
6 Workforce: emerging issues

Key points

- The aged care workforce is part of the broader health and community care workforce and comprises three key segments: formal workers, informal carers, and volunteers.
- Like health and community services, the demand for aged care services is expected to increase substantially over the next 40 years. Retaining and attracting staff poses several challenges for service providers and the broader community including: ensuring competitive rates of pay; improving the work environment in areas such as workloads, workforce culture and scope of practice; as well as improving opportunities for training and career advancement.
- Informal carers are instrumental in providing community aged care but their relative availability is expected to decline in the future.
 - This relative decline could be moderated somewhat by ensuring that informal carers are appropriately supported in their caring role.
- Volunteers also play an important role in the provision of aged care.
 - Although the potential pool of volunteers is expected to increase, the challenges for aged care providers will be to compete for and utilise them effectively.

This chapter provides a profile of the aged care workforce, including key trends over the last decade or so. The chapter then examines a number of challenges facing the aged care sector if it is to successfully adapt its workforce to the significant increase in demand for aged care services over the next 40 years. The examination extends the analysis of workforce issues related to aged care undertaken by the Commission as part of its study into *Australia's Health Workforce* (PC 2005a) for each of the three segments making up the aged care workforce, namely: the formal paid workforce; informal carers; and volunteers.

6.1 The aged care workforce — a snapshot

Workforce overview

The aged care workforce is part of the broader health and community services sectors that provide care and support services to the aged, either directly or indirectly.

As with health and community services, aged care providers will be seeking, in future years, to replace a growing number of retiring workers and retain existing staff to meet an accelerating demand for services. This will occur at a time when growth in the effective labour supply is expected to be lower than population growth. Given that most aged care services are labour intensive, as with health care, sizeable wage pressures are likely. However, as shown in this section, these pressures are likely to be more pronounced in aged care for a variety of reasons.

In 2001, the health and community services sectors employed 800 000 people, of which around a quarter were estimated to be employed in the aged care sector, mainly in residential and community care (AIHW 2003b; Richardson and Martin 2004; PC estimates¹).

Unfortunately, workforce data covering the two main areas of aged care — residential and community care — and the three main categories of workers — formal paid workers, informal carers and volunteers — are limited. Moreover, there are several problems with existing data sets including incompleteness, incomparability over time and a high level of aggregation (box 6.1).

¹ The number of residential care workers was estimated to be around 149 000 in 2001. Community care is provided to disabled persons of all ages. Around 75 per cent of home and community care services, which comprises the bulk of community care, are provided to persons aged 65 years or older (DoHA 2006e). Accordingly, the Commission estimated the community care workforce for the aged to be around 39 000 in 2001. This estimate does not include nurses and personal care assistants who provide nursing services to older persons as data on employment setting is not collected.

Box 6.1 **Aged care workforce — data limitations**

The main agencies involved in workforce data collection are the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW) and the National Institute of Labour Studies (NILS). Aged care workforce data are predominantly collected from periodic surveys. The *Census of Population and Housing* also provides information on the aged care workforce but is confined to primary labour, that is, it records only a person's 'main' job.

The usefulness of the data is limited for a variety of reasons. First, the survey methodology used by the ABS to collect data has not been designed to clearly distinguish the aged care workforce from the wider health and community services workforce. For example, community based care workers providing services to the aged are incorporated into a broad industry classification 'non-residential care services not elsewhere classified' (ABS 1993). Further, data relating to informal carers and volunteers do not distinguish between services provided to those who are aged and/or disabled (ABS 2004b, 2007h).

Second, surveys have not been conducted regularly or consistently over time. In addition, changes to survey methodologies make it difficult to identify changes in the number, composition and characteristics of workers. For example, changes in data definitions and survey coverage between periodic volunteer surveys make it difficult to compare data over time.

Finally, changes in aged care policy have not been reflected in the surveys and/or category definitions. For example, the amalgamation of 'nursing homes' and 'accommodation for the aged' to 'residential aged care' almost a decade ago has only recently been reflected in the updated standard industry classifications (ABS 2006a). In addition, there is no specific information relating to the community based aged care workforce, despite the growing emphasis placed upon 'ageing-in-place' (DoHA 2006c).

The most reliable and comprehensive survey of the formal paid workforce in residential settings was commissioned by the Department of Health and Ageing and undertaken by NILS in 2003. The Department, has commissioned a second survey that has been expanded to include the community care workforce. Results from this survey are expected to be available later in 2008.

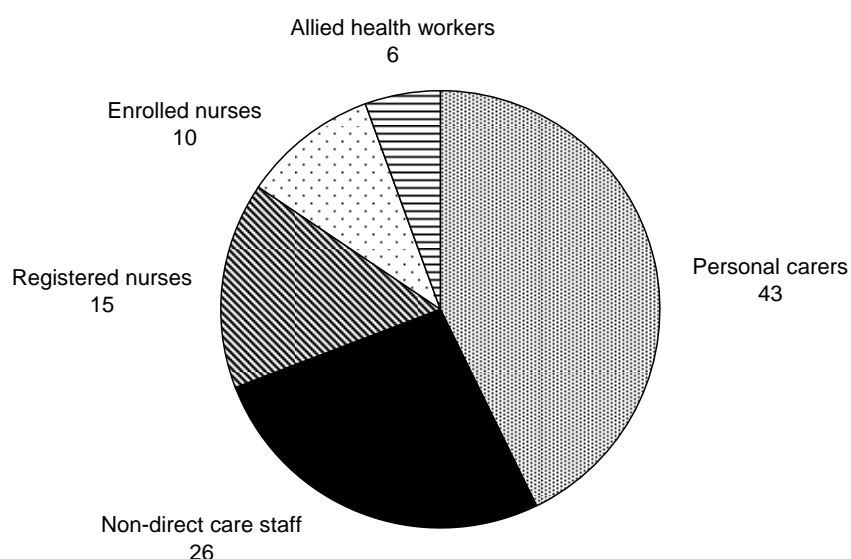
Sources: ABS (1993, 2004b, 2006a, 2007h); Healy and Richardson (2003); DoHA (2006c).

Residential aged care workforce

Residential aged care facilities employed at least 156 000 people or 1.5 per cent of the Australian workforce in mid-2003 (Richardson and Martin 2004). As illustrated in figure 6.1, over 40 per cent of the paid workforce is made up of personal carers, although it also features several other key groups including registered nurses, enrolled nurses, some allied health workers (such as diversional therapists and recreation officers) and non-direct care staff (such as cooks, cleaners and

administrators). Doctors and other allied health professionals (such as occupational therapists, dentists, physiotherapists, podiatrists and pharmacists) also contribute to the care of residents but are not considered to be part of the dedicated aged care workforce.

Figure 6.1 Composition of the residential aged care paid workforce
Per cent in 2003



Data source: Richardson and Martin (2004).

A 2003 profile of the aged care workforce shows significant differences with most other sectors, including health and community services. Residential aged care employees are more likely to be female, work shorter hours and be older than workers in the combined health and community services sectors and employees in general (table 6.1).

Table 6.1 Workforce characteristics: profiles for selected sectors

	<i>Residential aged care</i>	<i>Health and community services</i>	<i>All industries</i>
	%	%	%
Female	94	78	45
Part time	65	43	29
45 years or older	57	46	37

Sources: Richardson and Martin (2004); DEWR (2007).

In general, more clients were supported by fewer employees in metropolitan and regional areas compared with rural and remote areas in 2003. Just over half of residential care employees are located in metropolitan areas which account for 66 per cent of the sector's clients. In regional centres, there is an equivalent proportion of staff to clients, around 23 per cent. However, in rural and remote locations, 25 per cent of the residential workforce cares for only 11 per cent of the sector's clients (AIHW 2004d; Richardson and Martin 2004). The relatively smaller size of residential care facilities in rural and remote locations and the reduced opportunities to outsource some services (such as meal preparation and laundry) may, in part, explain the larger ratio of workers to clients in these areas (Richardson and Martin 2004).

The paid residential care workforce has changed in both size and skill mix over the past decade as a result of growth in the demand for aged care services and policy changes. In terms of size, the data suggest that the workforce declined between 1996 and 2000 despite servicing more clients, as indicated by the reduction in employees per operational place from 1.07 to 1.02 (table 6.2). However, the workforce expanded between 2000 and 2003 at a rate somewhat in excess of the growth in the number of operational places.

Table 6.2 Residential care employees and operational places, 1996 to 2003

	30 June 1996 ^a	30 June 2000 ^a	Mid-2003
Total employees	146 852	145 005	156 823
Operational places	136 851	142 342	151 181
Employees per operational place	1.07	1.02	1.04

^a Employees reported in the 1996 and 2000 Community Services Survey do not cover publically operated residential aged care facilities. Total employees are estimated by adjusting this data to incorporate publically operated places assuming that staffing ratios are equivalent across all types of operators.

Data sources: ABS (2001); AIHW (1997, 1998, 2007f); DHAC (2000a); Richardson and Martin (2004); PC estimates.

There has also been a shift in the skill mix of workers. Despite an overall increase in both the workforce and operational places, the number of registered and enrolled nurses working in aged care facilities decreased from 38 633 to 34 031 between 1995 and 2005 (AIHW 2008c). Factors contributing to this decrease include nurses preferring to work in other sectors and providers substituting personal carers for nurses. The later effect has resulted from changes to regulations prescribing staff numbers and work practices relating to how providers meet standards of care and resident's needs (Hogan Review 2004).

Community care workforce

In contrast to the residential care workforce, there is a dearth of information relating to the formal community aged care workforce.

