Home Care Package Environmental Scan

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Victorian Healthcare Association
Vision • Value • Voice

CONTENTS

ABBREVIATIONS

ACAT	Aged Care Assessment Team
ACPR	Aged Care Planning Region
AIHW	Australian Institute of Health and Welfare
CCW	Community Care Workers
CDC	Consumer Directed Care
CHSP	Commonwealth Home Support Program
DHS	Department of Human Services (Australian Government)
EBITDA	Earnings Before Interest Tax Depreciation and Amortisation
EBT	Earnings Before Tax
HCP	Home Care Package
MAC	My Aged Care
MPS	Multi-purpose Service
NDIS	National Disability Insurance Scheme
NPBT	Net Profit Before Tax
PAYG	Pay As You Go
SRHS	Small rural health service

EXECUTIVE SUMMARY

Background

The Victorian Healthcare Association (VHA) commissioned an environmental scan of the Home Care Package (HCP) sector for its members. This document provides an overview of information relevant to public sector organisations which are evaluating their positioning in relation to the HCP sector. The material presented in this document covers the following topics:

- Consumer and provider responsibilities
- The HCP sector
- Financial characteristics of the HCP sector
- Trends in the uptake of HCPs
- Fee arrangements and means testing
- Scope of delivery in the public sector
- The HCP workforce.

Approach

Research into these areas was informed by several information collection processes. These included a desktop documentation review, interviews with four HCP providers, consultation with VHA's reference group, and an analysis of relevant sector data, including material published by the Australian Institute of Health and Welfare. Information gathered through these processes was examined and key findings are presented in this document.

Findings

The HCP market has undergone considerable transformation over the last decade. A series of reforms including a shift towards consumer directed care (CDC) and decentralisation of planning and decision-making processes and service delivery responsibilities has changed the roles providers play in the administration of packaged care and increased the competition to deliver HCP services. In addition, the emergence of new community care programs and a shift in the demand for nursing staff has altered the manner in which providers deploy their workforce. These changes have a range of implications for current and prospective participants as summarised in the key findings of the project, presented on the next page.

KEY IMPLICATIONS FOR PUBLIC HOME CARE PACKAGE PROVIDERS

Key implication 1	The focus on CDC has increased the administrative load placed on providers. In addition to service delivery, providers have responsibility for: generating home care agreements, providing and explaining the Charter of Aged Care Rights to consumers, supplying consumers with a written care plan, developing individualised consumer budgets, and providing monthly consumer statements. Prospective providers should consider the necessary resourcing and budgeting required to complete these activities.
Key implication 2	Prior to entering the sector, public HCP service providers should analyse the level of competition and density of HCP consumers in their catchment regions. Strategic planning should also describe how entrants propose to attract and retain consumers and how they can develop a service model that allows for a level of profit acceptable to the organisation.
Key implication 3	Organisations offering complementary community services (e.g. National Disability Insurance Scheme, Commonwealth Home Support Program) may achieve operational efficiencies by using their existing workforce and systems to meet the needs of HCP clients.
Key implication 4	Providers must be willing to make investments in areas such as marketing and training of staff to ensure long term success.
Key implication 5	Providers seeking to enter the sector should consider the expected growth in HCPs over the medium to long term.
Key implication 6	When determining potential future demand in a geographic area, providers should consider the projected population over 70 and the number of part- and full-time pensioners expected to be residing in the region.
Key implication 7	In order for a fee schedule to be viable it must: / Cover all operating costs to avoid running at a loss. / Be competitive in the sector – the requirement for providers to publish their fees in a standardised template from 1 July 2019 will enhance the ability of consumers to directly compare provider fees. / Display affordability for consumers – a majority of HCP consumers are part- or full-time pensioners. Provider fees must be perceived as affordable for these consumers. Feedback from providers indicated that one way for public providers to achieve affordability was to keep costs down by exploring the potential for innovative service models (e.g. using staff across multiple programs, forming partnerships and consortiums with other health services).
Key implication 8	There is a high level of competition for consumers by non-government providers in metropolitan regions. Interviewed providers said that this presents a challenge for new entrants as attracting consumers can be difficult and may require a significant marketing investment. Operational efficiencies increase with larger numbers of consumers within a defined geographic catchment.
Key implication 9	Public HCP service providers hold a number of strategic advantages over private and not-for-profit organisations that can be used to attract and retain sector share in their respective catchment regions. However, new providers must also consider barriers that may affect successful entry into the sector including the constantly changing legislative and administrative requirements, high levels of market competition, managing consumer expectations, and lowering levels of sector profitability.
Key implication 10	Potential entrants must consider their reason for sector participation. Some providers engaging in the HCP sector are not profit focused but operate based on the needs of the community and to deliver a high-quality service.
Key implication 11	The HCP program may complement existing services offered by public health services and provide additional benefits to the organisation that should be considered, such as client retention.
Key implication 12	Ensuring access to a stable and competent workforce that understands the HCP sector will contribute to successful operation in the sector. This may be difficult given the increasing skill shortages faced by the industry.
Key implication 13	Prospective providers must determine whether they wish to operate under a direct care, brokered or consortium workforce model or a combination. Employment of a direct care workforce requires determination of the appropriate staffing mix and appointment of the appropriate contract awards for staff.

Home Care Package Environmental Scan

1 / INTRODUCTION

The Home Care Package (HCP) program provides a range of ongoing personal care, support services and clinical care services that aim to enable older Australians to remain living at home. Under this program eligible Australians can receive assistance with nutrition, hydration, meal preparation, continence management, mobility management, nursing, allied health, transport and management of skin integrity.

