ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

AGED CARE WORKFORCE

SUBMISSION OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

INTRODUCTION

1. This submission is provided in response to the matters the Royal Commission will inquire into at the public hearings to be held in Melbourne between Monday 14 October and Friday 18 October 2019. It addresses the matters the Royal Commission will focus on:
   a. How to enhance the aged care workforce’s capacity and capability to provide high quality care and support good quality of life to care recipients; and,
   b. Make the aged care sector a more attractive and rewarding place to work.

2. It is noted that Mr Rob Bonner (Director Operations ANMF SA) and Mr Paul Gilbert (Assistant Secretary ANMF Vic Branch) have lodged Statements with the Commission in response to Notices to Give Information issued by the Commission. This submission does not repeat the material in those Statements.

3. This submission addresses the subject matter of the Melbourne Hearings 3 for staff as they enter the workforce, the conditions and challenges of working in aged care, staff retention issues and what can be done to improve these with a focus the following:
   - SIZE AND COMPOSITION OF THE AGED CARE WORKFORCE (Paras 13-97)
     - IMPLICATIONS OF WORKFORCE DATA
     - EDUCATIONAL PREPARATION AND TRAINING PATHWAYS FOR THE AGED CARE WORKFORCE
     - SKILLS AND PERSONAL ABILITIES OF THE AGED CARE WORKFORCE
   - CHALLENGES IN ATTRACTING AND RETAINING AGED CARE WORKERS (Paras 98-224)
     - WAGES AND THE INDUSTRIAL LANDSCAPE IN AGED CARE
     - PROBLEMS CONFRONTING AGED CARE WORKERS
     - PERCEPTIONS OF AGED CARE AND CULTURAL VIEWS OF ELDERLY PEOPLE
   - EFFECTIVE RECRUITMENT AND RETENTION (Paras 225-251)

4. While the central focus of the aged care sector must be the people who access aged care services and their families, the direct care workforce is fundamental to ensuring that these people are involved in and receive safe, appropriate, quality care. The most recent figures indicate that 240,000 people work in direct care in aged care.¹

5. As Australia’s population ages and members of the ‘baby boom’ generation begin to reach a time in their lives when the need to access aged care services is likely to increase, the demand for a larger aged care workforce will necessarily increase. It is estimated that nearly 1 million workers will be required to meet Australia’s aged care needs by

¹ 2016 National Aged Care Workforce Census and Survey- The Aged Care Workforce, 2016 xvi
6. The current aged care workforce is on average older than the overall Australian workforce and as this workforce ages and enters retirement it will be necessary to ensure that younger workers enter the industry to take their place. Notwithstanding technological innovation and changes to service delivery models, current predictions indicate that our aged care workforce will need to grow by about 2 per cent annually, or triple from its current size, for the next 30 or so years to meet projected demand.\(^3\)

7. In order to have a viable workforce in aged care that is equipped to provide safe and quality care, both now and into the future, consideration must be given to the impediments and challenges of entering and remaining in the aged care workforce. Ensuring that a career in aged care is attractive and rewarding for workers will improve the quality and safety of care for aged care recipients by attracting and retaining people with the right attitudes, qualifications, and skills. A thriving, diverse workforce requires appropriate education and training, pathways into the workforce, career development, appropriate regulation, supportive working conditions, safe work design, and a well-funded sector that values and rewards its workforce. Our submission understandably focusses on nurses and care staff but we acknowledge the need for improvements for the wider workforce, including allied health, doctors and support staff.

8. However, A Matter of Care revealed that in relation to the workforce, despite being one of Australia’s most rapidly growing employment areas, the aged care sector suffers from many challenges related to attracting and retaining workers: high turnover and employee movement between organisations, poor employee engagement and enablement, challenges to attracting new employees, devaluation of jobs, poor workforce planning, casualisation, career bottlenecks, and poor recruitment, induction, and staff on-boarding. Indeed, as the Report notes; the aged care workforce faces significant cultural and operational barriers to change.\(^4\)

9. It is the Australian Nursing and Midwifery Federation’s view that along with the range of actions and improvements that are urgently necessary to address the systemic issues with Australia’s aged care sector, appropriate, safe, quality care for any person will not be feasibly achieved or sustained without the introduction of mandated minimum safe staffing levels. Increased funding that is transparently directed to providing care for aged care consumers, diverse skills, resources, training, and capabilities are required to care for everyone in aged care, but without the minimum numbers of the right kind of staff, that care cannot be delivered effectively or appropriately.

**THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION (ANMF)**

10. The ANMF is Australia’s largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF’s eight state and territory

\(^2\) A Matter of Care Australia’s Aged Care Workforce Strategy, Aged Care Workforce Strategy Taskforce, June 2018, 1.

\(^3\) Mr Trevor Lovelle, Chief Executive Officer, Aged and Community Services Australia, Western Australia, Committee Hansard, 27 September 2016, p. 1.

\(^4\) Ibid.
branches, we represent the professional, industrial, and political interests of more than 275,000 nurses, midwives, and care workers across the country.

11. Our members work in the public and private health, aged care, and disability sectors across a wide variety of urban, rural, and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfill their professional goals, and achieve a healthy work/life balance.

12. The ANMF represents almost 40,000 nurses and care workers working in the aged care sector, across both residential and home and community care settings.¹

**SIZE AND COMPOSITION OF THE AGED CARE WORKFORCE**

13. The size and composition of the direct care workforce in aged care is the key ingredient in the ability to provide a decent and dignified standard of care to our increasingly frail elderly population. Put simply, the elderly cannot receive proper care unless there is an appropriate number and mix of skilled and experienced staff, which includes registered nurses (RNs), enrolled nurses (ENs) and assistants in nursing/personal care workers (AINs/PCWs).

