Victorian Healthcare Association
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Submission

13 March 2020

Response to workforce submission: Counsel Assisting

The Victorian Healthcare Association is the peak body supporting Victoria's public health services to deliver high-quality care. Established in 1938, the VHA represents the Victorian public healthcare sector including public hospitals and community health services.

About the Victorian public aged care system

The Victorian public health system is the largest public sector aged care provider in Australia; with 178 public residential aged care services delivering approximately 10 per cent (5,000) aged care beds across Victoria. Over 89 per cent of Victorian public sector residential aged care facilities (PSRACs) are located in regional, rural and remote areas making public sector providers of residential aged care the sole provider in more than 50 locations across Victoria.

The state's hospitals and 28 registered community health services deliver approximately 11 per cent of Home Care Packages (HCP) and a significant proportion of Commonwealth Home Support Program (CHSP) services in Victoria. These organisations deliver community and home support, care relationships and carer supports, assistance with care and housing, and tailor responses to the unique needs of the communities in which they operate.

Without public sector services, many older Australians living in these areas would not have access to aged care that meet their needs near their homes, families and communities.

The Victorian Department of Health and Human Services Secretary Kym Peake made the following points in her submission to the Royal Commission:

- Cohorts of complex residents in PSRACS can be roughly delineated according to three groups, including those that have:
    - Complex health care or specialist care needs - including needs such as people requiring tracheostomy care, tube feeding, complex wound care, diabetes related issues, bariatric care, dialysis cases and conditions such as multiple sclerosis.
    - Difficult to manage behaviours - including verbal and physically disruptive behaviours resulting from conditions such as acquired brain injuries, dementia with severe behavioural and psychological symptoms, and neurological conditions.
    - Complex psychosocial care needs - people who have experienced prior trauma and those at risk of homelessness, and chronic mental illness (such as treatment resistant schizophrenia or depression).
- The cohorts in PSRACS consist of some of the most complex and vulnerable aged care clients in Victoria, with many residents at the most severe end of the care need continuum.
- While the Department does not collect specific data about the impact of nurse to patient ratios, it does collect data on a range of critical quality and safety measures in PSRACS. This data suggests that nurse to patient ratios, as part of a multifaceted approach to driving quality and safety, correlate with strong performance across PSRACS.
- PSRACS show strong performance relative to other residential aged care services on key indicators, including performance against minimum aged care accreditation standards.

This paper

The VHA welcomes the opportunity to make a submission on the Counsel Assisting's Submissions on Workforce. It is

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noted that the Royal Commission is required to inquire into: 'what the Australian government can do to strengthen the system of aged care services to ensure that the services provide are of high quality and safe and ensure that aged care services are person-centred.'

This paper responds to Counsel Assisting's submission across two key areas including mandatory minimum staffing requirements and funding for increased staff levels and reporting. The paper makes key recommendations regarding:

- Clarifying definitions
- health workforce planning and modelling
- staff shortages
- funding
- creating an even playing field for public sector aged care providers.

Mandatory minimum staffing requirements

The Victorian Government has a strong focus on quality and safety within PSRACS and has adopted nurse to patient ratios as a critical means of supporting appropriate care and quality of life for public sector aged care residents, which in turn supports workforce recruitment and retention. Nurse to patient ratios have existed in Victoria since 2000 and were legally enshrined in the Safe Patient Care (Nurse to Patient Ratios) Act in 2015 (the Act). The Act applies to public health services, extending to residential aged care facilities operated by these health services.

The VHA notes Counsel Assisting's support for the United State's CMS staff rating system, where time and daily resident data are submitted by nursing homes and then case-mix adjusted to account for differences in the resident mix and to enable comparison between facilities under a 5-star system. Counsel Assisting's submission in relation to staff ratios is that a model should be adopted that would see attainment of a 4-star rating under the current CMS staffing star rating.

Professor Kathy Eagar of the University of Wollongong advised the Royal Commissioners that in using this methodology, more than half (57.6 per cent) of Australian residents receive care in aged care homes that have unacceptable levels of staffing (1 and 2 stars). She noted that for all residents to receive care at least at a 4- star level would require an overall increase of 37.2 per cent in total care staffing. To achieve the 4-star rating, Australian facilities would need to deliver a minimum of 242 minutes of care per resident per week.

The VHA notes that Counsel Assisting has made the following recommendation for staffing numbers and mix:

An approved provider of a residential aged care facility should be required by law to have a minimum ratio of care staff to residents working at all times. The ratio should be set at the level that is necessary to provide high quality and safe care to the residents in its facility and should be based on the following:

- *It must be sufficient to achieve a 4-star rating under the current CMS staffing star rating as adjusted for Australian conditions.*
- *Average case-mixed total care minutes of between 186 and 265 minutes per resident per day from a trained workforce comprising nurses (including registered and enrolled nurses), and personal care workers.*
- *A minimum of 30 minutes of registered nurse care time per resident per day.*
- *In addition, at least 22 minutes of allied health care per resident per day.*
- *That there is a registered nurse (RN) present on each shift and available to direct or provide care subject to limited exceptions.*

Definitions

The VHA is seeking clarification regarding the definition of 'care staff' as included in Counsel Assisting's recommendation…to have a minimum ratio of care staff to residents working at all times. Currently no definition of care staff exists for aged care, which is problematic and may lead to a level of uncertainty as 'care staff' could cover any number of workers delivering aged care services including personal care attendants.