Paid carers to the aged and disabled with support workers from other occupations provide the bulk of formal community care (AIHW 2003b). Formal carers provide services to the aged in their own homes as well as in other settings including nursing homes, other accommodation for the aged and community health centres. As the standard industry classifications provide only a limited breakdown of workers by industry setting in this area, it is not possible to accurately identify the size of the workforce. However, the rapid growth of HACC, CACP and EACH programs over the past decade has significantly increased the demand for formal aged and disabled workers.

According to the 2001 *Census of Population and Housing*, there were almost 52 000 formal carers providing some HACC and CACP services, such as general household assistance, emotional support, care and companionship to the aged and disabled in their own homes (ABS 2006b; AIHW 2003b). Concurrent with the growth in community care, the number of formal aged and disabled carers increased by 44 per cent between 1996 and 2001. Nurses and personal care assistants also provide nursing services to older persons in their homes but data on employment setting are not collected.

Informal carers and volunteers

The aged care workforce also includes informal carers and volunteers. Again, data relating to the number of these workers, the services they provide, the quantity of hours involved as well as changes over time are quite limited. The latest available data indicate that the number of informal carers of the aged was around 2.3 million in 2006 (PC estimates²). While the services of volunteers are also important in the provision of aged care, the ABS survey of volunteers does not provide data on their specific contributions to the aged (ABS 2007h).

² The ABS General Social Survey estimates that, in 2006, around 3.1 million persons cared for someone with a disability, illness or old age in the last 4 weeks (ABS 2007e, data sheet 25). The Commission assumed that the distribution of informal care recipients was similar to formal community care services, where 75 per cent of services are provided to older people.

Current and prospective challenges

As outlined in chapter 3, demographic changes, various social trends and the preference of most older people to ‘age-in-place’ will present significant challenges to the aged care sector and its workforce over the next 40 years.

The *National Strategy for an Ageing Australia* (Andrews 2002a, p. 55) noted that in providing world class care over the coming decades:

Governments, service providers and professional organisations have the challenge of improving the attractiveness of the aged care sector for care professionals as well as addressing training, career progression and other issues.

From a workforce perspective, the aged care sector faces four key challenges in this context:

- Building an effective workforce with the necessary flexibility to provide appropriate care for older Australians in an environment where labour intensive activities will face growing pressures for workers given the anticipated slow down in workforce growth.
- Responding to the increasing demand for formal care services as Australia’s population ages and accommodating an expected decline in the availability of informal family carers and growing competition for voluntary workers.
- Upgrading the skills base and training opportunities available to workers to accommodate improved delivery of aged care services to older Australians.
- Adapting the aged care sector and its workforce to changes in consumer needs and preferences which seem likely to increase the demand for community based care relative to institutional forms of care.

Reflecting these challenges, a number of recent government aged care workforce initiatives have been shaped by recommendations from reviews including the *National Review of Nursing Education* (DEST 2002) and the Hogan Review (2004). These initiatives have focussed on improving the attractiveness of aged care wages relative to competing activities, providing extra support for education and training, and expanding assistance for informal carers. Beyond this, the National Health and Hospitals Reform Commission is due to report by June 2009 on a long term health reform plan to, among other things, provide a well qualified and sustainable health workforce in the future (COAG 2007).

Specific challenges pertaining to each of the three main categories of aged care workers are examined in the following sections.

6.2 Formal paid workforce

The Commission's *Australia's Health Workforce* (PC 2005a) study examined many parts of the broader health workforce involved in providing care services to the aged, either directly or indirectly. For example, general practitioners and allied health care professionals, including physiotherapists, podiatrists, dentists and pharmacists, all contribute to the provision of health care to the aged although they are not considered part of the formal aged care workforce. Residential care service providers have expressed concerns about difficulties in accessing regular and reliable services from general practitioners as well as allied health services for their clients (HRSCHA 2005).

Although these services are important in supporting a healthy aged population, the focus in this section is on the formal paid workforce of nurses and personal carers that deliver community based and residential care services to the aged. Due to the limited data available on the community care workforce, most of the analysis relates to the residential workforce.

A number of key studies and parliamentary inquiries have highlighted longstanding concerns about the size and make-up of the formal paid aged care workforce as well as the capacity of providers to retain staff (box 6.2). Representative of these is the Hogan Review (2004) which identified several key issues pertaining to the residential aged care workforce including:

- a general shortage of trained nursing staff, which is greater in the residential aged care sector than in other areas of the health system
- specific barriers to recruitment, retention and re-entry to the workforce
- the ageing of the nursing workforce
- differences between the states' and territories' regulatory frameworks governing training, medication management and employment conditions
- the changing profile of consumers which is expected to affect the nature and extent of demand for future services and the required skill mix of the workforce.

These issues are broadly similar to those identified by the Commission in its *Australia's Health Workforce* study (PC 2005a).

Accordingly, the remainder of this section examines those issues most likely to influence worker's decisions to enter, re-enter or remain in the aged care sector, namely: remuneration; working environment; and education and training.

Box 6.2 Aged care workforce issues highlighted by parliamentary inquiries and workforce surveys

The main issues identified by various stakeholders in submissions to parliamentary inquiries and workforce surveys encompass the absence of wage parity, unfavourable working conditions including excessive documentation and workloads, lack of education and training opportunities and the perception of a poor public image of working with the aged. Issues have also arisen concerning the availability of suitable workers in rural and remote communities as well as the handling of the needs of culturally and linguistically diverse clients.

In 2002, a Senate inquiry into nursing found that:

... the shortage of qualified staff (in aged care) has now reached a crisis point ... There needs to be a concerted and sustained effort to act and ensure that ... aged care nurses receive working conditions, remuneration and recognition commensurate with their training and professionalism. (SCAC 2002, p. 158)

These ideas were reiterated in a subsequent Senate inquiry covering aged care where the growing importance of community care workers was recognised. The reasons given for high turnover rates in this area included:

... low pay, lack of career path, having to work in relative isolation, occupational health and safety challenges associated with working in the client's own home and the age profile of the community care workforce. (SCARC 2005, p. 10)

A House of Representatives inquiry examining long term strategies for ageing noted that aged care workforce issues were among those most frequently raised in submissions. In addition to the issues raised above, the inquiry observed that:

Occupational health and safety issues, in particular those associated with managing challenging behaviours, the amount of lifting associated with frailty, and longer working hours to cover absences all contribute to shortages. (HRSCHA 2005, p. 182)

The University of Southern Queensland in conjunction with the Queensland Nurses' Union, undertook comparative surveys of the attitudes of registered nurses, enrolled nurses and personal carers in acute and aged care workplaces during 2001 and 2004. The 2004 study concluded that:

Reflecting the nature of work in aged care, these nurses were more likely to report that nursing work is emotionally challenging and physically demanding and that the workload is heavy ... They also believe that 'very seldom' are there sufficient staff employed to meet patient/resident needs ... half of the aged care sector nurses perceived morale to be low and over half considered morale to be deteriorating. Reflecting their low morale, they have the highest levels of reported workplace stress, believe their colleagues are unsupportive and are most dissatisfied with remuneration. (Hegney et al. 2005, pp. 219–221)

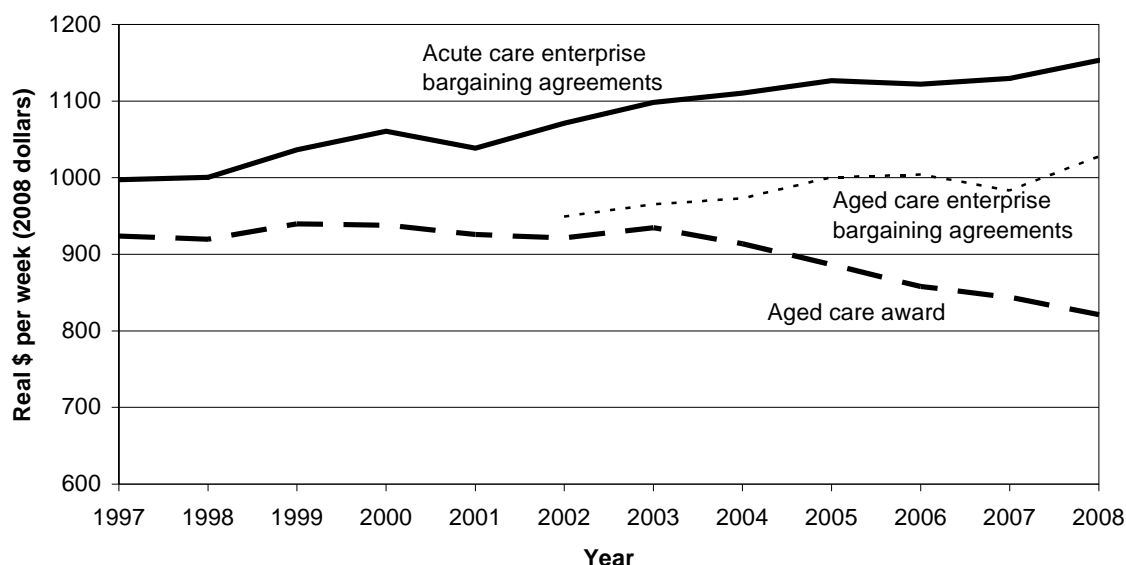
Recently, the NSW Nurses' Association undertook a survey of registered and enrolled nurses in aged care to investigate the use of unlicensed workers in medication management as well as broader workplace issues. Issues that participants would most like to see pursued by their association are excessive and unreasonable workloads, wage parity, protection of working conditions, inadequate staffing levels, training and education of unlicensed workers, excessive documentation and increased funding (Fethney et al. 2007).

