ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

FURTHER SUBMISSION OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION IN RELATION TO HOME CARE (SYDNEY HEARING 4)

INTRODUCTION

1. This submission to the Royal Commission into Aged Care Quality and Safety (the Commission) by the Australian Nursing and Midwifery Federation (ANMF) is made in response to three particular documents that have been made available by the Commission in advance of Sydney Hearing 4. On 19 August 2020, the ANMF was granted leave to appear at Sydney Hearing 4. Subject to the non-publication direction (NPD-0048) dated 5 August 2020, the ANMF was given electronic access to documents including the Response of Mable to the Commission's Draft Propositions (**RCD.9999.0469.0001**) and the Home Care Provider Survey - Analysis of Data Collected by Stewart Brown / Australian Government Department of Health (**RCD.9999.0444.0001**). Further, on 22 August 2020, the ANMF was given access to Counsel Assisting's **draft Outline of Proposed New Service Arrangements for Aged Care in the Community and Home**. The ANMF thanks the Commission for the opportunity to respond to the three documents prior to the hearing.

2. Firstly, the ANMF submits that the key recommendations made in our 'Final Public Submission' to the Commission (ANM.0022.0001.0001) should be equivalently regarded to apply where appropriate to the provision of safe, quality aged care in the context of peoples' homes in the community. In our Final Public Submission, we highlighted five key recommendations:[1]

    i. **Recommendation One**: Mandated Minimum Staffing Levels and Skills Mix
    ii. **Recommendation Two**: Legislated Requirements for Clinical Governance Leadership, and Expertise
    iii. **Recommendation Three**: Legislated Transparency and Accountability Measures
    iv. **Recommendation Four**: Ensure Workforce Capacity and Capability
    v. **Recommendation Five**: Registration for Unregulated Carers

3. As we highlighted in that submission, our recommendations are made with the intent that the Commission understands that these actions are vital to addressing the significant issues brought to light throughout the Commission's proceedings to date and that we believe the Commission should themselves put these forward as their own recommendations that will assist the realisation of safe, quality care that all Australians deserve as they grow older. In our Final Submission we provided references to each of our previous submissions where substantial evidence has been complied to support each of our recommendations. Here, we highlight that much of this evidence can be considered by the Commission to readily and unproblematically apply equally for both the residential and in-home segments of the aged care sector.

4. Most people who access aged care services in Australia do so within their homes and wish

[1] ANM.0022.0001.0001

for this to continue as they age. The Commission has heard that a large number of older people have a strong preference for accessing aged care services in their homes within the community, drawing attention to recent work commissioned from Roy Morgan. Considerable evidence also before the Commission, and further evidence that will be heard at future hearings including the upcoming hearing into funding, financing, and prudential regulation (14-22 September, 2020) highlights that a considerable proportion of future aged care will be provided where possible and desired by older people and their families in the home. It is also intended that the care provided in the home be able to safely and effectively meet the needs of people who might otherwise choose to receive care within the residential aged care setting until a point where providing care in the home is no longer 'safe'.

5. As in each of our previous submissions, the primary focus of the ANMF has been championing the interests, needs, and preferences of those who provide or receive care through Australia's aged care sector – both residential and in-home. Throughout the ANMF's submissions to the Commission, we have argued for changes that would benefit those who receive services and that would support positive experiences and outcomes that truly put people at the centre of the sector regardless of who they are or where they receive care. In our submission focusing on person-centred care (PCC),[2] we highlighted that all recipients of aged care should have access to and experience safe, best practice care regardless of their location, health conditions, personal circumstances, and background. We highlighted that older people, or their nominated family/loved ones where the individual cannot, must be the key decision-makers in their care with support and information from their care providers. We explained that the ANMF and its members support and actively promote PCC. The ANMF and its members seek to improve PCC principles and address gaps in practice in line with the broader drive to enhance the delivery of PCC across all health and aged care contexts and to actively involve older people, their family and loved ones in decision making related to their care. The ANMF and its members value and understand the importance of the relationship between older people, their relatives/loved ones, and staff members and seek to work in partnership with them to deliver best-practice PCC. Thus, PCC is a fundamental theme of all our submissions, as it is PCC that all nurses strive to provide as a central element of their registration standards regardless of where that are is provided.