The VHA also considers that the inclusion of 'allied health care' is not clear. The VHA is seeking clarification regarding the definition of 'allied health care,' for example does it refer to allied health type services which are currently often delivered by non-allied health professionals such as nurses, personal care attendants and lifestyle workers under the direction of an allied health professional or does it refer to direct care delivered by an allied health professional.

Workforce modelling and planning

While the VHA supports efforts aimed at improving quality and safety of care for older Australians, the VHA has identified a number of barriers to achieving minimum ratio of care staff to residents, much outside the direct control of the industry. For example, all levels of the health system are struggling to attract and retain the right people with the right skills to meet the changing needs of communities. This is the result of a number of factors, however, one of the critical issues for health and social care in Australia, including for aged care, is that the supply of health and care professionals has been unable to keep pace with demand.

Currently, there are recorded shortages of most health professionals including not only nurses but many key allied health professions across Australia. If Counsel Assisting's recommendation is that allied health professionals are included in any subsequent ratios beyond the nursing workforce, there will be significant recruitment challenges for aged care providers across the country; these challenges will be experienced most acutely in regional, rural and remote areas.

The proposed inclusion of allied health workforce in the ratios also presents considerable financial implications for public sector providers of aged care; indeed the financial implications will also be felt across non-government providers who currently do not have any workforce ratios in place.

Furthermore, the lack of coordination and level of competition for similar workforces across health, aged and disability sectors and metropolitan, regional and remote settings means that any attempt to secure the supply of staff in the aged care sector is likely to have serious and impacts on other parts of the system or will simply not be achievable, particularly in rural and remote areas.

In addition, when it comes to health and care workforce modelling and planning, Australia has a history of fragmented and unaligned planning approaches that have resulted in both the over and under supply of health professionals. Before changes are implemented across the aged care setting, a more coherent national system to develop and oversee workforce strategy and ensure its alignment with the changing models of delivery of health and social care is needed. Siloed workforce planning cannot continue; an effective approach to planning for the workforce needs to consider the requirements of all sectors holistically.

To be most effective, workforce reform across the aged care sector must be driven by access to nationally consistent data. That said, there are acknowledged limitations in the systems and processes that currently provide workforce data. For example, reliance on surveys that are voluntary and have variable response rates or are national in scope and coverage with limited ability to interrogate below the state/territory level impinge the ability to undertake effective workforce planning.

The VHA recommends that:

- that the Counsel Assisting further define 'care staff' and 'allied health care' to remove any level of ambiguity of uncertainty
- counsel Assisting has recommended at least 22 minutes of 'allied health care' per resident per day. Clarification is required on the definition of 'allied health care' as it could refer to allied health type services (which are currently delivered by non-allied health professionals in addition to allied health professionals) or if it refers to 'allied health activity'
- if minimum ratios of care staff to residents are legislated for nursing, care and allied health workers, an examination of workforce availability and the impact it would have on other parts of the health system

- before changes to the ratio are can therefore be implemented across the aged care setting, that there needs to be a more coherent national system is adopted aimed at to developing and overseeing the health workforce strategy and ensure alignment with the changing models of delivery of health and social care
- there should be significant investment in data infrastructure must be realised to inform health human resources planning and management that goes beyond the aged care sector in Australia; coupled with ongoing investment in accessible, comparable and comprehensive data.

Funding for increased staff levels and reporting

The VHA notes Counsel Assisting's recommendations that:

- *It is clear…there is a need for additional investment in care funding, the majority of which is required to improve the staffing mix and to increase staffing levels to an acceptable standard. I recommend that increased funding be provided as one element of a comprehensive reform of the total aged care funding model.*
- *As part of a broader strategy of assisting providers of aged care services in remote and regional areas to remain financially viable, there may be a role for the Commonwealth government to provide targetted financial assistance to enable minimum staffing ratios to be met.*
- *All approved providers must provide the Department with quarterly staffing levels for registered and enrolled nurses, allied health and other care staff by shift in residential care. The Department must publish this information at a service level.*

In 2017, StewartBrown estimated the effect of potentially legislating direct care staffing hours to 4.3 hours per resident per day would increase staffing costs by an overall average of $53.09 per bed per day ($19,379 per bed per year) which at that time would have resulted in 85 per cent of survey participants operating at a loss. They concluded that it would require an estimated additional government subsidy or consumer funding of about $2.4 to $3.5 billion a year.