Remuneration

The reason most commonly cited by employers experiencing difficulties in attracting and retaining staff in the aged care sector is the substantially lower remuneration of its employees compared with similar employment settings (see, for example, Richardson and Martin 2004; SCARC 2005; Fethney et al. 2007).

It is not uncommon for nurses employed in aged care to be paid at least 10 per cent less than their peers in the acute care sector for performing similar or equivalent work. For nurses in most settings, there has been a general trend, over the last 10 years, to adopt enterprise bargaining agreements and move away from award wage structures. As evident from figure 6.2, the median real wage gap between aged care nurses on enterprise based agreements and those working in public hospitals has been maintained since 2005. As a result of the comparatively low wages in aged care, registered and enrolled nurses continue to be attracted to other parts of the health and community care sectors.

Figure 6.2 Comparison of registered nurse remuneration^a



^a Median national Registered Nurse (Level 1, year 8) wage in January of each year, adjusted using the GDP deflator.

Data sources: ABS (*Australian National Accounts: National Income, Expenditure and Product, March 2008*, Cat. no. 5206.0); ANF (Melbourne, pers. comm. 21 May 2007 and 16 June 2008).

Dissatisfaction with remuneration among the aged care workforce is not just confined to nurses. Relative to their skills and responsibilities, comparatively low wages are also paid to personal carers who comprise the bulk of the formal paid aged care workforce (figure 6.1). In a submission to the *Inquiry into Quality and Equity in Aged Care* (SCARC 2005), the Health Services Union NSW (2004, p. 70) representing residential aged carers commented that:

Members find it grossly unfair that they receive \$13.53 an hour for the complex, emotionally and physically demanding work they perform, many of them with TAFE certificate qualifications in aged care, when their children if they worked as a checkout operator for Bi-Lo or Coles could earn \$14.13 an hour, or at Hungry Jacks for \$14.86 an hour. Further, members get very frustrated that they receive substantially lower pay than workers doing similar or equivalent work in a public hospital setting.

As outlined in section 4.3, funding arrangements for aged care constrain the capacity of service providers to offer competitive wages to their staff. Currently, adjustments to recurrent aged care funding are determined according to movements in the Commonwealth Own Purpose Outlays (COPO) index which reflects changes in both the Safety Net Adjustment, that is, the minimum wage as determined by the Australian Fair Pay Commission, and the Consumer Price Index (CPI), using weights of 3:1 respectively. The basic annual indexation outcome has averaged just over 2 per cent for the past decade. But according to ACSA (2008a, p. 13), the funding formulae 'do not reflect the real costs nor bear any direct relationship to the costs of providing care' which is conservatively estimated to be rising by 7 per cent per annum.

That said, there have been several government initiatives directed at enhancing the capacity of the residential aged care sector to offer competitive wages relative to the acute care sector. These began with the allocation of \$211 million over four years in the 2002-03 Budget (Andrews 2002b). In addition, the Conditional Adjustment Payment (CAP)³ provided a further \$877.8 million over four years from 2004-05. This represented an annual increase of 1.75 per cent above the basic care subsidy and formed part of the *Investing in Australia's Aged Care: More Places, Better Care* package (Bishop 2004). This package was pitched at encouraging residential care providers to 'pay competitive wages' and improve the flexibility of staff training arrangements. As part of the 2008-09 Budget, the CAP was increased by a further 1.75 per cent to 8.75 per cent of the basic aged care subsidy and a review announced to evaluate the effectiveness of this measure in encouraging efficiency through improved management practices (Elliot 2008a). The review will also examine the need for and level of any further medium term financial assistance and is due to report by the end of October 2008.

³ The CAP was conditional on providers supplying audited financial statements and a summary of training undertaken for each facility to the Department of Health and Ageing. In addition, facilities were required to participate in periodic workforce censuses.

Despite these initiatives, wage differences between the aged care and acute care sectors have not narrowed (figure 6.2). There are two main reasons for this (SCARC 2005). First, the extra funding is broadly similar to funding increases in the acute care sector. Second, there is no requirement on aged care providers to direct the extra funding towards paying higher wages to their workers.

The cost of achieving wage parity has been estimated at around \$450 million in 2008 (ANF 2008). Additional amounts of around \$100 million in subsequent years would be necessary to maintain wage parity under the current COPO adjustment arrangements.

The capacity of the sector to recruit and retain staff depends, in part, on aged care providers' ability to offer comparable wages and conditions with other sectors (DoHA 2005c). The pressure on providers to improve wages and conditions will increase in line with the growing demand for aged care services and as competition for workers intensifies across the economy as a result of slower workforce growth arising from overall population ageing. These pressures, however, may be moderated somewhat through productivity improvements linked to the wider use of information and assistive technologies and the application of more flexible workplace practices (chapter 7).

Working environment

In addition to relatively low remuneration, a number of aspects of the current working environment in aged care settings negatively impact on the job satisfaction of employees, thus contributing to high rates of turnover. Providers, industry groups and researchers consistently raise three key issues in this area, namely: workloads (including documentation and quality of care); workplace culture; and scope of practice.

Workloads, documentation and quality of care

High workloads relative to comparable nursing environments diminish the job satisfaction levels of aged care staff. Workloads in aged care settings have been elevated by a number of factors.

Increasing numbers of residents with higher and more complex care needs have added to the workloads of care staff in residential care settings. Indeed, the staff ratio has exhibited little change despite the proportion of residents classified as requiring 'high care' increasing from 56 to 69 per cent between 1996 and 2006 (AIHW 1999, 2007f) (see table 6.2). As a result, a 2003 survey reported that over two-thirds of direct care employees in residential facilities felt they were not able to

spend enough time with each resident and were too rushed to do a good job (Richardson and Martin 2004).

The provision of quality care requires adequate staffing levels with an appropriate skill mix. Over a quarter of aged care nurses responding to a Queensland survey stated that they did not believe that there were enough qualified staff to meet client needs (Hegney et al. 2005). Another more recent study of aged care nurses in NSW found that:

... just under three quarters of respondents did not support a model of care whereby registered nurses fulfil the role of care facilitator/planner only with all direct care tasks, including medication administration, delegated to unlicensed workers. (Fethney et al. 2007, p. 2)

The amount of documentation necessary to comply with various regulatory requirements affects how workers allocate their time. For example, some workers feel they have to perform unpaid overtime to complete their work as there is not enough time allocated in their shift. Others claim they reduce the amount of nursing care provided so they can complete the necessary documentation. For many, the documentary requirements are seen as reducing the time available for staff to provide services that enhance the quality of life and care of residents (Richardson and Martin 2004; Hegney et al. 2005; Fethney et al. 2007).

The regulatory burden associated with some aspects of the Resident Classification Scale (RCS) reporting framework was considered excessive by workers, managers and government (Hogan Review 2004; Australian Government 2007). As a result, the new Aged Care Funding Instrument (ACFI), implemented in March 2008, was developed in consultation with the sector to lessen the documentary burden through the introduction of a paperless (electronic) system. In addition, the ACFI does not require ongoing care documentation to support funding claims. Unlike the RCS, it is only necessary to perform an assessment when a client requires a significant change in their underlying care needs, necessitating a movement between funding categories (DoHA 2007a). In the view of Holy Family Services (2007, pp. 3–4), the ACFI places ‘a greater focus on essential documentation related to resident care rather than documentation for the sake of documentation obligations’.

This initiative highlights the benefits of governments focussing on best practice regulatory design and review principles so as to minimise the extent of unnecessary or avoidable regulatory burden. The introduction of new technologies may also result in better care through more effective management of client records.

Workplace culture

A supportive workplace culture that takes account of professional and personal needs and aspirations is essential to securing an adequate nursing workforce. Service providers and managers can nurture a constructive workplace culture, in aged care settings and nursing in general, through:

- engendering a positive work environment in which staff feel valued and are able to make their full contribution
- supporting professional development
- promoting workplace safety and cultural sensitivity
- encouraging a better work/life balance (DEST 2002).

Workplace culture is a multi faceted concept encompassing areas such as morale, safety, development opportunities, job design, conflict resolution, cultural sensitivity, and equity and diversity.

Staff morale has been reported as lower in aged care than in other nursing settings (Hegney et al. 2005). A contributing factor was the amount of abuse that aged care workers received from managers and their colleagues and violence from clients and their families. Given the level of abuse and high workloads, it is not surprising that over 50 per cent of aged care nurse respondents reported extremely high stress levels. These conditions result in a considerable level of workforce turnover, agency employment and workforce shortages in some occupations such as registered nurses.

Managers can contribute to improving workplace culture by encouraging workers to undertake professional development. Support may involve flexibility in rostering hours, time off to study and financial assistance to cover incurred costs. Development may be either formal, such as through a TAFE or university program, or informal, such as attending a relevant seminar.

Occupational health and safety is also a concern among aged care workers reflecting relatively high levels of physical injury arising from excessive workloads and the need to move patients (SCAC 2002; SCARC 2005). For example, in South Australia, the three most common hazards, on average, are:

- Manual handling — one in 15 workers each year
- Slips, trips and falls — one in 50 workers each year
- Aggressive or resistive residents — one in 200 workers each year (WorkCover Corporation 2001).

Respect for cultural sensitivities is an important facet of aged care. For example, services for Indigenous clients are expected to respect gender taboos, ensure adequate community contact (for example, with traditional healers, younger generations and local organisations) and maintain a dedicated core of local Indigenous staff in addition to fulfilling the normal requirements of aged care services (Kimberley Hostels 2003).