6. The current and future provision of aged care in the home does and will clearly demand a significantly sized, trained, supported, and equipped workforce and so will necessitate actions that will ensure workforce capacity and capability that will be similar to those that we have previously put forward as supporting the training, recruitment, retention, and regulation of the residential aged care workforce. The ANMF agrees that the potential for workforce growth in the in-home/community aged care sector in Australia is considerable and that with this opportunity to develop what will be a large proportion of Australia's future workforce comes the responsibility to ensure that it is well equipped, supported, and sustainable.

7. With the necessary growth of Australia's aged care workforce, particularly in the case of our personal care worker classification, also comes the need to ensure that this segment of the workforce is properly educated, trained, and regulated. The ANMF and others have previously submitted evidence now before the Commission that this currently unregulated aged care workforce must be regulated in a similar fashion to nurses and other healthcare professionals. The ANMF submits that the lack of regulation of the care workforce increases the risks associated with substandard training, lack of ongoing training and development,

[2] ANM.0004.0001.0001

and lack of accountability for conduct that falls short of required standards. Ours and others' calls for registration for personal carer workers is equally relevant and necessary for those who provide care within peoples' homes in the community.

8. The ANMF submits that the urgent need for legislated clinical governance, leadership, and expertise necessary for the provision of safe, quality care in residential aged care is equally vital for aged care that is provided in the community. The Commission has before it considerable evidence that many provider organisations – both those that provide residential and home care services - have little to no representation of clinical expertise currently within their governance structures. For a sector that is responsible for providing a considerable amount of clinical care, this is unconscionable. Currently, and especially if aged care in the home is expected to involve an increasing amount of care to meet high level health needs, clinical governance, leadership, and expertise at all levels of a provider organisation is essential.

9. We submit that the composition of the in-home, community aged care workforce must also be underpinned by evidence-informed policy and decision-making to ensure safe, quality care and the safety and wellbeing of members of the workforce itself. Mandated minimum staffing levels and skills mixes, particularly where people will require a significantly higher level of clinical care than is currently provided in peoples' homes will be vital to ensuring that aged care in the home does not fall to the current abysmal standards that have become commonplace when providers do not and will not deploy a sufficiently trained, adequately supported, resourced and remunerated workforce of nurses, care workers, allied health professionals, and other staff.

10. The Commission has before it, considerable evidence demonstrating the lack of transparency and accountability within the aged care sector. As we have done regarding the residential aged care sector, the ANMF has emphasises the critical need for much greater transparency and accountability across the aged care sector with regard to how funding of the sector is directed and how the sector is held accountable across a range of measures, including acquittal of funding and in broad terms accountability through regulation within the sector. We hold the same position regarding the need for transparency and accountability within the in-home/community aged care sector and our recommendations on these matters apply here equally.

11. The remainder of the present submission is divided into subsections each concerning our considered responses to each of the reports. The following are discussed:

    i. Draft Outline of the Proposed New Service Arrangements for Aged Care in the Community and Home, Counsel Assisting, Royal Commission into Aged Care Quality and Safety
    ii. Response to the Royal Commission into Aged Care Quality and Safety's Home Care Hearing Draft Propositions, Mable (RCD.9999.0469.0001)[3]
    iii. Home Care Provider Survey Analysis of Data Collected, Stewart Brown/ Australian Government Department of Health (RCD.9999.0444.0001)[4]

[3] RCD.9999.0469.0001
[4] RCD.9999.0444.0001

i. Draft Outline of the Proposed New Service Arrangements for Aged Care in the Community and Home

12. The ANMF is pleased to have the opportunity to provide comment on Counsel Assisting's Draft Outline of the Proposed New Service Arrangements for Aged Care in the Community and Home. As we have already told the Commission, we are in broad agreement with many of the proposals put forward by the staff of the Commission.[5]

13. We agree unreservedly that older people need and deserve safe, respectful, and empowering care wherever they receive it. We agree that it takes too long for many people to receive this care and that too often the care that is provided does not meet the individual person's needs or preferences.