14. The most comprehensive data available on the size and composition of the aged care workforce is provided in the National Aged Care Workforce Census and Survey (NACWCS), commonly known as the "NILS report", commissioned by the Department of Health and published periodically since 2003. The most recent data available is the 2016 Report published in 2017. ⁵ This data shows a significant change in the skill mix of direct care staff over the last decade in both residential and community aged care. This is a trend which is continuing and which needs to be addressed urgently both now and as we plan for future needs to develop an aged care workforce which is equipped to meet those needs.

**Current Composition of the Residential Aged Care workforce**

15. Overall, total PAYG employment in residential aged care in 2016 is estimated at 235,764, an increase of approximately 50 percent since 2003. Out of this total, 153,854 are employed in direct care roles. Specifically, Nurse Practitioner (NP), Registered Nurse (RN), Enrolled Nurse (EN), Personal Care Attendant (PCA), Allied Health Professional (AHP) and Allied Health Assistant (AHA) roles.

16. While the overall number of people employed in aged care appears to have grown, since 2003, the estimated proportion of employees working in direct care roles has continued to decline from 74 percent in 2003 to 65 percent in 2016. ⁶ The table below shows the respective number of employees over this period:

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⁵ The Aged Care Workforce 2016, op.cit.
⁶ Ibid., 12.
Table 1: Size of the residential aged care workforce, all PAYG employees and direct care workers: 2003, 2007, 2012 and 2016 (estimated headcount)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All PAYG employees</td>
<td>156,823</td>
<td>174,866</td>
<td>202,344</td>
<td>235,764</td>
</tr>
<tr>
<td>Direct care employees</td>
<td>115,660</td>
<td>133,314</td>
<td>147,086</td>
<td>153,854</td>
</tr>
</tbody>
</table>

Source: Census of residential aged care facilities (weighted estimates)

17. The occupational composition of the direct care workforce has also changed dramatically over this period. Registered nurses made up 21% of the direct care workforce in 2003 but only 14.6% in 2016. Similarly, enrolled nurses have gone from comprising 13.1% of the direct care workforce in 2003 to 10.2% in 2016. In contrast, the number of care-workers, (AInNs, PCWs however titled), have increased from 67,143 in 2003 to 108,126 in 2016 comprising 71.5% (almost three quarters) of the direct care workforce. In 2003 carers made up 56.5% of the direct care workforce.7

18. Tables 2 and 3 and Figure 1 below show the changing size and composition of the direct care workforce in terms of headcount and full time equivalent employees:

Table 2: Direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated headcount and per cent)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner (NP)</td>
<td>n/a</td>
<td>n/a</td>
<td>294</td>
<td>386</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(0.2)</td>
<td>(0.3)</td>
</tr>
<tr>
<td>Registered Nurse (RN)</td>
<td>24,019</td>
<td>22,399</td>
<td>21,916</td>
<td>22,455</td>
</tr>
<tr>
<td></td>
<td>(21.0)</td>
<td>(16.8)</td>
<td>(14.9)</td>
<td>(14.6)</td>
</tr>
<tr>
<td>Enrolled Nurse (EN)</td>
<td>15,604</td>
<td>16,293</td>
<td>16,915</td>
<td>15,697</td>
</tr>
<tr>
<td></td>
<td>(13.1)</td>
<td>(12.2)</td>
<td>(11.5)</td>
<td>(10.2)</td>
</tr>
<tr>
<td>Personal Care Attendant (PCA)</td>
<td>67,143</td>
<td>84,746</td>
<td>100,312</td>
<td>108,126</td>
</tr>
<tr>
<td></td>
<td>(58.5)</td>
<td>(63.6)</td>
<td>(68.2)</td>
<td>(70.3)</td>
</tr>
<tr>
<td>Allied Health Professional (AHP)*</td>
<td>8,895*</td>
<td>9,875*</td>
<td>(1.8)</td>
<td>(1.4)</td>
</tr>
<tr>
<td></td>
<td>(7.4)</td>
<td>(7.4)</td>
<td>(5,001)</td>
<td>4,979</td>
</tr>
<tr>
<td>Allied Health Assistant (AHA)*</td>
<td></td>
<td></td>
<td>(3.4)</td>
<td>(3.2)</td>
</tr>
<tr>
<td>Total number of employees (headcount) (%)</td>
<td>115,660</td>
<td>133,314</td>
<td>147,086</td>
<td>153,854</td>
</tr>
</tbody>
</table>

Source: Census of residential aged care facilities (weighted estimates).

*In 2003 and 2007 both of these categories were combined under 'Allied Health'.

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7 Ibid., 13
Table 3: Full-time equivalent direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated FTE and percent)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner</td>
<td>n/a</td>
<td>n/a</td>
<td>190</td>
<td>293</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(0.2)</td>
<td>(0.3)</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>16,265</td>
<td>13,247</td>
<td>13,939</td>
<td>14,564</td>
</tr>
<tr>
<td></td>
<td>(21.4)</td>
<td>(16.8)</td>
<td>(14.7)</td>
<td>(14.9)</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>10,945</td>
<td>9,856</td>
<td>10,999</td>
<td>9,126</td>
</tr>
<tr>
<td></td>
<td>(14.4)</td>
<td>(12.5)</td>
<td>(11.6)</td>
<td>(9.3)</td>
</tr>
<tr>
<td>Personal Care Attendant</td>
<td>42,943</td>
<td>50,542</td>
<td>64,669</td>
<td>69,983</td>
</tr>
<tr>
<td></td>
<td>(56.5)</td>
<td>(64.1)</td>
<td>(68.2)</td>
<td>(71.5)</td>
</tr>
<tr>
<td>Allied Health Professional*</td>
<td>5,776* (7.6)</td>
<td>5,204* (6.6)</td>
<td>1,612* (1.7)</td>
<td>1,092* (1.1)</td>
</tr>
<tr>
<td>Allied Health Assistant*</td>
<td></td>
<td></td>
<td>3,414</td>
<td>2,862</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(3.6)</td>
<td>(2.9)</td>
</tr>
<tr>
<td>Total number of employees (FTE)</td>
<td>76,006</td>
<td>78,849</td>
<td>94,823</td>
<td>97,920</td>
</tr>
<tr>
<td>(%)</td>
<td>(100)</td>
<td>(100)</td>
<td>(100)</td>
<td>(100)</td>
</tr>
</tbody>
</table>

Source: Census of residential aged care facilities.

