ALZHEIMERS AUSTRALIA

Submission to the Productivity Commission

Australia's Health Workforce: Productivity Commission Position Paper

November 2005

EXECUTIVE SUMMARY

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Alzheimer's Australia supports the initiatives proposed in the Productivity Commission's Position Paper on *Australia's Health Workforce* to introduce mechanisms that will foster national consistency in shaping Australia's health work force.

Given the terms of reference of the study, Alzheimer's Australia is concerned by the narrowness of the interpretation of Australia's health workforce in the Position Paper and its proposals. Specifically, given the demand for innovative and integrated models of care which will result from the dementia epidemic that will occur in Australia in the next half century as a consequence of our demographics, the Paper's failure to take account of the broadest possible range of health workers in its study is of concern. For example, exponential growth in aged care facilities and community care will require growth in numbers of allied and ancillary health workers and workers from the community services sector who provide health services.

Alzheimer's Australia suggests that the current Position Paper not be regarded as definitive but rather as a work in progress. In this spirit, we believe that further work should be undertaken to provide a holistic integrated approach to the future composition and needs of, and for, the health workforce.

Alzheimer's Australia strongly recommends that:

- Workforce issues in the community services sector which impact on delivery of health services are researched in order to ensure that sufficient funding is available to ensure supply of health workers with community services qualifications.
- A complementary study is undertaken of health workforce delivery models which will address the interdependence of the community services and health sectors and their workforces. This study should take into account the roles of allied health workers, ancillary health workers and workers with community services training in health settings other than the clinical model.

I would like to thank Helen O'Brien, the National Training Manager, Alzheimer's Australia for her work on this submission.

Glenn Rees
National Executive Director

8 November 2005

Introduction

This submission has been prepared by Alzheimer's Australia in response to the Productivity Commission's Position Paper (September 2005) on *Australia's Health Workforce*.

Alzheimer's Australia (AA) is the national non-government peak body in Australia representing people living with dementia and their families and carers and provides leadership in policy and services. Our constituency includes people with dementia, people at risk of dementia, their families and carers, professionals working in support of people with dementia, residential and community care providers.

Alzheimer's Australia notes that the recently released Productivity Commission's Position Paper is the outcome of "a research study to examine issues impacting on the health workforce including the supply of, and demand for, health workforce professionals…"[1] The terms of reference further add" The study is to be undertaken in the context of the need for efficient and effective delivery of health services in the environment of demographic change, technological advances and rising health costs"[2].

Alzheimer's Australia commends the Commission on its vision to ensure high quality of health care with safety through an integrated approach to the health workforce in terms of need, education and training, registration, accreditation and financial arrangements, as the underlying basis for the proposals in the Paper. The move towards national consistency by proposing over-arching agencies that foster innovation, reduce "silos" and separate governance arrangements from requisite input of professional expertise in areas such as accreditation and registration is a big step forward in shaping a health workforce for future and emergent needs.

We welcome the concept of an advisory health workforce education and training council which is intended to fill the currently existing gap in developing a holistic agenda for education and training for the entire health workforce. However, we are concerned that this body must establish a broader mandate than that of the Commission when undertaking this study. As supporters of the need for ongoing examination and reflection on the changing nature of the health workforce, Alzheimer's Australia can see that the proposed advisory health workforce improvement agency is a potential forum for clear and transparent examination of issues of national significance and act as a vehicle to drive reform.

In the context of the above terms of reference, Alzheimer's Australia wishes to provide comment on:

- The demographics of dementia
- Supply of, and demand for, health workforce professionals
- Government initiatives to support dementia and aged care
- Efficient and effective delivery of health services

[1] Productivity Commission 2003 *Australia's Health Workforce: Productivity Commission Position Paper*, Productivity Commission, Canberra p. iv
[2] Ibid p. iv

The demographics of dementia

It is disappointing that, despite submissions from a number of expert organisations, dementia receives no mention in its own right as a special need for consideration in the Paper. In the context of the Commission's terms of reference, dementia is one of the most significant issues which will impact on the health workforce.

In a background paper prepared for Alzheimer's Australia 2005 *National Consumer Summit – Making a Difference*, the position is clearly stated: "In line with the structural ageing of the Australian population, the incidence and prevalence of dementia is expected to rise exponentially over the coming years. Currently, around 185,000 Australians are estimated to be living with dementia. After the age of 65, the likelihood of being diagnosed with dementia doubles every five years. With the projected rise in Australia's aged population, the number of people living with dementia is estimated to be around 265,000 in 2020 and 500,000 by 2050 "[3]. Quality of care for these individuals is linked with the model of care being utilised, in a continuum from professional to self managed care.