14. We agree that all support and care for older people in the community and home should be focussed on;

    i. preserving and restoring capacity for independent and dignified living to the greatest extent;
    ii. strong partnerships and collaborative working relationships between the person, their carers and family, support workers and between providers; and
    iii. respecting their choices about how to best maximise their wellbeing and quality of life.

15. Overall, we refer the Commission back to our submission in response to the Draft Propositions noted above, however we do wish to provide some further comment on a key element that is also raised within Counsel Assisting's outline.

16. The ANMF has previously noted that the role of a 'care finder' has now become increasingly apparent within many reports and discussions regarding the future of both residential and now in-home aged care. We have highlighted in our response to the Draft Propositions that on occasion, this role has not been clearly defined or distinguished from the role of a 'care manager'. It is clear within the Draft Propositions and in Counsel Assisting's outline that the role of 'care finder' carries with it a significant degree of power and responsibility across a wide array of an older person's needs from initial assessment of their aged care and health care needs, to financial, housing, social, personal care, and support for decision making in relation to the 'entitlement' that covers what services a person can expect to be funded to receive. It is however unclear who this person would be, what their qualifications are, how they would be regulated, and who they would be employed by. The level of insight and knowledge this role is expected to have is considerable and the scope of their expertise is clearly diverse and complex. The ANMF submits that this 'care finder' or 'care manager' role must be more clearly teased out and explicated in order for an in-depth understanding to be achieved regarding how exactly this role would operate within the aged care sector.

17. The ANMF draws the Commission's attention to our previous submission in response Counsel Assisting's submissions on aged care program redesign (ANM.0019.0001.0001) where we engaged at length with the proposal for 'care finders' within the residential aged care sector. We submit that the role of 'care finder'/'care manager' be best suited to a

[5] ANMF Response to Home Care Hearing: Draft Propositions (21 August 2020) (ANM.0023.0001.0001)

registered nurse with an appropriate degree of education, training, and experience to take on this diverse and high-level position which may address older peoples' needs both within the community and in residential aged care contexts.

18. We recommended that this role should be filled by a registered nurse who also engages in assessment and case management working in partnership primarily with the older person, their family and loved ones, as well as their multidisciplinary care team regardless of setting (i.e. home/community care or nursing home). This role could be titled 'aged care nurse navigator' and draw strongly from exiting nurse navigator models. At paragraph 60 in that submission we also suggested that following additional scoping work, aged care nurse navigator teams be integrated with aged care assessment teams (ACAT) and regional assessment services (RAS) and these be joint units funded by the Commonwealth Government but run by State and Territory health departments and departments of communities and justice to allow for both the social and healthcare needs of older people and their informal carers.[6] This is in line with aged care nurse navigators taking on the roles of 'care finder', assessor, and case manager.

ii. Response to the Royal Commission into Aged Care Quality and Safety's Home Care Hearing Draft Propositions, Mable (RCD.9999.0469.0001)

19. The Commission has invited responses to draft propositions prepared by Counsel Assisting prior to the Sydney hearing which will enquire into the design of in-home care. A response to these propositions has been prepared by Mable, operator of an online platform which looks to link care workers with people requiring care in the home. At the request of Counsel Assisting the ANMF provides comment on the response that has been provided to the Commission by Mable.[7]

20. Mable Technologies Pty Ltd is a registered Australian private company.[8] In providing home care Mable's primary business operations look to connect independent (sub-contracted) care workers with people seeking in-home care, these services are provided both to people requiring aged care and disability care. The allocation of care worker to care recipient is facilitated via an online platform.

21. In providing their response to the Commission, Mable broadly sets out two principles and future expectations which they propose the Commission consider in their final recommendations. The first of these principles suggest the Commission refer to legislative and policy documents including the User Rights Amendment (Consumer Directed Care) Principles 2015, policy guidelines for the Supported Decision Making in Aged Care, and the operational manual for Home Care Package consumers. All documents which the ANMF notes are reflective of the status quo.