*In 2003 and 2007 these categories were combined under 'Allied Health'.

Figure 1: Number of the occupations for the residential direct care employees (headcount and FTE)

Note: Nurse Practitioners and Registered Nurses were combined under 'Registered Nurse' in 2016 in Figure 3.1 and Figure 3.2. Allied Health Professionals and Allied Health Assistants were combined under 'Allied Health' in 2003, 2007, 2012 and 2016 in Figure 3.1 and Figure 3.2.

19. The shift in the composition of residential aged care workforce over this period saw...
the number of all direct care employees increase by 33%, while the number of registered nurses actually decreased by 6.5% in terms of numbers and 10.5% on a full time equivalent basis. Over the same period the number of residential places increased by 30% and the dependency/acuity levels of residents increased from 64% assessed as “high care” in 2003 to 89% in 2015.

20. The 2008 NILS Report Who Cares for Older Australians\(^8\) highlighted the shift noting a significant restructuring of nursing staff in nursing homes with an overall increase in nursing care delivered by staff other than registered and enrolled nurses. The Report states:

"Overall, these figures suggest a significant reorganisation of care in residential aged care homes so that more care is provided by PCs and less by nurses. Moreover, a greater proportion of new hires continue to be PCs suggesting that the trend towards increased use of PCs will continue"\(^9\).

21. This trend was confirmed in the 2012 Report and noted again in 2016:

"...residential facilities continue to rely increasingly on PCAs to provide direct care to residents. There has been some increase in the number of RNs, but there has been a corresponding and larger fall in the number of ENs. PCAs are the only residential direct care occupational category to substantively raise its share of employment since 2012..."\(^10\)

22. The steady decline in the percentage of nurses in the residential aged care workforce is of great concern. Older Australians, particularly those receiving residential aged care services, are characterised by increasing and significant care needs, multiple diagnoses, comorbidities and polypharmacy. It has been estimated that on average they have 3.4 to 4.5 separate diagnoses, 6 comorbidities, and are taking 8.1 medications.\(^11\) Research also points to a rising trend of avoidable and premature deaths in Australian aged care facilities.\(^12\)

23. In responding to these care needs, the aged care sector must have the capability and capacity to deal with the often complex care required around core clinical activities such as wound care, medication management and pain management. This means it is essential that the aged care workforce has the appropriate number of skilled staff, including RNs and ENs and care workers. The trend of reducing numbers of RNs and ENs in the aged care workforce must be reversed. This does not mean that care-workers should be replaced by nurses, rather that the entire workforce needs to grow. As one member told us in the 2019 ANMF National Aged Care Survey:

"The main problem we have is that we very rarely have the minimum staffing levels as required by government standards. They replace RNs with ENs and replace ENs with PCWs. The skill set is not there and residents suffer. There are very few casual workers available to fill sick leave. If we are one down one nurse

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\(^{8}\) Martin B. and King D., 2008 Who Cares for Older Australians? National Institute of Labour Studies, Flinders University, Adelaide, Australia

\(^{9}\) Ibid, 10

\(^{10}\) Ibid, 12


is responsible for 15 high care residents two thirds unable to walk due to dense strokes and need lifting machines. A device you cannot use on your own. Working at these levels leads to staff breaking down due to being over worked."

Characteristics of employment in residential aged care

Gender

24. In 2016, 87 percent of the direct care workforce were female. By occupational group, 87.6% of RNs are female; 91.4% of ENs; 86.2% of PCAs and 88% of allied health workers are female. (p.17)

Age

25. The latest report notes the age of the direct care workforce is slightly younger than in previous years with the proportion of the workforce under the age of 35 increasing from 19 percent in 2012 to 25 percent in 2016.

26. The median age for all direct care occupations is 46 years, down from 48 in 2012. This is attributed to the impact of the recent recruitment of a greater number of younger people.13

27. Table 4 below details the median age of recently hired employees in each occupational group demonstrating the change in the age structure in 2016 compared to 2012.14

Table 4: Median age of the residential direct care workforce (number of years), by occupation, all direct care employees and recent hires: 2012 and 2016

<table>
<thead>
<tr>
<th></th>
<th>All direct care employees (Column 1)</th>
<th>Recent hires* (Column 2)</th>
<th>Difference in years in median age recent hires relative to all direct care employees (Column 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2016</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>47</td>
<td>42</td>
<td>-5</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>50</td>
<td>37</td>
<td>-13</td>
</tr>
<tr>
<td>Personal Care Attendant</td>
<td>46</td>
<td>35</td>
<td>-11</td>
</tr>
<tr>
<td>Allied Health</td>
<td>50</td>
<td>33</td>
<td>-17</td>
</tr>
<tr>
<td>All occupations</td>
<td>46</td>
<td>36</td>
<td>-10</td>
</tr>
<tr>
<td><strong>2012</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>51</td>
<td>47</td>
<td>-4</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>49</td>
<td>44</td>
<td>-5</td>
</tr>
<tr>
<td>Personal Care Attendant</td>
<td>47</td>
<td>38</td>
<td>-9</td>
</tr>
<tr>
<td>Allied Health</td>
<td>50</td>
<td>41</td>
<td>-9</td>
</tr>
<tr>
<td>All occupations</td>
<td>48</td>
<td>40</td>
<td>-8</td>
</tr>
</tbody>
</table>

13 Ibid., 15
14 Ibid., 17
Source: Survey of residential care workers. *Recent hires have been employed for 12 months or less.