Given the seriousness of this issue, the impact of various types of service delivery models on health workforce planning that ensures quality care is essential. The Commission has stated that consideration of models of care is outside of the terms of reference; their emphasis is on mechanisms for the health workforce to shift and change as models of care change. This leaves the mechanisms for consulting and driving reform in models of care, particularly non medico-centric, unclear in terms of their alignment with the proposed national agencies.

Whilst Alzheimer's Australia acknowledges the Commission's view that their concentration should be on mechanisms and governance issues that will drive workplace innovation and change in a nationally consistent manner, we believe that further underpinning work, such as an in-depth study of models of care and their implications for the workforce needs to be done in order to inform the work of the proposed agencies.

Supply of, and demand for, health professionals

The paper would have benefited from terminological clarity on what is understood by the "health workforce" as distinct from the "health sector" or the" health profession" or "health workers" or "health industry". Another term requiring definition is "allied health workers".

Whilst draft proposals 4.1 and 10.2 point to the need for innovation in the health workforce, there is no detail on how its multitudinous composition will be addressed. The reader must assume that the proposed workforce education and training council will act in a complementary manner with the proposed advisory health workforce improvement council to ensure that the whole constituency, including vocational education and training (VET) trained workers, is properly accounted for in workforce planning and innovation.

[3] Alzheimer's Australia 2005,'A brief overview- Australian Government support for ageing research and dementia', *Alzheimer's Australia National Consumer Summit – Making a Difference*, October 2005, AA, Canberra, p. 1

The significance of the interdependence of the community services and the health sectors and their workforces has not been sufficiently addressed. Alzheimer's Australia strongly supports any measures to increase the supply of health professionals as proposed in the Paper, for example the need for more Registered Nurses; however, this area of skills shortage should be considered in the context of changing workplace roles and client demands. We strongly urge the Commission to undertake a further, complementary study of the health workforce delivery models which will take into account the roles of allied health workers and workers with community services training in health settings other than the clinical model. We believe that increasing demands for aged care in particular, will drive considerations of changes in skill mix.

The requisite expansion in health education and training proposed in the Paper takes no account of the many roles and functions in providing allied health services covered by the Health Training Package, such as ambulance services and health technicians. With increasing demand and rising costs of health service provision, there needs to be attention paid to adequate supply of these workers. Similarly, the Paper does not address the importance of supply of workers with Community Services package qualifications who provide many essential services that should be seen as contributing holistically to the support of a client's health care; for example, such as providing carer support which is responsive to the specific nature of dementia, in the case of Aged care workers. The need for community services workers with training in Aged care to provide care in residential and community settings and the additional pressures of servicing rural or remote communities, means that the expansion of health professional education cannot be considered in the limited sense contained in the paper if the end concern is quality of care for a client. The proposed model of considering the needs of health professionals by enhancing transparency and contestability of (higher education) institutional and funding frameworks and establishing a single national accreditation agency that may be later extended to vocational education and training (VET) does not support proper workforce planning or take account of supply and demand. The Community Services and Health Industry Skills Council, in its May 2005 submission to the Productivity Commission, made the point clearly:" In the health industry, only 47% of workers have qualifications delivered by the higher education system. In community services, the figure is 17 %".[4] On this basis, the Paper's concentration on University and postgraduate education takes account of some, not all of the issues.

We recognise that the Commission has interpreted its terms of reference not to include community services workers and strongly urge that the issue of demand for workers with community services training be addressed in a future study. A recent paper to the Aged care Workforce Committee, a working group established to provide the Department of Health and Ageing with advice regarding the implementation of various initiatives announced under the current Budget package, *Investing in Australia's Aged Care: More Places, Better Care*, identifies and discusses various issues relating to the Community Aged care workforce which would assist in informing such a study (Appendix 1).

[4] Community Services and Health Industry Skills Council 2005 *Submission to Productivity Commission: Health Workforce Study – Issues Paper* , CSHITC, Sydney, p. 4

Workforce Planning

Evidence gathered by the Department of Employment and Workplace Relations indicates that:

- The Australian workforce overall is ageing and shrinking:
- The available workers are growing older.
- There are fewer younger workers entering the market.
- We are living longer, retiring earlier, and having fewer babies.

Consequently, employers are facing a worker crisis with more people expected to leave the workforce than join over the next decade.

