
14 The formal aged care workforce

Key points

- The formal aged care workforce predominantly comprises nurses, care workers and general support staff, including cleaners, laundry workers and catering staff. Medical practitioners and allied health professionals provide health care services which complement, and affect the demand for, aged care services.
- Aged care services are labour intensive, particularly direct care services. As such, access to a sufficient and appropriately trained labour supply is essential to ensure that quality and safe care can be delivered when and where required.
- The demand for aged care workers is expected to significantly increase over the next 40 years as a result of the increasing number of older Australians requiring care and support and a decline in the relative availability of informal carers.
- The supply of workers is problematic. The formal aged care system currently faces difficulties in attracting and retaining workers. These difficulties are expected to intensify due to increasing competition for workers as the overall labour market tightens in response to population ageing.
- A comprehensive aged care workforce strategy needs to be independently developed to identify and address ongoing and future workforce issues.
- Workforce strategies should include:
 - paying fair and competitive wages, improving access to education and training, developing well articulated career paths and better management, extending scopes of practice, and reducing regulatory burdens
 - ensuring that the pricing of services recommended by the proposed Australian Aged Care Commission takes into account appropriate staffing levels, skills mix and remuneration arrangements
 - providing more training opportunities including professional development for staff, particularly those in remote locations.
- While the delivery of many training courses is of high quality, there are some registered training organisations that are not delivering accredited courses to the standard required and there is a need to review the content and delivery of vocational education and training courses.
- Putting in place measures to facilitate the transfer of skills (including language skills) by reducing the regulatory burdens and costs associated with employing aged care workers from overseas is likely to pay significant dividends in the future.

As outlined in chapter 3, the demand for aged care workers in Australia is expected to rise significantly as a result of the increasing number of older Australians requiring care and support and a decline in the relative availability of informal carers. This chapter examines the implications for the formal workforce. Issues affecting the availability of informal carers (the principal means of delivering care to older Australians) and volunteers are discussed in chapter 13. Appropriate access to medical and allied health professionals is also an important aspect of delivering quality care to older Australians and is discussed in chapter 10.

This chapter outlines the scope of aged care workforce considerations and provides an overview of the current aged care workforce (section 14.1). An analysis of future aged care workforce requirements is presented in section 14.2. Issues related to improving the attractiveness of the aged care sector, including remuneration, the working environment, and education and training, are explored in section 14.3.

14.1 Who delivers care services to the aged?

Scope of workforce considerations

Many older people require a variety of different care and support services. Most of these services are provided by family, friends and other informal carers (chapter 13). Personal and health care services represent the vast majority of services provided under the aged care system.

Services are also delivered through health and other social support systems, including disability and welfare. The capacity of the aged care system to provide timely and appropriate care can be significantly affected by access to services in other support systems, especially health services. A number of benefits can be realised where the interfaces between these systems are improved, including seamless service delivery and a reduction in service gaps for the client, enhanced efficiency in service delivery and reduced incentives to shift costs between services.

A range of support services are delivered to many older people by workers who do not require aged care specific skills (for example, tradespeople involved in home modifications, drivers involved in community transport or cooks preparing meals for residents). It is important that there are enough of these types of support workers that are appropriately trained, but the education and training of these workers should be considered in the context of their respective sectors. However, some aged care support workers are covered by the relevant industry award, such as cleaners in

residential aged care, and the capacity of employers to pay fair and competitive wages is considered in the remuneration discussion (section 14.3).

The importance of labour in caring for the aged

Caring for older people is labour intensive and requires a variety of skills. The aged care sector competes for care workers with a number of other sectors, primarily the health sector and the social and community services sector, but also with other sectors in the economy. There is a relative shortage of qualified workers in most of these sectors and there is strong competition for workers, especially nurses although this, as yet, has not flowed through to higher wages. This competition is expected to intensify as the demand for aged care, disability care and health care services increases and the broader Australian labour market tightens as a result of population ageing.

There may be some opportunities to reduce the labour intensity and alter the skill mix involved in delivering aged care through new models of care and the use of assistive and information technologies. However, most applications of technology adopted by aged care providers have acted to complement the workforce — for example, by improving the working environment and improving the quality of care — rather than substitute for it. It would not be prudent to assume that technological developments will significantly reduce the relative demand for labour in the future, although demand side pressures should lead to ever more efficient ways to deploy labour.

Profile of the current aged care workforce

Aged care employees make up around 23 per cent of the total health care and social assistance industry workforce (ABS 2009b; Martin and King 2008). Aged care employees involved in direct caring activities represent around 25 per cent of all employees engaged in health and community services occupations (AIHW 2009b; Martin and King 2008).

As noted by the Commission previously (PC 2008), data on the entire aged care workforce is not comprehensively nor consistently collected and reported. The Australian Bureau of Statistics (ABS) only collects detailed information about the residential aged care workforce while the community aged care workforce is part of a broader category which encompasses all workers involved in the delivery of community care services, including disability services. Other work undertaken to map the aged care workforce, such as that by Martin and King (2008), provides

better coverage than the ABS data but still is considered to underestimate the total aged care workforce.

There were an estimated 262 000 people working in the aged care sector in late 2007 (Martin and King 2008). Of these, 175 000 provided services in residential aged care facilities (RACFs) and 87 000 provided aged care services in community settings. The vast majority of these workers (79 per cent) provided direct care services to older Australians while the remainder delivered support services.

Compared to the broader health and community services industry and all industries, residential and community aged care employees are more likely to be female, work fewer hours and be older (table 14.1).

Table 14.1 Workforce characteristics: profiles for selected sectors, 2007

	<i>Residential aged care</i>	<i>Community care</i>	<i>Health and community services</i>	<i>All industries</i>
	%	%	%	%
Female	93	91	79	45
Part time	69	59	42	28
45 years or older	60	70	46	37

Sources: DEEWR (2008); Martin and King (2008).

There is some evidence to suggest that the direct care workforce is being under-utilised, with a significant proportion of this workforce reporting that they would like to work more hours. Martin and King (2008), found that:

- in community care over 40 per cent of the workforce would like to work at least one hour more per week
- in residential care over 27 per cent of the workforce would like to work at least one hour more per week.

It is difficult to determine trends in the total aged care workforce over time due to limitations in the data collected and the irregularity of data collection, especially for community aged care workers. Despite these limitations, there is evidence to suggest that the workforce is growing in response to the increased supply of aged care services. For example, Martin and King (2008) reported that the residential aged care workforce grew by just over 10 per cent between 2003 and 2007. ABS sub-industry workforce data also shows a steady increase in total residential aged care workers (ABS 2009b).

Given the increasing importance of aged care services into the future, the Commission believes there is merit in developing more appropriate classifications

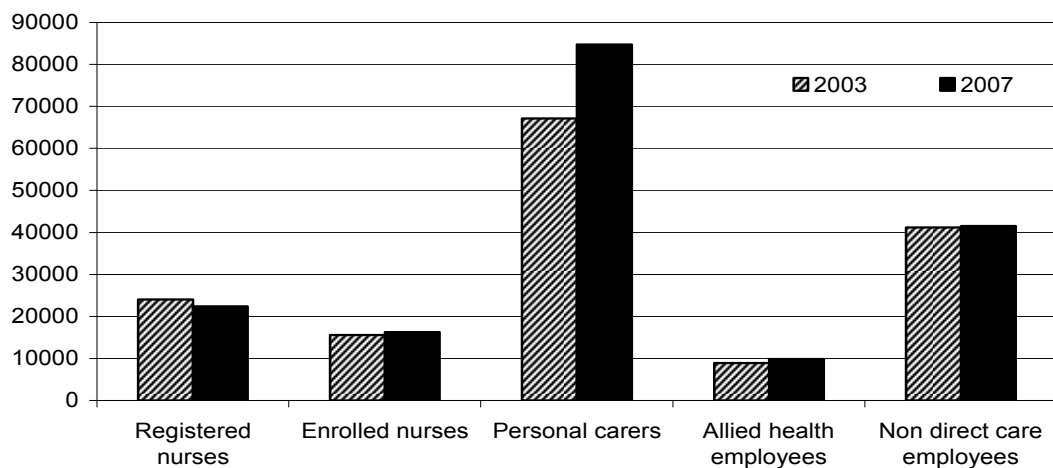
for improving the collection of data on the number and skill levels of workers in the aged care sector. For example, consideration should be given to redefining the ABS sub-industry classifications to reflect changes in aged care policy (for example, by reflecting the development and expansion of relatively intensive community aged care programs — CACP, EACH and EACH-D).

Residential aged care workforce trends

As illustrated in figure 14.1, personal carers have accounted for almost all of the growth in the residential aged care workforce since 2003. This occurred while there was an overall rise in both the number of residents and their dependency level, as reflected by the increasing proportion of high care residents in RACFs.

Figure 14.1 Residential aged care employment

Total employees, 2003 and 2007



Data source: Martin and King (2008).

