents receiving meals out of generosity from the local hotel. A service provider approached the hotel to

provide meals for one of these people through their scheme, but the associated paperwork was too onerous and they decided just to do it on their own. These people have declined offers of other help from concerned residents. If available, the community would like formal help to be available, due to concerns over their ability of the aged people to carry out domestic cleaning.

A previous resident moved to Quilpie to live with family due to deteriorating health and dementia as there were no appropriate services in the Windorah region. There are perhaps four other couples/residents that are higher functioning and do not require home help due to independence and family assistance. One other resident who lives on his own, and while independent and self-caring, could need assistance in the very near future.

Other than the meals provided by the hotel, the community keeps an eye on the aged and ensures they are looked after informally.

Jundah
In Jundah, there are eight aged pensioners, all living in their own homes. Of these, three are in their 80s, one receives in-home care through the kindness of two caring citizens; another is receiving in-home care assistance from family including evening meals. The others manage by themselves and who may get assistance from friends if the need arises.

Barcoo Shire Council's Mayor, Bruce Scott, is working on an integrated care project (ICIF Western Corridor Project) with the Central West Hospital and Health Service, RFDS and allied health providers for the provision of better and more coordinated primary health, chronic disease management, aged care, early childhood etc. across the communities of Birdsville, Bedourie, Boulia, Windorah, Jundah, Stonehenge and Yaraka.

Blackall-Tambo LGA

In Blackall, the Church of Christ runs all the aged care programs and from Council's perspective it is running really well. In Tambo, Council run the Tambo Multi-Purpose Centre (including Community Home Support and Disability Services). Council staff run the services with funding through the State and Federal Governments.

Transport is their biggest issue – was is most needed is a bus to transport older people to attend social events out of the region. The other issue the Blackall Tambo region is facing is access to Allied Health, with residents having to travel to access services.

Council has an excellent working relationship with the Western Queensland Primary Health Network. Council provide Winter Packs and Personal Care Packs to older residents to ensure they have the essentials.

Central Highlands LGA

An ageing population was identified as a challenge in the long-term Community Plan for the Central Highlands Region. After considerable consultation across thirteen communities in the development of the Community Plan, striving to be an age friendly region is important to the people of Central Highlands. One goal is to plan and provide opportunities and initiatives for older people to actively or passively participate in community life and access a range of accommodation and care options. In partnership with other levels of government, human service providers and the community, Council aspires to achieve this goal so that older people may age in place and keep connected to the communities they helped build.

Central Highlands Regional Council (CHRC) internally have statements in the strategic framework that support planning for inclusive communities, all ability and age friendly. Retirement villages or

assisted living complexes are encouraged in the region via Council's planning processes, and this is reflected by making them code assessable as opposed to impact assessable.

Council is investigating ways to incorporate and incentivise the development of adaptable housing (i.e. housing that is suitable for all abilities - an elderly person can live there in an assisted sense or the same dwelling suitable for a family to live as well), which would be more sustainable over time. The Parks People Play Strategy also reflects Council's commitment to an age friendly region, this is focussing on creating a thriving inclusive community, collectively working together as a network to achieve greater efficiency gains.

Issues that impact on the quality of life of older people and influence their ability to age in place are:

- transport
- availability and affordability of suitable style accommodation, and the impact of the State's Social Housing Policy
- access to Dementia care services (none in the region)
- cost of living – Council's considerable pensioner rate reduction is an incentive to remain in the Central Highlands
- ability to navigate, access and understand the aged care maze as the Aged Care reform is being implemented. Minimal clear information readily available if the aged person does not have access to or computer skills. Rural people are suspicious of service providers from outside their locality.

Issues for aged care providers include:

- Large geographic area and relatively small population. The region covers nearly 60,000 square kilometres covering 13 communities, which is challenging to deliver outreach services to the rural areas. The cost of fuel and staff travel time is not considered in any program funding. The cost to deliver a service in Brisbane from one suburb to the next is significantly different to delivering a service in Central Highlands where the distance for the service to travel may be at least 400km round trip, or considerably higher if accessing health services in Rockhampton. This makes the cost of service exorbitant and not likely to be delivered.
- Rural areas have a limited supply of an appropriately skilled workforce, especially speciality areas such as dementia care.
- Navigating the pathway without clear direction as to what service they will provide in the future after the full implementation of the Aged Care Reform.

CHRC has commissioned a Community Transport Feasibility Study and a Community Transport Business Case. Council recognised personal access and mobility to services and regional centres can influence the quality of life of residents in the region. CHRC facilitated a Community Transport Reference Group, and a broad cross section of the community sector were represented not only aged care services.

The Feasibility Study objectives were to assess the need and viability of a community transport service and identify two models that would provide affordable, accessible, reliable and sustainable community transport intra- town and inter- regional. The Mobility Centre and District model were closely analysed selected as best fit for the region, and the Mobility Centre was selected as it had met the criteria formulated and appeared to require less additional resources and infrastructure to establish the model and roll out.

The Transport Business Case was commissioned to take the information gathered in the Feasibility Study and investigate further. Initially the Mobility Centre model was based on services working collectively, and aggregating transport funding to fund the new proposed transport solution. During this research period, the Australian Government commenced implementing massive change, with the introduction of the National Disability Insurance Scheme and the change to Commonwealth

Home Support Package, this means agency block transport funding will transition to client centred funding. This impacted on the rigour of the Business Case, and after all the consultation only two agencies participated in supplying transport data for analysis.

Gladstone LGA

Under the Gladstone Regional Council Planning Scheme, there are a multitude of Zones that support aged care, care facilities and allied health land uses across all the major townships within the Gladstone Region (Gladstone, Boyne Island/Tannum Sands, Agnes Water and Calliope). Given the availability of land within the Region, Council's Development Services Department are comfortable that should an Applicant approach Council with a proposal to construct such land uses, their Planning Officers would be able to provide ample sites and locations which support such developments.

Generally, most sites that are allocated an urban zone are either afforded reticulated water and sewer infrastructure as well as appropriate storm water and road infrastructure. However, this does depend on the discrete location of each site. With respect to public transport, Buslink provides a service within the Gladstone and Boyne Island/Tannum Sands community.

Council are in the process of progressing the Philip Street Integrated Health Precinct. Also, a large parcel of land within the Tannum Sands Community (Lot 500 SP 215266) owned by Council is currently for sale and was previously marked for a potential aged care/retirement facility.

CQUni and Mercy Health and Aged Care Central Queensland Ltd (Mercy CQ) are partnering in plans for Australia's first intergenerational village in Gladstone. Announced in April 2017, the Gladstone health and aged care precinct would enable integration of clinical practice and training for CQUni students. The University is working with the Queensland Government to secure approval for consolidation of campuses at the Gladstone Marina, so the development can proceed on the site of their Gladstone City Campus in Derby Street. The So Glad Health and Aged Care Precinct concept includes:

- CQUni teaching and learning facilities
- a residential aged care facility operated by Mercy Health providing work-related learning opportunities for CQUni students
- retirement and supported living
- affordable/student and short-term accommodation
- sporting and community facilities, including retention of the existing athletics oval; and
- commercial/retail/local services catering for the needs of residents and visitors to the precinct (CQUniversity Australia, 2017).

Livingstone LGA

Livingstone Shire Council conducted a Community Summit in 2014 and a Needs Analysis in 2016. The projected population of Livingstone Shire shows that residents aged 60 and over will increase from 21% to 32% by the year 2036 (Queensland Statisticians Office 2015).

Community survey results

A Community Survey was conducted in 2016 with the following issues relating to respondents aged 60 or over regarding the question "How can Livingstone Shire be more senior friendly?":

- more public seating 7.84%
- senior's centre 7.84%
- improve library service/quality of books 5.88%
- more parking 3.92%.

In addition, conversations with senior residents discovered that barriers preventing senior resident's access were:

Financial

- cost of transport (public and private)
- cost of activities
- concerns regarding extra costs (e.g. Income only allows for the essentials)
- cost of technology
- cost of rates, rent, insurance etc.

Accessibility

- public transport is; not frequent enough; has limited stops; other users are not accommodating
- pathways/walkways/beach accesses need significant upgrading/modification and need to link effectively

Awareness

- how to access information (i.e.; many didn't know they could receive the Community Centre newsletter via post)
- concern information is being missed as many didn't know how to access information online

Social

- fear/anxiety about capacity to participate, and stigma/discrimination due to age
- some activities are inappropriate (i.e. "Will Making is patronising").

Providers survey results

All services delivering to Livingstone Shire residents aged 60 or above were approached to complete a survey to inform this needs analysis. Below are the responses received from various questions:

"What in your experience, is a NEED for senior residents in Livingstone Shire?"

- local health services
- residential respite places in nursing homes
- socialisation, very many lonely people around
- social connection/inclusion is a huge gap
- services for those over 65 years old. Many of our services cut off at age 65.

"How can Livingstone Shire be more 'senior friendly'?"

- having seniors at council meetings
- providing an advocacy officer for seniors
- less demand for 1 bedroom units at CARV
- approvals in place: 62 Independ Living Units being constructed Oak Tree, Yeppoon
- retirement villages can be built in low- or medium-density residential zones
- smaller housing: planning scheme provides opportunity for the development of smaller housing options at many low-medium density locations in the Shire
- residential care facilities: encouraged to locate in proximity to centres and near higher order roads and public transport (preferably medium-density) in Yeppoon and Emu Park.

Trends/issues from 2014 Livingstone Community Summit Report with regards to Aged Care (input from 19 people):

- access to affordable and timely transport services
- falling trend in volunteer contributions and red tape around volunteering
- rigidity of program guidelines for aged care
- respect for individuals in care, their choices, needs and wishes is not being maintained
- lack of inclusion (in the community)
- good communication between care providers
- lack of Yeppoon-based services

- disability access to beach
- expense – cost of accessing services
- access to allied health staff, specialists and services
- lack of respite services available (overnight, day)
- lack of education.

Trends/issues from 2014 Livingstone Community Summit Report with regard to Senior (input from 19 people):
- seniors living longer
- number living on the coast is increasing annually
- people retiring earlier
- need to get Senior involved in community
- lack of suitable infrastructure such as paths, pedestrian and pedestrian crossings that are senior friendly
- uncertainty of what is available and how to connect people to what is available
- more health services including radiology, oncology and mental health.

Longreach LGA

Central West Hospital and Health Services

The Central West Hospital and Health Service is a 31-bed acute facility provides the Longreach community with integrated health services across a wide range of specialty areas. The Longreach Hospital offers mental health and alcohol, tobacco and other drug services, allied health, physiotherapy, dietitian, occupational therapy, podiatry, social work and grief and loss counselling.

Service hours:
Outpatients Monday to Friday 8.30am to 5.00pm
Doctor appointments 9.00am-1.00pm
Weekends 9.30am to 6.00pm
Accident and Emergency services are available 24 hours, 7 days a week - staffed 24 hours a day by Registered Nurses.

Longreach Dental Clinic

Queensland Health offer Public Sector oral health services through a state-wide network of dental clinics. The services provided are subject to the clinical judgment of the dentist based on the assessment of the individual. Services that are available are diagnostic, scaling and cleaning, restoration, and simple extractions.

Rockhampton LGA

Growth in the Aged Care and Allied Health Services sector sits within the "Health Care and Social Assistance Services" top priority sector for the Rockhampton Region, as adopted in the *Advance Rockhampton Economic Action Plan* (November 2016). Key information is as follows:

Aged Care Market and Need Profile

As the Capital of Central Queensland, the Rockhampton Region is home to aged care and allied health facilities services for the 226,314 residents of Central Queensland reported in the 2016 Census. This population includes over 28,000 people aged over 60 years according to the 2016 Census and is growing as new residents move to the Rockhampton Region and wider Central Queensland area. Within the Rockhampton Region, Council has adopted a population growth target to double the 2015 resident population by 2050 and published this target in the 2016 Rockhampton Region Economic Development Strategy. As at March 2017, Council's aged care facilities register

included over 825 beds within 12 key facilities. The Rockhampton Region also has 8 retirement village facilities, plus a variety of other aged care and allied health services and facilities. Given this growth and existing strength, it is not surprising that the Federal Department of Employment projects in the five years to May 2022 employment in the related Health Care and Social Assistance industry will grow by an additional 4,400 jobs on top of the 15,100 existing jobs in Central Queensland. The Rockhampton Region is positioned to accommodate most of that growth.

Expansion Potential

Council has undertaken extensive community engagement and encouraged discussion in the media to raise awareness of the potential for aged care and allied health facilities being developed within key centres, including within the CBD.

Specifically, Council responded to community input and suggestions to establish aged care and allied health as a key theme in the Rockhampton CBD Redevelopment Framework in July 2017. For example, a 'Key Change Making Project' adopted in the Framework and that Council will deliver is "A2e: Retirement Aged Care Housing Strategy to increase the Diversity of product and population in the CBD" (p.28).

In order to further support expansion in the sector, Council is currently actively investigating and receptive to opportunities to attract 'high rise' and other innovative models of developing and expanding aged care and allied health facilities in the Region's key centres. The potential for such new types of facilities has been identified in the Australian Financial Review and other reputable publications, as an opportunity to provide care that is fully connected to the city's amenities and conveniences. Council has been monitoring examples of new aged care development models such as the 'U City' development by the Uniting Communities community services organisation in Adelaide and methods of re-purposing existing buildings such as the Oryx Communities project to transform a five-star resort into a premium aged-care facility in West Perth.

'Aged Care and Retirement Facility' category development applications made between 1 August 2017 and 31 December 2019 are given special designation as eligible for consideration for tangible financial and non-financial support via Rockhampton Regional Council's Development Incentives Policy. Council offers a free "Duty Planner" service that may be booked through 1300225577 to provide information to individuals and organisations interested in undertaking developments, and the Advance Rockhampton business unit of Council is available to provide detailed information about opportunities in the aged care and allied health facilities sector via advancerockhampton@rrc.qld.gov.au.

Strong Labour Market

Council is encouraging job seekers within the region to seek to join the Aged Care and Allied Health Services sector, and encouraging new residents to move to the Rockhampton Region to become part of the sector. Events are being conducted to help current and prospective residents become aware of the existing and emerging career opportunities in the Region, and to connect employers and prospective employees. This includes the 'Gear Up Rocky Job Readiness Expo' to be held on the 29th of November. Council also makes 'Live Rockhampton' promotional video content available for free for local employers in the aged care and allied health care sector to be able to embed into their job vacancy advertising, to help them attract talent. For example, the Central Queensland Health and Hospital Service routinely embed Council's videos into their advertisements when they seek to recruit staff via the Queensland Government's Smart Jobs (www.smartjobs.qld.gov.au) platform.

Fostering Innovation

Rockhampton's Smart Hub business incubator has a growing membership of businesses and entrepreneurs associated with the Aged Care and Allied Health Services sector, and has fostered

multiple commercial innovations via a focus on the sector in its 'Start Up Stars' and GovHack programs. Aged Care and Allied Health Services businesses looking to relocate to Queensland from other states or nations are eligible for up to $100,000 in HotDesQ grant funding to assist with their costs if they move to the Rockhampton Region's Smart Hub.

6. Care workforce and allied health

Aged care is a labour-intensive activity. The number of available workers, their levels of skill, and how they are managed will affect how much services cost and how well they are delivered (CEPAR, 2014).

Some are non-direct care workers with a managerial and support role (coordinators, managers, administrators, and ancillary workers involved in cleaning, catering or maintenance); others are direct care workers (registered and enrolled nurses, community care workers or personal care assistants, and allied health professionals and assistants). Community care involves more non-direct care workers (38%) than residential care (27%), split between coordination, management and administration. In residential care, most non-direct care workers (72%) are ancillary workers.

While nurses are often in demand in the aged care sector, their shortage and higher cost has meant that lower skilled community care workers or (residential) personal care assistants make up a vast majority of the direct care workforce (81% and 68% in each sub-sector respectively). The importance of such care workers has increased over time. For example, the proportion of personal care assistants in the residential direct care workforce increased by 10 percentage points since 2003. While the proportion of nurses in aged care has declined, the industry remains their single biggest employer, particularly for unregistered nurses (AIHW, 2013).

Need for a quality workforce: aged care and disability care

For many years, the ageing and disability sectors have approached the workforce issue from radically different perspectives. In ageing, the emphasis has been on demonstrating professional competence wherever this is required. While few, if any, qualifications beyond a police record check and a driver's licence are necessary for staff in many areas where personal care is involved, professional competency is essential (Fine, 2017).

Allied health professionals providing services for aged persons

Allied health professionals provide a range of critical health and health-related services for Australian consumers across a broad range of conditions. Allied health services can usually be accessed directly by any patient paying privately without a referral. This includes people who may claim rebates through a private health insurer.