Various recent workforce surveys continue to highlight workplace culture as an area of concern (Hegney et al. 2005; Sargent et al. 2006; Fethney et al. 2007). However, service providers and workforce managers who promote a positive workplace culture which supports employees may increase job satisfaction and improve the attractiveness of aged care settings.

Scope of practice

Continuing health workforce shortages, combined with the need to efficiently use existing resources in the face of increasing demands for services, have contributed to calls for the scope of practice of workers in health as well as aged care to be extended to improve the effectiveness and productivity of the overall workforce (WGACWQ 2001; PC 2005a).

Scope of practice refers to ‘the full spectrum of roles, functions, responsibilities, activities and decision-making capacity which individuals within a profession are educated, competent and authorised to perform’ (Fox-Young and Ashley-Coe 2006, p. 2).

Within aged care there are several opportunities to realign workforce roles and create new roles to promote better care outcomes. For example, the effective provision of community care services often requires that workers are flexible and capable of performing a variety of tasks. Similarly, in rural and remote settings, there is a premium on making good use of available skills and being adaptable in the workplace.

Nurse practitioners are registered nurses whose scope of practice can be extended to include prescribing particular medications, referring patients to other health care professionals and ordering particular diagnostic investigations in accordance with clinical guidelines (ACT Health 2006). Nurse practitioners have the potential to significantly improve access to medical services for the whole community.

However, regulatory and funding barriers to the wider use of nurse practitioners constrain their capacity to provide services. Nurse practitioners are not permitted to bulk bill under the Medicare Benefits Scheme and do not have access to Pharmaceutical Benefits Scheme provider numbers which limits access to

subsidised medications. This means that clients receiving services from nurse practitioners in aged care settings generally have to pay more than if the same service was performed by a general practitioner (PC 2005a). Further, there is, as yet, no uniform national accreditation and registration regime for nurse practitioners (DoHA 2007e).

One way to reduce the workloads of registered nurses is to increase the scope of practice of enrolled nurses, specifically in medication management (WGACWQ 2001; DEST 2002). The previous Australian Government supported training for enrolled nurses in aged care settings to undertake courses in medication management in an attempt to ease workforce shortages (Bishop 2004). However, regulations that limit the range of medications that enrolled nurses with appropriate qualifications can administer, in some states, have limited scope for improvements in this area.

Increasing the scope of practice may also be feasible for personal carers who support allied health services. The Commission in its *Australia's Health Workforce* study noted 'that many submissions called for greater development of an "assistant-in" stream of workers to take over some of the less skilled tasks' (PC 2005a, p. 14). For example, some participants argued that developing 'assistants-in-physiotherapy' could allow basic movement and exercise services to be provided without the direct supervision of a physiotherapist. This may be beneficial for the client and cost effective, provided that safety and quality are maintained.

The Australian Medical Association and nursing organisations, among others, have expressed concerns about expanding scopes of practice and the impact this could have on safety standards and public confidence (see, for example, ANF Victoria 2005; NSW Nurses Association 2005; Nurses Board of Western Australia 2005; PC 2005a). The Commission has proposed a health workforce improvement agency which would undertake an objective and transparent assessment of the potential opportunities for, and concerns relating to, expanding the scope of practice (PC 2005a). In response, the National Health Workforce Taskforce was established by COAG to inform development of practical solutions on workforce innovation and reform (COAG 2006).

Facilitating workplace change and innovation in job design through extending the scope of practice is also likely to improve job satisfaction. Allowing workers with appropriate training to provide services in more flexible ways may make the aged care sector more attractive to current and prospective workers and thereby help to alleviate workforce shortages.

Education and training

In a broad sense, the objective of aged care workforce education and training is to underpin the efficient and effective delivery of aged care services. This can be achieved by ensuring that there is an appropriate number of workers who are equipped with the right skills and competencies. In addition, pathways for career progression through upgrading and retraining should be available to ensure that the skills of workers are responsive to the changing demands placed on them.

Education and training outcomes for aged care workers are significantly shaped by the configuration of the broader health and education systems. Settings in these systems clearly impact on the demand for and supply of aged care workers and the resources available to educate and train them.

In addition to formal education, ongoing training for residential aged care workers is available through *The Aged Care Channel* (Martin 2008). Satellite technology is utilised to deliver live, interactional, educational programming to participating aged care facilities. The programs are designed to complement formal training and cover topics important to aged care including infection control, continence management, mental health, teamwork, elder abuse, medication management and occupational health and safety. *The Aged Care Channel* was launched in 2003 and since then its membership has grown to over one third of all aged care facilities.

In rural and remote areas, the costs of education and training are higher due to a lack of local infrastructure and the need to replace workers for longer when they travel for training. Satellite transmission services through *The Aged Care Channel* and the development of nursing degrees through distance education for enrolled nurses may help to alleviate these challenges.

This section is divided into two parts to reflect the demand for different types of workers and how they are trained. Registered nurses are highly skilled, extensively trained and in demand from all sections of the health care sector, both in domestic and international settings. By comparison, enrolled nurses and personal carers have shorter training programs and are not considered to have the same current and prospective shortages.

Registered Nurses

Registered nurses (RNs) receive three years of undergraduate training in a university setting and undertake clinical placements before registration. RNs are a crucial component of the aged care workforce. They manage teams of care staff and provide specialist skills, including complex medication and care tasks.

The *National Review of Nursing Education* highlighted a shortage of RNs in all settings of around 10 000 (more than 5 per cent of RNs at the time) (DEST 2002). This shortage is expected to continue as more ‘baby boomer’ nurses retire and the demand for health care services, including nursing, increases due to an ageing population (CDNM 2006).

Since the Review, Australian Governments have recognised the need to fund an expanded number of undergraduate places. Provision has been made to increase the number of places by 10 141 or 43 per cent between 2003 and 2011. However, aged care specific places, as allocated to those universities with aged care specific specialisations, only make up around 11 per cent of the total increase and there is no requirement for graduates to enter the aged care sector. Further, just increasing the number of funded places alone will not be sufficient to attract RNs to aged care in the absence of supporting initiatives to improve remuneration and working conditions.

Australian Governments have also developed specific scholarship programs to encourage RNs into aged care settings. In response to the *National Review of Nursing Education*, funding was provided for up to 2000 aged care scholarships over eight years from 2003 (Andrews 2002c; Santoro 2006b). To ensure that recipients are dedicated and likely to remain in aged care, preference has been given to existing enrolled nurses and personal carers, especially in rural and remote areas. More recently, an additional 410 post graduate nursing scholarships were provided to increase skills and encourage more people to enter (or re-enter) the community aged care sector (Pyne 2007b).

Tertiary institutions are increasingly recognising aged care as a specialist field because of its growing importance in health care. For example, the Queensland University of Technology’s School of Nursing has reviewed the adequacy of its undergraduate nursing courses covering aged care. The review identified the need for specific teaching resources in areas such as the management of challenging behaviours including pain management, medications and polypharmacy⁴, wound management, continence, nutrition and hydration, transitional care, Indigenous and culturally and linguistically diverse ageing issues and palliative care for those with end stage dementia (QUT 2004).

Since then, and in collaboration with the sector, Queensland University of Technology and Flinders University, have developed specific courses and practical rotations to train RNs for aged care roles and to promote a positive image of

⁴ Polypharmacy refers to the concurrent use of multiple medications which occurs more frequently with aged clients. The risk of adverse drug events such as falls, confusion and functional decline rises with the use of multiple medications (NPS 2000).

working in the sector (QUT 2004; Flinders University 2006). In addition, Charles Sturt University has begun RN training for enrolled nurses through its distance education program to help increase the skills of the rural aged care workforce (CSU 2007).

Although enrolments and completions for undergraduate nursing courses have increased over the last 7 years, there is still a significant degree of unmet demand — that is, the number of potential students who are eligible and would like to study nursing but are not offered a place (table 6.3). Targeted programs to increase the number of undergraduate places since 2003 have reduced the level of unmet demand from its peak.

Table 6.3 Unmet demand for selected undergraduate courses, 2001-2008

	2001	2002	2003	2004	2005	2006	2007	2008
Number of eligible entrants in nursing not offered a place	1544	2934	4861	4545	2716	2408	2866	2833
Unmet demand (%) ^a								
Nursing	14	26	37	33	20	17	18	18
Health other ^b	22	29	33	34	23	19	17	15
All courses	19	24	28	28	19	15	15	15

^a Unmet demand is the difference between eligible applicants and those offered a place. ^b 'Health other' includes allied health services, such as podiatry, occupational therapy and physiotherapy, but excludes medical and dental studies.

Sources: Australian Vice-Chancellor's Committee (2002—2007); Universities Australia 2008.

Concerns about insufficient places are ongoing despite the recent increases. In this context, the Australian Nursing Federation has suggested that recent initiatives are unlikely to adequately satisfy the expected demand for RNs, as almost half of existing nurses are older than 45 years and will be looking to retire over the next 20 years (ANF 2006).

Increased funding for training of itself will not be sufficient as changes in client demand, such as the increasing incidence of dementia and frailness, will impact on the type of training required. More teachers and preregistration clinical places will also be necessary to impart the specialised skills required for providing quality care to clients with these special needs.

Enrolled nurses and personal carers

Personal carers and enrolled nurses account for over half of the aged care workforce (figure 6.1) and train at TAFEs to Certificate Levels III and IV respectively. Personal carers are unlicensed workers who generally have vocational qualifications

and undertake routine tasks in the provision of services to assist clients in their daily living activities. By contrast, enrolled nurses must be qualified and register with the relevant state or territory Nurse Registration Board or Council. They may undertake more complex tasks than personal carers including medication management and client monitoring.