There is a trend towards employing less skilled (and lower cost) staff in residential settings in the delivery of direct care services. Despite an increase in the workforce overall, the number of full-time equivalent registered and enrolled nurses working in RACFs fell from 27 210 to 23 103 between 2003 and 2007 (table 14.2). This represents a decrease from 35.8 per cent to 29.3 per cent of all full-time equivalent direct care employees in only four years, with most of the reduction occurring at the registered nurse level.

While the substitution towards less skilled workers may be partly driven by financial constraints and difficulties in attracting and retaining nurses, the scopes of practice for some personal carers have also been widened (for example, undertaking medication management). Such initiatives have many benefits, including increasing

the workplace satisfaction of personal carers and improving their skills. Importantly, as recognised by the Australia Health Ministers' Advisory Council, it meets a fundamental workforce principle that:

... to ensure the best use of scarce workforce resources, wherever possible, services should be delivered by staff with the most cost effective training and qualification to provide safe, quality care. (2005, p. 9)

Table 14.2 Residential aged care employees engaged in direct care^a, 2003 and 2007

Occupation	2003				2007			
	Number of employees	%	Full-time equivalent	%	Number of employees	%	Full-time equivalent	%
Registered nurse	24 019	21.0	16 265	21.4	22 399	16.8	13 247	16.8
Enrolled nurse	15 604	13.1	10 945	14.4	16 293	12.2	9 856	12.5
Personal carer	67 143	58.5	42 943	56.5	84 746	63.6	50 542	64.1
Allied health employees	8 895	7.4	5 776	7.6	9 875	7.4	5 204	6.6
Total number	115 660	100	76 006	100	133 314	100	78 849	100

^a Full-time equivalent data is only available for employees engaged in direct care activities, not all employees.

Source: Martin and King (2008).

Reforms aimed at increasing competition between providers and innovations in models of care and scopes of practice, together with team-based health care, have the potential to offer further improvements in delivering safe, quality care, as well as enhancing the productivity of the workforce.

Community care workforce snapshot

There were an estimated 87 500 employees delivering community aged care services in 2007 under the six community aged care programs — HACC, CACP, EACH, EACH-D, Day Therapy Centres and the NRCP (Martin and King 2008). This is probably an underestimate of the total number of community care workers due to limitations in data collection.

Community care workers, equivalent to personal care workers, comprised over 80 per cent of direct care employees in 2007. There is limited use of enrolled nurses and registered nurses — 2.5 and 10 per cent of the workforce, respectively, in 2007. This reflects the large number of low intensity care services delivered in community settings that do not require high levels of clinical skills and qualifications.

14.2 Future aged care workforce requirements

An important consideration when examining labour force supply and demand is the substitutability of labour across occupations. Australia's labour force supply is limited in several dimensions:

- first, by the working age population
- second, by the participation in the labour force of those of working age (the participation rate), for both men and women and by age range
- third, for those that seek employment, the relative scope for not only obtaining a job, but also the number of hours that the potential worker wants.

Government policy can affect the quantity and quality of labour supply in a number of ways. A sound policy approach can remove distortions that discourage people who have a capacity to undertake work, allowing them to enter or return to the labour market. It can also provide incentives for the under-employed to increase the hours that they work — one example of which might be a more flexible industrial relations system. Policy also has a role in promoting skill development in the areas where it is required which, in turn, can lead to a better qualified and more capable labour force. Migration policy can increase the supply of labour through both skilled and unskilled migration.

Within these parameters, however, there is a limit to the supply of labour that can be mobilised in Australia. Aged care is difficult to target directly as it is just one of many sources of demand for labour at a range of skill levels. It is in this context that the report examines aged care labour force issues.

Projections of aged care workforce demand

The industry and governments recognise that Australia faces a significant shortfall in coming years of appropriately skilled aged care workers — nurses, carers and allied health workers (PC 2008). Given the fundamental reforms recommended by the Commission, there are various, and at times opposing, impacts on the demand for skilled workers. For example, the lifting of supply of restrictions on community and residential places is expected to increase the demand for services. This is likely to be offset to some extent by higher co-contributions which may temper somewhat the demand for formal services. The complex demand and supply environment, long lead times for education and training, and data problems mean that, at best, projections out over long time horizons are indicative only (PC 2005).

That said, DoHA in its initial submission to this inquiry stated:

Assuming that the ratio of number of aged care workers to the size of the population aged 70 or over remains constant, then by 2050 a total of 827 100 will be engaged in the provision of aged care ... [This] will account for about 4.9 per cent of all employees in Australia. (sub. 482, p. 38)

DoHA's estimate indicates that under current policy arrangements the aged care workforce will need to increase by between two and three times as a direct result of Australia's ageing population. The Australian Government has invested substantially in education and training through increasing the number of courses for registered and enrolled nurses and care workers, and has developed various incentive programs to encourage workers to enter or re-enter the aged care sector. Programs to increase the skills of personal care workers through vocational education and training have been acknowledged as beneficial by participants to this inquiry (for example, Havilah Hostel, sub. 384).

Australia is not alone in facing the challenges of delivering quality aged care to an ageing population. A recent OECD Health Policy Studies paper concluded that:

In absolute terms, by 2050, the demand for LTC [long-term care] workers (on an equivalent full time basis) is expected to about double in Japan, the USA and Canada, and about triple in Australia, New Zealand, Luxembourg and the Slovak Republic. (2011, p. 78)

As outlined in chapter 3, the significant increase in the number of older people and a relative decline in the availability of informal carers will result in a significant increase in the demand for aged care services. As aged care services are labour intensive, the delivery of these services will require a commensurate increase in the aged care workforce.

The Commission has calculated that, based on the estimated demand projections under its proposals and assuming that models of care are maintained at 2007 levels, there would be need for about 980 000 aged care workers by 2050. Information about the underlying data and assumptions used in calculating this estimate can be found in appendix E.

In responding to these demand pressures, the supply of personal care workers and enrolled nurses will be driven by the relative attractiveness of aged care compared to alternative employment options. Basic personal care skills can be developed reasonably quickly, but so can the skills associated with similar paying work. While most aged care providers will support skill development, current remuneration and working conditions are considered strong disincentives to entering and staying in the sector.

Registered nurses and allied health professionals will also be in greater demand. As is the case for personal care workers, the key to attracting and retaining these workers will also be to offer fair and competitive remuneration and satisfying working conditions. Competition from other employers, such as hospitals and specialised health services, will intensify as demand for these services also grows.

The Commission's proposed phasing out of supply constraints in community and residential care is likely to increase the demand for workers over the next few years. This is particularly the case for community care, where it is expected that the rate of growth will be relatively high and the capital investment required to expand is relatively low. Indeed, there are concerns about the capacity of some registered training organisations to deliver adequately trained personal care workers with enough practical experience to deliver quality care in a community setting with limited supervision.

Given the inherent uncertainty of projecting demand and supply over a long time horizon, there is a need for either an ongoing or periodic evaluation of the key demand and supply factors, including the models of care employed and technological developments. Such an evaluation could either be undertaken as part of the systemic review proposed as an element in the Commission's implementation plan (chapter 17) or be an ongoing role for an appropriate agency.

Models of care

Models of care will change in the future in response to:

- changes in the underlying client mix
- enabling providers to deliver a wider range of services,
- changes to the characteristics and scopes of practice for workers
- technological advances and changing regulatory requirements.

As summed up by the Community Services and Health Industry Skills Council (CSHISC), there is a need for greater skills development to facilitate models of service delivery which:

... emphasise maintaining functional independence for individuals and meeting complex demands ... This continues the need to develop more advanced career paths within service provision roles and to develop management capacity. (2010, p. 7)

This sentiment was echoed by a number of submissions which consider that changes to the current models of care are necessary to provide person-centred care with the appropriate skill mix (Debra. King, sub. DR530; Michael. Fine, sub. DR592).

The underlying client mix is expected to change as a result of an ageing population and an increasing diversity in care needs and preferences. Reflecting consumer preferences, and in response to the relaxation of supply constraints, more older people are expected to receive a broader range of services in the community at high levels of intensity. In addition, the recent trend towards higher intensity services being provided in residential settings is expected to continue, requiring more highly skilled care workers, such as registered nurses and clinical care specialists, to deliver these services.

Models of care will also evolve in response to the wider range of services that providers will be able to offer. For example, the Commission is proposing that aged care providers also be allowed to deliver certain health services, such as sub-acute care.

Scopes of practice changes may result in a further expansion of the roles of some workers, including personal carers and allied health assistants. However, these skills will only be developed if workers have an incentive to invest in the associated training. Having clearly defined career paths with commensurate remuneration to reflect these increases in skills would provide financial incentives to workers.

Further, there may be greater scope for clinical care specialists to deliver more services in aged care settings, particularly if limitations on the range of services aged care providers can offer are relaxed. Current funding arrangements make it uneconomical for such workers to be employed by aged care providers directly but there is the potential for this to change in the future.

Reducing the regulatory burden may also affect models of care by allowing providers to better use the skills of their workers. Some submissions have noted that poor skill mix and regulatory restrictions on who can undertake what tasks have resulted in qualified nurses becoming ‘conditioned to work as part of a production line’ (Y.H. Jeon, sub. DR593, p. 1).