In this context, the competitiveness of attracting people to the health industry is questionable; as both the health sector and the Aged care component of the community services sector which also works within the health industry are often characterised by:

- Lack of attractiveness to young people
- Low remuneration
- Demanding working conditions
- Difficulties in maintaining currency of skills
- Difficulties in obtaining work release to undertake training/re-training.
- Low rates of return to the workforce
- Female domination, resulting in breaks from work and part-time work

The Paper does not make any links to existing Government initiatives aimed at addressing these issues, such as:

Mature Aged Worker Incentive

The Australian Government has a broad commitment to providing support for mature aged workers. Disadvantaged mature aged workers face particular barriers to employment and training. Therefore an employer of a disadvantaged worker (aged 45 years or older) may attract a special $825 Mature Aged Worker Commencement Incentive and an $825 Mature Aged Worker Completion Incentive. Many employers are unaware of these incentives.

The Australian Government's Mature Age Employment and Workplace Strategy (MAEWS).
MAEWS seeks to improve the labour force participation of mature age Australians as a key strategy for managing the impact of demographic change. Currently, this strategy is being implemented by some Australian Government Departments; a consideration of how the scheme might act as a model to target specific shortages of workers in the health workforce (broadly defined) may be useful.

Rising health costs

Given the projected escalation in numbers of people with dementia in Australia over the next 50 years, the associated health costs can be expected to rise exponentially. Access Economics in its report *The Dementia Epidemic: Economic Impact and Positive Solutions for Australia* identified three types of costs associated with dementia. When comparing direct health system costs of mental disorders in 1993-94, dementia accounted for 23.6% or $714 million, accounting for nearly one quarter of all mental health system costs in 1993-1994. By 2002, the costs of dementia were estimated as $3.2 billion, due to a 62% increase in the number of people with dementia over the period, a 37% increase in costs. Given the rapid growth of dementia prevalence, direct health care costs are estimated to grow by 84% to 6.0 billion by 2011.

The health workforce has seen some changes in responsibilities to take account of realities and economies e.g. in allocating some responsibilities from Registered Nurses to Enrolled Nurses. This trend of reviewing the role and nature of the workforce can only be expected to continue in order to strive for greater impact and efficiency. The concept of the health workforce will need to focus more strongly on prevention, early intervention and health, incorporate multiple models of service and actively pursue revision of responsibilities in the light of changing technologies and workforce training/up skilling.

Alzheimer's Australia also strongly believes that, in any consideration of widening the range of delegated services, the needs of the consumer must be paramount in driving the decision making process.

Conclusion

Whilst we welcome the direction of the proposals contained in this Report, we remain concerned that the focus on health professionals is too narrow and therefore will not address the workforce composition or variety of models of care that will be necessary to care for the rapidly increasing numbers of people with dementia in Australia. We urger that a mechanism be developed for further work to be done on the changing nature of work, roles and responsibilities in the health profession in its broadest sense, and that these continue to be monitored in order that change may be nationally implemented with maximum efficiency and cost effectiveness and best practice in utilisation of our workforce resources.

Glenn Rees
National Executive Director

8 November 2005

References

Access Economics 2003, *The Dementia Epidemic: Economic Impact and Positive Solutions for Australia*, Access Economics, Canberra.

Alzheimer's Australia 2005,'A brief overview- Australian Government support for ageing research and dementia', *Alzheimer's Australia National Consumer Summit – Making a Difference*, October 2005, AA, Canberra.

Community Services and Health Industry Skills Council 2005 *Submission to Productivity Commission: Health Workforce Study – Issues Paper*, CSHITC, Sydney.

Productivity Commission 2003 *Australia's Health Workforce: Productivity Commission Position Paper*, Productivity Commission, Canberra.

The Community Aged Care Workforce – Discussion Paper

Prepared for the Aged Care Taskforce Meeting, Canberra, 12 October 2005 by:
Glenn Rees, Alzheimer's Australia and Colleen Doyle, La Trobe University

Background

- Worldwide there is concern about the shortage of suitably qualified workers who are interested in working and staying in the aged care workforce. In Australia, while this concern has resulted in a number of recent reports and policy initiatives, many of these initiatives have concentrated on the residential aged care workforce, and on shortages of nurses and doctors.

- With increased emphasis in Australian health policy on community health care, what information do we need about the workforce providing direct care to elderly people living in their own homes?

- A recent Senate report on Quality and Equity in Aged Care (June 2005) identified a number of key areas that have yet to be addressed in describing and developing the community care aged care workforce. In their submission, the Queensland government noted that "*there is a paucity of information about the community care workforce*" (p.10, 2005). The Senate report received submissions indicating that there was high turnover of workers especially in rural areas, although there are few studies to support these submissions. It was further submitted that in order to ensure that older people remain in their homes there is a need for a more highly skilled workforce.