22. Mable's second principle refers to learnings provided through implementation of the National Disability Insurance Scheme (NDIS), citing the scheme as the *'most successful example of a transition to individualised funding in practice'.* The ANMF notes that this statement regarding the success of the NDIS transition appears to miss many issues and

[6] ANM.0019.0001.0001
[7] RCD.9999.0469.0001
[8] https://abr.business.gov.au/ABN/View?abn=80162890379

problems highlighted regarding the NDIS in David Tune's recent report.[9] For example, key findings of the report include findings that the rollout of the NDIS has not been smooth for all participants. Feedback to the review showed that some participants:

i. found the transition to the NDIS confusing and frustrating, with some people saying they 'missed' the supports offered under state and territory systems, particularly active case management;
ii. are frustrated about delays and lack of transparency around how the NDIA makes decisions;
iii. want to have more support to become informed and effective consumers;
iv. feel the NDIS is too complex and difficult to navigate;
v. feel they are not recognised as the experts in their disability; and
vi. feel NDIA staff do not understand disability or appreciate the challenges people with disability face as part of everyday life.

23. The ANMF submits that while the lessons learned regarding the rollout of the NDIS may offer insight into similar processes in the aged care sector, an unswerving focus on the purported success of the NDIS may be unrealistic.

24. In setting out their future expectations for the delivery of in-home aged care, Mable poses the following,

> *(Do) "we see a future of care at home (i) where empowered and informed people are at the centre connecting with other people and services within their community, with dignity and choice, supported by independent care managers and safeguards, or (ii) where providers are at the centre, subject to heavier regulation and compliance, and higher costs - as the means of driving quality of outcomes and safety."*

25. The ANMF has a number of grave concerns with the response Mable provided to the Royal Commission on the Home Care Hearing: Draft Propositions - RCD.9999.0469.0001. Mable is an online platform which has a number of independent workers with a range of experience and skills. Mable is only a connecting point between individuals, independent workers and in some cases providers. They manage the online profiles for the person receiving care and the worker. Using data inputted by each person, the platform undertakes the analytics to provide an individual who they suggest would be suitable to meet the person's needs.

26. Staff engaged through Mable are treated as independent contractors, which may be a legally dubious characterisation of their employment and can be engaged by providers or individuals on a short-term basis. It is up to workers who register with Mable to provide details of their qualifications and appropriate checks, such as proof of registration. While Mable advises checks will be conducted, this does create risk of unsuitable workers being engaged in aged care due to a lack of oversight. This was apparent most recently where

[9] Tune D. Review of the NDIS Act report. 2019. Available online: https://www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability-national-disability-insurance-scheme/review-of-the-ndis-act-report

Mable provided numerous unsuitably qualified and experienced workers in response to the disastrous COVID-19 outbreak in Newmarch House in New South Wales.[10]

27. The ANMF submits that Mable does not have sufficient governance processes including clinical governance to support quality care being delivered in the home, as Mable suggests it is the responsibility of the independent worker to ensure these are met. Mable outlines in their terms of reference under the section titled 'No Warranty' that: 24.2 Mable is not involved in the actual transaction between Customers and Support Workers. It is questionable how this is possible with the current regulation requirements for approved providers which are receiving government funding.

28. As an online platform, Mable also doesn't have the ability or capacity to support these independent workers in home care delivery, including support for the worker when they need assistance while providing care. They do not provide processes for education or development for workers who are completing care independently without connection to other workers or health professionals.

29. The Royal Commission has heard extensive evidence about the risks of insecure work in aged care in relation to quality of care, brought sharply into focus during the COVID-19 outbreak in Australia, and the difficulties in recruiting and retaining suitably qualified and experienced staff in aged care. The ANMF is extremely concerned that Mable, being a short-term labour hire option for staffing in aged care, significantly exacerbates those risks and problems.