HCP services are delivered by a range of organisations across Victoria. Service providers can be categorised into public (14 per cent), private (21 per cent) and not-for-profit (65 per cent) organisations. Public sector HCP providers in Victoria are comprised of public hospitals, registered community health services, multi-purpose services (MPS) and small rural health services (SRHS).

The HCP program bridges the gap between the low-level services available through the Commonwealth Home Support Program (CHSP) and the high level of support available in residential aged care. HCPs are categorised by levels (1, 2, 3 and 4) with funding and care intensity increasing with each level.

Over the past five years significant reforms have been introduced by the Commonwealth Government with the aim of increasing choice, flexibility and access to services for HCP consumers [1]. Given the dynamic nature of this sector, VHA has produced this environmental scan to assist members with their understanding of the HCP sector and to make decisions regarding their involvement. This resource was developed through a number of processes including a review of relevant documentation, analysis of HCP data describing distribution across Victoria, completion of interviews with four public HCP service providers (a large regional provider, a regional community health service, a rural multi-purpose service and a small rural health service) and consultation with VHA's reference group.

This document explores six topics relevant to public HCP providers, including:

- Consumer and provider responsibilities
- The HCP sector
- Financial characteristics of the HCP sector
- Trends in the uptake of HCPs
- Fee arrangements and means testing
- Scope of delivery in the public sector
- The HCP workforce.

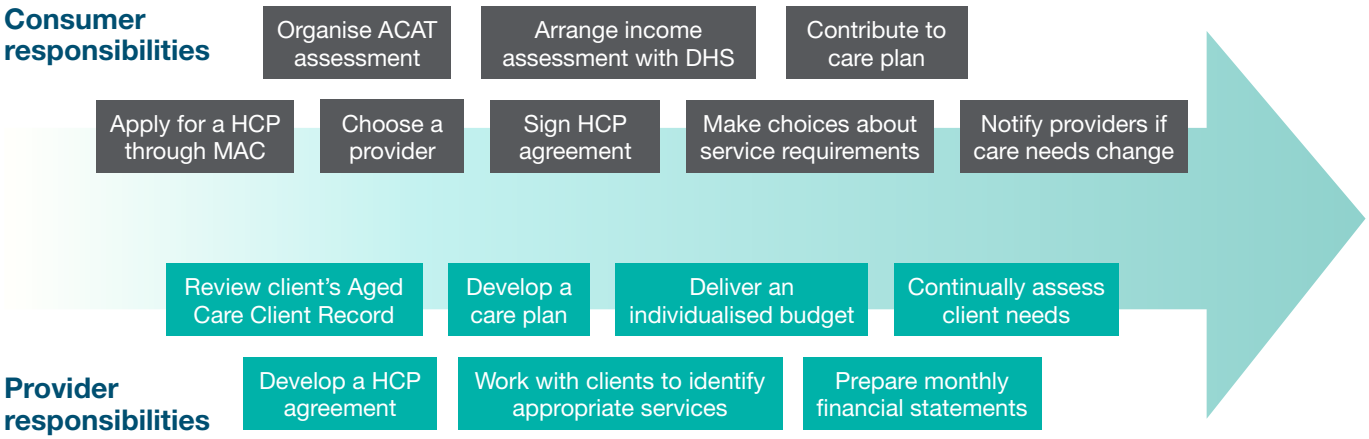
Additional information on each of these areas is available in a separate technical paper.

2 / CONSUMER AND PROVIDER RESPONSIBILITIES

What the published information tells us

With the introduction of the Consumer Directed Care (CDC) reforms in 2015 and the subsequent Increasing Choice in Home Care reforms in 2017, the Commonwealth Government has sought to decentralise the HCP sector and empower consumers to make choices regarding their care. In doing so, the administrative requirements faced by providers have been altered. The current roles and responsibilities of providers and consumers are summarised by Figure 1.

Figure 1: Consumer and provider responsibilities



What case study providers told VHA

'The constantly changing legislative environment continues to increase the administrative burden placed on providers.'

- Large regional provider

'Operating in the HCP sector requires a lot of organisational structures to be in place. Staff have to be trained in relevant legislation, new policies need to be developed …'

- Small rural health service

'Emerging technologies may offer the opportunity for efficiencies to be created in the years to come.'

- Large regional provider

Implications for Victorian public HCP service providers

- The focus on CDC has increased the administrative load placed on providers. In addition to service delivery, providers have responsibility for: generating home care agreements, providing and explaining the Charter of Aged Care Rights to consumers, supplying consumers with a written care plan, developing individualised consumer budgets, and providing monthly consumer statements. Prospective providers should consider the necessary resourcing and budgeting required to complete these activities.
- Existing and new entrants must also consider reform and legislative changes that affect the HCP operating environment. Examples of changes include: the new Aged Care Quality Standards (1 July 2019), the Charter of Aged Care Rights (1 July 2019), the standardised fee schedule template to be published by all providers on the My Aged Care website (1 July 2019) and the potential for change arising from the findings of the Royal Commission into Aged Care.
- Providers should consider creating administrative efficiencies by combining the requirements of HCPs with other community programs run by the organisation to ensure staff time is used effectively.

A detailed description of provider and consumer responsibilities is provided in the technical paper (Section A).