**Type of employment and hours worked**

28. Overwhelmingly, the direct care workforce in residential aged care is employed on a part-time or casual basis (88.2%). Table 5 below shows the breakdown in employment type by occupation with 67.7% of RNs, 78.9% of ENs and 80.3% of PCAs employed on a part-time basis.\(^{15}\)

<table>
<thead>
<tr>
<th>Table 5: Form of employment of the residential direct care workforce, by occupation: 2012 and 2016 (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>2016</strong></td>
</tr>
<tr>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
</tr>
<tr>
<td>Personal Care Attendant</td>
</tr>
<tr>
<td>Allied Health</td>
</tr>
<tr>
<td>All occupations</td>
</tr>
<tr>
<td><strong>2012</strong></td>
</tr>
<tr>
<td>Registered Nurse</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
</tr>
<tr>
<td>Personal Care Attendant</td>
</tr>
<tr>
<td>Allied Health</td>
</tr>
<tr>
<td>All occupations</td>
</tr>
</tbody>
</table>

Source: Census of residential aged care facilities. Row percentages shown.

29. Overall, 44% of the direct care workforce is working 35 hours per week or more. By occupation, hours of work vary. For RNs, 41.8% work 35 to 40 hours per week, as opposed to 38.2% of ENs and 31.8% of PCAs. PCAs (57.2%) and ENs (47.6%) are the most likely to be working less hours in the range of 16 to 34 hours per week.\(^{16}\)

30. The report notes that a high proportion of the direct care workforce (44%) want a change in their hours of work with 30% indicating they want to work more hours. This indicates there is a significant degree of under employment and potential to increase hours of care within the existing workforce.

**Current Composition of the Community Aged Care Workforce**

31. The Aged Care Workforce, 2016 report, (the NILS report) also provides data on the size and composition of the direct care workforce in the community aged care sector.\(^2\)

32. The NILS report states the '2016 census estimates that total employment in home care and home support aged care is 130,263 workers, of which 86,463 are in direct

\(^{15}\) Ibid., 25
\(^{16}\) Ibid., 26
care roles.\textsuperscript{17} Tables 6 and 7 below show firstly the headcount by occupation for the years 2007, 2012 and 2016 and secondly by Full Time Equivalent (FTE).

Table 6: Direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated headcount and per cent)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>2007</th>
<th>2012</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner</td>
<td>n/a</td>
<td>201</td>
<td>53</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>7,555</td>
<td>7,631</td>
<td>6,969</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>2,000</td>
<td>3,641</td>
<td>1,888</td>
</tr>
<tr>
<td>Community Care Worker</td>
<td>60,587</td>
<td>76,046</td>
<td>72,495</td>
</tr>
<tr>
<td>Allied Health Professional*</td>
<td>3,921</td>
<td>3,921</td>
<td>4,062</td>
</tr>
<tr>
<td>Allied Health Assistant*</td>
<td>(5.3)</td>
<td>(4.2)</td>
<td>(4.7)</td>
</tr>
</tbody>
</table>

Total number of employees (headcount) (%)

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2012</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>74,067</td>
<td>93,359</td>
<td>86,463</td>
</tr>
</tbody>
</table>

Source: Census of home care and home support aged care outlets.
*Note: in 2007, these categories were combined under Allied Health.

Table 7: Full-time equivalent direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated FTE and percent)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>2007</th>
<th>2012</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner</td>
<td>n/a</td>
<td>55</td>
<td>41</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>6,079</td>
<td>6,544</td>
<td>4,651</td>
</tr>
<tr>
<td>Enrolled Nurse</td>
<td>1,197</td>
<td>2,345</td>
<td>1,143</td>
</tr>
<tr>
<td>Community Care Worker</td>
<td>35,832</td>
<td>41,394</td>
<td>34,712</td>
</tr>
<tr>
<td>Allied Health Professional*</td>
<td>2,948</td>
<td>2,618</td>
<td>2,785</td>
</tr>
<tr>
<td>Allied Health Assistant*</td>
<td>(6.4)</td>
<td>(4.8)</td>
<td>(6.3)</td>
</tr>
</tbody>
</table>

Total number (FTE) (%)

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2012</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>46,056</td>
<td>54,537</td>
<td>44,087</td>
</tr>
</tbody>
</table>

Source: Census of home care and home support aged care outlets.
*Note: in 2007, these categories were combined under Allied Health.

33. The tables show there has been a decrease in numbers in the direct care

\textsuperscript{17} Ibid, 69
workforce between 2012 and 2016, both as measured by 'headcount' and 'full-time equivalent'.

34. Figure 2 from the NILS report\(^\text{18}\) (Fig 5.12, p71) shows the share of occupations for the home care and home support direct care employees as both headcount and full time equivalent (FTE) in per cent of total workforce and Figure 3 shows the number of occupations in headcount and FTE\(^\text{19}\).

Figure 2: Share of the occupations for the home care and home support direct care employees (headcount and FTE, per cent)

![Chart showing share of occupations for the home care and home support direct care employees (headcount and FTE, per cent)]

Figure 3: Number of the occupations for the home care and home support direct care employees (headcount and FTE)

![Chart showing number of the occupations for the home care and home support direct care employees (headcount and FTE)]

Note: Nurse Practitioners and Registered Nurses were combined under 'Registered Nurse' in 2016 in Figure 5.1 and Figure 5.2. Allied Health Professionals and Allied Health Assistants were combined under 'Allied Health' in both 2007, 2012 and 2016 in Figure 5.1 and Figure 5.2.