The adoption of assistive and information technologies may also prompt changes to the models of care. For example, greater use of in-room hoists in residential settings and the adoption of communication technologies for consultation and monitoring in community settings will lead to adjustments in care models.

But positive change will need managers who have the vision to develop and adopt new models of care, to set up rigorous trials, to evaluate their outcomes and to disseminate the results. This will require the development of leadership skills, including at the middle management level, to execute these changes successfully.

14.3 Addressing direct care workforce challenges

A number of aged care providers report increasing difficulty in attracting and retaining staff. Martin and King (2008) report that the number of RACFs with at least one equivalent full-time vacancy for a direct care worker increased from 37 per cent to 50 per cent between 2003 and 2007. For community care service providers, 29 per cent indicated that they had vacancies for direct care workers at the time of the survey in 2007. Residential care providers indicated that they had most difficulty attracting registered nurses in a reasonable period of time, while community care providers had relatively more difficulty finding community care workers.

Martin and King (2008) also indicated that the sector overall has a high turnover rate, with around one in four personal carers having spent less than a year with their current employer. Turnover in residential aged care is one third higher than for the health care and social assistance industry and slightly higher than for the economy in general (ABS 2008c). Baptistcare (WA) outlined its experience with high turnover in a tight labour market:

Our staff turnover is currently running 29% per annum (and on the increase as resource projects in WA come on line). It peaked two years ago with the previous resources boom in WA at almost 38%. This is typical of the industry in WA (based on recent network benchmarking). Such a high turnover has a major impact on operating costs (recruitment and training), operational efficiency and, importantly, has implications for quality of care. (sub. 426, p. 6)

Froniditha Care provided an industry perspective about the challenges arising from the poor image of the sector:

The issues for Fronditha are shared by the industry at a national level ... concerning the image of aged care, career structures and pay discrepancies between the acute sector and aged care. (sub. 436, p. 10)

The Australian Nursing Federation (Victorian Branch) noted:

The preliminary findings of the 2010 University of Melbourne longitudinal study reveal a worsening picture, with 44.5% of participants who had left aged care at the time of the study citing working conditions, inadequate staffing levels, poor staff resident ratios, too much paperwork or poor pay as their reason for leaving. Significantly, the study also found that poor working conditions had driven some staff to retire earlier than they otherwise would have done had working conditions been better. (sub. 341, p. 70)

The Quality Aged Care Action Group captured the concerns of many participants:

We recognise that there is a shortage of nurses across the health system and that aged care is suffering as part of this. We also know that there are added barriers to attracting

nurses to aged care: lower wages, high workloads and difficulty meeting professional responsibility, less nurses in the skill mix means less opportunity for professional collaboration and support, and the limited career paths and barriers to accessing professional development. (sub. 346, p. 10)

For some providers, recruitment and retention challenges are exacerbated not only by high turnover, but also by the relatively high use of temporary or ‘agency’ staff. These factors affect the capacity of providers to deliver continuity of care, put more stress on ‘regular’ workers, negatively affect the working environment (including for visiting health care professionals) and can unsettle older people, thus reducing the quality of their care experience. In addition, there can be substantial costs associated with high turnover rates, including advertising for new positions, inducting new workers into the organisation, training them, and employing agency staff to fill shifts. In some cases, it may be more cost effective for providers to invest in higher wages, rather than incur the costs associated with high turnover rates.

The Commission notes, however, that during its industry visits it met with a number of providers and their staff who said they had minimal turnover and virtually no use of agency staff. When questioned, both providers and staff attributed this to good management practices. The variability of management within the aged care sector is an important determinant of the attractiveness of individual service providers as places of employment — it is also fundamental to ensuring the sustainability of the industry as a whole, since high turnover rates reduce continuity of care for care recipients and the overall efficiency of labour and make it even more difficult to meet the demographic and skills challenges. While there have been significant investments aimed at improving the clinical care skills of aged care workers, there has been much less focus on developing management capacity and anecdotal evidence suggests that the majority of managers were formerly clinical staff with limited experience in management roles.

Improving the attractiveness of aged care and developing a sustainable workforce to meet future demand will require an integrated approach in a number of areas, particularly paying staff competitively, fostering a rewarding working environment (especially through better management) and providing further opportunities for skill development (including increasing scopes of practice) and exploring the opportunities to source care workers internationally.

Action in one area alone will not be enough to set the industry on a sustainable path. A recent OECD Health Policy Studies paper considers a multi-faceted approach essential to developing an aged care workforce which can meet the challenges of delivering care to ageing populations around the world (Colombo et al. 2011).

There is a role for government in setting prices for care services which enable employers to pay fair and competitive wages. In addition, governments can also take action to support the delivery of quality education and training, and reduce unnecessary regulatory burdens. Solutions also lie with aged care providers, as they too have a responsibility for ensuring that they provide an attractive workplace.

Innovations in governance arrangements have been suggested by some participants in developing an appropriate workforce policy response. This issue is reviewed later in this section.

Remuneration

The relatively low remuneration of aged care workers is consistently raised as a key issue in attracting and retaining workers. There are a number of factors that have kept wages relatively low, including:

- inadequate price setting and indexation of care subsidies
- poor bargaining positions of a highly feminised, part time workforce which has had limited success in raising wages significantly above the relevant industry awards.

Care workers and support workers

Carer workers, including assistants-in-nursing, personal care workers and community care workers, deliver the majority of aged care services to older Australians. However, both providers and unions consider that their remuneration does not reflect the underlying value of their work. For example, Amaroo Care Services advised that:

While aged care workers may have a passion for their work in making a difference for the elderly they care for or support, it remains a sad indictment upon our social values when an entry level zoo keeper attracts a base rate of \$19.50 per hour for tending to animals while an entry level personal carer or support worker only attracts \$15.90 per hour for providing care to our elderly in accordance with a new Australian industry award that came into effect during July 2010. (sub. 98, p. 14)

United Voice, representing many care and support workers, has argued that the process of conventional enterprise bargaining has failed to deliver wage growth in the aged care sector to a level that is 'fair' when compared to workers with similar qualifications in other industries.

The lack of opportunity for effective enterprise bargaining has contributed to the ongoing undervaluation of aged care employees' remuneration. This in turn has meant the wages of aged care employees are behind relevant community standards.

Employees at all levels, and particularly at levels where employees hold vocational education qualifications, are paid significantly less than other employees performing work requiring the same levels of qualification and/or experience. (sub. DR845, p. 16)

In this context, United Voice maintained that a certificate III aged care worker was comparable in skill to a certificate III metal worker. However, wages between the two sectors are substantially different where metal workers have been able to exercise bargaining strength and wages are significantly higher as a result (earning between \$23 and \$34 per hour).

Recent cases presented before Fair Work Australia (FWA), such as the Equal Remuneration Order and Low-Paid Authorisation, may not, in themselves, substantially raise the level of pay for historically low paid staff in aged care and comparable community services sectors (box 14.1). However, whether by this mechanism or by bargaining between employers and employees directly, the Commission's recommendations provide an opportunity to address a pay anomaly by putting the aged care sector on a sustainable footing.

The large proportion of part-time and casual employment (not always by choice) translates directly to the total take home pay of these workers and makes the sector relatively unattractive for workers (including a number of males) who are looking for full-time employment.

The current *Aged Care Award 2010* and continued funding restrictions may also limit the capacity of providers to attract and retain support workers with specialist skills, such as 'maintenance staff, builders with expertise in disability modifications, gardeners, bus drivers and catering staff' (National Presbyterian Aged Care Network, sub. 110, p. 7).

Registered and enrolled nurses

Registered and enrolled nurses are also relatively poorly paid compared to those performing similar roles in alternative settings. For example, the Australian Nursing Federation (ANF) submitted that:

A national shortage of nurses and the wages gap between nurses working in the aged care sector and nurses working in the public hospital sector is exacerbating recruitment and retention difficulties in the aged care sector. The wages gap currently stands at 44.6% or \$393.77 per week national average under an Award and 15.2% or \$168.52 per week national average under an Enterprise Bargaining Agreement (EBA). (sub. 327, p. 2)

This gap has been widening over time, as outlined by the Commission previously (PC 2008).

Box 14.1 Fair Work Australia and the aged care sector

Fair Work Australia (FWA) handed down decisions in the first half of 2011 on two cases affecting workers in the aged care sector — the Equal Remuneration Order (ERO) and the Low-Paid Authorisation (LPA).

Equal Remuneration Order

The ERO application sought principally to apply the wage rates and classification structure of the Queensland Social and Community Services (SACS) award to employees in the SACS industry nationally. The Queensland SACS rates were initially fixed in an equal remuneration decision by the Queensland Industrial Relations Commission in 2009.

FWA reached the conclusion that for employees in the SACS industry there is not equal remuneration for men and women workers for work of equal and comparable value by comparison with state and local government employment. However, FWA also concluded that there were significant differences between the ERO and the Queensland case. As such, it considered that adjustments to the modern award were a more appropriate means to redress gender-based undervaluation of work but did not agree that the gap in pay was entirely attributable to gender. At this stage, it is unclear how the modern award will be adjusted.