However, a range of national and state-based funding schemes and programs are available to help people access allied health services by meeting some or all of the cost of allied health services. That includes services provided by community or Aboriginal health services, Medicare funded services, and allied health services provided by aged care or disability providers. In these cases, people may need a referral, typically from a general practitioner.

The allied health sector is extremely diverse, with aged persons tending to require the following services:

- Arts Therapy / Occupational Therapy
- Audiology / Speech Pathology / Optometry
- Physiotherapy / Chiropractic / Exercise Physiology Orthotics / Prosthetics / Podiatry
- Dietetics / Pharmacy
- Psychology / Rehabilitation Counselling / Social Work.

A number of stakeholders who provided input into this report, stressed the importance of ensuring adequate mental health services are made available to ageing persons. Stakeholders advise the that mental health is an important area of need, especially for older men who have an extremely high suicide rate. Mental health is also a strong predictor of physical health outcomes for both men and women.

Findings of the inquiry into Future of Aged Care Sector Workforce

An inquiry on the aged care sector workforce, first referred by the Senate of the 44th Parliament on 1 December 2015, was finally completed (after delays due to dissolution of the Senate 2016 and an extension to reporting time) in mid-2017. The enquiry was undertaken to "review the current frameworks under which aged care providers recruit, train and retain their workforce, and to anticipate the impact of current and expected changes to the aged care service sector, and the workforce which will be needed to deliver those services in the years to come."

The committee was impressed by the dedication, passion and commitment of aged care workers and service providers operating in a very challenging and changing environment. Their 19 recommendations are detailed below.

Recommendation 1

That the aged care workforce strategy taskforce be composed of representatives of service providers, workforce groups, including nurses, care workers/personal care attendants, medical and allied health professionals, and others, and representatives of consumers and volunteers. Representatives of workers, care providers and consumers from regional and remote areas should also be included.

Recommendation 2

That the government, as a key stakeholder in aged care in terms of regulation, policy, intersections with other sectors and the coordination of government involvement, and as the key source of funding and revenue for the aged care sector, must be an active participant of the taskforce and must take ownership of those aspects of the workforce strategy that will require government intervention and / or oversight.

Recommendation 3

That the aged care workforce strategy includes a review of existing programs and resources available for workforce development and support and ensure consideration of the NDIS Integrated Market, Sector and Workforce Strategy to identify overlapping issues and competitive pressures between the sectors and how they may be addressed.

Recommendation 4

That, as part of the aged care workforce strategy, the aged care workforce strategy taskforce be required to include:

- development of an agreed industry-wide career structures across the full range of aged care occupations
- clear steps to address pay differentials between the aged care and other comparable sectors including the disability and acute health care sectors
- mechanisms to rapidly address staff shortages and other factors impacting on the workloads and health and safety of aged care sector workers, with particular reference to the needs of regional and remote workers including provision of appropriate accommodation

- development of a coordinated outreach campaign to coincide with developments introduced through the workforce strategy to promote the benefits of working in the aged care sector.

Recommendation 5

That the aged care workforce strategy taskforce includes as part of the workforce strategy a review of available workforce and related data and development of national data standards in a consultative process with aged care sector, and broader health sector and other relevant, stakeholders. Any nationally agreed data standards should enable comparison across and between related sectors where possible.

Recommendation 6

That the aged care workforce strategy includes consideration of the role of informal carers and volunteers in the aged care sector, with particular focus on the impacts of both the introduction of consumer directed care and the projected ageing and reduction in these groups.

Recommendation 7

That the national aged care workforce strategy includes consideration of the role of medical and allied health professionals in aged care and addresses care and skill shortages through better use of available medical and allied health resources.

Recommendation 8

That the government examine the introduction of a minimum nursing requirement for aged care facilities in recognition that an increasing majority of people entering residential aged care have complex and greater needs now than the proportions entering aged care in the past, and that this trend will continue.

Recommendation 9

That the aged care workforce strategy include consideration of and planning for a minimum nursing requirement for aged care services.

Recommendation 10

That the government consider, as part of the implementation of consumer directed care, requiring aged care service providers to publish and update their staff to client ratios in order to facilitate informed decision making by aged care consumers.

Recommendation 11

That the government take immediate action to review opportunities for eligible service providers operating in remote and very remote locations to access block funding, whether through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program or through other programs. The committee further recommends that consideration be given to amending the 52-day limitation on 'social leave' for aged care residents living in remote and very remote aged care facilities.

Recommendation 12

That the Department of Health review the implementation of consumer directed care to identify and address issues as they emerge. Specific attention should be paid to any impacts on remuneration, job security and working conditions of the aged care workforce, and impacts on service delivery in remote and very remote areas, and to service delivery targeting groups with special needs, as identified in the Section 11-3 of the Aged Care Act 1997.

Recommendation 13

That the aged care workforce strategy ensures consideration of the service delivery context in which the workforce is expected to perform. The strategy should also include medium and long term planning for location- and culturally-specific skills, knowledge and experience required of the aged care workforce working with diverse, and dispersed, communities throughout Australia. This must specifically include addressing workforce issues specific to service delivery in remote and very remote locations.

Recommendation 14

That all recommendations of the Senate Education and Employment References Committee inquiry into the operation, regulation and funding of private vocational education and training (VET) providers in Australia be implemented.

Recommendation 15

That the aged care workforce strategy taskforce work with Australian Skills Quality Authority to establish nationally consistent minimum standards for training and accreditation.

Recommendation 16

That the aged care workforce strategy taskforce work with the Australian Nursing and Midwifery Accreditation Council (ANMAC) to establish aged care as a core part of the nursing curriculum, establish dementia skills training, and develop greater collaboration between the sector and nursing colleges to increase student placements in aged care facilities.

Recommendation 17

That the government and the aged care workforce strategy taskforce develop a specific strategy and implementation plan to support regional and remote aged care workers and service providers to access and deliver aged care training, including addressing issues of:

- the quality of training
- access to training
- on-site delivery of training
- upskilling service delivery organisations to deliver in-house training
- additional associated costs relating to regional and remotely located staff. This strategy should take account of consultation and analysis such as that undertaken through the Greater Northern Australia Regional Training Network (GNARTN).

Recommendation 18

That the government work with the aged care industry to develop scholarships and other support mechanisms for health professionals, including nurses, doctors and allied health professionals, to undertake specific geriatric and dementia training. To succeed in attracting health professionals to regional and remote areas, scholarships or other mechanisms should make provision for flexible distance learning models, be available to aged care workers currently based in regional and remote areas, and include a requirement to practice in regional or remote locations on completion of the training.

Recommendation 19

That the government examine the implementation of consistent workforce and workplace regulation across all carer service sectors, including:

- a national employment screening or worker registration scheme, and the full implementation of the National Code of Conduct for Health Care Workers
- nationally consistent accreditation standards
- continuing professional development requirement

- excluded worker scheme
- workplace regulation of minimum duration for new worker training.

The regulation of the workforce must address:
- historical issues impacting on employment of Aboriginal and Torres Strait Islander peoples
- ways to ensure the costs of this regulation are not passed on to workers.

Health Workforce Queensland: feedback

Health Workforce Queensland have provided the following information about barriers to working in a rural setting. This supports a large body of evidence for the medical workforce surrounding the factors associated with recruitment to remote and rural practice. The drivers and barriers to recruitment in remote and rural regions are different to those that impact on retention; however, they clearly interface. These factors are a complex interplay between personal, professional and environmental factors.

The following factors should be considered and applied to develop strategies to support the attraction and engagement of a high-quality health providers:
- nature of the work
- financial reward
- rural background
- intrapersonal factors
- social and lifestyle factors.

Of similar importance, the causative factors related to a GP's decision to leave rural practice should be carefully considered when developing a package of incentives and supports that may be available to the incumbent provider. The most commonly cited challenges for health professionals in remote and rural locations) include the topics listed below.

Professional issues for health professionals in remote and rural locations:
- staff shortages and lack of access to locums, manifesting as high workloads and lack of access to leave
- limited access to professional development
- limited opportunity for career development
- challenges to maintaining confidentiality in small towns
- lack of access to specialist support pathways
- unrealistic workplace or community expectations
- inadequate resources and inappropriate infrastructure
- poor access to quality IT and communication systems
- professional isolation due to reduced local access to peers and networks.

Personal, social and family issues for health professionals in remote and rural locations:
- social isolation, including distance from family and friends and lack of social support
- lack of social and cultural facilities in the community
- risk of burnout
- blurring of personal and professional boundaries
- finding appropriate employment for partner or suitable education facilities for children
- cost of travel.

Heart of Australia

Heart of Australia is a customized road train that is a specialist medical clinic-on-wheels. It delivers fortnightly or monthly specialist medical investigation and treatment clinics to regional, rural and remote area communities across Queensland, including Emerald, Barcaldine, Longreach. A range of services are offered, some of which require a GP referral.

The timetable and other information can be viewed on their website - http://www.heartofaustralia.com/.

Royal Australian College of General Practitioners | Rural

In February 2016, the Royal Australian College of General Practitioners surveyed rural general practitioner (GP) members on aged care services, with over 490 providing feedback. The key barriers to the provision of rural GP-led aged care outside of the practice setting included the following lists.

Service constraints:

- time constraints and workload
- financial feasibility
- difficulty meeting after hours and home visit requirements
- poor service integration
- deficient allied health service mix.

Workforce barriers:

- inadequate remuneration
- lack of skill recognition
- local GP workforce shortages.

Broader factors:

- lack of geriatrician support
- bureaucracy and red tape
- inadequate level of qualified nursing staff in residential aged care facilities (RACFs).

RACGP | Rural recommendations:

- Reward complexity through extending MBS items to capture unpaid and underpaid service elements.
- Drive efficiencies through measures which alleviate service burden by improved case management and coordination, including: improved internet speeds in RACFs; better access to secure links to practice clinical information systems; simplifying prescribing arrangements; streamlining discharge planning process.
- Provide funding supports which enable continued independent living, including expanding residential in-reach services to help address capacity issues in acute care.
- Fund supportive infrastructure, built and functional supports, to improve local service capacity.
- Ensure the full multidisciplinary team is well supported and capable of delivering the level of care required in each setting, with a priority on skill capacity within RACFs.
- Prioritise GP skill-acquisition in psycho-geriatrics, dementia and BPSD skillsets to address increasing demand.
- Invest in eHealth solutions including a 'store and forward' national Telehealth service to facilitate easy access for rural GPs to broader specialist advice.
- Funding to support accessible training options for rural GPs to undertake training from within their rural community (Royal Australian College of General Practitioners: Rural, 2016).

Findings from DSS Stocktake and analysis of Commonwealth funded aged care workforce activities

Key findings from the Department of Social Services Stocktake and analysis of Commonwealth funded aged care workforce activities included:

- **Key Finding 1:** The greatest proportion of Commonwealth funded workforce activity has been directed towards workforce training, education and upskilling (59.3% of all identified activities, programmes or initiatives).
- **Key Finding 2:** The specific target groups funded are the general aged care workforce, aged and/or community care service providers and specific workers within the aged care industry such as care workers, enrolled nurses, registered nurses, and assistants in nursing.
- **Key Finding 3:** Programme effectiveness needs to be better designed, measured, demonstrated and shared through formal evaluation, which includes industry input.
- **Key Finding 4:** Consideration should be given to developing specific strategies in respect of the workforce in regional and remote areas.
- **Key Finding 5:** Fostering leadership capacity at an industry wide, organisational and individual level will underpin a strong and sustainable aged and community care workforce.
- **Key Finding 6:** Consideration should be given to the development of a nationally coordinated workforce development strategy and capability framework taking into account how aged care could better plan, collaborate and combine effort with health and disability services.
- **Key Finding 7:** There is an increased need to support carers in their caring role.
- **Key Finding 8:** At an industry level future workforce planning will need to develop strategies that address the industry's needs across the entire workforce.
- **Key Finding 9:** When developing the aged care workforce consideration needs to be given to groups with special needs and areas of emerging priorities.
- **Key Finding 10:** An aged care workforce may be attracted and recruited through quality work placements for vocational education and training, undergraduate, and post-graduate students.
- **Key Finding 11:** To support retention, increasing effort could be directed toward identifying people with desired attitudes, behaviours, motivation, values and demonstrable skills such as communication and decision making.
- **Key Finding 12**: Greater targeting and evaluation of workforce training and education is needed to ensure responsiveness to identified workforce or skill gaps in the industry.
- **Key Finding 13:** There is variability in the quality of aged and community care training.
- **Key Finding 14:** There is a need to support education and training of volunteers to foster workforce attraction and retention (Department of Health, 2015).

The report estimated that there will need to be about 56,770 additional full time aged care workers over the decade from 2013 to 2023.

Regional, rural and remote service provision

Analysis of the information captured within the Matrix indicates that a small proportion (approximately 3.7%) of Commonwealth Funded Aged Care Workforce Activities was directed toward, or involved aspects specific to regional, rural and remote service provision. Of the total reported funding across all Stocktake activity, approximately 7.9% was attributed to this theme. Examples of programmes that are specific to this theme identified within the Stocktake include the *Aboriginal and Torres Strait Islander Rural and Remote Aged Care Training programme* and *Indigenous Remote Service Delivery Traineeships Programme.*

Additional observations

In recognition of the stress, professional isolation and disengagement experienced by remote and mobile workers within their Victorian community care organisation, Benetas Home Care undertook

an amalgamation process and modified working processes. This included new job roles, opportunities for leadership, and the creation of regional teams with a designated in-home service delivery manager to provide support, training and supervision. In addition, technological innovations were introduced including an eRoster system to enable them to view their rosters remotely, online access to emails, and client information, and a text messaging system which enabled changes in appointments or cancellations to be communicated quickly to mobile staff.

Q8 of the report asked whether RTOs anticipate there will be training or skills gaps in the future. The majority, or 86.2%, of respondents (of 114 survey participants) anticipated a training or skills gap/s for industry workers in the future, with the remaining 13.8% disagreeing (*n* = 109).

What will these training or skill gaps be?
Respondents anticipated that the gaps identified above will continue to be an issue in the future. Furthermore, respondents indicated that the following gaps may arise (*n* = 89):

- practical training placements / training around use of assistive technologies
- enough workers to meet demand
- skills around promoting leisure and health and keeping people in their homes
- consumer directed care
- sexuality and equity
- promoting mobility (physiotherapy, falls prevention etc.)
- meeting changes in relevant regulations and legislation.

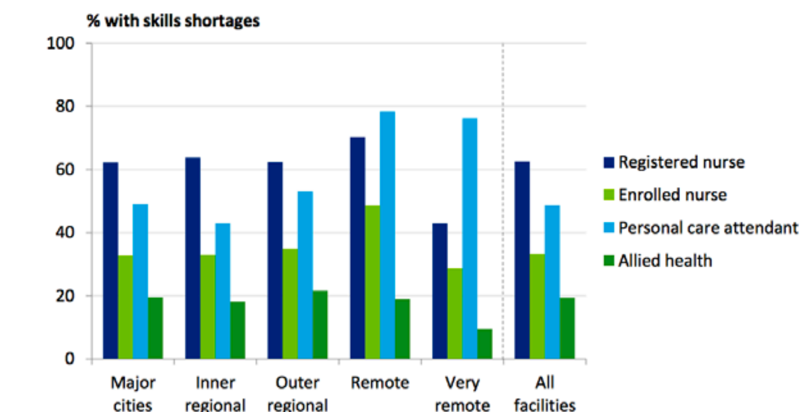
Aged care jobs

The aged care sector contributes significantly to employment in the Australian economy, employing across a range of occupations. These include 'direct care' jobs such as nurses, care workers and health professionals, as well as 'other' jobs such as management and administrative positions, pastoral care and ancillary care (Deloitte, 2016). The aged care sector has grown from a total of approximately 262,000 workers in 2007 to 352,000 workers by 2012, representing a 34% growth in the size of the aged care workforce over the five-year period (Deloitte, 2016).

Skills requirements

The aged care workforce has become increasingly qualified over recent years, particularly workers in direct care roles. In 2012, 87% of the direct care workforce had post-secondary school qualifications, an increase from 80% in 2007. However, many residential aged care facilities are reporting skills shortages across a range of direct care occupations (Deloitte, 2016). The various skills shortages are shown in Figure 29.