\(^{18}\) Ibid., 71

\(^{19}\) Ibid
35. The NILS report data shows that the total workforce reduced in headcount size by 13% and the total headcount size in direct care by 7% between 2012 and 2016. The NILS report estimates the reduction in FTE to be 19% and also suggests the discrepancy between the reduction in headcount and FTE means there was an increase in the proportion of workers employed for fewer hours.20

36. The above tables show that not only has there been a reduction in the total size of the workforce, there has also been a reduction in the proportion of registered and enrolled nurses relative to the whole workforce between 2007 and 2016 and again between 2012 and 2016.

Table 4: Employees not providing direct care in the home care and home support aged care workforce, by occupation: 2016 (per cent)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>2012</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Manager/co-ordinator</td>
<td>33.2</td>
<td>29.8</td>
</tr>
<tr>
<td>Management</td>
<td>22.3</td>
<td>25.6</td>
</tr>
<tr>
<td>Administration</td>
<td>35.3</td>
<td>37.0</td>
</tr>
<tr>
<td>Spiritual/pastoral care</td>
<td>1.6</td>
<td>0.5</td>
</tr>
<tr>
<td>Ancillary care (home maintenance, modification, etc.)</td>
<td>7.7</td>
<td>7.1</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Census of home care and home support aged care outlets.

Employment arrangements for home care workers

37. The NILS report shows the number of workers employed under permanent part-time arrangements has increased from 62% in 2012 to 75% in 2016.21

38. The percentage of community care workers in part time employment increased from 63% to 79% from 2012 -16.22

39. In 2016, across all occupations, including allied health - when casual is added - nearly 90% of workers are part time or casual.23

40. A significant number, 40 percent of community care workers indicated they would prefer to work more hours.24 As with in the context of residential aged care, this indicates that there is a significant degree of under employment and

20 Ibid., 70
21 Ibid., 84
22 Ibid
23 Ibid
24 Ibid., 86
potential to increase hours of care within the existing workforce.

IMPLICATIONS OF WORKFORCE DATA

41. From 2012 to 2016 the total FTE percentage of the direct care nursing workforce has reduced from 16.3% to 13.2%. Employment of registered nurses has reduced from 12% to 10.6% and enrolled nurses from 4.3% to 2.6%. As case managers are often registered nurses, or ideally should be registered nurses, it is likely that the reduction in qualified staff would potentially impact both the skills and numbers of case managers in the sector.

42. The ANMF is concerned about the reduction in overall nursing numbers and the proportional changes, as reductions in appropriately qualified care workers have direct implications for the quality and safety of the care delivered.

43. It is increasingly well documented that dilutions in the skills mix of nursing and care workforces lead to poorer health and care outcomes. A short summary of this evidence is at Attachment 1 to the ANMF’s Submission ANM.0002.0001.000125

44. In addition, there is also international evidence which demonstrates the improved health outcomes in community care when delivered within qualified nurse-led models. A short summary of this evidence is at Attachment 2 of ANM.0002.0001.000126.

Employment in residential and community aged care compared with the nursing workforce and Australian workforce

45. Table 5 below compares characteristics of the employment between the residential aged care, community care, nursing workforce in general and the Australian workforce as a whole based on 2016 data.

46. The residential and community care workforces are overwhelmingly female dominated across all classifications. In 2016, 87% of the residential direct care workforce was female27 and in home and community care 89% of the direct care workforce was female.28

47. Across the three occupations, RN, EN, AIN/PCW/CCW, the community care workforce is slightly older than the residential care workforce. Nurses employed in both residential and community care are older than the average age of nurses in general. For RNs, the median age is 47 and 48 in residential and community care respectively compared to an average age of 43.9 for RNs generally. Similarly for ENs, median age is 50 and 51 in residential and community care, compared to an average of 46.1 for ENs in general. For the AIN/PCW/CCW group, the community care workforce is older than the residential care workforce – 52 compared with a median age of 46 in residential care.

48. Overwhelmingly, the residential and community care workforce is employed on a part

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25 ANM.0002.0001.0018-0019
26 Ibid., 0020
27 The Aged Care Workforce, op.cit., 15
28 Ibid., 74
time basis. (A significant number of employees in both the residential and community care workforce, (30% and 40% respectively), indicated they want to work more hours suggesting a significant level of underemployment in the sector). The percentage of part time employment for all nursing and carer occupations is well above the rate of the Australian workforce in general. In residential care, 78.1% of the direct care workforce is employed part time compared to 32.7% in the general community. In community care, the figure is 75.3% compared to 32.7% in the Australian workforce.

49. Additionally, full time employment is extremely low in both the residential and community care sectors. Just 11.9% and 11.2% of the direct care workforce are employed full time in residential and community care respectively. Compared to 62% in the Australian workforce.

50. The percentage of direct care employees in both residential and community care engaged on a casual or contract basis is below the general workforce figure of 25%. 10.1% in residential and 13.5% in community care.