What the available information tells us

The development of packaged care to support older people living at home has occurred over a quarter of a century. The first planning target for care package places was introduced in 1993. This set a target of 7.5 home care places per 1,000 people aged 70 years and over. Since then the goal for care package availability has been repeatedly adjusted upward, to the point where intended availability is now six times the original target, or 45 HCP places per 1,000 people aged 70+ years [2].

By 30 June 2018 the total number of HCPs in Australia had grown to 90,646 (an increase of 95 per cent from 30 June 2008) with 23,205 (25.6 per cent) being offered in Victoria [3] [4]. This is in line with the 25.5 per cent of the 70+ population that currently resides within Victoria [3].

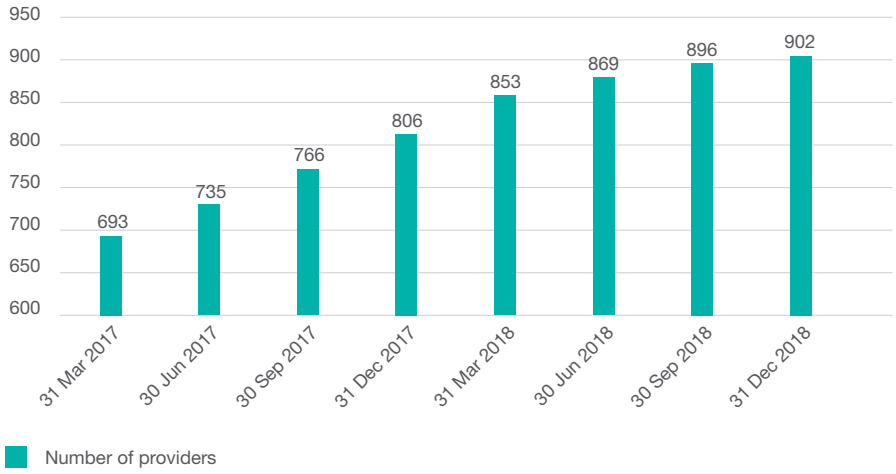
Current demand for HCP services

In line with the over 70 population density, metropolitan areas, and in particular the Southern and Eastern Metropolitan Regions, have the highest number of HCP consumers. This trend is likely to continue in the short term with these regions also containing the largest numbers of individuals waiting for a HCP in the National Prioritisation Queue[1]. In the non-metropolitan regions, Gippsland and Barwon-South Western have the highest number of package recipients [7].

Supply of HCP services

As part of the *Increasing Choice in Home Care* (2017) reforms, several legislative changes were made to enhance the accessibility of HCP services for consumers. This has resulted in a rapid increase in competition with the number of providers rising by 30.2 per cent across the country between 31 March 2017 and 31 December 2018 [9]. A similar rate of increase in competition has occurred across the country as described by Figure 2.

Figure 2: Change in the number of national HCP providers between March 2017 and December 2018



Numbers of HCP providers across Aged Care Planning Regions (ACPR) in Victoria align strongly with the number of HCPs available in each region. The largest number of providers are operating in the Eastern (53) and Southern Metropolitan (60) areas. The Grampians (19) and Gippsland (20) regions have the lowest numbers of service providers [11].

1. Once clients have received approval for a HCP they are place onto a national queue to await the availability of a suitable package. Their position in the queue takes into account two factors: the client's priority for home care services as determined by the Aged Care Assessment Team (ACAT) during their comprehensive assessment and the date the client was approved for home care at a specific package level.

Competition

Table 1 provides an indication of competition across ACPR by comparing the number of providers in a region to the total number of operational HCPs at 30 June 2018.

Table 1: Number of providers per 1,000 HCPs by ACPR

ACPR	Victorian Average	Barwon- South Western	Eastern Metro	Gippsland	Grampians
Ratio	12.7	13.9	11.6	11.9	16.8

ACPR	Hume	Loddon-Mallee	Northern Metro	Southern Metro	Western Metro
Ratio	18.9	8.9	10.7	11.2	16.3

Table 1 describes the level of competition across ACPRs by providing the ratio of providers to the number of operational packages in each region. (Source: AIHW, 2018)

Table 1 reveals the greatest competition for HCP services is occurring in the Hume (18.9 providers/1,000 HCPs) and Grampians (16.8 providers/1,000 HCPs) regions. The Loddon-Mallee (8.9 providers/1,000 HCPs) and Northern Metropolitan (10.7 providers/1,000 HCPs) have the lowest levels of providers in comparison to the number of HCPs available.

What case study providers told VHA

Having an established market presence was the '… only reason for continued involvement'. Providers considered that 'entering the market as a new provider [is difficult] … due to the level of market competition and high administrative burden.'

'Due to the lack of providers operating in [remote regions], it is difficult to broker a workforce for service delivery.'

- Large regional provider

'Prospective organisations seeking to enter the HCP market should determine whether the HCP industry aligns with their core business. Choosing to enter the market without having alignment of services would be very difficult.'

'It feels like the number of providers in the market has doubled in the last five years.'

- Regional community health service

'[Our catchment] is a geographically dispersed region which has a rapidly ageing population … this can make service delivery challenging.'

- MPS

Implications for Victorian public HCP service providers

- Prior to entering the sector, public HCP service providers should analyse the level of competition and density of HCP consumers in their catchment regions. Strategic planning should also describe how entrants propose to attract and retain new and existing consumers and how they can achieve an efficient service model that allows for a level of profit generation that is acceptable to the organisation.
- The unique geographic characteristics of a catchment, such as client density and remoteness, should be considered by providers.
- As demonstrated in Table 1 the Northern, Eastern and Southern Metropolitan regions have relatively low levels of competition for packages compared to the rest of the state. These regions warrant further investigation by prospective providers.