Low-Paid Authorisation

The LPA applications sought to rectify the historic undervaluation of personal care and support workers in the residential aged care sector (regardless of whether they are covered by an enterprise agreement or the award) in specified areas and enrolled nurses in the aged care sector in Western Australia. The intention of the application was to permit United Voice and the Australian Workers' Union (QLD Branch) to bargain for a multi-enterprise agreement covering all employees named in the applications.

FWA accepted that in general terms employees in the aged care sector are low-paid and those under award agreements should be granted a LPA to pursue a multi-enterprise agreement. However, it also decided that employees covered by enterprise agreements should be excluded from the LPA. At this stage, it is unclear what the final outcome will be for those covered by the LPA.

Sources: FWA (2011a, b).

Some providers indicated in consultations that they pay the equivalent or above public sector wage rates for highly qualified staff, such as registered nurses and facility managers. Other providers also indicated that paying competitive wages is important to attracting and retaining staff, but inadequate funding and indexation mechanisms do not allow them to do so (chapter 5).

While it is not known how many aged care nurses are paid under award agreements compared to enterprise bargaining agreements, the College of Nursing claimed that relatively low remuneration in aged care settings:

... strongly supports the community and health professionals' belief that aged care nursing is inferior; this creates workforce issues around recruitment and retention and overarching work force planning. (sub. 86, p. 7)

The disparity in wages between the public health system and the aged care system can create issues within the aged care system. For example, some combined aged care and health services (such as multi-purpose services in New South Wales) are operated by state government health departments and pay public sector wage rates. As such, these services can be more attractive to workers and can potentially exacerbate attraction and retention difficulties facing aged care providers in the same geographical location.

As with personal carer workers, there are limited financial incentives for nurses to upgrade their clinical skills to become clinical specialists or nurse practitioners. For example, many nurses have undertaken training to enable them to practice as nurse practitioners, but the funding of care services means that aged care providers cannot afford to employ them in these roles.

Realising fair and competitive wages

As the Australian Government is a significant source of funding for services employing aged care workers, it will incur the budgetary consequences of wage rises to the extent they are reflected in increased subsidy levels. The Australian Government, in its submission to the Equal Remuneration Case for Social and Community Service Workers, noted that:

If any additional Government funding is provided, it would likely come at the expense of other Government funded services. (Australian Government 2010g, p. 10)

The National Aged Care Alliance, in its submission argued for:

... a dynamic and resourced workforce planning regime with adequate funding to ensure sufficient skilled, appropriately qualified and competitively remunerated staff are attracted to and retained in aged care and respected for their work. (sub. 88, p. 8)

Increased funding will not necessarily be reflected in increased wages for aged care workers. For example, previous attempts by the Australian Government to encourage aged care providers to 'pay competitive wages' have not narrowed the wages gap for nurses. One of the reasons cited for this was that there was no specific requirement for providers to direct the extra funding towards higher wages (PC 2008).

As competition for skilled health workers intensifies, it will be increasingly difficult for aged care providers to withhold salary increases in the context of higher funding levels. In the Commission's view, it is unlikely that wages for aged care workers will become or remain competitive unless there is an independent mechanism for assessing the efficient cost of delivering care and setting scheduled care prices accordingly. To this end, the Commission is proposing that the prices for care services be recommended to the Australian Government by the Australian Aged Care Commission (AACC) following an independent analysis and for the recommendations to be published to ensure transparency (chapter 15). This analysis should take into account the need to pay fair and competitive wages to all aged care workers as well as the appropriate skill mix and staffing levels for the delivery of those services. In doing so, however, the AACC should avoid being overly prescriptive as to the labour force structure which could restrict the scope for providers to be innovative in their models of care and the recruitment and deployment of their workforce. For example, some providers may choose to have relatively more high skilled (or low skilled) workers or to substitute capital for labour. The Commission considers it important that providers are able to differentiate their product offerings from their competitors to drive innovation and service quality.

While there may be concerns about higher funding levels flowing through to wages, providers are unlikely to be able to staff their services in a tight labour market unless they pay competitive wages. However, the industry has historically used the award as a benchmark in setting wages for personal carers and support workers. It may be that the award remains an important mechanism by which fair and competitive wages are determined.

It should be noted that increases in wages to fair and competitive levels will increase the quantum of public funding for aged care, whether under the current aged care system or the Commission's proposed system. It would equally flow through to the level of public expenditure projected by the *Intergenerational Report 2010* (Australian Government 2010d). Importantly, therefore, funding increases related to fair and competitive wages are independent of, and separate from, the fiscal impacts of the Commission's proposed aged care reforms.

In increasing the level of the sector's funding to recognise the need for higher wages, the Government should be cognisant of the distortions caused by the fringe benefits tax (FBT) exemptions available to workers in Public Benevolent Institutions and public and not-for-profit hospitals. FBT exemptions can lead to different after-tax salaries for nurses undertaking the same work who are notionally on the same gross salaries but work for different providers (box 14.2).

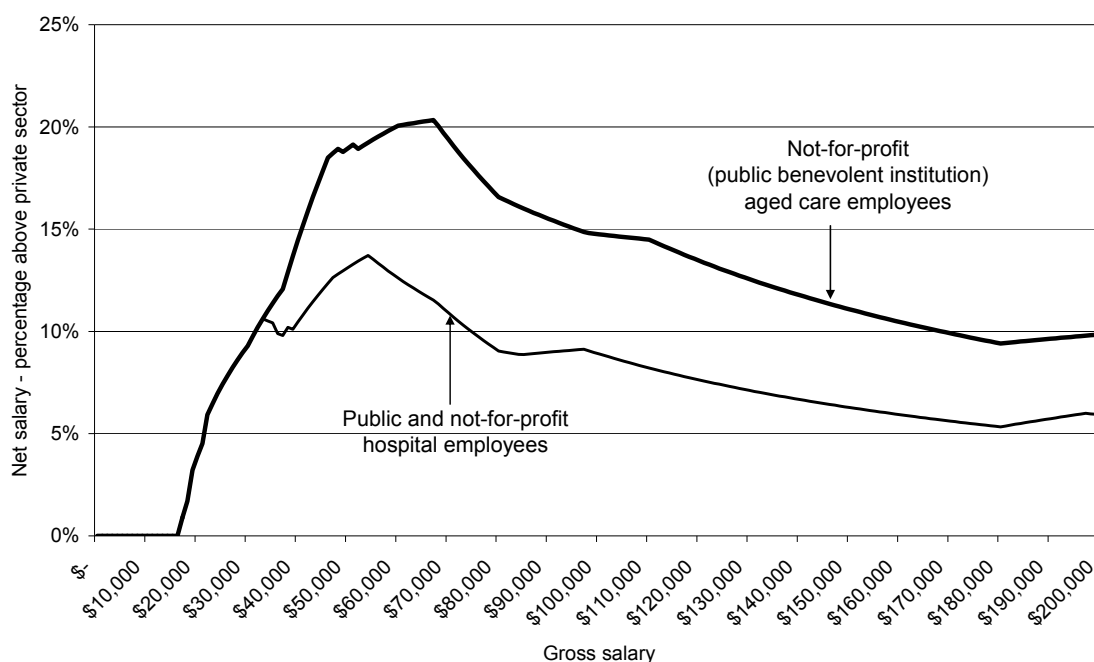
Box 14.2 FBT concessions and competitive wages

One of the difficulties workers face in comparing wages is differences in taxation treatment of wages from different employers. This arises because of fringe benefits tax (FBT) exemptions provided to employees at public and NFP hospitals and employees at NFP aged care providers. Where workers at these institutions use these exemptions, their take home pay can be considerably higher than that of their counterparts earning the same before-tax wage. For example, an employee of an NFP aged care facility on \$65 000 per annum could have a take home pay that was 20.3 per cent more than an employee on the same salary at a private aged care facility (figure 14.2).

This occurs because employees of NFP aged care facilities can claim up to \$30 000 in FBT concessions, while employees of public and NFP hospitals can claim up to \$17 000 in FBT concessions. And the range of expenditure eligible for these concessions is broad, including groceries, rent and mortgage payments. In addition, these limits do not include the uncapped meal entertainment benefit, although some organisations impose a de facto limit on their employees' use of the benefit.

Figure 14.2 Fringe benefit tax benefits

After tax salary: percentage increase compared with for-profit aged care employees^a



^a Excludes potential benefits from the meal entertainment allowance. Assumes that employees at each income level use the full relevant FBT concessions: \$17 000 for public and NFP hospital employees and \$30 000 for NFP aged care providers.

Sources: PC (2010b) and Commission estimates.

An increase in the level of remuneration for aged care workers will have a flow-on effect to other factors affecting the workforce. For example, the image and reputation of the sector as an area where caring work is valued would be enhanced by better wages. In addition, the quality and continuity of care may be increased as workers are more content to stay in the sector and turnover is reduced. In turn, this may allow more funding for education and training to be targeted towards up-skilling the workforce, rather than basic training for new entrants who are unlikely to stay for long under current conditions.