Gender and Age comparison table

<table>
<thead>
<tr>
<th></th>
<th>Residential aged care (1)</th>
<th>Community care (1)</th>
<th>Nursing Workforce (NHWDS) (2)</th>
<th>All Occupations (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RN</td>
<td>EN</td>
<td>AIN/PCW</td>
<td>RN</td>
</tr>
<tr>
<td>Female</td>
<td>87.6%</td>
<td>91.4%</td>
<td>86.2%</td>
<td>93.7%</td>
</tr>
<tr>
<td>Male</td>
<td>12.6%</td>
<td>8.6%</td>
<td>13.8%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Age</td>
<td>47 median</td>
<td>50 median</td>
<td>46 median</td>
<td>48 median</td>
</tr>
<tr>
<td>FT</td>
<td>22.4%</td>
<td>13.4%</td>
<td>8.9%</td>
<td>34.9%</td>
</tr>
<tr>
<td>PT</td>
<td>67.7%</td>
<td>78.9%</td>
<td>80.3%</td>
<td>59.4%</td>
</tr>
<tr>
<td>Casual</td>
<td>9.8%</td>
<td>7.8%</td>
<td>10.8%</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

Notes:
2. National Health Workforce Dataset (NHWDS) 2017 – (Fact Sheet 2016 data)
3. ABS 2019, customised report. Labour Force, Australia, Quarterly May 2019 for employees by paid leave entitlement status by select occupations
ABS 6333.0 Characteristics of Employment, Australia. August 2016

51. The data in table 5 indicates the aged care workforce is older than the general nursing and care worker average. The sector needs to consider how to attract younger people into the workforce. The issues identified below at paragraphs 70-87 in relation to education,
training and transition programs are relevant to the attraction and retention of a younger and or less experienced workforce.

52. As stated above, the data also shows that there is a high level of part-time work which indicates some workers may be underemployed and therefore there is capacity in the existing workforce that is under-utilised. This capacity should be utilised in particular as the existing workforce already has training, skills and experience.

Migrant workers in aged care

53. The ANMF does not support the international recruitment of nurses and carers by employers as a strategy to resolve 'so called' workforce shortages created by the failure to address longstanding and ongoing attraction and retention problems in the aged care sector. There is no evidence to suggest there is a genuine skill shortage of nurses or carers in the aged care sector nationally.

54. It is however, acknowledged that in some states and in rural and remote areas there are local shortages, making it difficult to meet appropriate staffing levels and skills mix. It is also acknowledged that permanent skilled migration has and will continue to be a source of nursing staff in aged care.

55. The ANMF supports international and domestic mobility of nurses and midwives. Both professions have a strong tradition of international collaboration and employment, moving around the globe to gain further training, different clinical and professional experiences, and to provide valuable care to vulnerable populations during humanitarian crises. There is also clear merit in international exchange and cultural diversity, as well as the economic benefit of remittances and transfers in technologies.

56. We recognise that in many cases the motivation to work in other countries is linked to more and better employment opportunities, higher salaries, better working conditions and improved capacity for career advancement. Increasingly the opportunity to work and live in a better and safer environment for themselves and their families is an important factor.

57. Our union generally favours permanent migration but recognises there is a place for temporary skilled migration programs where there is evidence of a genuine short term and unexpected domestic skill shortage.

58. In addition, our acceptance of the need for temporary skilled migration is conditional on the implementation of policy and regulatory arrangements that discourage employers accessing offshore labour without first investing in training and undertaking genuine testing of the local labour market. These arrangements must also provide safeguards and protections for both local and overseas workers to ensure decent wages and conditions of employment and prevent exploitation in the workplace.

59. The ANMF advocates for the ethical recruitment of offshore nurses and midwives. The ANMF policy on the international recruitment of nurses and midwives is annexed to this submission and marked ANM.0013.0002.0001.

60. We also understand the need for international students to have the ability to earn an income while studying to meet their living expenses and course fees.
61. Nursing features strongly in Australia’s skilled migration programs including the Temporary Skill Shortage visa (subclass 482) program (and the former subclass 457 program) as well as other temporary and permanent visa grants. Since 2012-13 registered nurses have been one of the top five occupations granted permanent visas under the General Skilled Migration (GSM) scheme.

62. In tables 6 – 10 below we set out data on holders of visa subclass 457/482 and numbers granted to overseas nurses from 2010 to 2019 for registered nurses in general and separately for Registered Nurses (Aged Care). Please note that since the introduction of ANZSCO in 2010 (formally ASCO) there are 14 registered nurse occupational categories which international nurses can be nominated under including Medical, Aged Care, Educator, Nurse Practitioner, and Community Health.

Table 6: Number of subclass 457/482 visa holders snapshot dates 2010 to 2019

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<tr>
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<tbody>
<tr>
<td>457</td>
<td>3472</td>
<td>3171</td>
<td>3925</td>
<td>4260</td>
<td>3637</td>
<td>2540</td>
<td>1998</td>
<td>1833</td>
<td>1960</td>
<td>1197</td>
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<td>n/a</td>
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<td>n/a</td>
<td>n/a</td>
<td>92</td>
<td>977</td>
</tr>
</tbody>
</table>


Table 7: Registered Nurses (Aged Care) Number of subclass 457/482 visa holders snapshot dates 2010 to 2019

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<thead>
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<th></th>
</tr>
</thead>
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<tr>
<td>457</td>
<td>74</td>
<td>344</td>
<td>765</td>
<td>995</td>
<td>857</td>
<td>611</td>
<td>475</td>
<td>450</td>
<td>481</td>
<td>302</td>
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<tr>
<td>482</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>9</td>
<td>190</td>
</tr>
</tbody>
</table>


Table 8: Number of subclass 457/482 visa grants financial year 2005-06 to 2017-18 and to June 19

<table>
<thead>
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</thead>
<tbody>
<tr>
<td>457</td>
<td>2609</td>
<td>3011</td>
<td>3375</td>
<td>3977</td>
<td>2624</td>
<td>2146</td>
<td>3095</td>
<td>2853</td>
<td>1489</td>
<td>993</td>
<td>1009</td>
<td>1074</td>
<td>1028</td>
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<tr>
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<td>n/a</td>
<td>n/a</td>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>116</td>
<td>1060</td>
<td></td>
</tr>
</tbody>
</table>

Table 9: Registered Nurses (Aged Care) Number of subclass 457/482 visa grants financial year 2005-06 to 2017-18 and to June 2019

<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>457</td>
<td>382</td>
<td>632</td>
<td>612</td>
<td>337</td>
<td>248</td>
<td>241</td>
<td>265</td>
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<td>19</td>
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<tr>
<td>482</td>
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<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>11</td>
</tr>
</tbody>
</table>


63. The numbers of Enrolled Nurses (411411) holding a temporary resident (skilled) visa are low with just over 50 as at June 2017-18 and 22 at June 2019.