Further information on the HCP sector is available in the technical paper (Section B).

4 / FINANCIAL CHARACTERISTICS OF THE HCP SECTOR

What the available information tells us

The Aged Care Financing Authority provides the most recent financial performance data for Australian public sector HCP providers. The data presented in this report is based on information from 2016–17 and is therefore unlikely to accurately reflect the financial impact of the *Consumer Directed Care*[3] [10][11] reforms which have taken place since 2015. The typical returns on services for Australian public HCP service providers over the 2016–17 financial year is provided in Table 2 below.

Table 2: Financial performance of Australian providers (2016–17)

Financial indicator	Australian public sector HCP providers	Australian Private HCP providers	Australian not-for-profit HCP providers
Average EBITDA[4] per consumer	$1,883	$6,767	$2,621
Average NPBT[5] per consumer	$1,803	$6,717	$2,460
EBITDA margin	9.0 per cent	18.7 per cent	10.1 per cent
NPBT margin	8.6 per cent	18.3 per cent	9.5 per cent

Source: Aged Care Financing Authority Annual Report, p. 69

Table 2 shows that private sector organisations are able to achieve significantly higher profit margins in comparison with those in the public sector.

A more recent analysis of the sector conducted by accounting firm StewartBrown revealed that profitability of the overall sector declined in 2018, with earnings before tax (EBT) of $3.48 (earnings before tax) per client per day compared with $5.37 in 2016–17. The reason for this decline was in part attributed to a higher amount of unspent funds by consumers [13].

Revenue

While providers generate a majority of their income through the delivery of services, management and administration fees are also important sources of income as demonstrated by Table 3. Revenue sources for HCPs include Commonwealth contributions in the form of subsidies and supplements, consumer contributions (the basic daily fee and income tested care fee) and other revenue sources (consumer contributions for non-home care related services, interest income and state and territory payments).

Table 3: Breakdown of public sector HCP provider revenue streams

Income type	Average income per consumer per day 2015–16 ($)	Percentage of total	Average income per consumer per day 2016–17 ($)	Percentage of total
Provision of care / services charged to consumers	47.15	61.5	44.71	61.5
Management fees charged to consumers	11.12	14.5	10.27	14.1
Administration of packages charged to consumers	13.63	17.8	12.88	17.7
Unspent funds and exit amounts deducted	3.64	4.7	2.98	4.1
Other revenue	1.16	1.5	1.87	2.6
Total	76.7	100	72.71	100

Source: Aged Care Financing Authority Annual Report, p. 71

3. Consumer Directed Care refers to a series of reforms introduced in 2015 that aimed to increase the flexibility and choice in care and services that consumers receive.
4. Earnings before interest tax depreciation and amortisation
5. Net profit before tax

From 2015–16 to 2016–17, the relative contribution of each income source remained the same. However, with the exception of 'other revenue', income from all other sources decreased coinciding with the HCP's transition to delivery based on application of CDC principles.

Expenditure

Publicly funded HCP service providers on average incurred the lowest expense per consumer per day ($52.43) compared to profit providers ($80.93) and not-for-profit providers ($64.05) [1]. Table 4 provides a breakdown of the costs incurred by Australian public sector HCP providers.

Table 4: Profile of costs incurred by HCP service providers

Cost area	Cost per consumer per day for public HCP providers ($)	Percentage of total cost for public HCP providers	Cost per consumer per day for private HCP providers ($)	Percentage of total cost for private HCP providers	Cost per consumer per day for not-for-profit HCP providers ($)	Percentage of total cost for not-for-profit HCP providers
Salaries	23.84	45.5	52.91	65.4	35.91	56.1
Administration and management	6.41	12.2	10.95	13.5	10.40	16.2
Other care related expenses	21.17	40.4	14.67	18.1	15.65	24.4
Other expenses and non-direct care costs	1.02	2.0	2.40	3.0	2.09	3.3
Total	52.43	100	80.93	100	64.05	100

Source: Aged Care Financing Authority Annual Report, p. 72

Public HCP providers experience lower salary, administration, non-direct care costs and 'other expenses' in comparison with private and not-for-profit providers. Public providers do, however, have the highest comparable 'other care related expenses'.

What case study providers told VHA

'Clients who are approved to receive a high-level package and are given a lower level interim package can often be unprofitable. Unsuspecting new providers who accept these client types will have to service these clients at a loss.'

- Large regional provider

'New organisations should consider how they intend to market themselves and their marketing budget. Marketing strategies are important given the increase in market competition.'

'There are a lot of structural things that had to be in place. This is not a disadvantage, but it was hard work … Staff had to be trained in areas like the legislation that applies to HCPs. New policies needed to be developed. A resource guide to help with this process would have been useful.'

- SRHS

Implications for Victorian HCP service providers

- Organisations offering complementary community services (e.g. National Disability Insurance Scheme (NDIS), CHSP) may achieve operational efficiencies by using their existing workforce and systems to meet the needs of HCP clients.
- Providers should pay close attention to competitor fee structures and pricing strategies for their catchment areas and determine how their own pricing strategy allows for the greatest amount of revenue generation.
- Providers must be willing to make investments in areas such as marketing and training of staff that are required for long term success.

Additional information on financial characteristics of the HCP sector is provided in the technical paper (Section C).