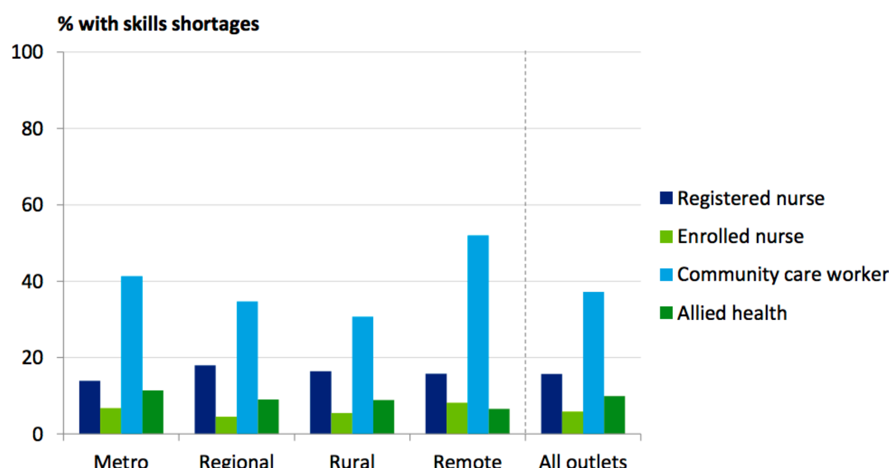
Figure 29: Skills shortage of residential direct care workforce, 2012 (Deloitte, 2016)



Within residential aged care facilities, skills shortages are the greatest for registered nurses, with over 62% of all facilities in 2012 reporting a skills shortage (DSS, 2012). There are particular shortages in remote locations, with the average vacancy for a registered nurse at 15 weeks, compared to 7 weeks for all facilities (DSS, 2012). While very remote locations report a lower skills shortage compared with all facilities, this could reflect the limited residential care services provided in very remote regions which could lead to relatively low labour demand for higher-care roles such as registered nurses in these areas.

The top three reasons given by surveyed facilities for the skills shortage include: (1) a lack of specialist knowledge; (2) geographic location of facility; and (3) recruitment too slow. Workers have also identified the following three areas of training as being the most valuable for the future: (1) dementia training; (2) palliative care; and (3) wound management. On average in 2012 in the community care segment, fewer facilities reported skills shortages compared with the residential sector. The occupation with the highest skills shortage is community care workers (CCWs) (37% of outlets) (Figure 30). Shortages of CCWs were more likely in outlets in Metropolitan and Remote areas, while shortages of registered nurses were more likely to be reported by outlets in Regional areas (Deloitte, 2016).

Figure 30: Skills shortage of community direct care workforce, 2012 (Deloitte, 2016)



Industry growth

As a labour-intensive industry, the growth of the sector will be mirrored in growing requirements for workforce:

- **Increasing demand:** The Productivity Commission (2011) noted that to meet ever increasing demand, the aged care workforce would be required to quadruple by 2050.
- **Increased competition in labour markets:** Workforce shortages may potentially be exacerbated as sectors competing for the same workforce, such as disability services, simultaneously grow.
- **Diverse and increasingly complex need:** Increasing rates of complex chronic conditions and a mismatch between the native language of some older Australians requiring care and the current workforce presents some challenges in keeping pace with the diversity and skills required to care for the ageing population (Aged Care Financing Authority, 2016).

Characteristics of the aged care workforce

According to the Department of Health, 2017, the aged care workforce is older than the national average, generally in good health and has high levels of post-school education and training. Overall the direct care workforce is relatively stable, with only a small minority indicating an intention to leave the sector within 12 months. The residential workforce is getting younger and the home care and home support workforce is getting older. Characteristics of the aged care workforce are listed in Table 11.

Table 11: Aged Care Workforce Characteristics

Residential direct care workforce	Home care and home support direct care workforce
87% female	89% female
Median age 46 years	Median age 52 years
70% are Personal Care Attendants (PCA)	84% are Community Care Workers (CCW)
32% born overseas	23% born overseas
78% employed on a permanent and part time basis	75% employed on a permanent and part time basis
10% of the workforce are casual or contract employees (down from 19% in 2012)	4% are casual or contract employees (down from 27% in 2012)
80% of workers engaged in work-related training (mostly mandatory) in the previous 12 months	75% of workers engaged in work-related training (mostly mandatory) in the previous 12 months
58% of workers undertook Continuing and Professional Development (CPD)	48% of workers undertook continuing and professional development (CPD)
Source: (Department of Health, 2017)	

There are indications of modest under-utilisation of the workforce as a whole Training. A much smaller proportion of CCWs than other occupations in home care and home support undertook training or CPD, suggesting a training gap. There is a lower level of work related training than in 2012. Priority areas identified for future training included dementia, palliative care and (in home care and home support) mental health. A lack of access to training for workers in regional and rural areas is evident Skill shortages (Department of Health, 2017).

The incidence of skill shortages has declined considerably since 2012, particularly in residential facilities. Shortages are more prevalent outside major cities, and vacancies are harder to fill in remote and very remote areas, especially for RNs in residential facilities Job satisfaction. Job satisfaction is high across all work aspects except for pay. Home care and home support workers reported greater job satisfaction for time available to care for clients and having freedom in their work and less stress and pressure than their residential care counterparts. In both sectors, workers reported that the most stressful aspect of their jobs was the unanticipated changes in work patterns including working longer than scheduled and variations being made to hours or location of work at short notice. Source: (Department of Health, 2017)

Economic contribution

The aged care sector's total economic contribution to Australia in 2014-15 was $17.6 billion, equal to approximately 1.1% of GDP, and 277,500 full-time equivalent (FTE) jobs, equal to 2.8% of the labour force (Deloitte, 2016). Deloitte Access Economics estimates that in financial year 2014-15 the aged care sector directly contributed $13.5 billion in value added to the Australian economy and supported approximately 238,000 FTE jobs. The indirect economic contributions include:

- building cleaning, pest control and other support services 7%
- professional, scientific and technical services 7%
- food and beverage services 10%
- employment, travel agency and other administrative services 14%
- residential care and social assistance services 23%
- other industries 39%.

Fitzroy & Central West's aged care workforce

According to the Primary Health Network Western Queensland, every area within Western Queensland is currently classified as a district of workforce shortage (KBC Australia, 2016). This is when the population has less access to Medicare-subsidised medical services when compared to the national average.

The impact of not having a particular service is especially significant in smaller/regional locations than if it were to occur in a city as the Case Study below outlines.

Case Study

The medical centre in the township of Calliope (home to approximately 5,000 people) closed in August 2017, having many repercussions for elderly people and their carers. The closure requires them to travel for nearly 30 minutes to see GPs in Gladstone.

Many elderly persons don't drive, so have to rely on others, as there is a lack of bus services to Gladstone. For those requiring fortnightly visits for their health needs, the situation is a real challenge. The closure followed an ongoing struggle the medical centre had to attract GPs to the area (The Observer, 2017).

It is understood that the situation occurred after two doctors (a husband and wife team) left the medical practice and the vacant positions could not be filled.

Aged Care and Allied Health Employment and Vacancy rates by LGA

The following tables lists aged care and allied health practitioners in the Fitzroy and Central West areas of Queensland, by profession and Local Government area.

The number of practitioners is based on the practitioners that were both registered and employed in that year. The 2016 Allied Health data is unavailable at the present time. Estimated to be available from September 2017. Headcounts of less than 4 in a cell cannot be published for confidentiality reasons. These have been replaced with a 'np'. Graph data source: NHWDS Nursing and Midwifery Data 2013-2016, NHWDS Allied Health Data 2013-2015.

Table 12 (encompassing information for various Allied Health professionals): Headcount of Aged Care and Allied Health practitioners in the Fitzroy and Central West areas of Queensland, by Profession and Local Government Area, 2013-2016*

AGED CARE	2013	2014	2015	2016
Banana Shire Council	19	19	17	17
Barcaldine Regional Council	5	4	6	8
Barcoo Shire Council	0	0	0	0
Blackall - Tambo Regional Council	4	4	6	np
Central Highlands Regional Council	13	21	20	17
Diamantina Shire Council	0	0	np	0
Gladstone Regional Council	63	49	48	50
Longreach Regional Council	7	12	9	12
Rockhampton RC + Livingstone SC	222	209	223	223
Winton Shire Council	np	5	np	4
Woorabinda Aboriginal Shire Council	np	np	4	5
Total	**338**	**325**	**336**	**338**

INDIGENOUS HEALTH	2013	2014	2015
Banana Shire Council	0	0	0
Barcaldine Regional Council	0	0	0
Barcoo Shire Council	0	0	0
Blackall - Tambo Regional Council	0	0	0
Central Highlands Regional Council	0	0	0
Diamantina Shire Council	0	0	0
Gladstone Regional Council	0	0	0
Longreach Regional Council	0	0	0
Rockhampton RC + Livingstone SC	0	0	np
Winton Shire Council	0	0	0
Woorabinda Aboriginal Shire Council	0	0	0
Total	**0**	**0**	**np**

CHIROPRACTIC	2013	2014	2015
Banana Shire Council	np	np	np
Barcaldine Regional Council	0	0	0
Barcoo Shire Council	0	0	0
Blackall - Tambo Regional Council	0	0	0
Central Highlands Regional Council	5	5	6
Diamantina Shire Council	0	0	0
Gladstone Regional Council	11	10	10
Longreach Regional Council	0	0	0
Rockhampton RC + Livingstone SC	14	12	14
Winton Shire Council	0	0	0
Woorabinda Aboriginal Shire Council	0	0	0
Total	**31**	**28**	**31**

CHINESE MEDICINE	2013	2014	2015
Banana Shire Council	0	0	0
Barcaldine Regional Council	0	0	0
Barcoo Shire Council	0	0	0
Blackall - Tambo Regional Council	0	0	0
Central Highlands Regional Council	np	np	0
Diamantina Shire Council	0	0	0
Gladstone Regional Council	7	6	6
Longreach Regional Council	0	0	0
Rockhampton RC + Livingstone SC	np	4	4
Winton Shire Council	0	0	0
Woorabinda Aboriginal Shire Council	0	0	0
Total	**11**	**11**	**10**

DENTISTRY	2013	2014	2015
Banana Shire Council	4	5	np
Barcaldine Regional Council	np	np	np
Barcoo Shire Council	0	0	0
Blackall - Tambo Regional Council	0	0	0
Central Highlands Regional Council	13	17	17
Diamantina Shire Council	0	0	0
Gladstone Regional Council	38	48	46
Longreach Regional Council	np	np	np
Rockhampton RC + Livingstone SC	79	91	95
Winton Shire Council	0	0	0
Woorabinda Aboriginal Shire Council	0	0	0
Total	**137**	**164**	**165**

MEDICAL RADIATION	2013	2014	2015
Banana Shire Council	np	np	np
Barcaldine Regional Council	0	0	0
Barcoo Shire Council	0	0	0
Blackall - Tambo Regional Council	0	0	0
Central Highlands Regional Council	4	np	4
Diamantina Shire Council	0	0	0
Gladstone Regional Council	13	15	16
Longreach Regional Council	np	4	np
Rockhampton RC + Livingstone SC	39	39	44
Winton Shire Council	0	0	0
Woorabinda Aboriginal Shire Council	0	0	np
Total	**60**	**62**	**69**

OCCUPATIONAL THERAPY	2013	2014	2015
Banana Shire Council	np	np	np
Barcaldine Regional Council	0	np	0
Barcoo Shire Council	0	0	0
Blackall - Tambo Regional Council	0	0	0
Central Highlands Regional Council	9	8	8
Diamantina Shire Council	0	0	0
Gladstone Regional Council	17	21	19
Longreach Regional Council	np	np	4
Rockhampton RC + Livingstone SC	62	64	60
Winton Shire Council	0	0	0
Woorabinda Aboriginal Shire Council	0	0	0
Total	**93**	**99**	**94**

OPTOMETRY	2013	2014	2015
Banana Shire Council	np	np	np
Barcaldine Regional Council	0	0	0
Barcoo Shire Council	0	0	0
Blackall - Tambo Regional Council	0	0	0
Central Highlands Regional Council	4	np	4
Diamantina Shire Council	0	0	0
Gladstone Regional Council	7	8	7
Rockhampton RC + Livingstone SC	0	0	0
Rockhampton Regional Council[3]	18	18	18
Winton Shire Council	0	0	0
Woorabinda Aboriginal Shire Council	0	0	0
Total	**30**	**30**	**30**

OSTEOPATHY	2013	2014	2015
Banana Shire Council	0	0	0
Barcaldine Regional Council	0	0	0
Barcoo Shire Council	0	0	0
Blackall - Tambo Regional Council	0	0	0
Central Highlands Regional Council	0	0	0
Diamantina Shire Council	0	0	0
Gladstone Regional Council	0	0	0
Longreach Regional Council	0	0	0
Rockhampton RC + Livingstone SC	np	np	np
Winton Shire Council	0	0	0
Woorabinda Aboriginal Shire Council	0	0	0
Total	np	np	np

PHARMACY	2013	2014	2015
Banana Shire Council	8	10	12
Barcaldine Regional Council	np	np	5
Barcoo Shire Council	0	0	0
Blackall - Tambo Regional Council	np	np	np
Central Highlands Regional Council	18	16	20
Diamantina Shire Council	0	0	0
Gladstone Regional Council	36	31	30
Longreach Regional Council	5	np	4
Rockhampton RC + Livingstone SC	83	84	86
Winton Shire Council	np	np	np
Woorabinda Aboriginal Shire Council	np	0	np
Total	**157**	**148**	**162**

PHYSIOLOGY	2013	2014	2015
Banana Shire Council	8	4	6
Barcaldine Regional Council	np	np	np
Barcoo Shire Council	0	0	0
Blackall - Tambo Regional Council	0	np	np
Central Highlands Regional Council	13	17	14
Diamantina Shire Council	0	0	0
Gladstone Regional Council	32	41	34
Longreach Regional Council	np	np	5
Rockhampton RC + Livingstone SC	59	70	74
Winton Shire Council	0	0	0
Woorabinda Aboriginal Shire Council	0	0	0
Total	**116**	**137**	**135**

PODIATRY	2013	2014	2015
Banana Shire Council	0	0	0
Barcaldine Regional Council	0	0	0
Barcoo Shire Council	0	0	0
Blackall - Tambo Regional Council	0	0	0
Central Highlands Regional Council	np	np	np
Diamantina Shire Council	0	0	0
Gladstone Regional Council	4	np	4
Longreach Regional Council	np	4	np
Rockhampton RC + Livingstone SC	19	18	18
Winton Shire Council	0	0	0
Woorabinda Aboriginal Shire Council	0	np	0
Total	**28**	**29**	**28**

PSYCHOLOGY	2013	2014	2015
Banana Shire Council	4	np	np
Barcaldine Regional Council	0	0	0
Barcoo Shire Council	0	0	0
Blackall - Tambo Regional Council	0	0	0
Central Highlands Regional Council	5	5	5
Diamantina Shire Council	0	0	0
Gladstone Regional Council	24	21	23
Longreach Regional Council	4	np	np
Rockhampton RC + Livingstone SC	95	93	89
Winton Shire Council	0	0	0
Woorabinda Aboriginal Shire Council	np	np	np
Total	**133**	**125**	**122**

7. Current and future issues / trends

A range of current and future issues are featured in this section, along with trends and examples from around Australian and internationally. This includes a summary of responses from various organisation to the Aged Care Legislated Review December 2016, as this provides insights into the issues facing these organisations.

Meeting the needs of an ageing population

The Productivity Commission believes the total private and public investment requirements to meet the much greater numbers of aged people over the next 50 years are estimated to be more than 5 times the cumulative investment made over the last half century, which reveals the importance of an efficient investment environment (Productivity Commission, 2013). Key points from their research paper *An Ageing Australia: Preparing for the Future* are presented below.

Labour participation rates are expected to fall from around 65 to 60% from 2012 to 2060, and overall labour supply per capita to contract by 5%.

Average labour productivity growth is projected to be around 1.5% per annum from 2012-13, well below the high productivity period from 1988-89 to 2003-04. Real disposable income per capita is expected to grow at 1.1% per annum compared with the average 2.7% annual growth over the last 20 years.

Collectively, it is projected that Australian governments will face additional pressures on their budgets equivalent to around 6% of national GDP by 2060, principally reflecting the growth of expenditure on health, aged care and the Age Pension.

Major impending economic and social changes can create the impetus for new reform approaches not currently on the policy horizon. For example:

- The design of the Age Pension and broader retirement income system might be linked to life expectancy after completion of the current transition to 67 years in 2023.
- Using some of the annual growth in the housing equity of older Australians could help ensure higher quality options for aged care services and lower fiscal costs.
- Wide-ranging health care reforms could improve productivity in the sector that is the largest contributor to fiscal pressures. Even modest improvements in this area would reduce fiscal pressures significantly.

The Productivity Commission has estimated that by 2050 the aged care workforce will need to have grown to around 980,000 workers. It is vital that the sector and its workforces are monitored in order to keep all stakeholders informed and help the design and implementation of new policies to meet this growth (Department of Health, 2017).