Table 10: International nursing student enrolment count (General nursing course required for initial registration) 2010 to 2017

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overseas</td>
<td>6,825</td>
<td>6,959</td>
<td>6,832</td>
<td>6,780</td>
<td>6,878</td>
<td>7,466</td>
<td>8,168</td>
<td>9,078</td>
</tr>
</tbody>
</table>


64. It is worth noting that student visas include a visa condition that, once the course has commenced, students may work for up to 40 hours per fortnight while their course is in session and for unlimited hours during course breaks.

65. An additional visa, the Temporary Graduate visa (subclass 485), allows an overseas student to work in Australia temporarily after graduation. This visa is for international students with an eligible qualification who graduate with skills and qualifications that relate to an occupation on the Skilled Occupation List, which includes nursing and midwifery graduates.

66. Overall the work rights provided to temporary visa holders in nursing under subclass 482/457, and subclass 485, along with international students and working holiday makers, constitute a significant migrant workforce that has an impact on the domestic nursing labour market including in the aged care sector.

67. Nurses with temporary work visas are employed across all sectors of health, community and aged care. Residential aged care and private hospital employers employ the bulk and they are also widely employed in state and territory public sector facilities. International students feature strongly in the residential aged care sectors where they are employed in care-worker roles during their undergraduate studies.

68. As outlined in the Royal Commission into Aged Care Quality and Safety Background Paper 2, immigration may offer some assistance in addressing skill shortages in aged care workforce. However, in addressing Australia’s future aged care workforce needs, it will be important to remember that demand is not seasonal and is not subject to changes due to economic conditions. Its growth is primarily driven by demographics. It is therefore better suited to being staffed by a stable, long-term workforce than a temporary migrant workforce with high turnover or workers staying for long periods but with limited rights. For example, Callister et al have argued that ‘Aged-care clients are a vulnerable group and
if they are looked after by another vulnerable group, without the protection of permanent residency or citizenship, this may impact on quality of care. 29

**EDUCATIONAL PREPARATION AND TRAINING PATHWAYS FOR THE AGED CARE WORKFORCE**

69. In understanding the aged care workforce’s capacity and capability to provide high quality care and support good quality of life to care recipients, the educational preparation and training pathways for the workforce must necessarily be considered.

70. In Australia, the aged care nursing and personal care workforce comprises three categories of worker; two categories are qualified professional nurses, the registered nurse and the enrolled nurse, with the third category being an unregulated care-worker. These workers are further supported by nurse-practitioners, who are registered nurses with post-graduate education at Master’s level and are clinical experts in a specific area of practice.

71. The ANMF’s submission to the current Independent Review of Nursing Education – *Educating the Nurse of the Future* (annexed and marked ANM.0013.0003.0001) provides a detailed overview and analysis of the education of registered and enrolled nurses, and nurse practitioners. The submission assesses the effectiveness of the current education of nurses, including articulation between the three levels of nurses, and provides an analysis of the current shortcomings of nursing education. The submission further proposes strategies that the ANMF recommends are required to address the deficiencies we have identified in the system. We refer the Commission to the attached submission for this information.

72. Given the above, the remainder of this section focuses on the educational preparation of care-workers as well as the issues related to nursing and care-worker education as they specifically apply to the aged care sector.

**Educational preparation of care workers**

73. A care worker, (however-titled, e.g. personal care worker, assistant in nursing) is an unregulated worker who provides aspects of nursing care and personal care in the community or in residential facilities. There is currently no regulated minimum education requirement for care workers. It is estimated that 67% of care workers 30 have a Certificate III in aged care while the remainder possess no formal educational preparation for care delivery. Care workers who do not have a Certificate III may have a level of ‘on the job training’ being delivered by providers, however this training is not consistent or regulated, in theory and/or practice delivery.

74. The Certificate III in Individual Support, the principal qualification for preparation to work in the aged care sector, provides baseline training for a care worker in attending activities of daily living, emotional support and observational skills. It introduces care workers to the aged care sector and care delivery. Ideally it should be conducted over a minimum of nine months with a mix of theory and work place experience, including workplace

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30 Nils report
placements which amount to a total of 120 hours.

75. However, there are a number of issues with the qualification, which predominantly relate to its delivery. There are sector wide concerns about the current theory (which is currently under review), content and work placement delivery, the lack of regulation of the program and, for some programs, the adequacy of student learning outcomes. There are examples of the program being delivered in significantly shorter time than the identified minimum nine months. There are also considerable inconsistencies in theoretical inclusions and the quality of workplace placements across the sector.

76. The ANMF has received wide feedback from both aged care nurses and workers and from industry that the program in many instances is not meeting the requirements for the role of a care worker due to inconsistencies with its delivery. We receive frequent reports that the care workers who have completed a program have not gained the required skills and knowledge the qualification is designed to deliver. They lack the requisite skills for dealing with elderly people and the specific conditions of ageing, even at Certificate III level, and many do not possess first aid skills even though they are very often likely to be the first responder in a residential aged care setting.