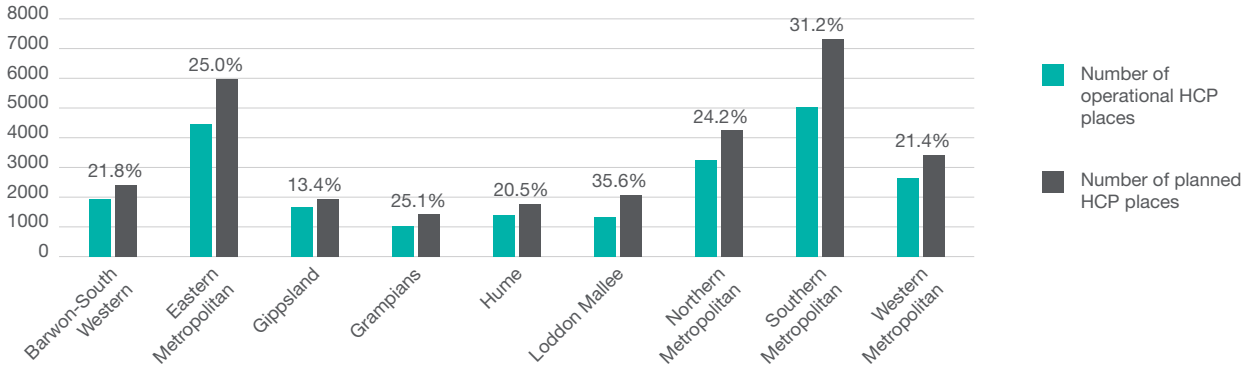
5 / TRENDS IN THE UPTAKE OF HCPS

What the available information tells us

A comparison of planned and operational HCP places

The Commonwealth Government's planning ratio of 45 HCP places per 1,000 people aged 70+ provides a guide on the number of HCPs targeted to service the population. In practice the number of HCPs operating in each region is vastly lower. Figure 3 demonstrates the difference between the number of HCPs theoretically required to service the population according to the government's planning ratio and the actual number of operational HCPs by ACPR at June 2018.

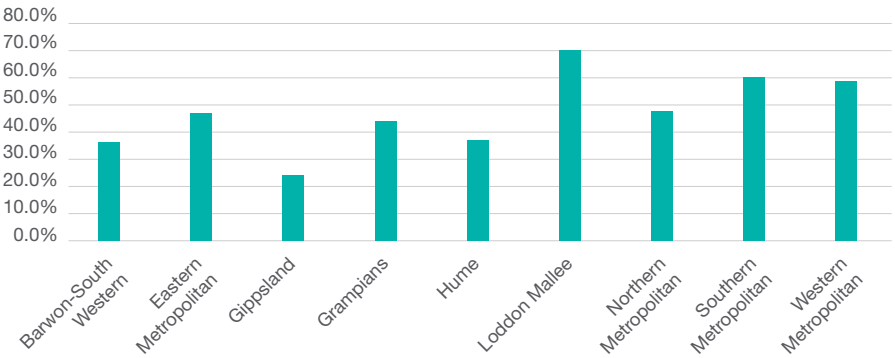
Figure 3: Comparison of operational HCPs to planned places across Victorian regions[6]



The regions with the largest difference between planned and operational HCP places were Loddon Mallee (-35.6 per cent) and Southern Metropolitan (-31.2 per cent). The difference between population demand and operational places may in part be explained by regions in which a higher proportion of the over 70+ population are part- or full-time pensioners who make up a majority of HCP consumers [2]. The Gippsland (-20.5 per cent) and Hume (-21.4 per cent) regions represent the areas where HCPs are closest to meeting the planned ratio targets.

It is possible that the geographic variation displayed in Figure 3 reflects historical allocations of Community Aged Care Packages, prior to the implementation of the reforms in February 2017 that allocate packages based on need from the new centralised waiting list. It could be expected that regional variation will reduce over time in response to centralised allocation process.

Figure 4: Projected growth of HCPs across ACPR by 2021



Projected demand

Figure 4 provides the projected growth of HCP places across ACPR by using projections of the 70+ population and applying the HCP planning ratio. These estimates can be used as a guide for future service demand across each region. The largest increase in operational demand between 2018 to 2021 is expected in Loddon Mallee (+69.7 per cent) and Southern Metropolitan (+59.6 per cent) while the Gippsland (+24.1 per cent) and Hume (+37.0 per cent) regions are expected to experience the lowest increases in HCPs.

6. Note: Planned operational places have been calculated by applying a 3.91 per cent population projection to 2017 population data. This percentage increase was based on the increase in the over 70 Victorian population projected by ABS between June 2017 and June 2018.

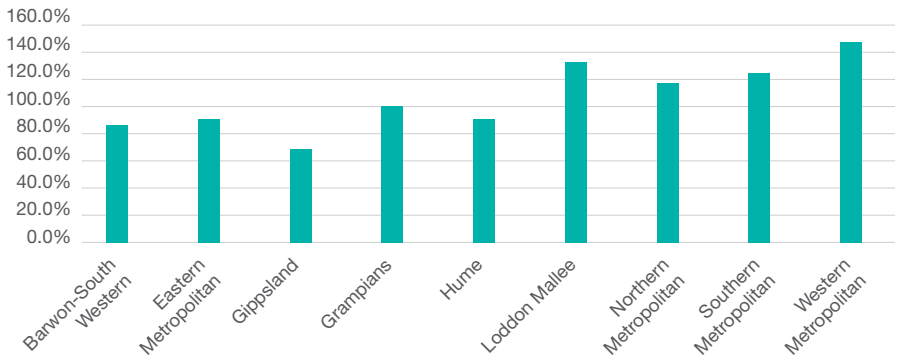
Figure 5 provides the estimates of HCP demand expected across ACPR by 2031. The largest increases in demand are expected in the Western Metropolitan (+147.9 per cent), Loddon Mallee (+132.4 per cent) and Southern Metropolitan (+124 per cent) while the lowest increase in HCPs are expected in Gippsland (+68.7 per cent), Barwon South Western (+86.2 per cent) and Hume (+89.7 per cent).