The reduction in the estimated size of the direct care workforce in the home care and home support sector, combined with the likely increase in future demand for care provided in this setting may cause concern. The 2016 NACWCS sought to identify potential workforce competition with the disability sector. At present, there appears to be very little interaction at the workforce level between the aged care and disability care sectors. However, given the full National Disability Insurance Scheme (NDIS) roll out over the next two to three years, this could have substantial impacts on the aged care workforce (Department of Health, 2017).

There is some concern in the home care and home support sector about the impacts of aged care reforms (particularly Consumer Directed Care) on working conditions and employment. The impact of these reforms should be closely monitored particularly in light of the unexpected decline in the

estimated size of this workforce. Responding to change, a majority of residential facilities continue to be large in scale but utilising a smaller proportion of direct care workers, while home care and home support outlets are growing in size, with the larger ones expanding their workforces at a faster rate than the smaller ones (Department of Health, 2017).

Workforce and skills requirements

As the aged care sector grows and the services provided continue to change, the skills that required of the workforce will also evolve. The aged care workforce employs over 350,000 workers and has grown by 34% over a five-year period, as discussed in Section 2.1.3. Given the significant role played by the workforce in delivering aged care services, it will be important that both existing employees and future workers entering the aged care sector are equipped with the necessary skill sets.

There is increasing demand for a more highly skilled aged care workforce as older Australians enter residential care at later stages and with more complex medical conditions and comorbidity. This is already apparent in parts of the workforce, with 62% of residential facilities reporting a skills shortage of registered nurses. Our consultations with providers of residential aged care services indicated that admitting residents with higher care needs on average means that providers need to upskill their workforce.

This could, for example, include hiring more registered nurses in residential homes that had previously been lower care facilities. Providers noted that it can be challenging to source sufficiently skilled and experienced registered nurses, particularly in regional areas, and that in-house training and mentoring are often required. The difficulties faced by aged care providers in attracting and retaining these workers could increase in future as the sector continues to grow and as competition for highly skilled care workers increases. This could particularly affect home and community care services, where the rate of growth is likely to be high, and where the labour intensity of supplying these services is also relatively high. In addition, advances in medicine and patient care mean that continuous training and skills development are necessary in the aged care workforce. These advancements mean that in order to provide best practice patient management and residential care services, workers must be updating their skills on an ongoing basis, particularly in areas where boundaries are often challenged and new areas explored, such as managing patients with cognitive issues (Deloitte, 2016).

Technology can help to augment the labour requirements of aged care providers. Section 4.1 highlights how the use of new technology can improve the efficiency of aged care services. However, it is important to note that these technologies can only be used appropriately if the aged care workforce is suitably skilled. The Productivity Commission (2011) suggested that technology adopted by the aged care sector will complement the workforce – such as by improving the quality of care or the working environment.

In doing so, it will be important that aged care workers both now and in the future are able to access the training required to operate new technologies. Stakeholders across the aged care sector have important roles to play in addressing these skills requirements. As highlighted in the Aged Care Roadmap (2016), service providers, governments and education institutions all need to work together to address the skills challenges facing the industry. Our consultations suggest that aged service providers will need to play the most significant part in attracting, retaining and training their workforce, as described in Box D below. It is up to the providers themselves to identify how the skills requirements in their organisations are changing as the industry grows and the nature of aged care service delivery evolves, and it is also the responsibility of these providers to communicate these skills requirements to other stakeholders across the industry.

As a sector with significant labour demand and that will face increasing competition for skilled workers, providers must offer an attractive environment in order to engage new and existing workers to the aged care sector. The Aged Care Roadmap notes that government and education providers can also play a role in developing a well-trained workforce that is adept at adjusting care to meet the needs of older Australians. As a funder and regulator of the aged care sector, the government has a responsibility to ensure that the policy environment is sustainable and stable, and will facilitate the growth of a viable industry in the future. In addition, government policy in relation to education, employment and immigration can also have implications for the workforce and skills supply more broadly.

Future workforce challenge

Beyond this, education providers such as universities and vocational education and training (VET) providers can work to ensure that their course offerings are relevant to the skills required in the aged care sector and address industry needs, as well as providing accessible and up-to-date research. As highlighted in the Roadmap, collaboration and partnerships between industry, vocational, higher education and research organisations will be required to ensure that an appropriately skilled aged care workforce can be developed to deliver flexible, quality aged care services into the future (Deloitte, 2016).

Government estimates, based on a constant ratio of aged care workers to people aged 70 and over, suggest that the sector would require around 830,000 workers by 2050, more than double the current number (DoHA, 2010). Similar estimates by the Productivity Commission (2011) put the number at 980,000 workers by 2050. With an average annual growth rate of 2.6% between 2008 and 2050, employment growth in the sector is expected to exceed the rest of the economy (similar growth results, but for the direct care workforce only, were obtained by the OECD (Colombo et al., 2011).

But the number of workers needed would be higher still if we sought to keep constant the current ratio of aged care workers to the population aged 85 and over – set to grow faster than younger age groups. The calculation (based on series B of ABS 2013c), results in a figure closer to 1.3 million workers, requiring an average annual growth rate of 3.5%. Of course, such a mechanical calculation takes no account of productivity improvements.

Any rate of increase above employment growth will pose a considerable challenge for the sector and for policy makers; more so given increasing competition from health care, which is itself affected by an ageing population, and disability care, which is seeing increases in funding in Australia. Staff shortages are a risk to quality in aged care, but may also pose a fiscal risk for government as the main care funder (CEPAR, 2014). They suggest responses should be to respond by measure to improve:

- recruitment - target specific groups, with programs for young people, those who previously worked in the sector, women re-entering the labour market, aged care workers wishing to work more hours, family members of care recipients, foreign-born workers through targeted migration (which Australia is well placed to exploit), and men, who are currently under-represented in aged care
- retention - valuing workers, not only financially, but also through quality training, career prospects, supportive, safe and well-resourced workplaces, flexible work patterns, job status and recognition. Valuing existing workers also includes helping those who are older to stay on rather than retire too early
- productivity – could include technology, a learning culture, better management, delegation and staff mix, different business model that better integrates care services.

Patients with complex needs

An article in *Aged Care Insite* cites information from a new report by The Grattan Institute. The institute says Medicare – designed five decades ago – focuses on one-off conditions that can mostly be managed in a single doctor's visit. But now with an ageing population, chronic disease is an increasing burden on the health budget and the system isn't designed to deal efficiently with patients with complex needs. The existing fee-for-service rebate creates incentives for GPs to see more people for shorter visits, meaning they get paid more if they schedule a second consultation with someone rather than dealing with all the patient's problems in a single, longer appointment.

"In a number of countries now, practices that do better, have better processes and better outcomes, their patients get rewarded financially for that," Duckett said. "But without data you can't actually design those sorts of things and you can't implement them."

Future reform also hinges on better co-ordination between governments, and an end to buck-passing. "The commonwealth and the states need to stop bickering and sign up to joint agreements," Duckett says. He recommends governments sign new agreements that commit the states to supporting the primary health networks, thus reducing demand on hospitals, and with specific goals and joint accountability for failing to meet them.

The failure to properly co-ordinate primary health care, particularly for those with chronic illnesses, is leading to more people going to hospital, which is much more expensive for taxpayers. However, the steps to overhauling the system have to start with getting better information (Avenell, 2017).

The financial impact and stresses of arranging unplanned residential aged care

Financial issues and choices as people age are complicated and unclear to the majority of Australians, who aren't aware of the intricacies and ramifications until they are thrust into the situation when they, or their loved one's situation suddenly changes.

In some instances, when a parent is admitted to hospital, the family has to quickly review the various options (if there is a choice of care facilities), fill in an application form to each residential care provider and provide many accompanying documents (many of which have to be verified by a JP or equivalent). This stressful situation is made worse if the aged person doesn't have an Enduring Power of Attorney and/or Advanced Health Directive in place.

Added to this, is the need to understand the implications of the financial costs of moving to aged care. This of course, depends on the assets of the aged person, whether they have a partner who will still be residing in the family home, and a variety of other aspects.

Alternate views on who should be involved in care decisions

In collating information for this report, there have been many one-on-one conversations with doctors and other health professionals, and Managers from service organisations. While there are subtle differences in each individual's opinion, people generally have one of two opposing views about who should be involved in decisions about care:

- One group believe that it is solely up to the aged person and they have the right to decide what care they want and when it is appropriate to move into residential care.
- The other group have a more holistic view about the issues and consider the needs of all close parties (family or key carer/s) involved with that person.

It could be coincidental, but workers who spend large amounts of time with the aged person overwhelmingly were in the second group. The differences in view could relate to:

- the amount of time the worker spends with the person, so may better understand the person
- the amount of time or opportunity the worker has had to communicate with loved ones associated with the aged person, so may have a more informed view
- knowledge of family pressures or stress that may be impacting the situation
- concern about Elder Abuse
- by whom the worker is employed
- the training/education that the worker is using in the decision-making process
- the knowledge the worker has about the client's condition and any impacts it may have on decision-making.

Issues highlighted by Aged & Community Services Australia

In a phone interview, their CEO, Pat Sparrow, highlighted a number of issues that were particularly important for aged people in regional, rural and remote regions:

- The Government's current market approach to aged care will not work for regional, rural and remote areas, so it is important to determine what will be viable (with regards to funding) in these locations.
- Rural properties cause difficulties when assessing assets, especially those that are the home to two-three generations of family.
- Transport costs for Home Care services do not change for clients that are in rural and remote locations. It will be important for Government to look at how else to deliver services to make services to people outside metropolitan areas practical and efficient.
- It may be more efficient and practical for someone local (rural and remote) to be contracted to help with support: e.g. household support, with other local community members carrying out various tasks for efficiency.
- Supported housing should be considered for a cheaper and better way to deliver home care.
- Need to consider the things that make rural and remote providers successful.

Priority issues outlined for Government action in their 2017/18 Pre-Budget Submission (ACSA, 2017):

- Industry-led development of an Aged Care Workforce Strategy.
- Development of an aged care funding system that provides certainty and adequacy of funding for the future growth required.
- Industry assistance funding is required to assist aged care providers deliver new aged care models, in particular supporting remote, rural and regional aged care providers to adapt systems.
- Delivery of Government commitments
  - improvement and expansion of My Aged Care platform
  - more effective (DHS) systems
  - improved targeting of viability supplement for regional aged care facilities
  - extending funding for unannounced compliance site visits
  - implementation of dementia friendly communities and specialist dementia units.
- Project funding to progress the Aged Care Roadmap.

New models of providing care

Australian aged care is undergoing major changes following a landmark review and announced reforms. As in other countries, the policy area is seeing trends toward more consumer-centred, community-based, independence-focused models of care. These also hold out a promise of greater cost efficiency – a concern for policy makers given an increasingly ageing population.

Business practice and organisational leadership may have a strong influence on the success of aged care providers and on workforce and care quality outcomes. CEPAR researchers are evaluating a program aimed at improving aged care managers' leadership capacities, empower staff and disperse decisions. The trial is the first of its kind in the sector, with control groups and a double-blind process (CEPAR, 2014).

In recent years, there have been changes to the traditional models of residential aged care. Some homes offer a range of additional services including a bowling green, library, hair salon, cafe and gyms. At Wheller Gardens in Brisbane's north side, children from Marchants Childcare centre visit regularly and spend time interacting (singing, playing games and special events) with aged residents of the facility under their Intergenerational Program. Similarly, students from secondary schools on the Capricorn Coast visit residents at Sunset Ridge, Zilzie. The programs are mutually beneficial, providing company and spontaneity for the residents and valuable interactions for the children and students.

Consumer directed care (CDC) and aged care services

The following 4 paragraphs, part of a 2016 report by Deloitte Access Economics for Aged Care Guild, include pertinent information.

The provision of aged care services is moving towards a consumer-centric model for both home care and residential care services. CDC has embedded consumer-centricity in home care, with the residential care sector embracing CDC principles (KPMG, 2014). For example, our consultations with residential care providers highlighted the more personalised style of service preferred by many new resident and that, as a result, some facilities are now offering relationship-based rather than task-based care, where a dedicated team of staff attends the same group of residents in order to develop a lasting and personalised service relationship (Deloitte, 2016).

In the future as the aged care system transitions further towards a market-based, consumer-driven system, aged care providers will be required to tailor their services and packages to suit consumer preferences. Our consultations suggest that consumers of residential aged care are increasingly willing to pay for more specialised or 'high end' accommodation and services, and the industry is adapting to this by investing in modern facilities and refurbishing old homes. The range of lifestyle activities on offer at residential facilities is also increasing to meet consumer demand, including better dining experiences, more outings and recreational activities (Deloitte, 2016).

A more consumer-centric model for delivering aged care suggests that service providers will need to consider the increasing diversity of older Australians and their preferences and expectations, including cultural, linguistic, sexual and gender diversity. As the Productivity Commission (2011) noted, catering to diversity is essential to providing quality aged care services – for example, a resident in distress will tend to revert back to familiar cultural or linguistic practices, making it crucial to have services in place to provide the appropriate assistance (Productivity Commission, 2011). At the same time, providing aged care services that address these diversity considerations is likely to raise costs for providers (Deloitte, 2016).

The increasing number of consumers who are preferring to 'age in place' also has important implications for the future of the aged care sector, as more Australians take control of decision-making relating to their care. With many Australians choosing to remain at home on a home care package before entering residential accommodation at an older age, residential providers are increasingly accommodating consumers with higher care needs. This represents an opportunity for aged care providers to offer a wider range of services across both residential and home care to meet future consumer demands and preferences. Providers could also leverage other services and industries in order to supply combined or integrated packages to the market (Deloitte, 2016).

The traumatising impact of aged care service inaccessibility

Interviews conducted as part of a research project in rural communities of New South Wales, revealed that inaccessibility of residential aged care places caused many to experience loss, loneliness and a sense of social disconnectedness. The affected rural older person is exiled from their home community only to return to be buried. There are implications for the family and the rural community who are distanced by kilometres, transport and finances and, more significantly, by the emotional ties that bind families, friends and communities.

The participants whose experiences were explored in this article described a sense of being in exile when residential aged care services are inaccessible in their local communities. The sense of exile is felt not only by the person moving away but also by their family, friends and neighbours. For this reason, rural residential aged care service delivery should be based on the identified needs of the older person and those who love and care for them (Bernoth MA, 2012).

Problems faced by the elderly in rural and remote areas

Lack of choice

Aged care provision in rural and remote areas may be limited to one or two providers who have less need to compete for custom, through marketing or self-promotion, than their metropolitan counterparts, leading to 'information-poor' consumers. A small pool of providers may also result in lack of service differentiation or innovation (National Aged Care Alliance, 2017).

Issues engaging with My Aged Care

Older people living in rural and remote areas experience the same issues with My Aged Care, that have been identified in more populated areas, but their experience is exacerbated by the following:

- poor or intermittent internet coverage
- lack of access to computer equipment, especially Aboriginal and Torres Strait Islander people living in remote areas
- lack of access to alternate sources of information
- difficulties relating to distance, time and cost for services, including assessors' capacity to provide face-to-face assessment in people's homes (National Aged Care Alliance, 2017).

Challenges in attracting and retaining staff

According to the Australian Nursing and Midwifery Federation, attraction and retention problems in the aged care sector are not new. The challenges are well understood across the industry:

- low wages and poor conditions
- inadequate staffing levels and workload issues
- unreasonable professional and legal responsibilities
- lack of career opportunities
- stressful work environments
- poor management practices
- a poor perception of aged care in general (CEPAR, 2014).

Responses to Aged Care Legislated Review December 2016

The following information has been taken from responses from the various organisation to the Aged Care Legislated Review December 2016. They can be viewed in full at: https://agedcare.health.gov.au/reform/aged-care-legislated-review/submissions.

Aged and Disability Advocacy Australia (ADA Australia) and Aboriginal & Torres Strait Islander Disability Network of Queensland (ATSIDNQ)

Controlling the places in regional and remote locations forces people away from their communities and the person becomes disconnected from family and friends. A recommendation for smaller communities is to engage with State Funded Health Services to apply for the implementation of Multipurpose Health Centres to ensure that people in community can age within their community.

Accessing aged care through My Aged Care was intended to reduce the complexities around accessing service and ensuring a consistent national approach. However, ADA Australia has identified that the introduction of My Aged Care has in fact made it more complex for consumers to connect with services as it has added more layers to the aged care system. The system relies on people being confident with accessing information via the internet or phone. Another concern is the timeframe for assessments conducted by ACAT. In some regions, the timeframes can exceed three months. There is also extensive paperwork required to be completed which is not made available in other languages or alternate formats. Many people find the process difficult and may discontinue the process of accessing the services they need. ADA Australia recommends that advocacy be a part of the end to end process of accessing aged care services. For MAC to be effective it needs to proactively recruit and train staff from special needs groups – for example, it is understood that there are currently no Aboriginal and Torres Strait Islander staff employed by MAC, and Aboriginal and Torres Strait Islander awareness training for MAC staff is not mandatory.