RECOMMENDATION 14.1

The Australian Aged Care Commission, when assessing and recommending scheduled care prices, should take into account the need to pay fair and competitive wages to nursing and other care staff delivering approved aged care services and the appropriate mix of skills and staffing levels for the delivery of those services.

Working environment

There are many rewarding features of aged care work which are often overlooked in discussions around recruitment and retention. Unlike some other health care settings, aged care offers employees the opportunity to develop longer term relationships with many of the people for whom they care. It can also offer greater flexibility, especially for workers who want a fixed roster as opposed to a rotating roster, or who want part-time employment. In addition, it can provide opportunities for nurses to use a wider range of their clinical skills and judgement in the delivery of quality care.

The government and the aged care sector could work together to promote these ‘positive’ characteristics so as to raise the profile of the sector to potential workers, particularly younger workers. For example, undergraduate nurse education could promote aged care positively as an industry within which to develop a career through advanced clinical placements in ‘teaching aged care facilities’ (see below) and the introduction of undergraduate electives that offer students an opportunity to undertake specific gerontological nursing education and training.

However, the reality also needs to reflect the rhetoric, particularly in regard to work environments, so that workers who are attracted to delivering aged care services have a desire to stay in the industry over the long term.

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However, the reality also needs to reflect the rhetoric, particularly in regard to work environments, so that workers who are attracted to delivering aged care services have a desire to stay in the industry over the long term.

Overall, direct care staff appear to be under increasing pressure to provide quality care. There is some evidence to indicate that workloads for aged care workers have increased. Between 2003 and 2007, the ratio of residents to full-time equivalent direct care staff increased from 1.85 to 1.99 (AIHW 2004b, 2008b; Martin and King 2008; Richardson and Martin 2004). This occurred during a period where the acuity of residents increased, as represented by the increasing proportion of high care residents.

At the same time as the acuity of residents increased, the proportion of personal care workers also increased and the proportion of registered nurses decreased.

The view that staff are under increasing pressure was shared in *Who Cares for Older Australians?* which reported that:

... many residential direct care workers feel that they do not have sufficient time or opportunity to engage in the caring tasks for which they were employed. (Martin and King 2008, p. 28)

Submissions and consultations indicate that the aged care working environment is characterised by heavy workloads resulting from strenuous physical activity, excessive regulatory reporting requirements and other administrative burdens (Manningham Centre, sub. 325; Queensland Nurses' Union, sub. 409). As a result, staff satisfaction is low and this may lead to high turnover which then contributes to an even more stressful working environment for staff at all levels.

Various proposals to improve the working environment of aged care workers and the quality of care they provide include introducing mandatory staffing ratios, the licensing of care workers and using information and assistive technologies to increase the time available for caring and to reduce the physical burden associated with caring activities.

Staffing ratios

Staffing ratios can provide a transparent mechanism to link the funding of care services with the provision of sufficient staffing resources to promote the delivery of an appropriate quality of care as well as staff satisfaction in the workplace.

While participants to this inquiry unanimously agreed that there were critical levels of staffing required to provided quality care, they held differing views about whether mandatory staffing ratios were an appropriate mechanism to deliver the care required and to improve working conditions for staff.

Unions representing nurses, and a number of nurses themselves, argued strongly for the introduction of mandatory staffing ratios to ensure the provision of appropriate standards of nursing care, particularly in residential settings. For example, the ANF considers that there should be:

... a guaranteed minimum of 4.5 hours of nursing care per resident per day... to be allocated equally across registered nurse, enrolled nurse and the nursing assistant [personal carer] workforce at an enterprise level. (sub. DR919, p. 1)

This staffing level is more than the average number of hours delivered to residents in 2007 as reported by Martin and King (2008).

Many other participants also supported the introduction of staffing ratios (box 14.3).

Box 14.3 Participants' views supporting the introduction of staffing ratios

Amanda London, an enrolled nurse working in aged care for three years:

... mandatory staffing levels are needed in the aged care sector to keep quality staff in the industry, and to ensure good standards of care in the future. (sub. DR500, p. 1)

Australian General Practice Network:

... insufficient staff ratios and staff shortages in RACFs frustrate health practitioner's efforts to provide quality care and discourage health professionals from providing services to RACFs. They also impact on the quality of care and overall wellbeing of residents. The introduction of measures that support appropriate staffing ratios in RACFs and promote sustainability, capacity and competency of the aged care workforce are critical first steps to address these barriers. (sub. 295, p. 14)

Aged Care Crisis Inc.:

Nurses and carers frequently report that they are not able to care for residents properly, given the conditions and time restraints imposed on them. It is clear that providers of aged care generally strive to operate with the fewest staff possible — at times placing vulnerable residents at risk. Most settings which care for vulnerable individuals, for example hospitals and child care centres, operate within a mandated staff/person ratio. It is intolerable that frail, older people do not have this protection. (sub. DR520, p.2)

Australian Nursing Federation (Victoria):

...legally mandated and fully funded nurses/PCW to resident ratios will provide an effective and transparent mechanism to realise adequate and stable staffing levels and provide the appropriate skill mix in residential aged care settings. Similarly, such a mandate has the potential to reduce the increasingly intolerable and unsafe workloads suffered by nurses and PCWs and in doing so resolve the most significant factor militating against the recruitment and retention of a sustainable aged care workforce and of quality of care – while at the same time improving the capacity of the aged care system to meet the complex care needs of residents. (sub. DR603, p.12)

Aged and Community Services Australia (ACSA) held a contrary view:

ACSA sees aged care primarily as a social and independent life care model rather than a pure medical or clinical one. Within this clients are able to exercise choice about the nature of the care they receive. Therefore providers must have capacity to change the staffing mix depending on the needs and desires of clients. (sub. DR730, pp. 35-36)

While the Commission agrees that aged care is not purely about medical or clinical care, as discussed in chapter 6, health care is a component of aged care. And, as outlined in box 2.4, care subsidies paid using the Aged Care Funding Instrument (ACFI) are paid for three care domains, one of which is 'complex health care'. In practice, however, the delivery of care by personal care workers and nursing staff needs to accommodate the changing needs of the care recipients.

As discussed in chapter 10, there is some evidence to suggest that higher nursing hours translates into better care outcomes but the evidence for aged care is not as strong as it is for acute care. Indeed, a number of participants pointed to the lack of hard evidence in this area. United Voice (formerly the Liquor, Hospitality and Miscellaneous Union), for example, said:

... there is dearth of Australian research into staffing ratios currently applying in residential aged care facilities and minimum staffing levels that are necessary to achieve acceptable quality outcomes. (LHMU, sub. 335, p. 11-12)

And ACSA suggested that mandatory staffing ratios in Victoria's public aged care facilities do not demonstrate better care:

There is no evidence to suggest that set ratios provide or guarantee better quality care. The Victorian Public Sector residential facilities operate with ratio and they do not argue that their care is better than other providers. (sub. 730, p. 36)

The ANF (Victorian Branch), however, indicated that the mandatory staffing ratios in that state have improved working conditions:

They have proved the crucial ingredient to reducing intensification of work, and improving staff satisfaction, attraction, recruitment and retention of high quality nursing staff to public sector aged care services in Victoria. (sub. 603, p. 13)

The College of Nursing indicated that an agreed staff ratio adapted to the resident mix:

... is an important tool in ensuring quality care and staff satisfaction. (sub. DR554, p.2)

However, they also commented that:

It is also recognised that issues around staffing mix and levels will not be entirely addressed with a simple mathematical ratio of staff : resident being put in place. Addressing this issue may require a comprehensive review of 'care' requirements and associated models of care/staffing skill mix. (College of Nursing, sub. DR554, p.2)

Further, imposing mandated staffing ratios could lessen incentives for providers to invest in innovative models of care. Innovations, such as through the application of technology and redesigning work practices, will be important in assisting the aged care sector to meet the expected increase in the demand for services.

In addition, some participants including the ANF and ACSA, observed that the introduction of staffing ratios in aged care where there is not currently the workforce capacity to meet the requirements imposed would present some difficulties.

On balance, the Commission considers that, at this stage, the imposition of a simple staff ratio is a relatively blunt instrument, particularly given that the care resident profile of every facility will be ever changing. Such ratios become particularly problematic for small facilities, and a rigid application of ratios could create operational difficulties for these facilities. Further, the existing quality accreditation process (supported by the complaints handling process) provides a mechanism for encouraging providers to apply an appropriate skills mix and staffing level in the delivery of community and residential aged care services (appendix F).

Beyond this, the Commission is proposing to strengthen the quality assurance framework by requiring that quality indicators be published to help care recipients and their families make informed choices about the quality of care and to enhance transparency and accountability around how funds are spent on care. The Commission is also suggesting that a facility publishes indicators staff qualifications and skills together with a profile of care recipients, as part of the proposed Quality and Outcomes Data Set (chapter 10).