30. Broadly, it also appears that many claims made throughout the document are unverified, or the mechanisms through which Mable implies an outcome, are unclear or ill-considered. To provide an example, Mable's response suggests the delivery of in-home care introduces logistical challenges where issues of efficiency places pressure on how workers are allocated to care recipients, adversely impacting on the recipients' choice of carer, and capacity to build meaningful relationships. Mable suggests simply that their platform minimises travel time and facilitates choice and social connection. This is clearly not a solution in consideration of the diverse and complex ways in which in-home care is currently, and will continue to, be delivered, and simply advertises Mable's capacity to deliver some level of in-home care via their platform.

31. Further, Mable indicates the draft propositions represent a departure from previously expressed observations made by the Commission, noting the propositions as being provider centric, based on regulation and compliance, to drive quality and safety, rather than person-centred and underpinned by (informed) consumer dignity and choice and a broader understanding that meaningful and enduring relationships are key to quality of life and safety. The ANMF suggests Mable's definition of person-centred care does not reflect a true representation of the needs and requirements of those who engage with aged care services. We refer the commission to the ANMF's definition of person-centred care as has already been laid out previously in this submission and others made to the Commission (see above).

[10] Gilbert L and Lilly A. 2020. Newmarch House COVID-19 Outbreak [April-June 2020] Independent Review Final Report. Available online: https://www.health.gov.au/sites/default/files/documents/2020/08/newmarch-house-covid-19-outbreak-independent-review-newmarch-house-covid-19-outbreak-independent-review-final-report.pdf

32. Primarily, the ANMF finds issue with Mable's consistent messaging in regard to the implied '*provider-centric*' nature of the propositions. Whilst the ANMF does not suggest the propositions do not reflect a degree of provider centricity -particularly in regard to the defined relationship between the provider and care manager, it is quite clear that Mable's recommendations are in themselves guided by benefit to the provider under a facade of consumer choice.

Degradation of the worker role

33. Labour hire through online platforms is the means by which the 'gig' economy operates. Workers are engaged to perform tasks and are generally treated as independent contractors. The labour hire platform is not the employer and as such is removed from legal obligations towards both workers engaged via the platform and the people who engage services. This has been illustrated in cases involving Uber and various food delivery platforms where the question of whether a worker is an employee or independent contractor have occupied considerable legal argument. The ANMF does not support the so called 'Uberisation' of aged care and considers this a significant risk to quality of care delivered and the personal safety of older people as well as the personal and professional safety of workers.

34. The ANMF through its submissions, particularly in relation to workforce, has argued that secure, ongoing work that is appropriately renumerated and offers decent working conditions is essential to providing safe and quality care. As is anticipated in the Draft Propositions, in order to increase both the amount of aged care being provided in the home and the level of care, the workforce will need to expand significantly both in number and skill level.

35. To achieve this, aged care services, whether in the home or in residential care, must be valued and made attractive as a career choice. This includes offering new employees induction, ongoing training, appropriate wages and importantly payment for work done beyond direct care hours, including travel time and administrative work. Home care by its nature is fragmented; workers move across multiple work sites and will often work alone in a person's home. Labour hire platforms further fragment the workforce- there is no common workplace, no connection with peers or mentors and contact with clinical and administrative supervisors may be sporadic and remote. This is a considerable risk to the safety and quality of the sector.

36. The ANMF considers that in order to build capacity in the home care workforce employees must be able to connect with peers and mentors and managers and have collective ability to negotiate to improve working conditions and wages. As has been identified, bargained outcomes are difficult to achieve in aged care, due in part to an already fragmented, casual and part-time workforce. The risk of engaging workforce via labour hire platforms, is a drive to lower hourly rates of pay and lower conditions due to siloing of the workforce. This in turn will not enhance working in aged care as an attractive, secure career option.