There needs to be reform of the process for accreditation of approved providers, particularly in rural and remote communities that acknowledges the difficulty in accessing an approved aged care provider in these communities. The review should seek to establish at a minimum, a mutual recognition of approval processes between the aged care and disability sectors.

With the impending portability of funding, an older person approved to receive an individualised Home Care package, is only able to approach an approved aged care provider to deliver their service. In regional, rural and remote communities there may not be any approved aged care providers, with at best only a single human service provider, health service or Local Government Authority in that location. It is an expensive and time consuming process to gain registration as an aged care provider, so these services are unlikely to put themselves through an accreditation process to support one or two individuals. This means that the older person is either unable to access support, or has to relocate to access support.

ADA Australia recommends that the aged care legislation be amended to recognise 'similar' accredited services in rural and remote areas for the purpose of delivering individualised packages. This is an approach that the NDIA should also seek to adopt; recognising approved aged care providers as a suitable auspice for a person with a disability's NDIS package.

Aged Care Guild

Recommendations included:

- That the Review examine the experiences of different population groups, their capacity to readily access aged care services and recommend improvements to which the sector might respond.
- That the Review critically examine the operability of the My Aged Care (MAC) portal and make recommendations on the improvements that could be made to better facilitate consumers' interactions and the performance criteria through which to assess MACs successful operation (i.e. consumer experience, referral wait times etc.).
- That the Review consider the extent to which government might be seeking to manage consumer choice in facilitating access to aged care services.

Alzheimer’s Australia

That the Review consider the role that consumers and carers can play in the implementation of the CDC model. Alzheimer’s Australia recommends that consumers and carers should be engaged as key partners in aged care quality and compliance processes.

That the Review ensure that informed decision making by all consumers, including those with dementia as well as their carers, should underpin the ongoing implementation of CDC, quality standards and processes and any future reforms for aged care services. That the Review consider the accessibility and usability of key consumer information sources such as My Aged Care.

Anecdotal evidence from our consumer networks indicates that there is still significant unmet demand for appropriate, high quality services for older people with dementia, particularly those living in rural and remote areas, those with significant behavioural and psychological symptoms of dementia, and those with a need for culturally specific services, such as older people with dementia from Culturally and Linguistically Diverse (CALD) backgrounds or from Aboriginal and Torres Strait Islander communities.

That the Review consider the need to mandate minimum ratios of staff to residents, and mandated minimum levels of qualified nursing staff to ensure to ensure quality and safety in residential aged care; Alzheimer’s Australia also recommends a requirement for all stand-alone residential aged care facilities to have a Registered Nurse on site at all times. Funding arrangements for aged care should support appropriate staff ratios and skill mix.

With regard to access to aged care services: Demand is growing at a faster rate than the supply of aged care services. There is also the perceived view that the move to CDC, and a market based system of supply and demand will fix inherent concerns with standards and quality of care that are widespread across aged care. Unfortunately, that’s unlikely to be the case for consumers of aged care services, and particularly for people with dementia. Relying on a market in aged care to drive quality improvement is unrealistic for a number of reasons including:

- consumer reluctance to leave a service once they enter due to the disruption of a move
- lack of competition in rural and remote areas
- the need for urgent access- which limits choice based on availability
- location preference having a large weight in decisions
- consumers’ lack of information about clinical standards and best practice of care.

That the Review consider and support a model of enhanced community-based aged care, which should be based around the provision of holistic care, in conjunction with other services, to enable people living with dementia to remain at home for as long as is feasible, if this is the person’s preference.

That the Review consider a residential aged care model that involves ensuring the environment is as home-like as possible, and takes a flexible approach to providing the best possible care for the individual resident. Key elements include resident-centred care with measures in place to cater for people with dementia; culturally appropriate care; involvement of relatives and friends; effective pain management; minimal use of restraint; and use of specialist supports.

Australian Medical Association

In order for the aged care system to evolve we must also consider that, like the broader health system, aged care impacts upon both State and Federal Government. However, there is a lack of coordination between the two. Aged care facilities are the purview of the Commonwealth but when a health complication arises, residents are often transferred to a hospital which is the responsibility

of the State Government. This means that the States often bear a financial cost resulting from issues that arise in a Commonwealth-run aged care environment.

Australia's ageing population will continue to increase the demand for aged care, which in turn warrants an increase in expenditure. The number of aged care beds in Australia increased by 27% from 2005-2015, resulting in an additional 40,000 new beds (Baldwin, 2015). However, this growth rate will not meet the demands of future growth.

RSM Australia has forecast a demand of 392,000 beds by 2025, while supply in this year based on current growth is predicted to be 262,000. This leaves an unmet demand for 130,000 beds, with Government funding restrictions and the time it takes to establish an aged care facility the major factors inhibiting supply (RSM, 2016). As a result, patients often end up in hospital, or have extended hospital stays, as they cannot get an appropriate place in an aged care facility.

Hospitals are not an ideal environment for the older population. Patients in Emergency Departments (EDs) have a higher risk of contracting an infection and the older population are more susceptible as their immune systems are often compromised. Further, they are more likely to have decreased cognitive impairment, which can result in anxiety and disorientation, and can increase the risk of injuries when attempting to mobilise unaided in a confused state. Pressure sores are common for elderly patients in EDs which warrants further attention from nursing staff. Residents in RACFs are usually on multiple medications and there is an increased risk of incorrect dosage at the wrong time in a busy ED environment.

Increasing the number of residential and home care places would contribute to preventing unnecessary admissions and reduce the risk co-infection and other hospital-induced complications.

Rural Aged Care

Rural aged care services remain limited in choice and rely on Government-based aged care facilities, as for-profit providers are increasing only in major cities. A supply-driven model may not be as effective in rural areas for this reason, and in turn affect the rate of aged care facility growth in rural areas, further reducing the amount of choice and resulting in the absence of some services.

Many rural doctors are pressured to treat older patients in RACFs due to the limited number of hospital beds in rural areas. RACFs are not funded to adequately tend to the needs of ill residents and therefore the quality of care they receive can be reduced. These challenges deserve the specific attention of those undertaking the review.

The lack of services is coupled with a shortage of medical practitioners in rural and remote Australia. This is due to the lack of funding to support the recruitment and retention of doctors and health professionals, and the limited availability of education and training facilities in rural and remote areas. Funding is also required to address that rural doctors are finding it difficult to find locum relief to maintain their Continuing Professional Development (CPD) points and find a work-life balance.

Older Australians should have access to aged care services in their own community instead of moving to a neighbouring town that is potentially hundreds of kilometres away from their home. Providing access to more remote communities would reduce the cost and travel times for families and friends to visit, thus improving the wellbeing of the resident. Further, the GP-patient relationship is undermined when the patient has to move from their community and as a result disrupts continuity of care. The familiarity a GP has with their patient, coupled with knowing the patients' history is essential to providing quality of care and may reduce the prevalence of referring patients to the ED. To ensure rural and remote areas are not left behind in this supply-driven system, the Government should conduct research into the value of investing in aged care for rural and remote areas.

Culturally and Linguistically Diverse (CALD)

In the case of Aboriginal and Torres-Strait Islander populations, it is important to ensure RACFs are culturally aware and informed, similar to the cultural understanding seen in Aboriginal Community-controlled Health Service. This will ensure smooth transition between the health system and the aged care provider. The goals outlined in the National Ageing and Aged Care Strategy are not being met. Our members have recently highlighted the communication difficulties both with CALD staff and residents of RACFs, and more awareness of the services and training available to staff is required if CALD residents are to receive equitable aged care.

Workforce strategies

With regards to Residential Aged Care, there are several significant barriers that limit the amount of medical care a medical practitioner can provide. These include:

- Poor access to properly equipped clinical treating rooms. Treatment usually has to be provided in a shared room where there is a lack of privacy for the patient and no equipment for the treating doctor, limiting the medical treatment that can be provided in that setting.
- An absence of information technology (IT) infrastructure to facilitate access to electronic patient records and medication management, which promotes a reliance on using time consuming paper files. This includes software that is user-friendly and appropriate to the needs of general practitioners, improved electronic interface between pharmacy services and aged care facilities records, and/or support for remote access to the practitioner's medical records. The software should also not require multiple logins in order to increase efficiency. A larger investment in IT could see better communication between the care team, faster access to hospital discharge summaries, fewer medication errors, and better access to Advance Care Directives.
- The My Aged Care Gateway should be interoperable with clinical software. The My Aged Care Gateway referral form needs to be integrated into general practice clinical software so that the form can be auto-populated, attached to the patient record, and securely sent.
- A strong financial disincentive for the medical practitioners to leave their surgery, with all its attendant costs, to provide services in aged care facilities.
- Limited MBS support for Telehealth services often means that the doctor needs to present at the facility or not be paid.
- A growing tendency to build facilities in the outer growth corridors or 'urban fringe' of metropolitan areas which further adds to the time spent by medical practitioners away from their surgeries. This also forces people to move further away from their community and reduces the likelihood of retaining their usual GP, which in turn breaks continuity of care.
- A lack of access to registered nurses with whom to co-ordinate care. Nursing services are currently provided in a variety of ways, and a lack of adequate nursing services impacts negatively on the timeliness and quality of care for residents.
- A number of AMA members identified a practical impediment to working in aged care facilities being the consistent lack of formal arrangements for doctors to be provided with after-hours access to the facility (including the provision of codes).
- An increasing use by aged care facilities of agency staff who are not familiar with residents which compromises continuity of care.

Conclusion

The aged care system needs to evolve in order to accommodate Australia's increasing ageing population, with the majority of issues in the lack of aged care staff and the absence of recognition in the role of the medical practitioner in effective aged care. Aged care providers should have arrangements in place to ensure that residents' needs for medical care are identified and that they receive ongoing access to medical care appropriate to their needs and that they age in place. This will include, but is not limited to:

- ensuring adequate numbers of appropriately skilled nurses are employed

- having management practices in place to ensure residents who require medical attention from a doctor are identified quickly, and that doctors are contacted
- providing doctors with access to properly equipped clinical treatment rooms that afford patient privacy
- providing doctors with access to information technology infrastructure, and patient records.

With support from PHNs, the Government needs to closely monitor the trends and needs of the ageing population to ensure a flexible and efficient supply-driven system and to ensure that rural aged care facilities are not left behind under this model.

Baptist Care Australia

Home services

A key issue for equity of access is with regards to travel for consumers in rural and remote areas. The travel costs associated with care workers attending to remote consumers can significantly reduce the level of services they receive.

Recruitment and retention

HOME SERVICE: Recruitment and retention of community care workers continues to be a challenge as there is strong demand for workers to support both aged care and disability. There has been concern around the quality of training being delivered by RTOs who have access to Government funding which requires providers to be vigilant about where prospective employees have received their qualifications. Course content has not been delivered in a way that really prepares the person for working in the sector. Where funding is released for RTOs some quality measurements need to be in place and consideration on setting minimum requirements on content and timeframe for training. One potential option may be to offer the training places to the approved provider to then select the most appropriate training agency to deliver the course content for achieving certificate III or IV. Another potential risk is the rise in the number of independent contractors where the risk is borne by the consumer. Are there plans for management and support for the consumer where the support provided is compromised?
RESIDENTIAL AGED CARE: not effective; rural/remote, not effective at all for senior recruitment.

Meals on Wheels Association

The dismantling of HACC and creation of the Commonwealth Home Support Programme (CHSP) has placed Meals on Wheels in an inappropriate funding and policy framework that is at odds with the initial concepts proposed by the Productivity Commission in its Caring for Older Australians Report. It proposed that just as health services, social housing and disability support services were not part of the formal aged care system, nor should meals and some other community support service types. Accessing simple meal services, often needed for relatively brief periods, has never been more complicated for older people.

Referrals to Meals on Wheels have plateaued or declined in some jurisdictions as a result of access reforms, with no evidence that consumer needs are being met through alternative service options. An increasing number of people whose only need is delivered meals, are informed at the access point that they are ineligible for government funded services and deflected to more expensive and less accessible private meal supply options, which don’t meet their nutritional or social needs or link vulnerable people into other services.

In March 2015, and in subsequent meetings and teleconferences, AMOWA flagged with the Commonwealth Department of Health our concerns regarding the proposed My Aged Care interface. These included: Lack of confidence in the service finder database as the primary means to recommend service providers to consumers who have difficulties shopping and/or cooking for

themselves; Unclear pathways for clients who had an identified need for meals and other food services; Likely unacceptable increase in delays between identification of the consumer's need for services (contacting MAC) and meal service commencement; Disrupted consumer access experience; Lack of consistency and poor process for identification of vital information at the screening and assessment stages; Potential that some consumers would fall through the gaps if deemed ineligible for the Commonwealth Home Support Programme.

Since 1 July 2015, all of the concerns highlighted above have become a reality. AMOWA recognises that disruptions during the implementation of major reforms are inevitable, and that some issues related to resourcing of MAC call centres appear to have been largely resolved. Further improvements are anticipated as a result of the current accelerated design process.

Given that approximately 40% of older Australians are poorly nourished or at risk of malnutrition, it is considered highly unlikely that the community need for meal support has reduced. The dearth of alternative service providers and low Home Care Package vacancy rates in most locations suggests that the consumers being referred are being deemed ineligible or advised to use online or other private meal options.

If the above is correct, there is significant risk of increasing the level of poorly and under-nourished older Australians, with high downstream costs to the health and aged care system, for the sake of 'saving' a very modest Government contribution to a meal service in which the customer is already paying the bulk of the cost. Data from the UK and US, following reductions in resources for community meal programs, should cause alarm for the Department of Health.

Mercy Aged and Community Care Limited

In the Home Care market, we are constantly receiving enquiries for L3 & L4 services but are unable to provide them as we have no additional packages available. This is not meeting the demand for Home Care nor reducing Residential Aged Care demand as originally anticipated under LLLB. Based on what we are experiencing, there is still substantial unmet demand for the right services and level of care, in both residential and home care markets. This is further supported through future estimates of bed numbers to meet the needs of an ageing population and the relative rate of development happening or planned to happen to meet those estimates. It is more than just a numbers and efficiency game. We must also ensure the care is effective in enhancing and maintaining the quality of life of those receiving services.

Mercy Health supports moving to a consumer demand driven model in residential aged care. However, in doing so, Mercy Health believes that we must ensure that those that are unable to make choices of their own must have appropriate advocates that can speak on their behalf. Furthermore, a key component of allowing choice of where and what services is replicating their previous lifestyle where possible, including accepting a reasonable level of risk taking with the Department supporting providers to accept the resident's choice to take risks. This will involve clear direction to the AACQA and support of providers in the media when allowing these choices.

The ability to choose what one does is currently often counteracted by the need to have a full risk mitigation approach to risk and safety management in order to meet AACQA requirements. There will need to be clear boundaries set as to where choice is allowed and is not allowed in residential aged care. For example, can a resident chose not to use a mobility aid when they have been assessed as a high falls risk, could a home have staircases or outdoor physical exercise equipment? How would such choices be acknowledged?

How does that impact on the duty of care obligations of the provider? Mercy Health and the ACU are currently involved in a collaborative research project that tests a CDC approach in RAC on resident quality of life outcomes. We will be pleased to share the findings with Government when

completed in mid-2017. Mercy Health supports a consumer demand driven model provided there is always a safety net provided by Government that enables special needs groups equitable access to services in their local area (urban, rural and remote).

My Aged Care has been very ineffective as a portal for information for potential residents. Many are just not aware of the site, don't access the internet, or find it very confusing. Whilst there are some useful documents (fact sheets) for providers to use, as a public portal it is not always that helpful as everyone's circumstances are different and the system itself is complex and highly administrative.

A person's journey into care starts at a highly emotive point for them and their family, and whilst the '5 Steps Process' is good, people very quickly get confused and anxious when underlying that are ACAT assessments, means tested fees, Centrelink forms (with over 140 questions), RADs and DAPs, no vacancies in their local area, need to sell the family home, etc. across various government departments – Health, Human Services and often Veteran Affairs where processes are not always aligned and data in each department can be different for an individual.

There is a lot of work required in developing the capabilities of My Aged Care and creating awareness of it with the public. Along with improvements to My Aged Care, an improved 'market face' of aged care is required with positive public messages and support of providers required. However, as a result of a poor launch of My Aged Care, this has supported sub-sector market growth through financial planners, advisors and aged care placement agencies. This in itself has improved awareness of services.