The sector may face shortages of personal carers and enrolled nurses due to the ageing of the working population and the diminishing pool of potential workers in general. This is not to say that these potential shortages will be chronic. The relatively short training periods needed to prepare workers for these roles affords the sector with some flexibility and may create opportunities for older or overseas workers to enter the aged care sector.

In recent years, Australian Governments have introduced a range of initiatives directed at strengthening the workforce of personal carers and enrolled nurses, including funding for:

- vocational education training for more than 24 000 personal carers, over four years, to gain basic skills to a Certificate III level, in response to the Hogan Review (2004)
- 6000 enrolled nurses to increase their scope of practice by undertaking training in medication management to partially reduce the burden on RNs, also in response to the Hogan Review (2004)
- an extra 6000 training places for personal care workers delivering CACP and EACH packages over the next four years under *Securing the Future of Aged Care for Australians* (AIHW 2007b)
- an additional 50 000 vocational training places over the next three years from July 2008 to address the current health workforce crisis with priority areas including enrolled nurses, dental health workers, allied health assistants, ambulance officers and Aboriginal health workers (Gillard and Roxon 2008)
- improved training and resources for some 1400 Indigenous home and community care workers who care specifically for Indigenous people (Elliot 2008c).

Where necessary, support has been given to personal carers to improve their basic language skills before vocational training in aged care. According to the Federation of Ethnic Communities' Councils of Australia (FECCA 2007), there is a pool of aged care workers who cannot undertake training because they do not speak fluent English. While the Australian Government has realised the importance of providing support for some workers to become fluent in English and to undertake aged and community care skills training, there is scope for further expansion.

There are significant benefits to clients, providers and funding agencies from appropriately matching workers with culturally and linguistically diverse clients. Communication in a client's original language can reduce the costs of care and distress, especially where clients suffer from dementia. However, the residential aged care workforce survey undertaken by NILS in 2003 noted that only 10 per cent of personal care employees from a culturally and linguistically diverse background use their language skills in their work (Richardson and Martin 2004).

The importance of enrolled nurses and personal carers in providing direct care services to the aged continues to grow. While government initiatives aimed at increasing the skill base of these workers have been successful over the last decade, more investment in training and education programs for those who have the most contact with clients is required. Such measures will contribute to building a sustainable and competent workforce as the demand for aged care services increases significantly.

6.3 Informal carers

As outlined in chapter 2, informal carers are integral to the ongoing welfare of older people, especially those with disabilities. The economic value of the services provided by these carers is significant and has been estimated to be in the vicinity of \$4.9 billion to \$30.5 billion in 2005 (0.6 to 3.5 per cent of GDP)⁵ (Access Economics 2005b). To place these figures in perspective, the 2004-05 gross value added by other sectors of the economy, expressed as a percentage of GDP, were: accommodation, cafes and restaurants (2.1 per cent), agriculture, forestry and fishing (4.2 per cent), and health and community services (6.0 per cent) (ABS 2004a).

Not only do informal carers provide services directly to the aged, they also play a role in the co-ordination and facilitation of formal community care services.

Given the importance of informal carers in the delivery of support services to the aged, two key issues arise. First, what is the likely future availability of informal carers? Second, are existing supports for these carers adequate or is there a need for improvement?

⁵ The upper bound was derived by estimating the cost of replacing informal care with comparable services from formal providers while the lower bound estimate reflects the opportunity cost to the nation of informal carers not participating in the workforce.

Views on the future availability of informal carers

Informal care is predominantly provided by spouses, partners or relatives and their relative availability is expected to decline over the next 40 years. The magnitude of the decline is uncertain as it will depend on a number of factors that are likely to have differing impacts (see, for example, AIHW 2004a; NATSEM 2004; PC 2005b). The major factors seen as influencing the availability of these carers are:

- increasing longevity of partners — raise availability
- increasing numbers of single person households — lower availability
- decreasing family size — lower availability
- increasing age of first time mothers — lower availability
- increasing female workforce participation rates — uncertain impact
- changing attitudes towards care by carer givers — uncertain impact.

The increasing number of partners that are living longer could increase the availability of informal carers. According to the *ABS Survey of Disability, Ageing and Carers*, partners comprise 34 per cent of all informal carers (ABS 2004b). The narrowing of the gap between male and female life expectancy is expected to reduce the need for formal care of widows and widowers.

The increasing prevalence of single person households (due to increased rates of separation and divorce and the decision of more people not to marry) is likely to decrease the availability of informal carers. Currently, 44 per cent of persons aged 65 years or older live by themselves (ABS 2005).

The decreasing average family size is likely to reduce the availability of children who can act as informal carers for their ageing parents. This trend is being driven by couples having fewer children than in the past together with the increasing incidence of single parent families (ABS 2005).

The decision to have children later in life may also reduce the number of women who are in a position to undertake caring responsibilities for their ageing parents. However, increased longevity is expected to result in the onset of disabilities at older ages which could partially offset this trend. Over the past 20 years, the average child bearing age has increased in line with the life expectancy of those reaching the age of 65 (ABS 2006d, 2007b).

Increasing female workforce participation may compound the anticipated shortage of potential informal carers. That said, most of the increase in female labour force participation in Australia over the past 20 years can be attributed to the growth in part time employment which need not be incompatible with performing a caring

role and may enable this group to provide informal care if they desire. The proportion of women working part time has increased from 37.6 to 45.2 per cent between 1986 and 2006 (ABS 2007g). Further, the trend towards greater flexibility in employment arrangements for some occupations may increase the capacity of some workers to provide informal care.

Changes in the willingness of family members, especially children, to provide informal care could lessen the availability of such care in the future. Some analysts of social trends point to a society that is becoming more fragmented with a diminishing sense of obligation and responsibility to family suggesting that the availability of informal carers may decline in coming years (see, for example, Johnston 1995). Others, such as Ozanne (2007), have highlighted the diversity and complexity of family forms and underlying values. Allied to this, de Vaus (1996), drawing on data from the Australian Family Values Survey conducted in 1995, notes that there is considerable variation in the extent to which people accept family obligations. In his view, the survey results:

... did not support the model of a society in which a sense of responsibility and obligation to older family members had been destroyed by rampant individualism. Nor was there evidence of generational self-interest. However, the acceptance of responsibilities and obligations to care and support elderly parents was by no means universal, unequivocal or without qualification. (de Vaus 1996, p. 20)

Interestingly, de Vaus (1996, p. 19) also observed that:

There appears to be a hierarchy of obligations. The more the obligation has a direct impact on people's lives the more reluctant they are to accept responsibility.

A number of analysts expect a shortage of informal carers to emerge over the coming decades (AIHW 2004a; NATSEM 2004; PC 2005b). These analysts have used a number of approaches to explore this development. One indicator of the potential availability of informal carers is the 'caretaker' ratio — that is, the population of females aged between 50 and 64 relative to the population of people aged 80 years or older. The caretaker ratio was designed on the basis that 70 per cent of family support is provided by women and that the majority of people aged 80 years or older need assistance (see figure 2.2 and Kelly 2005).

For Australia, the caretaker ratio is projected to decline from 2.5 potential carers per person aged 80 years or older in June 2004 to less than 1.0 in June 2044 (figure 6.3). The Hogan Review (2004) considered that this particular ratio is of limited use because most carers are not women aged between 50 and 64. But, a similar trend is observed, if the group of potential carers is broadened to include all females aged 20 to 69. The ratio of females in this wider age range to the population aged 85 or older (this age reflects greater life expectancy) falls from 25 potential

carers per person in 2001 to a little over 7 in 2041 (PC 2003). Regardless of which metric is used, the relative supply of informal carers is expected to decline.

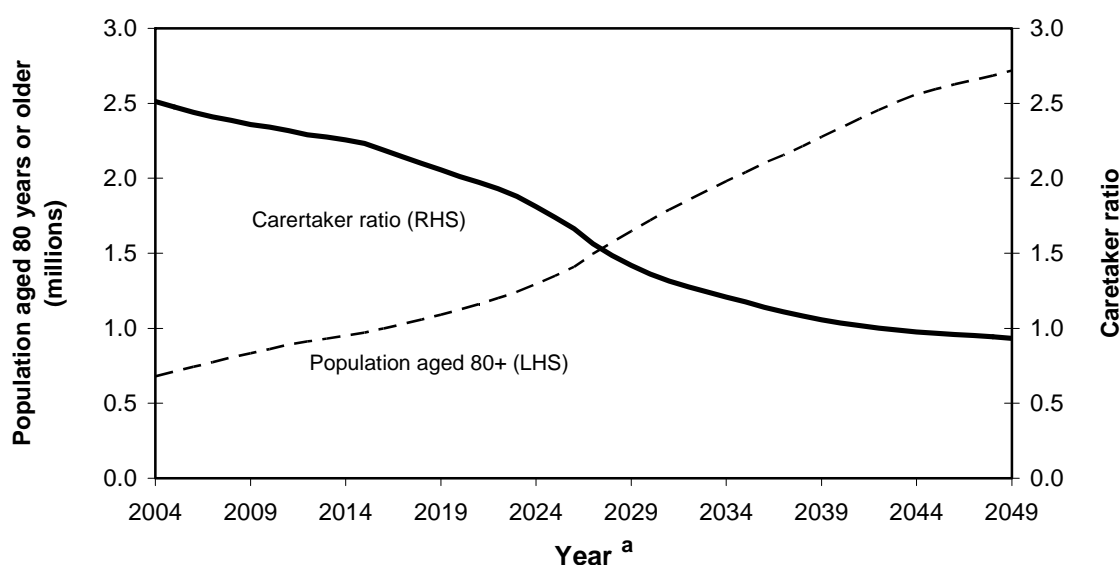
Another measure of the future availability of informal carers is a comparison of all potential carers, male and female, with older persons who have severe or profound disabilities. According to NATSEM (2004, p. 30), this ratio is expected to decline over the coming decades:

When the projections for the number of persons aged 65 years and over with a severe or profound disability and those likely to provide informal care are compared, it is clear that the growth in disabled persons will be much greater than the growth in carers.