- "*There is no comprehensive data source available for the community aged care workforce in Queensland that would enable Queensland Health to identify shortages of skilled staff, turnover rates or occupational categories/geographic areas where shortages are particularly severe*" (p.10, 2005)

- The National Aged Care Workforce Strategy (2005) provided an overview of work that has been undertaken on the aged care workforce. The strategy was concerned principally with workforce issues in the residential aged care sector, and focused on the nursing workforce. It also indicated that there is a lack of specific research into other aspects of the aged care workforce. The Strategy identified seven objectives for the development of the residential aged care workforce with desired outcomes and strategies to achieve the outcomes. Application of these development strategies to the community care workforce requires a sound information base on the current structure and dynamics of that sector.

- The Senate report (2005) noted: "*After so many years of reports and reviews, the [National Aged Care Workforce] Strategy is limited in scope as it is directed at residential aged care and does not encompass all areas of the aged care workforce. The Committee finds this a particularly disappointing*

aspect of the Strategy given the Commonwealth's policies aimed at keeping older people in their homes for as long as possible." (p.29, Senate Report, 2005)

- In a recent study of the residential aged care workforce in Australia, a number of issues of concern to workforce development and retention were raised in the face of persistent reports of difficulties in recruitment and retention in aged care, and in the tightening labour market in Australia generally (National Institute for Labour Studies, 2004). Therefore there is substantial information on residential aged care workforce that could be used as a comparison with the community care workforce.

- The Productivity Commission is undertaking some analysis of the health workforce, but with an emphasis on higher qualified staff such as doctors, nurses and allied health care workers.

- In order to provide adequate community care for older people who wish to remain in their own homes, Australia needs a vibrant, well trained community workforce with supports and infrastructure that recognises and values its importance.

Questions for discussion

In discussing the following questions, the Committee may wish to consider order of priority in a plan of action to address the questions (what is most urgent to address).

Workforce profile questions

1. What data is needed to facilitate effective workforce planning for the community care workforce?
2. What is the workforce profile for direct care workers providing community services?
3. What are the main influences on satisfaction of community care workers?
4. What incentives are there to work in community jobs rather than residential or acute care?
5. To what extent do community care workers come from residential care, work in both sectors or move from one sector to the other?

Planning questions

6. How are community service providers meeting the strategic objectives outlined in the National Aged Care Workforce Strategy?
7. What strategies can we put into place to ensure that the impact of shortages of care workers are minimised in the community care sector in the future?
8. What workplace practice models are being used currently?
9. What strategies are being used to attract and recruit staff for community care?
10. What strategies are being used to retain staff for community care services?
11. What strategies are being used to create and communicate a preferred image?

Education, training and skills questions

12. Are direct care workers in the community adequately prepared to work with people with dementia and their carers?
13. How are best practice principles being supported for community care workers?
14. What competency standards in dementia care are being used in community care settings?
15. What is the skills profile for case managers delivering aged care packages such as EACH, CACP, and EACH Dementia packages?

Regional, remote and CALD questions

16. What are the issues in regional or remote areas for the community aged care workforce?
17. How high is staff turnover, recruitment and retention of community care workers in the country compared with urban areas?
18. What are the special needs of CALD workers in the community?

Consumer input questions

19. What are the preferences of recipients of community care about the nature of the community care workforce?
20. What effect does the age, background, training and cultural background of the community care worker have on satisfaction of the consumer with service provided?

The way forward

To redress this imbalance in current knowledge of the community care workforce, we propose that the Committee considers commissioning a series of studies along the lines of the following:

1 – **A review** of background information such as ABS workforce data, to identify the main categories of workers in the community care field and inform the development of a suitable sampling frame and survey questions.

2 – A **survey** of home and community care providers. This survey will ask community care providers how they are currently addressing the key objectives identified in the National Aged Care Workforce Strategy and provide basic information about the profile of direct care workers in each organisation.
The survey will also provide a profile of the volume and qualifications of community aged care workers, as well as giving details on staff turnover, recruitment issues, management, strategic planning undertaken and skills profiles particularly in dementia care.

3 – A **survey** of individual direct care workers in community aged care settings

The survey content will include demographic details; professional training; work satisfaction; working conditions eg job security, flexibility, hours worked; crossover between residential and community care.

4 – A **qualitative study** of consumer perspectives on workforce issues. Interviews with older people receiving community care services and with a sample of community aged care workers from culturally and linguistically diverse backgrounds (CALD).

5 - A **forum** conducted in each state to present the results to relevant stakeholders in the Community Aged Care sector such as local government, other service providers and Peak bodies. The aim of the forums will be to assist in developing the response of the community care sector to the National Aged Care Workforce Strategy.

Recommendation

The Aged Care Workforce Committee discuss this paper.

Colleen Doyle
Glenn Rees
22 September 2005