Legislative reform needs to be aligned to the proposed Roadmap for reform. The effectiveness of the reforms so far has had positive impacts in improving accommodation returns for providers and establishing a framework (the means test) for managing Government funding – if politically acceptable to utilise it. The introduction of CDC into Home Care is good in principle but has created an administrative burden that has rendered L1 and L2 packages uncompetitive with private services or HACC, and a funding inefficiency with billions of dollars in funding tied up in unspent funds that could be used to support more people.

Aged Care needs to be more resident-centred and focused on enablement and wellness not care and dependency. Current funding models incentivise care and dependency and regulation and compliance add overheads and administration costs that use up high levels of funding.

National Rural Health Alliance Inc

The data shows that access to residential aged care in remote and very remote communities is extremely limited. The type of provider of residential aged care in rural and remote Australia differs from major cities substantially. The largest provider type in major cities is the private provider, but their market share outside major cities is extremely limited – particularly once you leave inner regional locations.

Our members advise that there is considerable unmet demand in the residential aged care and community context in rural and remote communities. A significant number of Australians are still being forced to take up residential aged care places that displace them from their community and family due to an insufficient number of places available within the community. Lack of access to higher level home care packages is also a significant issue. The lack of places in rural and remote communities result in more and more Australians with increasing community aged care needs accepting packages that do not cater for those needs on the basis that something is better than nothing.

Further, the lack of places, even in larger rural centres, makes it difficult for families to find residential aged care facilities where it is possible to visit and support family members relocating

from more remote communities (National Rural Health Alliance Inc, 2016). For carers this adds to the pain and guilt associated with no longer being able to care for their loved one in the family home.

Based on member feedback, the Alliance believes that unmet demand for culturally appropriate and safe residential aged care delivered in rural and remote communities has grown, not been reduced and that more flexibility needs to be provided to enable aged care providers in rural and remote communities to meet growing consumer needs.

It should be noted that moving to a consumer driven model rather than a supply driven model could be very difficult in rural and remote Australia given the small market ie. the small number of individuals seeking aged care services particularly in small rural and remote communities. In these areas, it is not financially viable to provide a wide range of services to small populations. For rural and remote aged care services to be delivered through a consumer demand driven model will require a significant change in emphasis in the current system of allocation of aged care places outside the major cities.

It is now possible to develop modelling tools that can make aged care place allocations based on consumer needs – at least in the sense of needs that can be incorporated in local health and demographic profiles. It is also important to recognise and accommodate the strong desire of rural and remote populations, particularly Aboriginal and Torres Strait Islander people, to retain their connection to place by remaining in their community. As people age, and particularly as they approach death, the need for connection to country, family and friends is paramount. We need to develop aged care models that are sufficiently flexible to accommodate those needs. We know of the impact the current system has on individuals who feel broken by their experiences in the current aged care system and their trauma at being forced to leave their families and home communities.

The Alliance believes that significant work needs to be done to develop the appropriately qualified workforce of the future in rural and remote locations. At present, there are significant difficulties in recruiting and retaining qualified staff, with significant use made of 457 visas. The Alliance believes that for rural and remote communities, the jobs of now and the future are in the service industries, such as aged care, child care and disability services. For many communities, struggling with rising unemployment, we need to take a broad community view on the skills the community will need in order to grow and flourish into the future and work with local schools and technical colleges to deliver training that is locally accessible and culturally appropriate and is able to feed into the local service industries.

In rural and remote Australia, one of the most difficult issues is the ability to access services that are close to community or family. No individual should feel that they have been ‘forced into exile’ in order to access aged care services (4), but unfortunately this is often the case. The combination of insufficient places in residential aged care facilities and insufficient community based places to support higher levels of care in the home means families and individuals are left with little choice but to relocate.

The Alliance supports investment in the aged care sector to support the cultural shift needed to operationalise a robust healthy ageing strategy that underpins the reforms in this area. This includes elements such as, being consumer-centred, greater service access in rural and remote communities, embedding wellness and restorative care principles within services and investing in interventions that will prevent age-associated decline and disability. The Alliance also supports a multi-sectoral approach to creating environments that support healthy ageing.

Presbyterian National Aged Care Network

Response to question "Whether the number and mix of places for residential care and home care should continue to be controlled": Creating alternative models which ensure access to aged care in rural and remote Australia.

Response to question: "Whether further steps could be taken to change key aged care services from a supply driven model to a consumer demand driven model":

- As indicated in our answer to 2.2, NPAC supports additional steps being taken to move towards a consumer demand-driven model of aged care funding.
- We note however that maintaining equitable access to aged care is vital in any market-based model. NPAC does not support Australia moving to a three-class system: haves; have nots; rural and remote.
- Due to Australia's geography and sparse population density in inland areas, NPAC believes we will need an alternative model developed that properly supports retention of infrastructure in rural and remote areas. This could include a mix of guaranteed or block funding alongside a variable consumer funding component.

Queensland Nurses Union

The Queensland Nurses Union responded to the Aged Care Legislated Review. Their response to the question "The effectiveness of workforce strategies in aged care services, including strategies for the education, recruitment, retention and funding of aged care workers":

While the aged care sector consumes considerable, and increasing, funding and resources ($14.8 billion in 2013-14), it is characterised by a range of endemic issues that will inhibit the capacity of the sector to meet the future workforce needs of older Australians. These issues include:

- lack of wage parity with other health care sectors with resultant recruitment and retention issues
- unfavourable working conditions and workloads
- lack of education and training opportunities
- a poor public perception of working with the aged.

The sector is also undergoing a shift in staffing and skill mix where the number of registered (RN) and enrolled nurses (EN) working in aged care is decreasing while the number of unregulated care workers is expanding. This shift is occurring at the same time as increasing acuity and care needs for those elderly Australians requiring residential aged care. For some time, the QNU has been campaigning for four primary goals:

- The introduction of mandated minimum staffing and skill mix requirements for nursing services in the aged care sector. This goal includes the mandated requirement for a 24-hour registered nurse presence for all aged care facilities where there are residents with high care needs and medication management by registered and enrolled nurses only.
- Achieving wage parity for aged care RNs, ENs, and assistants-in-nursing/personal (AINs/PCWs) with those in the public sector.
- The licensing and regulation of all AINs/PCWs and minimum qualifications standards.
- Improved transparency (including for outcomes in standards of care) and accountability for taxpayer provided funding for aged care.

These goals form the basis of an effective strategy that encourages recruitment and retention of the aged care nursing workforce.

The Australian Parliament has an opportunity here to improve the quality of aged care by legislating:

- minimum mandatory nurse to resident ratios

- minimum education qualifications for facility managers
- the mandatory application of professional nursing standards in aged care
- the mandatory physical presence of a registered nurse at all times in all aged care facilities
- more rigorous transparency and accountability for taxpayer funding to aged care including improved public reporting of staffing numbers, skill mix and outcomes
- a funding mechanism that will allow providers to raise and maintain pay rates to parity levels.

These are the mechanisms that will drive change in the sector and enhance the recruitment and retention of aged care nurses.

The Review should be made aware that there are aged care facilities in Queensland where one RN is accountable for the nursing care of up to 200 residents over an eight-hour shift. The Minister and Assistant Minister should act now to put an end to such high-risk practices.

Recommendations
The QNU recommends amendments to the Aged Care Act 1997 or other relevant legislation to provide:
- minimum mandatory nurse to resident ratios
- minimum education qualifications for facility managers
- the mandatory application of professional nursing standards in aged care
- the mandatory physical presence of a registered nurse at all times in all aged care facilities
- enhanced public reporting of staffing numbers, skill mix and outcomes
- an ongoing mechanism to ensure funding given to providers will be used specifically to raise and maintain pay rates for aged care nurses to parity levels.

Suncare Community Service Ltd

The level of unmet demand for Home Care Services has not reduced: regular comments from new consumers mention how difficult it is for them to understand the My Aged Care process, that they have received conflicting information from the operators at the National Contact Centres, are confused by the language used by sector employees; are confused about the various roles of the people contacting them and have consequently postponed seeking the services they need; the reablement approach is effective for short-term and/or simple areas of improvements in the consumer's capacity to attend to their activities of daily living, however, having then navigated the process of entering aged care services, a consumer will later identify other more long-term and complex needs; fees associated with the HCP can be prohibitive but not overtly identified as an issue by the consumer.

Workforce planning and development in the aged care sector is struggling to keep pace with the increasing demand for services, consumer directed practice and the overall changing culture of age care services in Australia. Coupled with the impending impact of the National Disability Insurance Scheme insufficient workforce supply is likely to put significant upward pressure on wages, reducing margins and the quantity and/or quality of services to consumers. A search for efficiencies has led to more part-time (low hours) contracts and more casuals staff. Staff churn rates are high and require significant expenditure in recruitment and induction of entry level staff. Despite the myth of younger people having a higher aptitude for Information Technologies (IT), entry level staff are often lacking in the basic of IT skills necessary to launch into an aged care career.

UnitingCare Australia

UnitingCare Australia believes that Australia should have universally accessible aged care system that is funded at a level that is sufficient to ensure services are available when and where they are needed to meet assessed needs. Inadequacy of funding is putting providers, particularly in rural and

remote areas, under tremendous strain and is impacting on the ability to deliver quality care to residents.

Modelling [Budget 2016, ACFI Modelling – Summary Findings June 2016] has demonstrated that the Australian Government's cuts to residential aged care funding of more than $2 billion, which were announced in the 2015–16 mid-year economic and fiscal outlook and the 2016–17 Budget, will place significant additional cost and service pressures on health and home care systems. This will make it harder for vulnerable and sick older people to access the care and support they need within the residential aged care system.

The Australian Government needs to recognise that in rural and remote locations the circumstances are very challenging and service providers need to receive higher levels of financial support to ensure equity of access. For instance, in one of the rural remote regions in which UnitingCare delivers HCPs, one hour of personal care from the only supplier in that region costs $60.50 for a standard shift plus $2.00/km for car usage. In a metropolitan area, the same hour of personal care costs on average $45.00 plus $1.00km for car usage. This talks to the attraction of a workforce and supply and demand tensions. In addition to the specific concerns about how deregulation will be implemented in rural and remote areas (outlined in section 4) there is a broad issue for all aged care homes in rural and remote areas, that the care component of their funding is grossly inadequate to cover the higher costs of delivery in these areas. Inadequacy of funding is putting providers under tremendous strain and is impacting on the ability to deliver quality care to residents.

Internet accessibility in remote areas is an additional issue, which particularly impacts on the capacity of Indigenous people to interact with My Aged Care.

It is clear from workforce projections related to growth in the aged care industry that there is and will continue to be significant additional requirements—not only does the workforce need to grow, but it will need to be increasingly composed of workers skilled in client-centred approaches to service provision, use of emerging technologies, and able to work under the direction of allied health workers to deliver in-home services. These requirements cannot be met from within the industry, but need planning and support from the education system.

Investment and sustainability of growth

The following 6 paragraphs are reproduced from the 2016 report by Deloitte Access Economics for Aged Care Guild.

Significant future investment is required in the aged care sector to ensure that the number of aged care places can meet demand for services over the coming years. In the residential sector alone, ACFA has forecast the need for approximately 82,000 additional places over the next decade in order to meet growing demand fuelled by the ageing Australian population. In addition to these new places, a significant proportion of existing stock will also be required to be replaced with new stock. Overall, this will require an investment of $33 billion in residential care over the next decade (ACFA, 2015) (Deloitte, 2016).

Over recent years, investment in residential aged care has been led by the for-profit sector. In the latest 2015 Aged Care Approvals Round, for-profit providers were awarded 63% out of 10,940 new licences, and private residential operators made up nine of the 10 largest allocations of residential places (O'Keeffe, 2016). In addition to these new licences, there has been a growing trend for private residential providers to acquire existing facilities in order to build up their portfolios and networks of residential homes in particular areas. Combined with the number of residential places allocated to private providers over recent years, this increasing consolidation within the residential care sector

has seen for profit providers increase the relative size of their operations over the past seven years (ACFA, 2015) (Deloitte, 2016).

However, not-for-profit providers also play an important role in the residential aged care sector. Growth in the not-for-profit sector is organic, with providers using surpluses from their existing operations to construct new facilities and renovate existing buildings to accommodate growing demand. This includes investing in growth in remote and regional areas, with many not-for-profit providers having historically operated residential aged care services in these remote regions. In addition, there has been some consolidation taking place in the not-for-profit sector over recent years, as smaller organisations have seen the value in merging with larger not-for-profit providers in order to provide residential care services (Deloitte, 2016).

Home and community care services will also need to grow in the future to meet consumer demand. As discussed previously, the increasing preference for Australians to 'age in place' will result in a significant increase in demand for home care, and create opportunities for aged care providers to offer innovative new services and products such as integrated home and residential care packages. While not-for-profit providers tend to be the main providers of home and community care, our consultations indicate that some private providers are taking up opportunities to invest in this area. These providers are seeking to expand their home care services and position themselves to provide packages to particular segments of the home care market, such as high-end palliative care (Deloitte, 2016).

Given the significant investment that will be required to accommodate future growth in the aged care sector, the dynamics of the policy and investment environment across the industry will become increasingly important. As the Aged Care Roadmap (2016) highlights, growth in the aged care sector will need to be sustainable from the perspective of the government's fiscal constraints, the viability and profitability of providers of aged care services, and the affordability of these services for older Australians. It will be important for the Government and other key stakeholders to be aware of how changes to regulation of the aged care sector could affect the sustainability of the sector. Appropriate attention must be given to the investment environment in order to ensure that the sector can grow sustainably and contribute to the welfare of older Australians as well as the nation's future economic prosperity (Deloitte, 2016).

Providing appropriate accommodation for an ageing population

Australian Network for Universal Housing Design

Australian Network for Universal Housing Design (ANUHD) believe that the homes we build for today should be fit for all of tomorrow's Australians. In 2016, they requested the Australian Government regulate minimum access features in the National Construction Code for all new and extensively modified housing. Their position is that:

- Current housing designs do not work for many people including older people, people recovering from illness or injury, mothers with prams and people who have mobility difficulties.
- Greater accessibility is cheap and easily achieved—with three simple features
    - an accessible path of travel from the street or parking area to and within the entry level of a dwelling
    - doors, corridors and living spaces that allow ease of access for most people on the entry level
    - a bathroom, shower and toilet that can be used by most people, with reinforced wall areas for grab-rails at a later date.

- An increased supply of accessible mainstream housing is critical to the success of the National Disability Insurance Scheme and the Aged Care Reforms.
- In 2010, Australian housing industry leaders agreed to provide these three simple features in all new housing by 2020. With a few exceptions, the housing industry has not responded. We anticipate that less than 5% of the 2020 target will be met unless these features are regulated.
- Regulation in the National Construction Code will provide a “level playing field” for the Australian housing industry and cost and production efficiencies for everyone.
- Regulation will lead to more inclusive and sustainable communities now and in the future.
- Regulating these three simple features will allow many more people to stay in their homes, and to visit others—regardless of their age, disability or life circumstances.

In April 2017, the Building Ministers Forum (BMF) agreed to propose to the Council of Australian Government (COAG) that a national Regulatory Impact Assessment be undertaken as soon as possible to consider applying a minimum accessibility standard for private dwellings in Australia. No action has been taken.

ANUHD has written to the Hon Craig Laundy MP, Chair of the BMF, to expedite the COAG’s consideration of the proposal for the national Regulatory Impact Assessment and, on their endorsement, to direct the Australian Building Codes Board (ABCB) to complete this work in time for the National Construction Code’s (NCC’s) 2019 review.

Features of an ABC interview on universal housing design with spokespersons from BKK Architects and ANUHD include (Australian Broadcasting Commission Radio, 2016) and a further personal interview with Margaret Ward from ANUHD are listed below:

- Generally, Australia is not designing houses that can be adapted, but build luxuriously rather than smaller dwellings.
- Current guidelines don’t require private spaces to be accessible, yet 60% of dwellings will have someone in them who will have a significant disability in the building’s lifetime.
- Draft Apartment design standards (Melbourne) is calling for 25% of all apartments to have 1 adaptable bedroom and 1 adaptable bathroom as part of their design.
- New structures should have grab rails and stepless showers that don’t appear to be for aged people; stepless entries; easy movement through the house; multigenerational living (so people can stay in house longer with a carer).
- Key problem is that most housing doesn’t have an architect involved and is designed and built long before the customer comes along; they either have to go through the bespoke process, or have to convince the builder to change what is already built or is designed.
- While influential leaders are around, the Housing Industry is slow-moving and is only interested in the Point of Sale. Needs a legislative response. Most countries that are ‘ageing’ have legislated on this after trying the voluntary approach (UK example – 1999 legislation – all housing must have basic access features).
- A lot of town houses are for older generation so the market is starting to shift; people starting to demand these features.
- Social housing owners learned to design well at the beginning so that ongoing costs are much less; allows range of people to go through the house over its lifetime; 50% now built to accessible level.
- Need to convince the Building Ministers Forum to agree that there needs to be regulatory impact of assessment made on housing for people. Prime Minister has sent letter to each premier to move forward for COAG to do this.
- Industry wanted to do be self-regulated but they haven’t acted. COAG has to agree to the assessment, and once assessment done they will agree, or not, to go ahead. Assessment would likely occur via the Building Codes Board – not expected until 2022.