NATSEM (2004) expects the demand for informal carers to rise by 160 per cent between 2001 and 2031, while the supply of informal carers is expected to increase by around 60 per cent during this period. These changes would combine to contribute to the carer shortfall quadrupling from 150 000 to almost 600 000 over this period.

Figure 6.3 Older female carers relative to the population in need

Females aged 50–64 years relative to the population aged 80 years or older



^a As at June for years shown.

Data source: Calculated using Series B from ABS (2006c).

The relative decline in informal carers may reduce the effectiveness and sustainability of community care programs in some instances. The presence of an informal carer generally facilitates the delivery of community care services, especially as a client's condition deteriorates. For example, a CACP census (AIHW 2004b) found that program recipients were more likely to have an informal carer as

the number of severe or profound core activity limitations increased (table 6.4). However, it should be noted that informal care is not necessarily essential for the formal delivery of community care as only half of the recipients of formal community care have an informal carer (AIHW 2004b; DoHA 2006e).

In many instances, however, informal carers play a crucial role and the expected relative decline in their availability could affect other aged care modes. In this context, the NSW Health submission to the *Inquiry into Quality and Equity in Aged Care* (SCARC 2005, p. 169) highlighted that the ‘lack of an informal carer ... is the single most common trigger for an older person moving into residential care’.

Table 6.4 Carer status of CACP recipients in 2002 by the number of severe or profound core activity limitations

Carer status	Number of severe or profound core activity limitations			
	0	1	2	3
Has no carer (%)	61.5	49.9	36.6	24.8
Has a carer (%)	38.5	50.1	63.4	75.2
Number of recipients ^a	3817	7674	10 867	2469

^a Excludes 612 care recipients for whom carer status or the number of severe or profound core activity limitations was not stated.

Source: AIHW (2004b).

Can existing support for informal carers be improved?

Informal carers provide support services, either with or without formal assistance, to the aged who predominantly reside in the community.

The adequacy of support provided to these carers impacts on their willingness and capacity to undertake and maintain a caring role. Informal carers are among the lowest socio-economic groups as they seldom undertake full-time work, thereby foregoing associated benefits such as superannuation and paid leave (ABS 2004b). Surveys of informal carers have also concluded that, in general, their caring responsibilities can also diminish their physical, mental and emotional health and wellbeing (see, for example, Briggs and Fisher 2000; Independent Living Centre of WA 2006).

Given the high personal costs that informal carers may experience, support mechanisms will play an important role in encouraging and ensuring that informal care services continue to be provided.

A number of reviews and commentators have been critical of existing support for informal carers despite the expansion of carer support programs by Australian Governments over the past few years (Carers Australia 2007a; Aged Care Assessment Service Victoria 2007; St Laurence Community Services 2007; UnitingCare Ageing NSW.ACT 2007). Among the issues raised, there are five key areas of concern:

- access to information about support services for clients and carers
- structure and adequacy of financial support
- access to respite and other care services
- workplace flexibility
- training and assistive technologies.

Access to information regarding appropriate services and assistance available to aged care clients and their carers plays an important role in helping the aged remain in the community for as long as possible. Recent initiatives to improve access to information regarding aged care services are outlined in appendix A. Notwithstanding these initiatives, the complexity of the system and confusion about how support programs interact limits access and use of aged care services. For example, Allen Consulting (2007, p. 16) found that:

... clients and carers identified a lack of information on community care services as a major barrier to access. This has the biggest impact on those who would be eligible to receive community care but are not currently in the system ... Carers in particular highlighted that access to services before a crisis point would be beneficial for the clients and also for the carer.

Financial support to eligible informal carers is provided by the Australian Government through a carer payment and allowance. This direct financial support does not fully compensate carers for the cost of their time, out of pocket expenses and lost opportunities. The level of support provided, over 50 per cent of private consumption per capita in 2003, is at the higher end of the spectrum compared with some OECD countries, such as Japan, Sweden and the United States, but is comparable with that provided in the United Kingdom (Lundsgaard 2005). However, these comparisons only take direct financial payments into account. For some OECD countries, indirect support to informal carers may be available through the personal care budgets of care recipients. Hence, the above comparison may be somewhat misleading.

The structure of financial support to carers has been subject to criticism because it can reduce the range of opportunities for some carers to participate in the workforce. Some carers value such opportunities for a variety of reasons, including engagement with the wider community. For example, the Taskforce on Care Costs,

representing 45 non-government organisations and businesses, highlighted that the structure of the Carer Payment works against maximising workforce participation because it does not consider the increased costs of providing alternative care arrangements when carers are at work (TOCC 2007). In addition, carers may not enjoy other benefits from working including opportunities to contribute to superannuation and participate in professional development activities.

Access to respite and other care services is important for informal carers. Respite care provides a break for carers to carry out other responsibilities or tend to their own needs. The Australian Government has recognised the importance of providing respite care. For example, funding for the National Respite for Carers Program increased from around \$20 million to almost \$170 million between 1996-97 and 2006-07 (Bishop 2004; DoHA 2007h).

The array of programs offering respite services has been widened to provide services during the day (for a few hours), overnight and for longer periods (up to three weeks) across a variety of settings. The Australian National Audit Office (ANAO 2005, p. 16) has commented that there is ‘insufficient communication and coordination between the National Respite for Carers Program and other community care programs’. Inconsistencies, gaps and duplication in the provision of respite services reduces its effectiveness with attendant impacts on the use of community care. Despite increased funding for community care, a significant unmet demand for respite services remains (Carers Australia 2007b; SCCA 2007). Further, Alzheimer’s Australia (2007) maintains that respite services may not be allocated equitably across all types of clients due to the high demand and low availability of these services. For example, carers of clients with high needs, such as dementia, often miss out on respite as providers choose clients with less complex and challenging behaviours.

A number of stakeholders have noted that integrating the array of respite programs (in terms of funding and administration) could enable better monitoring of client use and promote more equitable outcomes (ACAA 2007e; ACSA 2007b; Queensland Government 2007). In addition, greater integration of respite programs with other community care services has the potential to increase the continuity and flexibility of care.

Access to broader community care programs also remains a concern for informal carers (Allen Consulting 2007). For example, constraints on the availability of CACP and EACH packages create increased pressures on carers that are supporting care recipients waiting for a package to become available. In addition, limited flexibility in funding arrangements restricts the capacity of carers to respond in emergency situations that fall outside the scope of normal service arrangements.

More flexible work environments may provide opportunities for informal carers to undertake caring activities while maintaining their participation in the workforce. In 2003, approximately one quarter of carers reported that they either reduced their hours of work or ceased participating in the workforce altogether because of their caring responsibilities (ABS 2004b). In addition, the Taskforce on Care Costs found that 44 per cent of informal carers work in a role below their skill level because it gives them the flexibility they need (TOCC 2007).

The Business Council of Australia and Carers Australia have both recognised the need for workplace reforms that encourage employers to develop and implement more flexible strategies to assist carers in their caring roles (TOCC 2007). More specifically, the Business Council of Australia has proposed the establishment of a working group comprised of government, non profit organisations and business stakeholders to address the current barriers to workforce participation, including those experienced by carers. The Business Council of Australia (2007, p. 32) envisages developing a ‘Workplace Diversity Kit for business which highlights the need for and benefits of greater diversity in the workplace’.

Training and education can assist informal carers to maintain their caring role for longer. The state and territory branches of Carers Australia and Alzheimer’s Australia offer courses, workshops and seminars for informal carers in stress management, supporting families and coping with change. The Australian Government has funded dementia training for informal carers through these two organisations as part of making dementia a national health priority in 2005. However, there is no recurrent funding mechanism for the general or specific training of informal carers (Carers Australia 2007a).

The use of *assistive technologies* may also help carers support older people and reduce some of the physical and emotional burdens associated with caring. For example, assistive technologies may increase the capacity of informal carers to live independently of the person for whom they care. These include aids for those with disabilities, such as remote control appliances, movement sensors and voice reminders, can increase the ease of caring and prolong independence (McNelis 2007).

In acknowledging the importance of carers, the Australian Government has recently announced an inquiry to investigate how carers can be better supported (Macklin 2008). The Committee will report on:

- the role and contribution of carers in society and how this should be recognised
- the barriers to social and economic participation of carers, with a focus on helping carers find and/or retain employment

-
- the practical measures required to better support carers
 - strategies to assist carers to access the same range of opportunities as the wider community, including increasing the capacity for carers to make choices within their caring roles, transition into and out of caring and effectively plan for the future.

In the Commission's view, this investigation is timely as the effectiveness of support for informal carers influences the willingness and capacity of these carers to contribute their services. As the Department of Health and Ageing (DoHA 2003b, p. 21) has indicated:

The effectiveness of health and aged care services depends in part on the availability of informal carers. In turn, the capacity of carers to continue to maintain their caring role for a family member or friend and their attachment to the labour market, depends on the availability of quality, accessible and affordable aged and community care services, including respite care services.

6.4 Volunteers

In the context of aged care, volunteers provide a variety of support services including assistance with transport, home maintenance, and meal preparation and delivery. Volunteers may also help older people to feel less isolated by transporting them to social activities, developing social networks with the wider community and providing companionship. These services can assist older people to remain in their own homes, thereby reducing the likelihood of premature entry into residential care. As such, volunteers represent an important element of Australia's social capital and generate benefits to society through the support and services they provide.