That said, the Commission is also proposing that the AACC, an independent body, would undertake a public benchmarking study to determine the prices associated with entitlements to care services. This benchmarking study would need to take into account the appropriate staffing level and skills mix in the delivery of service entitlements to identify an efficient price for service delivery. The basis for determining prices would be transparent, which would impose a higher level of accountability on providers to allocate the appropriate skills mix and staff level to deliver quality care for a specific entitlement.

The Australian Government has engaged the ANF to undertake a ‘Researching Staffing and Skills Mix in Residential Aged Care Project’ (sub. DR919, p. 2). In effect, this project will address the earlier mentioned College of Nursing comment about the need for a comprehensive review of ‘care’ requirements. The outcomes of this research project should feed into the benchmarking study and a similar project should be undertaken for the delivery of community aged care services.

Licensing of all direct care workers

Licensing of all direct care workers was suggested as a mechanism to improve the quality of aged care services and lessen the supervisory burden on nursing staff. While there are national registration (licensing) requirements for enrolled and registered nurses which specify scopes of practice, a professional code of conduct and requirements for continuing professional development, there are no such requirements for personal care workers.

Participants put forward a variety of views regarding the need to apply a licensing regime to the personal care workforce (box 14.4).

One argument for a licensing regime is that because personal care workers provide health care services as part of delivering aged care, they should be licensed in the same way as other health care professionals — that is, through professional registration. However, aged care services are a combination of both personal care and health care and it is unclear how much health care, if any, is delivered by personal carers.

Given the similarities in roles, any licensing regime that was applied to care workers of the elderly would arguably also have to apply to care workers of other vulnerable groups, particularly child care workers and care workers providing services for people with a disability. As workers in these other sectors do not generally provide health care related services, it would not be appropriate to impose a health profession licensing framework on these workers.

Another argument advanced in favour of a licensing regime is that it would promote more uniform skill outcomes among personal care workers and, hence, improve the quality of care provided. Licensing through a mechanism similar to that for health professionals would produce workers who had defined scopes of practice, minimum qualifications and the requirement to undertake ongoing professional development. However, such a regime could exacerbate current workforce shortages, particularly in areas where there is already a tight labour market or where there are limited opportunities to undertake training and secure qualifications. As explained by ACSA:

If licensing was introduced then a large number of current workers would not comply and our experience is that many do not want to pursue formal qualifications. Licensing would make it even more difficult for providers in RRR [regional, rural and remote] and mining areas to fill positions. We would argue that professional development and role definition are the legitimate role of the employer in conjunction with the employee. (sub. DR730, p. 36)

Box 14.4 Comments on the need to licence personal care workers

Several participants were in favour of the introduction of a licensing regime for personal care workers.

Australian Nursing Federation (ANF):

ANF argues that assistants in nursing, however titled, should be regulated ... The licensing of this group of care workers will afford them benchmark education and make them accountable to the public for their practice... (sub. 327, p. 11)

Mercy Health:

We recommend a move to registration of PCAs [personal care assistants] to establish a base skill set nationally and to enhance the professionalism of this segment of the workforce. Registration of PCAs would enhance the attractiveness of the role and provide increased assurance to families that their loved ones are cared for by registered professionals. (sub. DR781, pp. 3-4)

J. M. Wynne:

Registration creates a body that vets candidates and supervises the standard of training... It leads on the establishment of professional associations that develop codes of conduct. (sub. DR568, p. 27)

In contrast, a number of participants opposed the introduction of a licensing arrangement for these workers.

Catholic Health Australia (CHA):

CHA considers that licensing of itself will do little to address the workforce pressures faced by the sector. Closer attention to the matters such as remuneration and workforce supply... especially measures to upgrade the skills of the workforce, have the potential to make a far greater positive impact on workforce issues... (sub. 217, p. 17)

Alkira Aged Care:

The registration of all workers would most definitely have a negative impact upon the ability to attract staff. (sub. DR686, p. 8)

Health and Community Services Union (HACSU) Tasmania:

HACSU is opposed to the licensing of personal carers in aged care. This would result in significant additional administrative burdens on the aged care sector without any appreciable gain. (sub. DR799, p. 19)

Royal College of Nursing, Australia (RCNA):

RCNA believes that it is premature to be considering the licensing of unregistered personal care workers. (2011, p.1)

Many submissions arguing against a licensing regime considered that a more appropriate and effective approach to increasing the skill levels of personal carers was through greater investment in education and training. For example, United Voice (formerly the Liquor, Hospitality and Miscellaneous Union) indicated that it:

... recognises the concerns of stakeholders over the quality of care. However, we believe that investment in training and qualifications of aged care workers is a more

nuanced, effective mechanism than simplistically requiring a licensing system. (sub. 335, p. 14)

In regards to concerns about the accountability of the actions of personal carers, Royal College of Nursing, Australia (RCNA) maintained that:

Currently, the legal responsibility for hiring appropriately skilled workers rests with employers, as it does in all other employment contracts. External registration adds a further dimension to this employment arrangement that is arguably unnecessary in the case of unlicensed care workers, as it imposes a level of accountability that extends beyond their employer. (sub. 352, p. 6)

The RCNA has outlined an alternative to licensing in its submission to the Australian Health Ministers Advisory Council on options for the regulation of unlicensed health practitioners, concluding:

Prior to any further consideration of registering personal care workers (however titled) RCNA believes it is critical to scope and develop a nationally endorsed practice framework for care workers (both qualified and not) that includes codes of ethics, codes of conduct and competency standards to assist and guide unlicensed care workers and the nurses to whom they report in the delivery of competent and safe care. (2011, p. 2)

The Australian Government allocated \$3.5 million over three years in the 2010-11 Budget to explore a national scopes of practice and competency framework for personal carers and assistants in nursing, including in aged care facilities (Australian Government 2010c). Like the RCNA, the Commission supports this initiative in preference to the implementation of a licensing system at this time.

Another alternative to a licensing regime would be the introduction of a ‘working with vulnerable persons’ requirement for aged care workers, as is required for those working with children. Such a requirement could strengthen the current criminal history checks required for personal carers working in aged care by also including a risk assessment. The introduction of a consistent and transferrable ‘working with vulnerable persons’ requirement for all people working with these groups may also improve worker mobility between sectors and jurisdictions, and be relatively efficient to administer. The Commission notes that legislation for a ‘working with vulnerable people’ checking system has been introduced into the ACT Legislative Assembly but has not yet been enacted (Birch 2011).

On balance, the Commission considers that a licensing regime for all carer workers is not appropriate and could introduce a level of inflexibility within the aged care system that could exacerbate labour shortages. Ensuring the delivery of quality care is more appropriately addressed through the accreditation process, training, professional development and other mechanisms. It should also be noted that

providers have a responsibility and duty to provide quality care and it is therefore incumbent on them to ensure that their employees have the appropriate skills and experience.

Reducing regulatory burdens and embracing technology

The excessive regulatory burdens associated with the accreditation process, acquittal mechanisms for funding, and mandatory reporting requirements for missing residents and assaults, were frequently identified as reducing work satisfaction and preventing greater productivity.

Submissions, such as Anglicare Sydney (sub. 272), generally indicate that the administrative and reporting burden was high, despite the introduction of the ACFI reducing it to some extent. Indeed, Manor Court Werribee Aged Care Ltd questioned the need for so much regulation:

Why do our staff need to spend 40% of their working time completing paperwork? It is under 20% in the hospital system. (sub. DR529, p. 2)

Both a reduction in unnecessary reporting (chapter 15) and the introduction of integrated information technology platforms for care administration could increase worker productivity. Simplified and streamlined information technology systems have the potential to reduce the amount of time spent by aged care staff in both reporting and coordination activities (for example, medication management and electronic reporting — box 14.5).

Electronic personal aged care records will assist in both reducing errors and avoid duplication in record keeping (chapter 9). The attachment of advanced care plans to these records will further enhance the continuity of care, especially where the care recipient moves between community, residential and acute care (hospital) settings.

In addition, the greater use of information technology to aid the process of providing care may increase the attractiveness of the sector to younger workers who are familiar with such technology and are looking to use it in their work.

The introduction of some assistive technologies (for example, in-room hoists and tracking devices — box 14.5) may reduce the physical burden on aged care workers and may also reduce time spent finding and transporting equipment to where it is needed. Such initiatives are likely to increase the amount of time that workers can spend with clients and improve occupational health and safety.

Box 14.5 Role of technology in improving working environments

Information and assistive technologies can improve the aged care work environment by reducing the physical and administrative burden on employees. As such, they can enable providers to support their workforce and better meet the needs of their clients.

In the area of information technology, a number of initiatives have been proposed to streamline reporting requirements and reduce the burden on care staff. Electronic medication management, care plans and quality reporting systems all have the potential to substantially reduce the paperwork burden and, to some degree stress, for staff, and improve care quality and continuity for older people receiving care.

In the area of assistive technology, there appears considerable potential to reduce the level of physical exertion and increase the time staff can spend with residents by introducing in-room lifting hoists. They can reduce workplace injuries (and compensation premiums) and resident injuries associated with lifting, repositioning and mobilising. In-room hoists also reduce the time staff spend looking for and moving other lifting devices, and can be used when the need arises.