Implications for Victorian public HCP service providers

- Providers seeking to enter the sector should consider the expected growth in HCPs over the medium to long term.
- When determining potential future demand in a geographic area, providers should consider the projected population over 70 and the number of part- and full-time pensioners expected to be residing in the region.

A full analysis of trends in the projected requirement of HCPs is provided in the technical paper (Section D).

Figure 5: Projected growth of HCPs across ACPR by 2031



6 / FEE ARRANGEMENTS AND MEANS TESTING

What the available information tells us

For consumers entering the HCP scheme since 1 July 2014, providers are able to charge consumers the basic daily fee (17.5 per cent of the single basic age pension) and the income-tested care fee only if their income is over the maximum income for a full pensioner [4]. Under this arrangement **the subsidy received by providers from the government reduces by the maximum amount of income-tested care fee the consumer may be charged**. The maximum subsidy amounts paid by the government for consumers who are **not** required to contribute through an income-tested care fee are provided in Table 5.

Table 5: Maximum government subsidy rates by HCP level

HCP level	Aged care services for people with	Yearly amount paid by the Australian Government (up to the approximate value of)
1	Basic care needs	$8,250
2	Low-level care need	$15,000
3	Intermediate care needs	$33,000
4	High-level care needs	$50,250

(https://www.myagedcare.gov.au/help-home/home-care-packages/about-home-care-packages)

Fees charged by providers can vary depending on the nature of services delivered and the model of service delivery. Providers are able to charge consumers for direct care, administration and case management services. An example of care fees charged and government subsidies received by a large regional public provider is given in Table 6.

Table 6: Indicative HCP fees for a large regional public provider[7]

Package level	1	2	3	4
Government subsidy per annum	$8,271	$15,046	$33,077	$50,287
Administration fee per annum	$1,489	$2,709	$5,954	$9,052
Care coordination fee per annum	$993	$1,054	$2,316	$2,514
Available to spend on services per annum	$5,789	$11,283	$24,808	$38,721
Exit fee	$500			

https://www.myagedcare.gov.au/service-finder/home-care-packages/result/bendigohealth)

What case study providers told VHA

Consumers have the right to elect if they want to receive case management services. 'The biggest difficulty is when clients and their families choose to self-direct. It's okay if service requirements don't change. Invariably they want case management in practice, but they're not prepared to pay for it [case management].'

- MPS

'The requirement for providers to publish fees in a standardised template on the My Aged Care website does not allow organisations to justify their fees.'

- Regional community health service

Implications for Victorian public HCP service providers

- Providers have a financial incentive to charge income-tested fees to consumers who entered into a HCP agreement from 1 July 2014 onwards. Providers who choose not to collect the income-tested care fee will not receive additional government subsidy payments and will incur any reduction in the fee as a cost.
- In order for a fee schedule to be viable it must:
  - Cover all operating costs to avoid running at a loss.
  - Be competitive in the sector – the requirement for providers to publish their fees in a standardised template from 1 July 2019 will enhance the ability of consumers to directly compare provider fees.
  - Display affordability for consumers – a majority of HCP consumers are part- or full-time pensioners. Provider fees must be perceived as affordable for these consumers. Feedback from providers indicated that one way for public providers to achieve affordability was to keep costs down by exploring the potential for innovative service models (e.g. using staff across multiple programs, forming partnerships and consortiums with other health services).

A full description of fee arrangements and means testing is provided in the technical paper (Section E).

7. From 1 July 2019 all providers are required to publish their fees in a standardised template on the My Aged Care website. Fee comparisons with other providers can be made by accessing this information.

7 / SCOPE OF DELIVERY IN THE PUBLIC SECTOR

What the available information tells us

Figure 6 provides the relative percentage of public providers by ACPR. It demonstrates that metropolitan areas contain significantly lower proportions of public providers in comparison with non-metropolitan areas.