The pressures on the aged care system outlined in chapter 3, together with the expected relative decline in the availability of informal carers, will increase the importance to society of making effective use of volunteers as a resource to complement other support services for the aged. In particular, the retirement of the baby boomers, associated with their better health and increased longevity, will potentially enhance the capacity of the 'Young-old' to support the 'Old-old'.

This section profiles the general characteristics of volunteers in Australia, considers their future availability and reviews the opportunities to make more effective use of them in future years. It is important to note specific data on the extent and nature of volunteering for aged care is not readily available. Further, comparing trends in the types of volunteering over time is difficult, other than at an aggregate level. This arises as various surveys are incomplete, not conducted at regular intervals and subject to changing methodologies.

Importance of volunteers in Australia

Volunteers in Australia contribute a significant amount of unpaid time and effort to a variety of activities and organisations including health and welfare, sport and recreation, emergency services, childhood development, overseas aid, conservation and animal welfare.

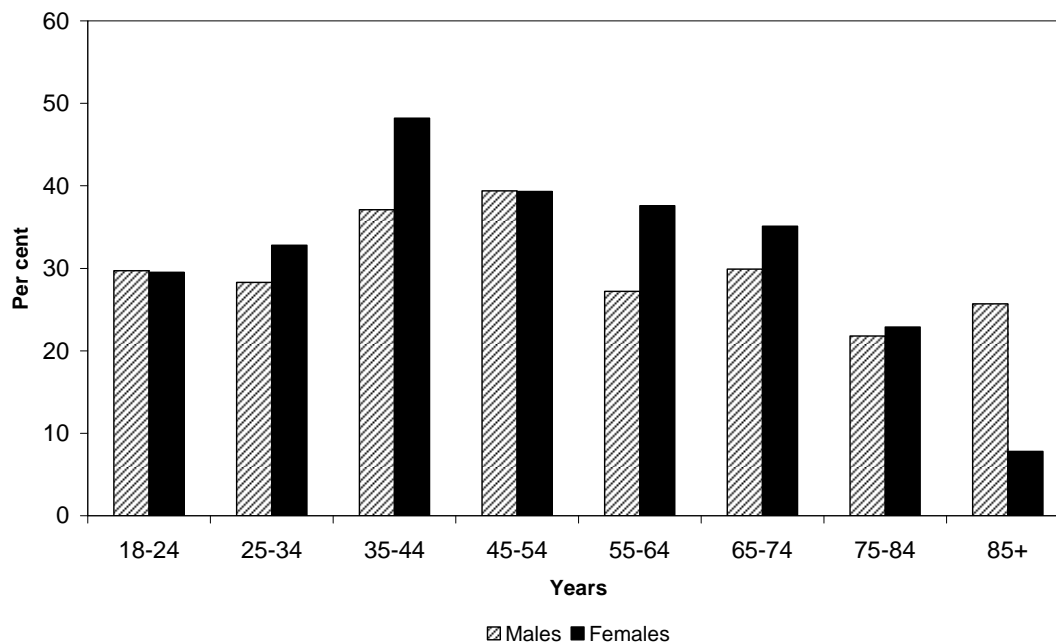
There are two broad types of volunteers: formal and informal. A formal volunteer is someone who willingly provides unpaid help as time, service or skills through an organisation or program (ABS 2007h). An informal volunteer, by contrast, may assist with caring and doing favours for family, friends, neighbours and others, but does not have a direct link to an organisation. By and large, volunteers are not substitutes for paid workers or informal carers; rather, they complement their contributions.

Informal carers are usually considered to be part of the broad definition of informal volunteers but this chapter treats informal carers separately to volunteers due to their direct relationship with the care recipient either as a relative, friend or neighbour. As such, informal volunteers are defined here to have no direct relationship with the service recipient. Using this definition, there were some 500 000 informal volunteers in 2006 who provided a service to someone other than a relative, friend or work colleague (ABS 2007h).

Over one third of the Australian population aged 18 years or older participated in some kind of formal volunteering activity in 2006. In total, it is estimated that 5.2 million people volunteered for formal organisations, contributing some 713 million hours of unpaid services to the community (ABS 2007h). The proportion of formal volunteers in the overall population has increased from around 24 to 35 per cent between 1995 and 2006.

Formal volunteering rates vary significantly according to age (figure 6.4). Overall, volunteering rates are highest for the middle aged (35–64 years). However, persons aged 65 years or older also have significant rates of volunteer involvement, except for women aged 85 years or older.

Figure 6.4 Participation in formal voluntary work by age and sex
Per cent of population, 2006



Data source: ABS (2007h).

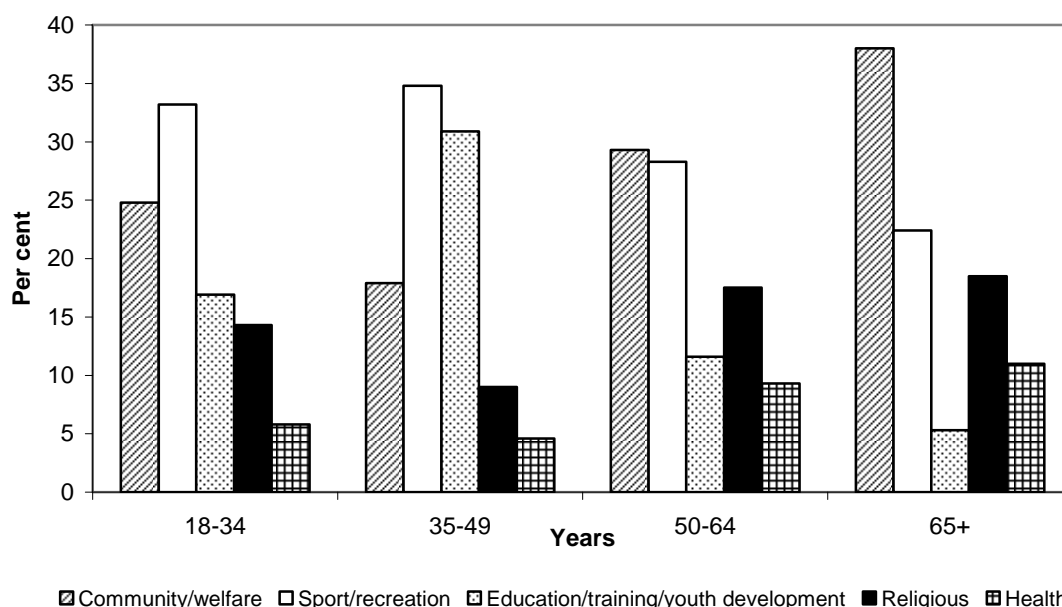
There are also distinct differences in participation rates between different volunteering areas⁶ (figure 6.5). Those aged 35–49 years predominantly volunteer in sport/recreation and education/ training. For volunteers aged 50–64 years, the two key areas of participation are community/welfare and sport/recreation. For those aged 65 years or older, the primary area of volunteering is community/welfare.

The average number of hours spent volunteering each year increases up to and including the 65–74 age group, reflecting the greater availability of time with retirement (ABS 2007h). However, after the age of 75 physical and mental health problems begin to hamper the capacity of many to volunteer.

⁶ The ABS defines five main types of volunteering areas — community and welfare (including emergency services and environment and animal welfare); education and training (includes parenting and children and youth); sport and recreation (including arts, heritage and other interests); religious; and health.

Figure 6.5 Participation in formal voluntary work by type of organisation and age

Per cent of population, 2006



Data source: ABS (2007h).

Volunteering services provide substantial benefits to the Australian economy, even though they are not counted as part of the nation’s GDP. Estimates of the economic value of these services depend on the definition of volunteering and method of estimation employed. For example, the Commission estimates⁷ the value of unpaid voluntary work, excluding care for adults and children, to have been \$14 billion in 2006. Alternatively, Ironmonger (2000) valued volunteer services at \$42 billion in 1997 using a broad definition of volunteering which included formal volunteering, doing favours for family friends outside the home, caring for adults and supporting other’s children.

A significant number of volunteers work in aged care. In 2000, there were 32 628 volunteers working in nursing homes and other forms of accommodation for the aged (ABS 2001). Of these, 70 per cent provided community service activities such

⁷ The value of volunteer services was estimated using data from *How Australians use their time 2006* (ABS 2008b, table 15), *Employee Earnings and Hours 2006* (ABS 2007d) and the *Census of Population and Housing 2006* (ABS 2008a). A market replacement cost approach, that is, what it would cost organisations and households to hire others to do the work for them, was used to derive these estimates based on de Vaus et al. (2003). The estimate, based on the 2006 survey by the ABS (2008b), is comparable with an earlier analysis by de Vaus et al. (2003), updated to reflect growth in population and wages.

as companionship and entertainment. Around 98 per cent of volunteers provided their services through non-profit organisations.

Data specific to volunteering in community care are not available. However, volunteers in programs such as meals-on-wheels have been essential to the success of the development of community care as a viable alternative to residential care (PC 2003).

Future availability of volunteers

A variety of factors are expected to influence the future availability of volunteers for aged care. They include:

- demographic change
- changes to age-specific participation rates
- changes to preferences for types of volunteering
- the capacity of aged care providers to attract volunteers.