Compounding this estimated financial stress, residents in PSRACs experience significant inequity as they receive less Commonwealth funding for their care and accommodation than those in non-government services, because of the Adjusted Subsidy Reduction (ASR) and the lack of access to Commonwealth capital grants and resident accommodation contributions (outlined below). This funding shortfall also seriously impacts on the viability of public sector aged care services.

State and territory governments are often the sole provider of aged care services in remote and rural (RRR) areas, and without them many older Australians would not have access to care and support near their families and communities. In addition, support for aged care services in rural areas sustains those communities. Forty per cent of aged care jobs are regionally based, and they also underpin those economies by utilising services in the area, such as pharmacy, laundry, food and construction.

Funding challenges have resulted in 74.1 per cent of RRR aged care facilities operating at a loss in 2018-19. In addition, the Aged Care Financing Authority (ACFA) stated in September 2018 that state/territory government facilities make even greater losses than other non-government providers.

Another factor is that the community's expectation of residential aged care has shifted to expect more hospital-like conditions and staffing. However, aged care is funded very differently to acute care. In 2015-16, the average cost per day was $1,428 for psychogeriatric care and $1,071 for rehabilitation services - while acute hospital care was funded at $2,003 per day.

In comparison, aged care providers receive, on average, $270 per resident per day to provide care and accommodation (2017-18). This is even lower for residents in public sector beds because of the specific historic funding anomalies not experienced by non-government providers, outlined below. This means that public sector providers would be under even more financial stress than non-government providers.

Adjusted Subsidy Reduction

The ASR applies to aged care services operated by state/territory governments. It applies a reduction of $13.21 per day per resident and results in approximately a nine per cent reduction of the average Aged Care Funding Instrument (ACFI) subsidy. Each ASR aged care bed receives about $4,800 less per year than a resident in a non-government bed. Some Victorian public sector aged care facilities were included in the recent Australian National Aged Care Classification fixed cost analysis - which concluded that the ASR should be discontinued and the public sector be funded in the same way as non-government. It is estimated that removing the ASR would be about $18 million per year.

Flexible Care Subsidy for multi-purpose services

The MPS model is a joint state/Commonwealth initiative that enables the delivery of integrated health, community and aged care in small rural communities. At establishment, the Flexible Care Subsidy, which funds MPS aged care beds, was based on an 'average rate' of funding for 'low' and 'high' care. Since this time, MPS beds have been funded at this frozen rate.

This 'average rate' of funding has not kept pace with resident acuity and complexity, leading to a shortfall in being able to meet increasing resident care needs. ACFI data shows the stark growth in acuity with residents assessed as 'high' for Complex Health Care growing from 12.7 per cent in 2008-09 to 53 per cent in 2017-18.

For example, in Victoria there were 378 MPS places funded at $15 million through the Flexible Care Subsidy (2017-18). This equates to about $39,600 per resident per year. In comparison, average ACFI funding for residents in non-government services was about $67,000 per year.

In 2017-18 MPS funding was $168.5 million nationally. To increase funding by 30 per cent would require additional expenditure of approximately $50 million per year; by 40 per cent $67 million per year.

Access to capital funding

Under the current framework, it is the responsibility of aged care providers to fund construction, maintenance and upgrade works to aged care facilities through operating revenues or Commonwealth subsidies and resident charges. However, state/territory aged care providers are not eligible for Commonwealth capital grants creating a significant disadvantage with the non-government sector. A further disadvantage to MPS agencies is that residents are not required to pay the accommodation contribution or payment which also limits income to refurbish or upgrade facilities for resident comfort.

The transition from traditional models of residential aged care to modern models of care, as desired by the community, has been slow for public sector providers, as a result of these funding inequities.

Additional funding the Victorian Government provides to PSRACS to support nurse patient ratios
By way of assessing additional costs, the Victorian Government provides approximately $97.8 million in supplementary funding to PSRACS subject to nurse to resident ratios each year. This translates to around $67 in additional funding per day for each high care bed operated by PSRACS.

As Counsel Assisting has noted, a thorough examination of funding impacts and additional sources of funding would be necessary.

If minimum ratios of care staff to residents are legislated for nursing, personal care and allied health workers, the VHA recommends:

- a thorough examination of the increased funding required and sources of that funding and the additional administration costs of publishing staffing data
- that the Government even the playing field for public sector aged care providers by:
    - discontinuing the Adjusted Subsidy Reduction (ASR) as residents of public sector residential aged care facilities should be able to access the same funding as other non-government aged care residents
    - redressing the funding shortfall of the Flexible Care Subsidy to Multi-purpose Service (MPS) to ensure it reflects the current cost of delivering care to an increasingly complex cohort of older people
    - extending the eligibility criteria to all public sector residential aged care providers to apply for Commonwealth capital grants
    - allowing public sector providers to claim the accommodation supplement and/or contributions to maintain capital infrastructure.

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