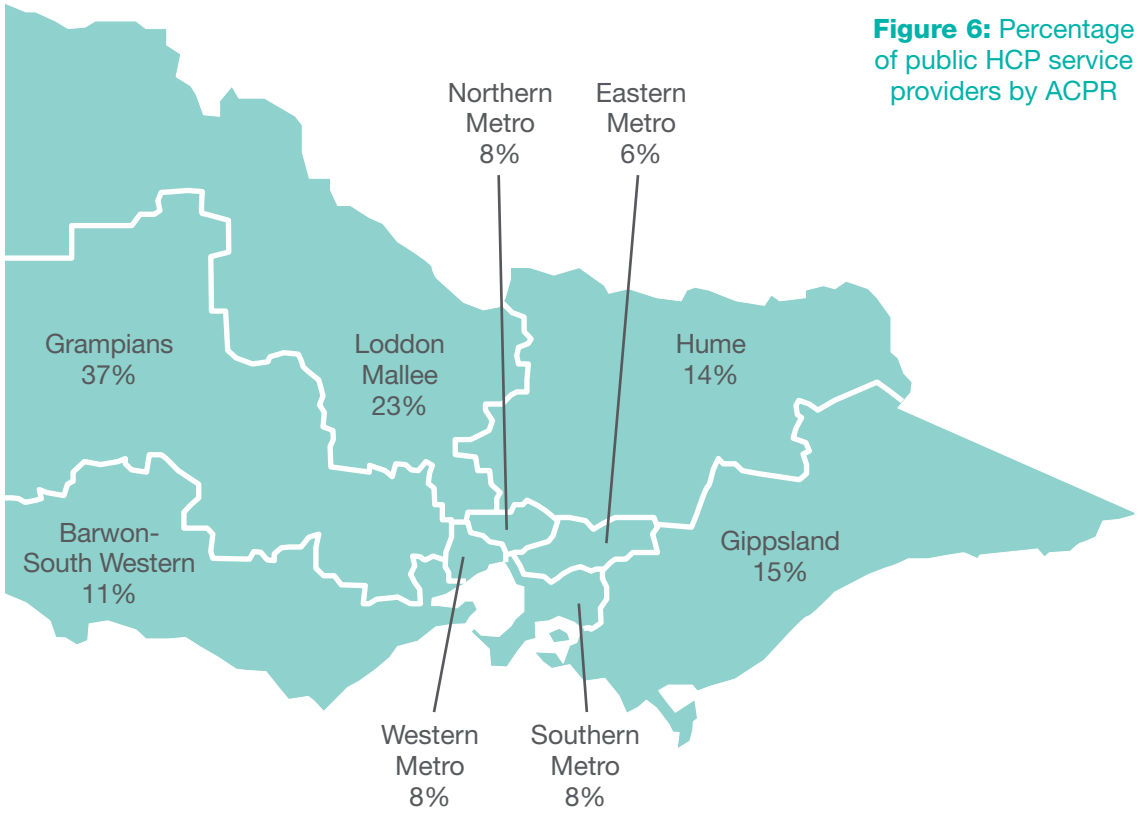


Figure 6: Percentage of public HCP service providers by ACPR

Enablers to sector entry

There are a number of advantages public HCP service providers have relative to other provider types that can support successful entry and operation in the HCP sector. These include:

- Having access to an established workforce: as demonstrated by Table 4, staff expenses represent the biggest cost incurred by HCP providers. Public HCP service providers who have access to an existing workforce that can be used to deliver HCP services are able to achieve operational efficiencies through lowered staff costs.
- Ability to retain staff: public healthcare organisations are able to offer benefits to staff that incentivise their retention. These benefits include salary packaging, additional training opportunities and the ability to retain staff providing access to a stable and consistently performing workforce. This is particularly important given the increasing skill shortage faced by this industry.
- Community recognition: local health services that are well recognised by their community as providers of health and community services may leverage off their public image to attract HCP clients as part of their marketing strategy.
- Referral pathways: providers offering other health and aged care services can use these programs as referral pathways into a HCP. This has the added benefits of increasing continuity of care for consumers that is built off positive consumer-provider relationships.

Barriers to sector entry

- The move towards a decentralised consumer directed care model has significantly increased competition in the sector as demonstrated by Figure 2.
- New providers may find it difficult to attract clients away from existing service providers.
- Continually changing legislative and administrative requirements impose cost uncertainty in the sector.
- The CDC model provides a platform for high consumer expectations. Inexperienced providers must be capable of managing these expectations.

What case study providers told VHA

'The main driver to [this health service's] involvement is fulfilling its obligations... to meet the needs of the community.'

- MPS

'Public organisations that provide only acute type services would find it difficult to successfully run a community health program.'

- Regional community health service

'We offer a range of community health services which are complemented by the HCP program providing a referral pathway for existing clients and allowing for continuity of care … It enables us to provide continuity of care.'

- SRHS

Implications for Victorian public HCP service providers

- There is a high level of competition for consumers by non-government providers in metropolitan regions. Interviewed providers said that this presents a challenge for new entrants as attracting consumers can be difficult and may require a significant marketing investment. Operational efficiencies increase with larger numbers of consumers within a defined geographic catchment.
- Public HCP service providers hold a number of strategic advantages over private and not-for-profit organisations that can be used to attract and retain sector share in their respective catchment regions. However, new providers must also consider barriers that may affect successful entry into the sector including the constantly changing legislative and administrative requirements, high levels of market competition, managing consumer expectations, and lowering levels of sector profitability.
- Potential entrants must consider their reason for sector participation. Some providers engaging in HCP sector are not profit focussed but operate based on the needs of the community and to deliver a high-quality service.
- The HCP program may complement existing services offered by public health services and provide additional benefits to the organisation that should be considered, such as client retention.

Further information on scope of delivery in the public HCP service sector is provided in the technical paper (Section F).

8 / THE HCP WORKFORCE

What the available information tells us

Table 7 compares the average number of hours required by different classes of staff to service HCP clients across Australia between financial years 2017 and 2018. It demonstrates that the overall staff time provided to service HCP clients decreased over the period, with the allocation of time to case management and advisory services increasing.

Table 7: Number of staff hours required per client day

Worker Category	Staff hours per client per day, 2016–17	Staff hours per client per day, 2017–18
Direct service provision	5.31	5.15
Agency (travel and planning)	0.44	0.22
Case management & advisory	0.83	0.87
Administration & support services (including co ordination)	0.58	0.46
Total staff hours	**7.16**	**6.69**

Source: StewartBrown, 2018, Aged Care Financial Performance Survey: Sector Report, p. 29

The Aged Care Workforce Report [5] provides an overview of the direct care staff categories employed by home care and home support providers (Table 8). It reveals a reduction in the number of registered nurses working across these sectors from 13.2 per cent in 2007 to 10.5 per cent in 2016. Over the same period, the proportion of community care workers (CCW) who provide the bulk of direct care, have remained relatively stable [5].