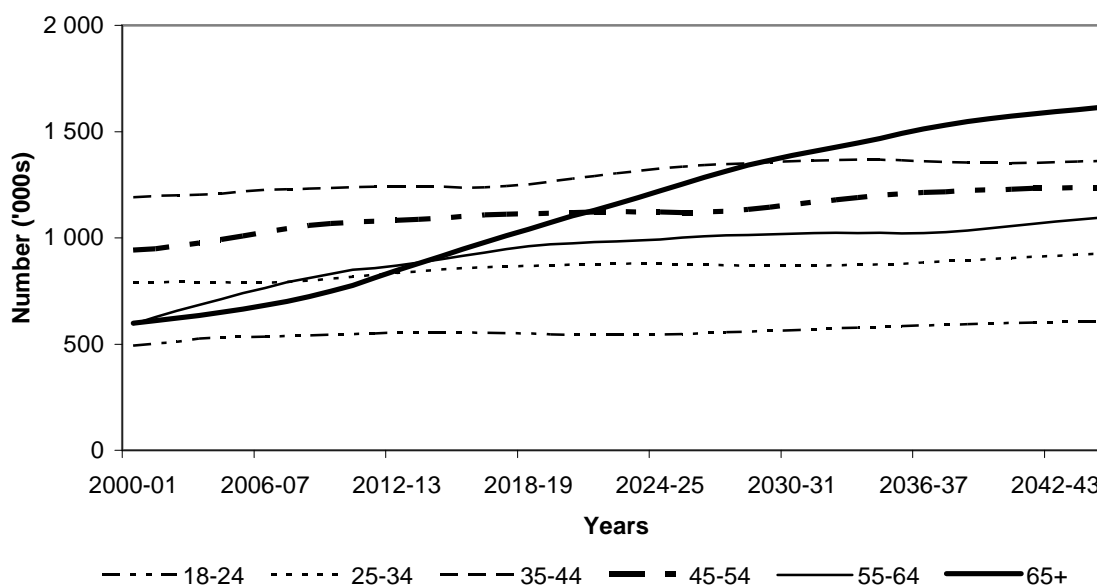
In general, future demographic changes are expected to increase the availability of volunteers.

Reflecting the growing share of the population aged 65 years or older, the Commission (PC 2005b) estimated that the potential pool of formal volunteers from this group is likely to more than double, from around 600 000 to 1.6 million between 2000-01 and 2044-45 (figure 6.6). In addition, the number of volunteers aged 45-54 and 55-64 years are expected to increase by 31 and 84 per cent respectively. By contrast, the Commission expects the number of younger volunteers aged 18-45 years to increase only slightly. These estimates assume constant age-specific volunteering rates over time.

Volunteers aged 65 years or older are more likely than younger volunteers to support the aged through community and welfare groups (figure 6.5). In this context, the ACT Government (2004, p. 18) has commented:

Volunteering is likely to be one of several areas in the community that will benefit from an ageing population in the ACT. The Territory currently has one of the highest rates of volunteering among the States and Territories, and the rates of volunteering among the growing number of retirees are expected to continue to grow over the next two decades.

Figure 6.6 Projected number of formal volunteers
2000-01 to 2044-45 assuming constant participation rates



Data source: PC (2005b).

What is not known is whether the propensity of older people to volunteer for organisations that support older groups will change. For example, changes in the perceived need for volunteers may influence the willingness of people to volunteer. Hence, the large projected growth in the number of older people may prompt others to volunteer for support roles.

The high rates of volunteering among the current cohort of middle aged (45–64 years) may continue into later life as this group is expected to be healthier and more active in their later years (Victorian Government 2004). Comparisons of volunteering surveys suggest that the participation rates of older volunteers are rising at a similar pace to other age groups (ABS 2007h). Workers seeking a partial transition from the workforce may create niche opportunities for volunteer organisations. However, the total amount of volunteering actually provided could be offset by higher workforce participation rates if the recent trend towards extended working lives continues.

Further, competition for volunteers from other areas may reduce their availability in community and welfare activities and religious organisations where older volunteers have traditionally been the main contributors. Organisations that currently rely on younger volunteers, such as sport, recreation, education and training, might face difficulties in attracting recruits in the future (Volunteering Australia 2004). In these circumstances, older volunteers may become relatively more attractive if their health and lifestyles enable them to perform such activities.

The availability of volunteers in helping the aged will also depend on the capacity of organisations that support the aged to tailor programs and activities which maintain and encourage participation by volunteers.

Making effective use of volunteers

Making effective use of volunteers presents a significant challenge for service providers and the community. For service providers, the goal is to get the most out of their volunteers' time while providing a rewarding experience for the individual. From a community wide perspective, the issue is whether there are regulatory or institutional barriers that inhibit these contributions. As a result, volunteer organisations and governments need to consider a range of issues including the role of information channels in effectively promoting and encouraging volunteering, the need for adequate and appropriate training and support (including compensation for expenses) and whether regulatory settings in certain areas (such as insurance and liability) may impair volunteering activities.

The growing competition for volunteers between entities both within and outside of aged care means that those organisations that do not provide a positive experience for volunteers (such as valuing their participation and showing an interest in connecting with them) will find it increasingly difficult to retain and attract them. Volunteers could be expected to look for well managed organisations that provide adequate support and a productive, interesting volunteering experience. In addition, the role of volunteers should be well defined and understood by the volunteer, organisation, recipient and other workers (Volunteering Australia 2005).

There is scope to expand volunteer participation in all age groups directed at providing support to the aged by better tailoring activities to volunteer characteristics. Organisations are responding to this challenge by facilitating:

- on-line volunteering — providing advice and skills from the home or office
- episodic volunteering — short-term opportunities to volunteer without regular or long term commitments
- corporate volunteering — employers encouraging teamwork, staff morale and giving back to the community
- family volunteering — combining the benefits of volunteering with the opportunity to spend time together as a family (Team Consultants 2002).

Where organisations find it difficult to match volunteers with recipients, governments can implement programs to act as a broker and reduce information asymmetry problems. For example, the Community Visitors Scheme provides a service that connects volunteers with residents of aged care facilities to enrich their

quality of life and reduce social isolation (DoHA 2002b). More broadly, the Australian Government has funded Volunteer Resource Centres to provide assistance and training to a wide range of organisations that use volunteers (FaHCSIA 2008).

The impact of rising costs associated with volunteering, especially out of pocket expenses, is likely to affect participation rates (Volunteering Australia 2007). In many instances, the costs associated with transport, uniforms, telecommunications, safety equipment, training and accreditation (such as first aid courses and police checks) may be partially or entirely borne by volunteers. The recent *Inquiry into the Cost of Living Pressures on Older Australians* (SCCA 2008, p. 105) concluded that ‘the capacity of older people to continue to provide such volunteer support was being diminished by increases in living costs’.

While volunteers do not want to be paid for their services, they do not want to be out of pocket (Volunteering Australia 2007). To address this problem and maintain a high level of volunteer participation, the Costs of Volunteering Taskforce, an initiative of Volunteering Australia, has suggested that these personal costs (at either an organisational or individual level) could be reimbursed through a number of options including government grants and tax benefits (Volunteering Australia 2007).

In 2008, the Australian Government announced it would expand the Volunteers Grants Program to \$64 million over the next three years, to help community organisations and their volunteers (Macklin and Stephens 2008). Part of this expansion is in response to a 40 per cent increase in petrol costs over the past five years. This will help around 6000 community organisations and their volunteers, particularly those delivering food, visiting older people in their homes, transporting them to various activities and giving other assistance requiring private transport.

Legislative reforms by federal, state and territory governments to the law of negligence, and specifically around volunteer liability, have reduced some of the impediments faced by organisations in accessing insurance (Barnett 2006).

However, the rising costs of liability insurance is an area of on-going concern for the volunteering sector (Volunteering Australia 2008). Volunteer organisations may lessen the extent of premium increases through reducing the risk and liability associated with their activities by ensuring:

- volunteers work in safe environments
- any ambiguity about where responsibility lies is reduced as far as is practical prior to the volunteer’s actual involvement

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- there is adequate training and supervision for volunteers, and that appropriate policies are in place and made available to the volunteers
 - there is adequate insurance coverage (Volunteering Australia 2006).

That said, the limits placed on policy coverage exclude some older volunteers (aged 80 or older) from participating as risk is considered to increase with age (Volunteering Australia 2008).

Addressing excessive regulatory burdens on volunteers and their organisations, particularly smaller groups, could improve their sustainability. For example, introducing transferable police checks for volunteers who provide services to multiple organisations would reduce the time and costs spent duplicating these processes. In addition, the COAG Business Regulation and Competition Working Group is considering ways to reduce the regulatory burden in relation to food regulation for not-for-profit groups (COAG 2008).

More broadly, some smaller organisations often do not apply for government funding because the complicated application forms, contracts and conditions would impose a significant demand on their resources (Stephens 2008). The Australian Government is aware of this problem and is exploring options to reduce red tape associated with securing government funding.

By promoting the skills and value of older people to the wider community, governments may influence societal attitudes towards older volunteers to overcome participation barriers that some volunteers may face. This approach may attract baby boomers that see themselves as ‘young’ and want to participate in challenging and creative volunteering opportunities (Team Consultants 2001). However, government ‘directives’ aimed at encouraging volunteerism are likely to be unsuccessful or even counterproductive as research suggests that top down approaches are not well received (NHMRC and Volunteering Australia 2003).

Volunteering activities not only benefit those directly involved but are also likely to have spill-over effects within the community which may reduce the costs of providing support services and/or improve outcomes in areas such as health and welfare. There will always be an excess demand for volunteer services as the spill-over effects of volunteering are not valued appropriately by the market. Therefore, governments need to be sensitive to the unintended consequences of policies that impact on the scale and scope of volunteer involvement, such as with liability and insurance, and which may inadvertently reduce the range of policy options available in the future.