Global positioning devices and other technologies that can assist in the location of necessary equipment may assist staff in more efficiently delivering the care required.

Source: Summit Care (2010).

Skills development and career paths

Opportunities for skills development, career paths and increased scopes of practice are important aspects of aged care that can be improved to attract and retain high quality direct care staff and to develop management skills. However, as noted above, workers must have incentives to develop their skills and this is not reflected in current remuneration patterns.

Consultations with providers indicate that those who report low turnover and limited use of temporary staff place a high value on supporting professional development. However, some of these providers also report that they are financially constrained in their ability to develop capacity and to support professional development, particularly as this requires giving employees paid time off to undertake education and training activities.

This problem is exacerbated in rural and remote areas where it can be difficult (and/or expensive) to find substitute staff and there are substantial costs associated with sending an employee to another location for training. For many in the rural and remote workforce who have family and/or community responsibilities, travel to undertake training can be exceedingly difficult. As such, there is a clear need to increase the level of locally delivered training within regional settings in order to

attract and retain local staff. This is particularly so for Indigenous staff who may not be willing to travel away from their communities for extended periods. Further, the lack of provision of housing both for staff and trainers in remote areas is a significant problem that requires attention. These issues are canvassed more extensively in chapter 11.

An issue raised consistently in submissions, consultations and hearings was the considerable variability in the education and training levels of personal carers and enrolled nurses, even between those with comparable qualifications (particularly at the certificate III or IV level) (box 14.6).

According to participants, one of the main contributors to this variability seems to be the marked differences in the delivery of courses by Registered Training Organisations (RTOs). For example, Aged Care Queensland (ACQ) submitted that:

... the current outcomes for delivering training are more heavily weighted on numbers rather than quality. ACQ members have reported concerns with fast track training programs, which deliver certificate III in less than a month. These programs undervalue the work of the sector, do not effectively link to the workplace, and are not conducive to quality training outcomes... (sub. 199, p.27)

Other participants were also critical of the poor quality of training provided by some RTOs, primarily in terms of the quality of trainers and assessors, course length and the extent and nature of practical experience included in training programs. Sophie Curtis, sharing her experiences, noted:

This course [Certificate III in Aged Care] can be delivered in as little as 3 months from a small office with no equipment or infrastructure and may include little or no practical placement...

I know of a RTO that employed a trainer that had qualified with Certificate III in Aged Care only 12 months before and whose industry experience was extremely basic... I have also been told of RTOs in Melbourne that offer this qualification in less than 2 weeks. (sub. DR693, p.2)

Although standards for the delivery of vocational education and training (VET) courses exist, it would appear that they are not being adequately monitored. As such, it would appear that the national standards for the registration and auditing of RTOs should be more rigorously enforced by VET regulators to ensure quality and consistency in course delivery and student outcomes.

Box 14.6 Participants views on the quality of VET course delivery by RTOs

Clare Dewan and Associates:

In relation to training I have observed the results of having little or no quality control processes in place for the Registered Training Organizations. While some produce excellent results, and some work closely with employers to obtain the results the employers want, there are too many who do not produce the results which are in either the interests of the employees or the industry... (sub. 119, p. 2)

Amaroo Care Services:

Frequently we receive applications from newly qualified personal carers who have been 'fast-tracked' through a 2 - 4 week Certificate III course who really have little idea of what they might be required to do on the job, having had insufficient course work and practical experience. The variance in quality of the training differs so much between RTOs and the industry requires greater consistency. Clearly a Certificate III and IV should equate to same standard. (sub. 98, p. 15)

Tablulam and Templer Homes for the Aged:

The current situation of a PCW being qualified as a Cert. 3 Aged Care Worker after 3 weeks of classroom and 2 weeks of workplace placement (without a qualified mentor/tutor) is totally indefensible and unfair to the PCW and the recipient of their attempts to care... The need for a minimum educational and industry standard is paramount if we are ever to get an overall, acceptable level of care for the frail elderly in Australia. (sub. DR535, p. 2)

VincentCare Victoria:

In part, the issues with PCWs relate to the inadequate quality control of the registered training organisations (RTOs) who deliver PCW courses. The implementation of such measures would ensure recipients of these courses receive adequate training to enable them to fulfil the necessary requirements of working in aged care. The length of the courses (both classroom contact time and practical placement hours) between RTOs is variable; ranging from an extremely short course of a couple of weeks with no clinical placement through to course over a period of months with participants completing 60 – 100 hours of practical aged care experience. (sub. 258, p. 19)

ANF (Victoria):

The most significant concern we have relates to the commitment of the employer to provide training, the quality of the training course on offer where it is offered, the mode of delivery and the standards and quality of the registered training organisation (RTO) providing the education. (sub. DR603, p.8)

ECH, Eldercare and Resthaven:

While the RTO sector is regulated there is great variation in the quality and competency levels of graduates. There is a national training framework with defined learning outcomes but the number of core competencies/units in each course varies significantly. The actual course time can vary from a couple of weeks to six months full-time, depending on credit transfers and recognition of prior learning. Much more consistency is needed through, perhaps, the introduction of a national curriculum and audits of RTO courses. (sub. 453, pp. 4-5)

Some participants, such as Clare Dewan and Associates, called for a broad review of the training system:

There needs to be a review into what the training has degenerated to and what is required to ensure people undertaking training are actually required to train in practical aspects of aged care so when they get into the sector they have the skills required for medication administration, hands on care and empathy for the residents/clients. (sub. 119, pp. 3-4)

There has been significant investment in education and training for personal carers by the Australian Government aimed at increasing the qualifications and skill levels of these workers. While the intent of this policy is commendable, it would appear that some training organisations are not delivering the desired outcomes for students or the aged care industry.

The Australian Government has identified that there are systemic problems with the VET system as a whole and is undertaking a broad range of reforms in the sector to create a national system of quality assurance and regulation, including establishing the Australian Skills Quality Authority and strengthening the Australian Quality Training Framework (Evans 2010). However, as this process is in the early stages of implementation, the Commission considers that an independent and comprehensive review of aged care courses, such as a National Strategic Industry Audit, is warranted to identify why there is such large variability in course delivery and what improvements are necessary to ensure that students demonstrate pertinent competencies on a more consistent basis.

Widened scopes of practice for workers can play an important role in the quality and efficiency of care delivery and in worker satisfaction, and will become increasingly important as broader health workforce shortages become more acute. The Community Services and Health Industry Skills Council (CSHISC) has worked with industry, governments and training institutions to develop a range of courses which enable workers to develop the skills they require in the delivery of aged care services and to undertake courses that can widen their scopes of practice, including in allied health assistant streams.

These courses should be promoted within the aged care sector to allow workers to diversify their skills and take on new roles in the provision of aged care services. More generally, for those workers interested in taking on more responsibility and undertaking further study to develop their skills, a number of career paths should be available to keep them motivated to stay in the sector. However, for these initiatives to be taken up, skills development should be rewarded through a graduated wage progression structure at clearly defined levels of competence.

The potential to increase scopes of practice is not limited to less skilled workers. In this area, the CSHISC is proposing to develop a range of advanced practice and leadership courses to promote further clinical skills development and enhance the management skills of workers in these roles. In relation to the development of clinical skills through ongoing professional development and nurse education, the RCNA considers that:

... work is needed to encourage the development of CNS [Clinical Nurse Specialist] and CNC [Clinical Nurse Consultant] roles so that their clinical seniority and expertise can contribute to quality care outcomes and the development of new clinically-effective models of care. (sub. 914, p. 1)

There is also significant potential for the expansion of nurse practitioners in aged care with the regulatory and funding impediments reduced by recent Government changes which facilitated access to Medical Benefits Scheme and Pharmaceutical Benefits Scheme subsidised care and medications. However, it is imperative that the pricing of care services allows aged care providers to consider implementing innovative models of care which involve nurse practitioners in care delivery.

Developing and implementing widened scopes of practice for health workers (including those working in aged care) is one of the tasks of the recently formed Health Workforce Australia, which was created following the Commission's report into *Australia's Health Workforce* (PC 2005a). The Commission notes that this project is in its early stages of development.

In Australia, there are currently only a limited number of specialist 'teaching aged care services' and student experiences of placements in mainstream aged care facilities are not always positive. Research suggests that student placements in facilities which offer a variety of tailored clinical experiences can have a significant effect on the attitudes of students towards older people and increase the attraction of the aged care sector as a graduate destination (Abbey et al. 2005; Robinson and See, sub. 231).

In addition to providing positive placement experiences, teaching aged care services can 'provide an infrastructure to support a robust and much needed program of research' (Robinson and See, sub. 231, p. 2) and support the development of management skills. These services also have the potential to provide opportunities for trainee doctors and allied health students to learn to work with older people in aged care settings. Such initiatives may increase the willingness of health professionals to provide services to older Australians.