Training and professional development

37. Access to ongoing training and professional development is also necessary both to provide opportunity to workers and to ensure practice is current, safe and high quality. The ANMF considers this is best achieved through direct employment, where a provider has oversight and the ability to assess training needs and deliver training in paid work time so as not to disadvantage employees. As noted above, many aged care providers do not have the clinical governance, leadership, and expertise to do this at this stage, so this is a criticism that can also be levelled at these providers. Training opportunities should also be offered that provide career development, and this may enhance minimum training requirements.

38. The suggestion made by Mable, that training be offered via funding to TAFEs and it be up to the individual to elect to access training,[11] is not satisfactory on its own. As noted by Mable, the individual's propensity for learning is the driver rather than assessment of objective training needs.

Workplace health and safety

39. Workers in home aged care must be provided with safe workplaces. This includes:

- Risk assessment of homes before commencing work and on an ongoing basis.
- Support and training to learn how to manage challenging behaviour, particularly that which may escalate to violence or harassment.
- The ability to safely withdraw services where a work site has become unsafe.
- To be supported when workplace health and safety issues arise.
- To have adequate rest breaks with suitable amenities.
- To include travel time as work time to avoid fatigue and driver risk.

40. The ANMF considers worker safety can only be appropriately achieved through ongoing employment and having workplace structures that promote and support workplace health and safety. When workers are engaged on a casualised or independent contractor basis, the ability to ensure workplace health and safety is limited and too dependent on the capacity of the individual worker to tackle problems. This will further erode attraction and retention of a suitable, high quality, sustainable workforce to the sector.

41. The problems of insecure work have been most dramatically highlighted in the current COVID-19 crisis, where casual or low paid workers have been compelled to work across multiple sites in order to earn sufficient income. Risks to public health are very clearly exacerbated in a workforce that is low paid, casualised and that does not have access to paid leave.

42. The Mable model offers workers information, tools and training modules via the platform. While these may be useful there appears to be no mechanism to assess the effectiveness of these tools and again it is heavily dependent on individuals having the ability to assess what is required and implement it on their own initiative. There is no oversight, direction or direct support offered in the model and therefore no ability to assess the effectiveness of the

[11] RCD.9999.0469.0010

measures. For a workforce that will be required to grow and increase in skill level over the coming years, it is not adequate to divest responsibility for training, development and safety to individuals.

Paid travel time and minimum hours per week

43. In regard to paid travel time and minimum hours per week as referenced in the draft propositions, the ANMF supports both as outlined in our response of 21 August 2020. We make the following comments with respect to Mable's response.

44. Mable suggests that if home care providers are funded to cover the cost of travel time between engagements, providers will be motivated to focus on logistics rather than delivery of care. The ANMF submits that travel time must be funded sufficiently to ensure safe and quality care can be delivered regardless of location of the recipient of care- it is inherent that care should be of equal quality in regional, remote and more sparsely populated areas as urban high-density living areas.

45. Mable suggests that its model overcomes this by having 'large numbers of people locally' delivering services to minimise travel time. This firstly ignores the issue of providing home care services in areas where there are not large numbers of people to provide services (i.e. regional and remote areas) and secondly promotes a fragmented, casualised, and potentially underemployed workforce as a solution.

46. Mable states that ensuring workers are engaged for minimum hours per week is challenging. The argument put forward by Mable that providing workers with minimum hours per week will undermine consumer choice and potentially reduce quality of care does not bear scrutiny. It is difficult to understand how workers required to work shorter hours over a range of engagements in order to earn a decent income will be in a position to provide better quality of care than an employee who is engaged in secure work with guaranteed minimum hours per week. The argument that consumers will receive more care if the care cost per hour is lower fails to recognise that it is the quality of care that is paramount. Safe and quality care must be delivered by staff who are suitably skilled and qualified to deliver that care to meet assessed needs, which includes recognising the diversity of care recipients and their needs.

47. Provision of minimum paid hours is an important part of attracting and retaining a skilled and secure workforce.

Price setting in an open market

48. In their submission Mable suggests government should not 'set prices' for the provision of care, including on-costs associated with the delivery of services. Mable states that prices should be determined by a free market and informed consumers. This position does not seem to reflect the complex variety of services available, and diverse requirements and capacity of the people engaging those services. This statement in itself is a reflection of Mable's poor consideration for what incorporates person-centred care. The ANMF refers to the apparent inverse relationship between for profit providers and quality outcomes in the delivery of care. As has been evidenced throughout the Royal Commission, it does not

appear that an unregulated and free market prioritises and ensures the safe and quality delivery of care to aged people.