Livable housing design – Government approach

In 2016, the Queensland Government established the Liveable Housing Design Working Group to identify opportunities to improve the uptake of liveable housing design features in homes. The group includes representatives from the building industry, community sector and government agencies. It identified potential strategies that could be used to increase the uptake of liveable housing design in Queensland's dwellings.

The Working Group proposed seven potential strategies and asked stakeholders their views on these late in 2016. Results from the survey could not be obtained. Livable Housing Australia (LHA) has published guidelines *Livable Housing Design Guidelines Fourth Edition* to provide a practical, common sense guide to liveability.
http://www.livablehousingaustralia.org.au/library/LHAGuidlinesEditionNo4-2017.pdf

There is now a national focus that will be overseen by Master Builders Australia.

Innovative building designs for accommodation

National Seniors Australia have created a Fact Sheet – *Design For An Ageing Population*. It contains the following information on innovative housing that has been built in various parts of the world for the ageing population (National Seniors Australia, 2015):

- Across Europe governments have collaborated to set up a panel of innovation to tackle housing for the ageing population. Gradmann Haus in Stuttgart, Germany, was designed according to a 'village street' concept for people with dementia. There are 24 ground-floor apartments in two loops connected to a social area, with 18 apartments for partners on the first floor. The design takes into account that some people with dementia like to move around and explore, so the design includes spacious, barrier-free areas ideal for strolling with views to the garden.
- The De Rokade Tower Block in the Netherlands was built within a community care and nursing home complex and includes a community hub. Only people over 55 years of age are allowed to buy an apartment in the complex. This complex has a kindergarten and other facilities that can be used by the neighbourhood.
- Another building project in the Netherlands gives students rent-free accommodation in return for them spending time and doing activities with the aged-care residents. This helps to reduce the residents' feelings of loneliness, disconnectedness and other negative feelings that can be associated with ageing.
- In Switzerland, a group of four women redeveloped a former embroidery factory and turned it into Solinsieme, a building with 17 private flats, and communal spaces (kitchen/dining/meeting room, a laundry and community room) that take up 20% of the floor space. The project was initiated to provide people in the second half of their lives with barrier-free access in the spaces where they lived.
- In Australia, The Arbour near Sydney was built for people aged over 55. This retirement complex comes complete with private and shared facilities, sustainable houses with courtyards and a diverse range of social, physical and intellectual activities.

Other housing / age-friendly options include:

- well-located, well-designed apartments close to community facilities are another option for Australia's ageing population in large cities. Apartment choices should ideally be available across suburbs to enable people to stay within the community they know if they wish such as the Park La Brea experience in Los Angeles. These may become the Naturally Occurring Retirement Communities (NORC) of tomorrow (Enguidanos, Pynoos, Siciliano, Diepenbrock, & Alexman, 2010)
- 8 80 Cities (www.880cities.org) is a concept that if everything we do in public spaces is great for an 8-year-old and an 80-year-old, then it will be great for all people. Commenced by Guillermo

Penalosa (a Canadian) in 2007, who wanted to help cities “move from talking to doing”, he commenced a non-for-profit organisation with the goal of promoting walking, bicycling, parks, and public spaces as a means to building healthier, happier, and more equitable communities. Since that time, the organisation has worked with over 250 communities across 6 continents.

Laneway temporary housing in Canada

The University of Calgary placed a temporary laneway house behind an inner-city home. The 800-square-foot living quarters behind a family home is touted as a cheaper alternative to a hospital or long-term care facility (Crowther, 2016):

- The home shares a backyard with the main house, and the residents can look after some informal childcare, and are just walk across the lawn to get to dinner. Family members have the peace of mind to know that if somebody is ill, that they're just right there.
- The building is designed so that it could be self-contained or have an above ground "umbilical cord" that could tap into water, heat, electricity, cable and internet from main home.
- If the pilot project goes well, the plan is to lease future laneway homes to families — similar to other medical equipment such as a wheelchair or heart-rate monitor.
- When the unit is no longer needed, it can be moved elseshere and used by another senior.
- The compact home has a long list of features designed to make life not only easier but also safer for seniors including handrails, lit flooring, easy-access storage and reconfigurable furniture; all finished with aesthetics and design in mind.
- “Grab bars and ramps are things which are considered essential in seniors’ homes but they’re ugly and they don’t make you feel good. We wanted to achieve an invisible prosthetic with this house; or at least a prosthetic with a high design value.”
- In addition to practical supports for the physical challenges of aging, the home also features a smart screen with memory prompts for things like medication and a webcam for remote doctor consultations. The refrigerator features a smart memo board which could turn written grocery lists and reminders into electronic notes for caregivers.

The model above requires ‘laneway’ zoning in city planning which may require Councils to rezone areas of towns and cities to provide ageing-in-place options for older residents. This would provide the option for people to build on their own property in a way that would allow them to downsize and makes it possible for seniors to make good decisions for their health and well-being as they age (Crowther, Multi-generational laneway living in Calgary, 2017). Diagrams of the laneway housing are shown in Figures 31 and 32.

Figure 31: Layout of the Laneway home from above

Figure 32: A Laneway house has been installed in the backyard in Calgary, Canada

Dementiavillage

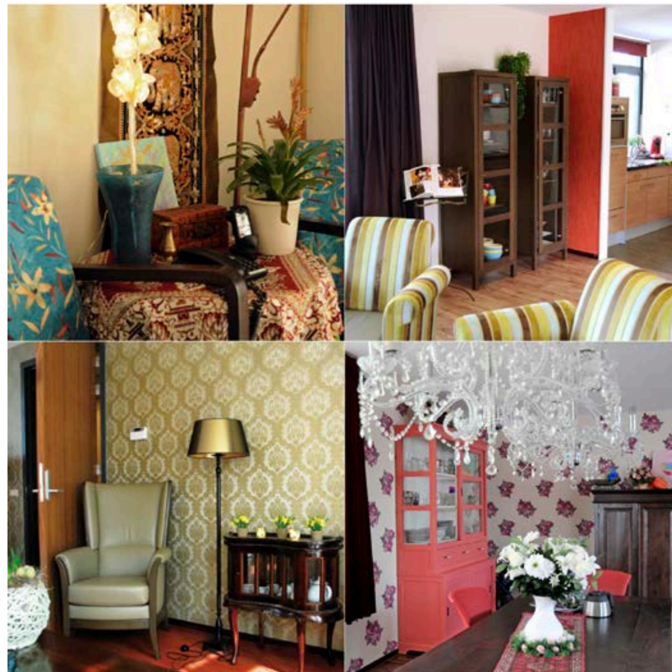
In the small town of Weesp, in Holland, at a dementia-focused living centre called De Hogeweyk, aka Dementiavillage, the relationship between patients and their care is serving as a model for the rest of the world. The idea came from a caregiver who worked with memory patients for decades. The village opened in 2009 and a similar 'village' (houses 150 patients in 23 homes) has opened in Bern, Switzerland, mimicking life in the 1950s. Hogeweyk is a solid podium of apartments and buildings, closed to the outside world with gates and security fences. Inside, it is its own self-contained world: Restaurants, cafes, a supermarket, gardens, a pedestrian boulevard, and more. The idea of the creators was to design a world that maintains as much a resemblance to normal life as possible — without endangering the patients. Figure 36 shows the 'supermarket' at Dementiavillage and Figure 33 shows the various décor styles for clients. At Hogeweyk, the interior of the security perimeter is its own little village — which means that patients can move about as they wish without being in danger. Each apartment hosts six to eight people, including caretakers — who wear street clothes — and the relationship between the two is unique. Residents help with everything from cooking to cleaning.

Figure 33: The 'supermarket' in the dementia-focused village of Hogeweyk in Holland

Other key features of Dementiavillage:

- the residents manage their own households together with a constant team of staff members. Washing, cooking and so on is done every day in all of the houses
- daily groceries are done in the Hogeweyk supermarket
- Hogeweyk offers its dementia-suffering inhabitants maximum privacy and autonomy. The village has streets, squares, gardens and a park where the residents can safely roam free. Just like any other village Hogeweyk offers a selection of facilities, like a restaurant, a bar and a theatre. These facilities can be used by Hogeweyk residents AND residents of the surrounding neighbourhoods. Everybody is welcome to come in
- people with dementia often struggle with unfamiliar spaces, colours, and even decor. At Hogeweyk, apartments are designed to reach familiar cultural touchstones, categorized into seven basic "genres" of design (refer Figure 34). Each apartment is different, catered to a particular lifestyle, so that their lifestyle is just like before. Sources: (Campbell-Dollaghan, 2014) and (Hogeweyk, 2017).

Figure 34: Apartment decor caters to various lifestyles so that village residents enjoy familiar surroundings



Alternative residential options

A number of alternative residential options have been proposed or constructed in Australia:

Intergenerational living

Homeshare matches older people with mature, responsible and reliable volunteers who provide company, security and practical support around the home in return for accommodation. Homesharing arrangements can also be put in place for people with disability.

The volunteer has to commit to being home most nights and often get one weekend off per month.

Community services groups in Melbourne’s north conduct this service (Care Connect and Spectrum Migrant Resource Centre Wesley Mission Victoria). A similar form of program is currently being trialled in an aged care home outside Amsterdam, Netherlands – reported to be working very well.

Communal houses with private spaces

Private homes purchased/shared with others: communal areas, along with private spaces – a do-it-yourself nursing home with the purpose being to allow couples to age autonomously in a space they'd never have been able to afford alone. House is financially divided so each person owns an equal portion of the estate.

Creative solutions for rural areas

The Barcoo Living Multi-Purpose Service in Blackall (the Service) provides services ranging from high and low level care to respite care, as well as home-based care. The Service is an innovative new model of service delivery which was the first service in Australia to operate under a tripartite agreement between Commonwealth Department of Health and Ageing, State Health Department and a non-government organisation, Care.

It allows the local community and service providers to work together under one management structure to plan and improve health and aged care services. This gives small communities having difficulty supporting a range of independently run services the opportunity to develop a more coordinated and cost effective approach to service delivery.

Creating Age Friendly Communities in small Towns Project

The *Creating Age Friendly Communities in Small Towns Project* forms part of a holistic solution to address aged care issues across the region. The Project, which was the recipient of $2.53 million through the Royalties for Regions Regional Grant Scheme, is integral to the Wheatbelt Development Commission's support for local governments to implement recommendations from the Central East Aged Care Alliance (CEACA) Aged Care Solution/s and the Wheatbelt Aged Support and Care Solutions (WASCS) Report.

The aims of the project are to improve the level of age-friendly infrastructure, services and inclusion across 42 Local Governments in the Wheatbelt. The Project assists local governments through a planning toolbox, a small grants scheme and a local transport solution.

The Age Friendly Audit Tool

The audit tool is a digital data capture tool (via Desktop of iPad) developed to assist Wheatbelt Councils to conduct the Age-readiness review to 'map and gap' age friendly community features and identify priority projects. It audits the location, condition and convenience of community and transport infrastructure and services, and other features applicable to the principles of Age Friendly Communities and has the ability to generate rich reports and export into a number of formats, including a Microsoft Word document or PDF.

Grants scheme

The *Creating Age Friendly Communities Small Value Grant Scheme* aims to improve age friendly community infrastructure and services in the Wheatbelt through funding projects that will enhance the quality of life as people age. All projects are expected to be completed by March 2016. $1.7M of infrastructure items were funded:

- age-friendly parks and open spaces
- a sensory garden
- improvements to footpaths, and additional disability parking.

Local Transport Solutions Project

The Creating Age Friendly Communities (CAFC) – Local Transport Solutions Project will assist to improve transport options for older residents living in the Wheatbelt. It will focus on identifying transport options from small towns to regional centres, allowing older residents across the region to

better access key services and infrastructure including health and medical, specialty retail as well as recreation and social opportunities.

Research results

An article in *Australian Ageing Agenda*, May-June 2016 issue has been summarised below:

In search of new models for rural Australia **by Linda Belardi**

The Wheatbelt Aged Support and Care Solutions project commissioned Melbourne-based firm Verso Consulting to conduct a needs analysis to identify new solutions for the region. The project report found that due to a significant shortage of appropriate aged care services, older people in the Wheatbelt were often forced to leave their communities to access care, and many of the current residential care facilities, including multipurpose sites, were outdated or built as low care facilities. Significant refurbishment would be required for many of the small facilities to meet modern aged care standards.

Following the 2014 research, which included public consultation with over 560 community members and service providers, a new model was proposed to improve aged care delivery:

- age-friendly communities
- appropriate and safe older person's housing built to universal design:
  - accessible housing built to universal design enabling ageing in place
  - allows aged care within small communities
  - relevant for event small townships, utilising local employment (for home support and packaged care) and supported by Telehealth for clinical supervision
- delivery of the full suite of community aged care
- residential aged care.

The report proposed piloting a new cluster model of accommodation and care involving:

- eight independent living units and a secure garden
- support by home care packages and 24/7 staffing
- a focus on high care clients
- a site co-located with a primary health facility
- family members being able to live with the client, or for short stays
- the delivery of dementia care if required
- the requirement for it to be block funded, which would need flexibility from the Department of Health to permit the pooling of home care packages in rural locations.

Age-friendly community plans

To plan for the future, some towns are developing Age-Friendly Community Plans. One such initiative has been carried out by a number of Shires in Western Australia. One of these is the Shire of Dalwallinu, two and a half hours' drive north of Perth.

It has been developed to ensure community members remain supported, healthy, happy and actively engaged in local community life. It followed on from work funded by the WA Government as part of the *Creating Age Friendly Communities in Small Towns Project* mentioned under Alternative Residential Options content earlier in this report.

They established an Age-Friendly Ambassadors' Group, carried out a desktop review of plans and publications, carried out an age-friendly community audit, engaged with community including focus groups with residents, and carried out community surveys. They then linked the findings with their Strategic Community Plan and reviewed opportunities to improve.

By analysing the eight domains of an age-friendly community, they identified four challenges:

- provision of suitable older person's housing
- access to in-home care and support services
- transport options within and beyond the local area
- consistent access to allied health services.

Their Plan that includes an 8-page priority action list can be accessed at:
http://www.dalwallinu.wa.gov.au/Profiles/dalwallinu/Assets/ClientData/Age_Friendly_Communtiy_Plan_-_FINAL2.pdf

Technological changes

Technology/information in aged care facilities

Aged care facilities using a variety of mobile information avenues to streamline care and allow staff to spend more quality time with residents:

- Clinical notes to record all clinical interactions in real-time whilst with the resident (for business - improves immediacy and accuracy for business; for staff - cuts down paperwork and allow more time with residents).
- Medication management via MedMobile apps to record the delivery of medication to residents
- Nurse call messaging.
- Internationally, aged care organisations providing clients with tablets to encourage social interaction, assist with medications or monitor vital signs.
- Emerging area is IoT (Internet of things) where everything is a connectable end point – includes smartphones and wearable technology on the consumer side, and managed assets, such as a refrigerator, on the provider side, with the ability to access and do a remote diagnostic on the asset. Other applications could include a person being able to control tasks: shut curtains; turn TV and air-conditioning on/off; make a video call; order food.
- Cloud based mobility platforms for organisations providing home care workers via mobile apps, location beacons: view rosters; locate and get directions to appointments; complete care notes (including voice-to-text dictation to save typing notes later); and record vehicle logs (used by Silver Chain and Able Tasman Village Association, Sydney).

The aged care sector can use technology to facilitate the labour-intensive components of service provision, and to deliver aged care services in a more efficient fashion. The Productivity Commission (2011) has promoted reforms to remove barriers to the adoption of cost-effective technologies. Aged care providers are beginning to use such technologies to increase the efficiency of their operations and improve their services to consumers. New technologies can be used to improve patient management practices and monitor residents in a less intrusive manner (Deloitte, 2016).

Allity, a residential aged care services provider in Australia, operates 44 homes across four states (Victoria, NSW, South Australia and Queensland). These homes provide around 3,700 residential care places across the nation, primarily in metropolitan areas. To provide an appropriate level of care and service to all residents in their facilities that provide expansive layouts, their technologies include:

- Systems to manage residents' care which can be tailored to individual needs as well as increasing the efficiency of staff, maximising their available time with residents.
- Care plans that can be centrally reviewed ensuring consistent high quality care is provided across the group.
- Using technology to remove institutional alarms and alert signage by replacing them with discreet phone messaging linked to nurse call systems.
- Connecting clients with their family and friends via the internet.
- Providing them with cinema experiences without leaving the home.