The Australian Government recently announced it will support the establishment of teaching residential aged care services over four years (Australian Government 2010c). The Commission supports the direction of this commitment but considers the non-ongoing nature and the relatively small level of funding to be inadequate to address current and future workforce shortages in the sector.

The expansion of graduate programs for registered nurses in aged care settings can provide a platform to develop specialised clinical and management skills in a collegiate mentoring environment. Some larger providers, such as BUPA Care (sub. DR794), recently initiated such programs as one approach to attracting more nurses into their operations.

Although these programs are only relatively new, submissions indicate that they have increased the recruitment of graduate nurses into the aged care sector and improved the variety of options available to registered nurses upon graduation. While larger aged care providers may have the economies of scale to develop such programs, it is unlikely that smaller providers will have the same capacity. To address projected workforce demand, there may be a role for the Australian Government to support the development of graduate nursing programs for organisations that do not have the capacity to take on graduates in a supernumerary capacity (that is, in addition to normal staff rostering through the induction process).

RECOMMENDATION 14.2

The Australian Government should promote skill development through an expansion of accredited courses to provide aged care workers at all levels with the skills they need, including:

- ***vocational training for care workers entering the sector and looking to upgrade their skills***
- ***adequate tertiary nursing places to meet the anticipated demand from the health and aged care sectors***
- ***advanced clinical courses for nurses***
- ***management courses for health and care workers entering these roles.***

RECOMMENDATION 14.3

The Australian Government, in conjunction with universities and providers, should fund the expansion of ‘teaching aged care services’ to promote the sector and provide appropriate training for medical, nursing and allied health students and professionals.

Given industry concerns about the variability in training outcomes for students, the Australian Government should undertake an independent and comprehensive review of aged care-related vocational education and training (VET) courses and their delivery by registered training organisations (RTOs). Among other things, the review should consider:

- *examining current practices that may be leading to variability in student outcomes, including periods of training and practicum*
- *reviewing procedures to ensure that VET trainers and assessors possess required current practice knowledge*
- *identifying whether regulators are adequately resourced to monitor and audit RTOs using a risk-based regulatory approach and have appropriate enforcement regimes that allow for appropriate and proportional responses to non-compliance by RTOs*
- *identifying reforms to ensure students demonstrate pertinent competencies on a more consistent basis.*

International migration

Skilled migration may also have a role in boosting the size and quality of the aged care workforce. A number of submissions argued for greater temporary or permanent migration of nurses and care workers (Alzheimer’s Australia NSW, sub. 455; Catholic Health Australia, sub. 217; DutchCare, sub. 129). For example, Catholic Health Australia stated:

Consideration also needs to be given to augmenting the local workforce by sourcing suitable staff from overseas, including staff who could receive further training in Australia. (sub. 217, p. 15)

An OECD Health Studies Report has commented that international migration of aged care workers may have a substantial and increasing role in meeting future workforce challenges (Colombo et al. 2011). It notes that some OECD countries have successfully increased their aged care workforces through targeted migration. However, language and cultural differences may adversely affect care quality due to communication barriers and lack of familiarity with equipment, medications or work practices.

There is some potential for Australia’s aged care industry to source workers from overseas to help to meet the expected growth in demand for aged care services. A discussion paper by Aged and Community Services Australia (2011) has outlined

the recent experiences of their members in recruiting overseas workers (box 14.7). Some providers have found recruiting personal carers through mainstream skilled visa programs (such as the section 457 visa program) to be virtually impossible due to the restrictions placed on these programs (ACSA, sub. DR730).

Box 14.7 Advantages and weakness of recruiting overseas workers

The advantages of recruiting overseas workers include:

- decreased agency costs
- easier and cheaper than trying to constantly advertise
- improved overall retention, if workers are treated well.

The disadvantages of recruiting overseas workers include:

- upfront time, cost and effort
- long lead times
- no guarantees the visas will be issued
- workers moving to another employer
- financial and emotional costs of assimilation
- prejudice or fear on part of some residents
- higher level of initial and ongoing supervision, particularly where there are concerns about clinical competence.

Source: ACSA (2011b).

In evidence provided at hearings, some providers told of employing registered nurses from overseas to work as personal carers for up to 2 years. Registered nursing qualifications obtained overseas are not automatically recognised in Australia and these prospective registered nurses have to undergo further assessment before they are allowed to practice. As personal carers, these workers were said to generally provide a higher quality of care than the average carer.

In addition to the transferability of nursing qualifications, providers who indicated mixed experiences in attempts to use skilled workers through sponsored migration programs citing the issue of English-language proficiency as a constraint on sourcing aged care workers, especially higher skilled workers, from some countries.

Targeted programs to increase the aged care workforce could be particularly useful in the provision of appropriate care for older Australians from non-English speaking backgrounds if the language skills of migrant workers and clients from linguistically diverse backgrounds were aligned (chapter 11). However, these workers will also

require competent English skills to communicate with management and other workers, and to complete care documentation. As such, they may require training either before they migrate or as part of their employment.

In locations where there is expected to be a medium to long term shortage of care workers, providers and government should work together to explore ways in which foreign workers with appropriate skills can supplement the local aged care workforce. On this issue, the Commission also notes the broader considerations surrounding the recruitment of competent health workers from less developed countries.

Overall, with the expected future demand for care workers due to the ageing of Australia's population and expectations for high quality care in a labour-intensive sector, the need for foreign workers to supplement the local labour force is likely to become more important. Putting in place measures to facilitate the transfer of skills (including language skills) by reducing the regulatory burdens and costs associated with employing care workers from overseas is likely to pay significant dividends in the future.

A strategic direction for aged care workforce policy

A number of participants have indicated during this inquiry that there is need to develop a strategic approach to addressing workforce issues. For example, ACSA considers that:

... our industry requires a more sophisticated workforce planning approach at a strategic and operational level because at present we do not know how many workers we will need in given areas, what qualifications they will require and where they are going to come from... Regional and local understanding of workforce needs is critical. Providers need assistance to understand about competitors in the market from within the industry and from outside; the qualifications that will be in greatest shortage; and local labour shortage numbers. (sub. DR730, p. 34)

Similarly, Dr King, co-author of the *Who Cares for Older Australians? A Picture of the Residential and Community Based Aged Care Workforce, 2007* (Martin and King 2008), believes that:

What is required is a comprehensive analysis of the impact of the changes to the model of care for the workforce. Without such an analysis, the aged care workforce will lack planning and adequate development... (sub. DR530, p. 2)

Indeed, the Australian Government has previously recognised workforce issues as a key part of the *National Strategy for an Ageing Australia* (Andrews 2001) which resulted in the release of a National Aged Care Workforce Strategy covering

residential aged care in 2005 (box 14.8). This strategy identified many important workforce issues (such as education, training and development) which have also been raised in this chapter. However, it did not highlight the key issue of remuneration and the role of the Australian Government as price setter and main funder of the aged care sector.

Box 14.8 National Aged Care Workforce Strategy

The National Aged Care Workforce Strategy was developed to identify the profile of the residential aged care sector and its needs between 2005 and 2010.

The strategy aimed to provide a people management and development framework for a sustainable and viable aged care sector. This framework outlined seven objective areas to increase the attractiveness and sustainability of the aged care sector:

- workforce profile — the sector contributes to, and has access to, reliable data for effective, collaborative planning and management of the workforce
- workplace practice models — these models address current and future needs
- leadership and management — can develop competent, effective and innovative teams
- education, training and development — underpin the sector
- a responsive workforce — the sector has the staffing numbers and skills to develop and maintain a positive workforce which responds to changing client profiles and can focus on resident outcomes
- status and image — the professional and community status and image of the sector makes it a desirable place to work
- effective linkages — the National Aged Care Workforce Strategy is linked to other relevant strategies, policies and plans.

Source: DoHA (2005).

While significant financial resources have been devoted to executing the National Aged Care Workforce Strategy, it is unclear how much progress has been made in achieving the strategy's stated objectives in the five year timeframe it was intended to cover. In commenting on the strategy, ACSA stated that:

While it is a useful document it is out of date and only addresses direct residential aged care staff. It fails to plan for community care, allied health and ancillary workers. This document should be updated and made more inclusive of all health care professionals that work in the industry as a matter of urgency. It would capture the myriad strategies that are required to address this multifaceted problem in a practical way within a broad environmental analysis. (sub. DR730, p. 35)

The Commission considers that the activities and outcomes of the National Aged Care Workforce Strategy should be fully evaluated and publicly released.

In the Commission's view, there would be value in key stakeholders (such as governments, peak industry bodies, Skills Australia and CSHISC) monitoring the extent to which existing workforce initiatives are effective or require modification and/or new initiatives to progress workforce development and sustainability. Skills Australia should have a role in workforce planning for the aged care sector, particularly in relation to the VET system. In addition, Health Workforce Australia should investigate all components of the aged care workforce together by including carers and the community care workforce in a single analysis. It should also report back to government regularly to help identify challenges that need to be addressed. The five year review proposed as part of the Commission's implementation plan could be used to examine, among other things, the workforce sustainability issue.