Table 8: Change in the direct care workforce profile (2007–2016)

Employee type	Percentage of total home care workforce		
	2007	2012	2016
Nurse practitioner	N/A	0.1	0.1
Registered nurse	13.2	12.0	10.5
Enrolled nurse	2.6	4.3	2.6
Community care worker	77.8	75.9	78.7
Allied health professional	6.4	4.8	6.3
Allied health assistant	6.4	2.9	1.7

Source: Australian Government Department of Health, 2016, The Aged Care Workforce Report, p. 70

Forty-nine per cent of home care and home support services across Australia reported a skill shortage [4]. Table 9 shows that this skill shortage affects all direct care staff and, with the exception of allied health staff (AH), is worse in more remote areas. It is noteworthy that CCWs in particular (who provide a majority of direct care services) are in short supply in remote and very remote areas.

Table 9: Percentage of home care and home support outlets reporting skill shortages by occupation

Location	Major cities of Australia	Inner regional Australia	Outer regional Australia	Remote Australia	Very remote Australia
Registered nurse	7.3	12.5	12.0	16.5	12.5
Enrolled nurse	1.7	2.8	3.5	3.4	5.6
Community care worker	33.1	33.7	32.3	34.8	43.1
Allied health assistant	7.1	7.8	6.2	4.1	2.8

Source: Australian Government Department of Health, 2016, The Aged Care Workforce Report, p. 120

Research into the future state of the workforce has found a gap of 26 per cent between demand and supply for aged care nurses by 2030 across Australia.

Employment conditions

Care staff directly employed by providers in the HCP sector can be contracted under a number of different industrial agreements. Table 10 provides an overview of employment arrangements for direct care staff across Australia. It reveals that a majority of staff are employed under enterprise agreements, followed by awards.

Table 10: Industrial employment arrangements for home care and home support workers (per cent), 2016

Type of employment condition	Proportion of condition type by workforce category (per cent)			
	Nurses	CCW	Allied Health (AH)	All occupations
Award	35.6	39.3	43.6	39.1
Enterprise Agreement	61.5	59.1	52.8	59.0
Common Law Contract	1.1	0.7	0.3	0.8
Individual Flexibility Agreement	0.7	0.3	2.8	0.4
Unknown	1.1	0.6	0.5	0.7
Total	**100**	**100**	**100**	**100**

Source: Australian Government Department of Health, 2016, The Aged Care Workforce Report, p. 126

Non- PAYG arrangements

HCP providers may use non-PAYG staff to deliver services, often arranging a supplementary workforce using a brokerage model, by engaging agency staff or by contracting self-employed staff. Table 11 shows which of these models are used most commonly by providers to recruit direct care staff.

Table 11: Percentage of home care and home support outlets using non-PAYG workers by occupation, Australia 2016

Occupation	Agency (per cent)	Brokered (per cent)	Self-employed (per cent)	All non-PAYG (per cent)^
Registered Nurse	3.2	3.2	0.2	6.5
Enrolled Nurse	0.5	0.7	0.0	1.2
Community Care Worker	8.6	12.7	1.8	21.2
Allied Health	2.0	4.0	2.7	8.3
All Occupations	11.8	15.4	4.5	27.1

^ NB: Totals from source document show variation from actual column and row totals.
Source: Australian Government Department of Health, 2016, The Aged Care Workforce Report, p. 127.

The data presented in Table 11 shows that over 1 in 5 CCWs are not directly employed by provider organisations.

What case study providers told VHA

- There were three types of workforces engaged by interviewed providers.
  - Employed workforce: providers who directly employ workers to deliver HCP services.
  - Brokered workforce: providers who contracted a workforce to deliver a service on their behalf.
  - Consortium model: a number of providers come to an agreement to share resources including staff that can be used to deliver a HCP service.
- Types of workers employed by case study providers included: registered nurses, enrolled nurses, personal care workers, case managers, case coordinators, senior supervisors, team leaders, managers and administrative staff.
- A majority of services delivered by case study providers were through personal care workers.

'[This organisation] currently employs one manager, two team leaders, three senior supervisors and twenty-five care coordinators that oversee the administration of HCPs. These staff also oversee other community services such as NDIS.'

- Regional community health service

'Having a registered training organisation operating from [this health service] is very helpful. It provides the program with access to a great training resource that can tailor courses to specific needs, e.g. assistance with supervising self-medication, first aid, training on individualised support.'

- MPS

Implications for Victorian public HCP service providers

- Public HCP service providers should service the HCP sector with a staffing model that minimises cost to the organisation.
- Ensuring access to a stable and competent workforce that understands the HCP sector will contribute to successful operation in the sector. This may be difficult given the increasing skill shortages faced by the industry.
- Prospective providers must determine whether they wish to operate under a direct care, brokered or consortium workforce model or a combination. Employment of a direct care workforce requires determination of the appropriate staffing mix and appointment of appropriate contract awards for staff.

Further information on HCP workforce is provided in the technical paper (Section G).

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Since 1938, the Victorian Healthcare Association has been supporting Victoria's publicly funded healthcare providers to respond to system reform, shape policy and advocate on key issues. The VHA proudly represents 96 per cent of the state's public hospitals and community health services.

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