- A current project is the evaluation of virtual reality options to allow residents to enjoy various locations around the world from the comfort of their bed (Deloitte, 2016).

Benefit of technology in delivering aged care services

There is strong empirical evidence that increased consumer choice improves consumer wellbeing (Productivity Commission, 2011). Aged care providers that are unable to meet preferences for increasingly personalised, specialised and complex care in a more consumer-centric market may not be viable in the future. However, the provision of such services can be costly given the scale and scope of aged care packages. In order to provide these services in an efficient manner, aged care providers will access new technologies in their customer care and management operations wherever possible.

Moving towards a consumer-driven market for aged care services will encourage competition and drive greater technological innovation within the sector. This was recognised by the Aged Care Roadmap (2016), which calls for an agile aged care sector with core standards regulated by government. The use of technology in aged care services will become increasingly important as the sector moves towards a more market-based system.

Some providers are considering how technology has the potential to improve aged care quality and efficiency. CEPAR researchers have looked at the various communication, enabling and safety technologies available. They found that some are more favoured than others. For example, aged care professionals find electronic health records useful while care recipients are most fond of 'Telehealth' (e.g. for video consultations with specialists). The research also finds that design and implementation obstacles need to be overcome, including a deficiency in training and management support (CEPAR, 2014).

Technology to assist with distance and disability issues

A Queensland IT entrepreneur has developed soon-to-be-released technology that will assist aged care clients who choose to age in place, with a range of tasks. It will also allow loved ones and carers to keep in touch with the person and monitor their condition. Portable devices (tablets) with specially-designed software and connectivity will make life easier in many scenarios including:

- networking with a range of health equipment via Bluetooth so that data from blood pressure devices, blood glucose monitors etc. is automatically uploaded, and alerts sent to pre-determined persons if medical conditions go outside 'normal' parameters
- pill containers opening at specific times and alerts/messages sounding as reminders to take medication or carry out procedures - reduces the chance of overdose (especially in dementia patients) and provides peace of mind for others
- alerts sounding if a person falls via networked wearable devices
- geo/virtual fencing technology advising if a person goes beyond a designated area
- access to a Library which has reference material, a calendar and games (to enhance mental stimulation)
- the use of Community Connect – encrypted software that enables people to connect with individuals and groups to keep in touch with friends, contacts and family members, reducing anxiety and loneliness
- allowing people to control the operation of doors and other equipment – assisting people with disabilities
- video consultations allowing medical personnel to communicate with and view the person carrying out simple tests
- being able to order meals and services remotely via the software.

Technology Roadmap

In June 2017, a *Technology Roadmap for the Australian Aged Care Sector* was published. It was prepared by the Medical Device Research Institute, Flinders University, for the Aged Care Industry IT Council (ACIITC). With the aged care industry undergoing unprecedented change due to reforms, business model transformation and technological disruption, the ACIITC recognised the need for further research and exploration of the contribution technological interventions could make to realise the Aged Care Roadmap's vision for the industry.

The Technology Roadmap for Aged Care in Australia acknowledges that aged care is facing three complex and intersecting issues which bring both challenges and opportunities. The issues are:

- population ageing that has never been experienced to the same level
- the rapid development of new technologies
- reform in the aged care sector that fundamentally changes the way in which older Australians will be supported.

The Roadmap details actions for technology-enabled systems, services, information and access, assessment and a technology-literate and enabled workforce. This includes elements such as:

- establishing a national data exchange and reporting hub
- embedding technology capability as an essential requirement of aged care delivery
- a government strategy to create an open ecosystem of secure data exchange
- network to link end users with technology developers
- establishment of a technology initiative fund
- digital literacy, technology equity and awareness raising strategies for consumers, supporters and providers
- A pilot project to trial technology in assessment and care planning
- training in automated assessment tools
- pilot programs to build service capacity via the use of technologies
- increased opportunities for online learning and videoconferencing
- informal carers included in paid workforce training to enhance digital literacy/confidence.

Tools to reduce barriers

Assistive technology - LifeTec is launching a digital learning project supporting people living with dementia to stay in their own home. A range of digital resources will grow capabilities in the sector, enabling people to engage with the benefits offered by smart assistive technologies for people living with dementia.

Nurse Practitioner services to deliver care

In the mid North Coast Local Health District of NSW, a 24-month pilot project was implemented to deliver care to older people in the community within residential aged care facilities (RACFs) or at home. The aim was to reduce avoidable hospital presentations and/or re-presentations from RACFs and the community. The pilot was very successful and has been implemented and is sustained in standard business. The implementation involved:

- A new model of care being developed, allowing care to be delivered to patients within the RACF or at home.
- The service being available on weekdays and based in the ED at CHHC. It is delivered by a NP, who is a registered nurse with additional education and experience. NPs can autonomously diagnose patients, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice.

- RACF staff trained in intravenous medication and intravenous and subcutaneous fluid administration, complex wound management and other common treatments, under the direction of the NP.

Benefits are:
- reduced the number of co-morbidities and avoidable presentations to the emergency department (ED)
- improved timely access to physical assessment and treatment for older people
- reduced costs and delays associated with patient transfers from RACFs to and from hospital
- improved the continuity of care for older people in RACFs, through a holistic and person-centred approach.

8. Recommendations

The following recommendations have been determined after reviewing the research available, and after considering the printed and verbal feedback from various organisations. Any particular recommendation made, may be appropriate for action by any level of Government, industry bodies or community businesses and organisations.

Implement best practice retention and recruiting

Various staff issues are occurring in regional, rural and remote locations in the FCW as indicated on pages 24-25, 59-60 and Section 6 regarding Care workforce and allied health, and in various issues mentioned in Section 7. The various recruiting methods being implemented by other Australian and international regional, remote and rural organisations and communities could be reviewed to understand best practice and determine ways to improve current processes. In addition, processes could be implemented so that existing staff are more likely to continue in current employment.

The aim would be implement more successful processes to: reduce staff turnover and length of vacancies; attract aged card and allied health workers to regions; and improve the quality of consumers' experience and engagement in care. Organisations who employ staff that are sent to these regions may also benefit from reviewing induction information to ensure staff are adequately trained on the specific needs of rural and remote clients.

Possible review content could include:

- exit interview processes, to understand employees' positive and negative experiences
- recruitment processes including understanding why workers enjoy regional, remote and rural locations, so that marketing is accurate, informative, relevant and targeted
- collaborative recruiting – working with others to include other sectors and reduce recruitment costs. There may also be potential opportunities to partner with large industry where this exists, for example a large mining company when advertising for staff could also advertise for aged care staff for local facilities. This may encourage a family unit into the area and would have benefits not just for the aged care services but community.
- constructive networking to foster relationships with potential recruits
- community collaboration to offer the best possible 'package'
- sound induction processes
- implementing mentoring for new recruits.

Benefits could also include: reduction in staff complaints and issues; enhancing staff development and performance; and improved workplace culture; and better patient outcomes.

Such a project could be more efficient and have the best outcomes if a number of relevant stakeholders collaborated.

Create Age-Friendly Community Plans

Similar to activities of Local Government Councils in the Wheatbelt area of Western Australia (as mentioned on pages 110-111), Councils within the FCW should consider the value of creating an Age-Friendly Community Plan to outline goals and priorities to create inclusive and vibrant places to live. Collaborating with other Councils during the research and planning process could provide financial and information-sharing efficiencies.

Invest in technology that improves quality of life for those who chose to age in place

Technology is being developed that will significantly improve the quality of life for persons who choose to age in place. Currently, under My Aged Care, traditional items such as walkers and mechanical devices for lifting are covered under home care packages. The scope needs to be reviewed and expanded so that digitally assisted technology is an approved service.

Create/investigate appropriate accommodation options

Advocate for age-friendly housing design

To allow people to stay longer in their homes and age 'in place', it will be important advocate for change to Building Codes for private dwellings (refer pages 99-100). To support these changes, it would be advantageous for Councils to encourage people building new houses to adopt the three key building design features suggested by Australian Network for Universal Housing Design:

- an accessible path of travel from the street or parking area to and within the entry level of a dwelling
- doors, corridors and living spaces that allow ease of access for most people on the entry level
- a bathroom, shower and toilet that can be used by most people, with reinforced wall areas for grab-rails at a later date.

Such advocacy could be part of a Council's Age-Friendly Community Plan. Having housing that is age-friendly would be appealing to investors and buyers, possibly increasing the value of the building.

Consider innovative housing solutions for older people

It could be worthwhile for rural and regional communities to collaborate to consider the various housing/living options that have been put into place in various communities within Australia and internationally (such as those highlighted in this report). As detailed in pages 104-109, elements of the various initiatives that may be appropriate are:

- as a solution to help current older residents stay in their homes longer.
- to incorporate/adapt elements during Council Strategic Planning processes.
- to consider when developing Age-Friendly Community Plans.
- to consider whether current planning processes need to be adapted via formal Council processes to accommodate the changes required. An example of this may be rules regarding locating additional buildings on the same block as an existing residence.
- to be developed further and marketed to interested investors.

It may be more efficient that communities pool financial and personnel resources to carry out elements of this process at the same time. For example, if the same building design was agreed to by various Councils in the FCW, economies of scale would provide lower costs to build the housing required. Additionally, Councils may find that by advocating the same 'proposal' to Government stakeholders, it may be easier to navigate the inevitable issues that would occur for the initiatives to be executed in reasonable timeframes.

Investigate the feasibility of relocatable accommodation

Similar to work done in the Wheatbelt of Western Australia (refer page 111), Councils may wish to collaborate to investigate the feasibility of clustered accommodation, specifically built for aged persons. By working together and researching costs to build appropriate accommodation that could

then be serviced efficiently by aged care providers, economies of scale may make the project attractive for investors, or to gain funding.

Relocatable houses could be the most appropriate type of building to service current and growing needs, and then, should future requirements change, they could be moved to another setting.

Shops incorporated into aged care facilities

Where economically viable, it would add value to aged persons and loved ones to have a range of shops as part of aged care facilities so that residents could easily visit a pharmacy, doctor, or other required services. Some facilities have incorporated an on-site hairdresser as part of their service offering, but this could be extended to include a broader range.

Meet the needs of Aboriginal and Torres Strait Islander people

Throughout the report, various issues were raised (particularly under the topic of Services for/needs of Indigenous Australians on pages 46-51), about the need to increase services for Aboriginal and Torres Strait Islander People.

The issues raised relate to two key requirements:

- The need to increase training of non-Indigenous workers employed in the aged care sector and allied health professionals in cultural information, to understand the unique pattern of need of ageing Aboriginal and Torres Strait Islander people and effective approaches when developing culturally appropriate and responsive care.
- The need to increase the numbers of Indigenous and Torres Strait Islander people that are employed in the aged care sector and as allied health professionals.

It would therefore be advantageous if businesses, organisations and all levels of Government review their policies regarding these two issues.

Encourage skill development in rural and regional areas

Feedback on the aged care and allied health workforce, as well as responses to the *Future of Aged Care Sector Workforce* inquiry (page 23-24 and Section 6 of this report) highlighted a variety of issues that concerned stakeholders.

To address some of these issues Economic Development groups, Chambers of Commerce, Councils, organisations and businesses could consider attracting/collaborating with industry groups and Registered Training Organisations to run aged care-specific training in their regions, encompassing entry-level training as well as professional development for nursing staff, and allied health professionals.

This would not only provide opportunity for jobs growth and pathways for unskilled/unemployed people, but allow staff to develop their knowledge and skills without having to travel to undertake training. The initiative would be a staff retention strategy as workers would be less likely to feel they are missing out on opportunities that are normally only available in metropolitan areas.

Prevent unnecessary and costly hospitalisations

In addition to expanded use of Telehealth, State or Federal Government should consider funding equipment such as mobile X-ray machines and other Models of Hospital Avoidance (refer comment on page 60). This would allow Aged Care Nursing Homes and other service providers to purchase such devices so that diagnostics could occur without the client having to leave the facility.

By extending primary and secondary care in nursing homes, it would also reduce the stress of relocation for the client (and their loved ones), and the considerable costs of Ambulance transfers and hospitalisation. The devices would also require regional staff to be trained of regional staff in the use the portable devices.

Improve communication, information and collaboration

Content in the report highlighted a range of issues on communication, lack of information (or difficulties for the ageing to easily access information) and collaboration. To assist overcome these problems the following are suggested:

Provide community-specific information on aged care

Information flyers could be developed by relevant LGAs or State Government, listing age-specific information and services relevant for, provided in, or visit the community. This would assist issues mentioned in pages 24 and 93. Once PDFs are developed, printable versions could be distributed through service providers, GPs, libraries etc. so that aged persons who can't access computer systems don't miss out.

This would ensure that:

- Aged persons are aware of what is available for them to access
- All stakeholders (including GPs, nursing staff, government personnel, service providers and allied health professionals working in the area) are aware of all the services available
- Make loved ones aware of the ageing process so that they can make more informed, and appropriate decisions when it comes time to contribute to end-of-life decisions.

It would also appear from stakeholder feedback that many elderly people do not have Advanced Health Directives and Enduring Power of Attorney documents in place (refer page 60). As this puts stress on loved ones when health issues arise, a campaign highlighting the importance of these documents could be helpful.

Regular review of the My Aged Care website and provision of alternative information

Throughout this document information from various sources includes comments and criticisms regarding the My Aged Care Website. It should be noted that in the last few months the website has been updated so it is designed and constructed in accordance with the World Wide Web Consortium's Web Content Accessibility Guidelines 2.0 standard, making the Website usable for a wide range of people with special needs. It includes links to other languages and where to find interpreters.

While comments about the accessibility of the Website, or suggestions for improvements are encouraged on the Accessibility page, it might be appropriate for Government to ask for feedback during interactions with industry representatives, and implement required changes 6-monthly as a minimum.

As not every person has the ability to access the Internet, other sources of information need to be available for aged persons and their carers. This could include a combination of:

- visits from My Aged Care personnel to regional, rural and remote areas at least annually so current and future consumers of aged care services are aware of assistance when it is required
- forms and documents being available and sent to those who phone and request information packs.

Partner and collaborate with universities

Similar to the partnership between CQUniversity Australia and Mercy CQ for the proposed intergenerational village in Gladstone, there may be value in exploring opportunities to blend training with aged care service provision and infrastructure development that brings economic benefits.

A partnership model of service provision would provide a steady flow of students, and eventually staff, by providing students with placements. This would also support evidence-based contemporary care models and ensure that training needs are being met, as well as the necessary research evidence being produced and applied.

Consider innovative ways to solve infrastructure for service provision

Infrastructure planning in smaller regional towns and rural areas should consider innovative ways to blend the community's recreational and aged care needs. Infrastructure can be designed so that the buildings are multi-purpose and can become Community Hubs.

Visiting aged care service providers can use the infrastructure to congregate on a regular basis (e.g. monthly), saving aged persons and their carers effort and time travelling for various appointments and information.

Encourage better communication/collaboration between providers

Feedback from stakeholders (refer pages 24, 60-63, 74) indicates that care is disconnected and there is poor communication and collaboration between providers and within the aged care sector. The responsibility to improve this situation lies with all stakeholders.

Issues include: multiple information systems; a need for referrals to be electronic and compatible with GP software; poor awareness of available services by provider and patient and the need for collaborative planning, design and delivery; a lack of integration of GP services with other services resulting in poorly coordinated and duplicated care; and multiple funding streams/sources resulting in duplicating services.

Plan for the future

Stakeholders in the FCW region need to consider the various opportunities that Australia's ageing population presents. To meet the needs of the FCW's share of 76,000 additional aged care places that will be required throughout Australia over the next decade (refer page 22 and Sections 2 and 3), significant investments will be required.

This will also include developing goods and services to meet the needs and preferences of ageing 'baby boomers', not only when they are in Residential Aged Care, but also to provide care while they age in place. The range of requirements encompasses not just personal care and general health requirements, but also transport, technology items, recreation etc.

Work collaboratively to develop relevant models of care

Many comments were captured in the report from stakeholders concerned about services for rural and remote clients. It will be important for service providers to collaborate to innovatively develop models of care that will work in rural and remote areas and advocate on behalf of aged people to the Federal Government to consider these so that:

- financial and efficient services can be provided to clients
- they receive equitable care and choices where possible
- the challenges they face are reduced, thereby relieving stress
- transport issues are reduced

- accessibility to specialists is increased.

Based on the Accessibility/Remoteness Index of Australia (ARIA), different models of care will be required for the various geographical ‘segments’, so a coordinated approach will be required to change the current system that many appear to find inequitable.

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