49. Overall, the ANMF considers Mable's responses to the Draft Propositions put forward by the Commission's staff to be ill-defined, poorly supported, and if acted upon, likely to result in the further degradation of the aged care worker role and general deregulation of aged care in the home. This will result in poorer quality, less effective care along with worse safety and conditions for staff and thus reduced attraction and retention of a suitable and stable workforce. Mable's response appears to reflect many of the harmful issues already present within the sector which impedes the provision safe, appropriate, person-centred care. Throughout the proceedings of this Commission it has become increasingly apparent that empowering and informing people to make decisions that are right for them regarding their care and ensuring they are connected with people and services within their community that provide safe, respectful, and meaningful care, requires the appropriate implementation of legislation, regulations, and reform that ensures providers are held accountable for the care they deliver and that the funds which they receive are directed toward the delivery of care. It is these measures which the ANMF has already put forward in our final submission, that will drive quality safety in aged care irrespective of context.

iii. Home Care Provider Survey Analysis of Data Collected, Stewart Brown/ Australian Government Department of Health (RCD.9999.0444.0001)

50. The ANMF is pleased to have the opportunity to provide comment the Stewart Brown Report (the Report) on their Home Care Provider Survey. The Report highlights that there is a national level information on the Home Care Packages Program reported in the Quarterly Home Care Package Program Data Reports available to the Department of Health, but that this dataset contains limited information data on the volume or cost to the consumer of specific services delivered under a Home Care Package, as this information is documented and agreed between the provider and the consumer.

51. To address this limitation, the Report describes the results of a national survey of home care providers conducted by Stewart Brown over two phases. The first phase (Financial Year 2018-19) achieved a considerably higher number of participants (data for 416 providers/45 percent of all approved providers/ 51 percent of all packages) than the second phase (September 2019 quarter, usable data from 98 providers/ 11 percent of all approved providers/ 16 percent of all packages).

52. The Report provides analysis of four core aspects:

    i. Total amount charged to a care recipient's package for a particular service or fee type
    ii. Total hours of service provided under the home care package
    iii. Correlation between the amount charged and the hours of service provided (price)
    iv. Funding received from subsidies and client contributions

53. The examination of these aspects has been done in consideration of; home care package levels, ownership structure, location of the packages, the size of the provider and also explored several demographic markers.

54. The main finding of the Report of interest to the ANMF is that while there has been an increase in the proportion of hours provided in home care that relate to allied health and nursing services and a downward trend of basic services with everyday living tasks, nursing care and allied health account for only a very small amount of the care currently provided in peoples' homes as part of their packages.[12] There is very little of the package used for nursing care services with less than 0.5 percent of charges for nursing care against a low care package (Level 1 or 2) and up to 2 percent for a Level 4 package. If, as anticipated, the in-home aged care sector is expected to be able to provide care up to an equivalent level as which may be delivered for people with the highest care needs in residential aged care, then the current utilisation of nursing and allied health care in the in-home/community aged care sector will necessarily have to increase considerably. As noted above, in our introductory remarks, the ANMF believes that the nursing workforce in in-home community aged care is a area for massive employment growth underpinned by a clear need for additional nursing care in the home. Our previous submissions regarding education, attraction, retention, and support for the workforce will be vital to ensure this occurs.

55. Unspent funding in home care packages may also reveal an opportunity where people are currently not accessing the full range of services they may want and need from aged care within their homes. Financial Year 2018-19 package utilisation across all levels average at 81 percent with best utilisation occurring at Level 4 packages (84 percent). Unspent funds averaged $7,521 across all package levels (FY2018-19) ranging from $2,098 (Level 1) to $15,182 (Level 4).

[12] RCD.9999.0444.0001