77. The Aged Services Industry Reference Committee (IRC) is currently undertaking a review of the current aged care program and related qualifications for work in aged care. We refer the Commission to the statement of Rob Bonner, Deputy Chair, Aged Services IRC for the details of this work.

**Regulation of education programs and care workers**

78. To ensure that people receive quality care, minimum standards must be set in place and consistent across the Vocational Education and Training (VET) and aged care sectors. Nurses are regulated health professionals and have clear minimum standards in place. However, care workers currently do not have effective regulatory requirements. They are not required to work in accordance with any professional standards and they do not have an effective process for managing complaints. Care workers do not have a minimum education requirement for entry to work in the sector, they do not have to maintain regular professional development or need to have professional indemnity insurance.

79. As care workers are not individually regulated or licensed, there is no requirement for the Certificate III in Individual Support program (or related qualifications) to be accredited by a national registering authority as must occur with programs leading to registration as a nurse. Instead, this qualification requires a single layer of regulation by the Australian Skills Quality Authority (ASQA), which, as has been outlined above, is not ensuring consistent and reliable outcomes across the sector nor is it ensuring the production of workers with the appropriate knowledge and skills to work effectively in the sector.

80. Additionally, as there is no national registering or licensing system in place for care workers, consumers, families or employers cannot check whether the care worker is appropriate to be looking after them or their loved one. This is compounded by the fact that many care workers are working independently, such as in the home environment. Currently, if a care worker is found to be unsafe in the care they provide and is dismissed from their employment, they can move onto another employer with a minimal checking process occurring or, on many occasions, without any process at all.

81. The difficult circumstances for many care workers created by the lack of appropriate
regulation around their work is currently exacerbated by the lack of qualified nursing staff in the aged care workforce. This has resulted in many employers placing excessive demands on care workers both in terms of workloads but also in terms of the level of care employers expect them to provide. They are expected to perform activities, which should be conducted by qualified nurses such as medication management and wound care, despite lacking the required underpinning knowledge and skills to perform these activities safely. This places both the workers and those in their care at unnecessary risk.

82. While the current educational preparation for care workers in the aged care sector is clearly insufficient, the ANMF argues that in some cases the system has been structured to provide a carer workforce that can be kept compliant, in insecure work and therefore, low paid, rather than to meet the care needs of older Australians. It is abundantly clear that this issue requires urgent attention.

Articulation between qualifications

83. As outlined above, articulation between Diploma, Bachelor and Masters level nursing programs is discussed in detail in the ANMF’s submission (education submission) to the current Independent Review of Nursing Education – Educating the Nurse of the Future (ANM.0013.0003.0001). This section therefore focuses on the articulation of Certificate level courses to higher and nursing courses and pathways into the aged care sector.

84. The Certificate III in Individual Support (CHC33015) qualification articulates well to the Certificate IV in Ageing Support (CHC43015), within the processes and policies housed within the Community Services Training Package which includes recognition of prior learning. If a care worker chooses to move into the nursing profession and they possess a Certificate III level qualification they are able to articulate into the Diploma of Nursing, which, as outlined in the ANMF’s education submission, articulates into the Bachelor of Nursing.

85. The challenges noted in the education submission in the articulation between the Diploma of Nursing and the Bachelor of Nursing programs are not insurmountable. The established difference between the two sectors (vocational and higher education) enables the nursing profession, with the two levels of nursing, to work effectively and enables a clear and distinct scope of practice between the two levels. This difference can be celebrated rather than seen as a problem. Many universities have already solved the challenge of articulation and have in place agreed approved entry pathways for enrolled nurses into the Bachelor of Nursing.

86. Articulation between the Certificate III in Individual Support and related programs could be significantly improved through regulation of care-workers as this would ensure a consistent minimum educational attainment for entry to practice. As this would establish a clear educational baseline it would allow much smoother articulation into nursing and other health professional qualifications, as well as into higher level certificate qualifications in relevant training packages.

Regulation of the aged care workforce

87. The ANMF refers to its previous submission ANM.0006.0001.0009-13 with respect to regulation of the workforce.
SKILLS AND PERSONAL ABILITIES OF THE AGED CARE WORKFORCE

88. In discussions of the aged care workforce, the need to ensure employment of the ‘right’ people, that is people with the ‘right’ attitude, is frequently raised, predominantly by aged care employers. The ANMF does not disagree, however we continue to maintain that the need to ensure employment of workers with the ‘right’ attributes for work in aged care must not override the need to employ sufficient numbers of appropriately qualified staff. Until this is achieved aged care workers, even those possessing the best attributes, will not be supported or enabled to provide safe, quality care. The following section outlines the ANMF’s views on the skills and personal abilities required by the aged care workforce.

89. In aged care, the ‘right individual with the right fit’ can be described as an individual with the appropriate attitude and aptitude to work in the sector.31 The ANMF believes that these qualities are possessed by individuals who are morally committed to the provision of holistic, high quality care to vulnerable sectors of the community. The individual’s ability to deliver and further develop this care is reliant on appropriate resourcing and support.32 Where this support is not provided, the development and quality of these individuals is inhibited. The current systemic problems in aged care, such as poor staffing, lack of employer support, and insufficient remuneration may lead to individuals with strong personal commitment to the provision of safe, quality care to burn out and/or leave the sector due to frustration with not being able to provide a high standard of care they expect of themselves and know that their residents deserve. As members told us in the 2019 ANMF National Aged Care Survey:

"My facility brought in staffing cuts over a year ago as profits were down to unsustainable levels. As a result, the facility has gradually gone downhill. Staff are beyond exhausted. Morale is extremely low. Residents are completely aware and deserve more. When us staff approach management to complain and request more staff we are good this is how it is, deal with it. The only reason most of us stay is we truly care and worry for our residents if we leave."

"Please advocate and get changes needed. I am trying desperately hard to get back into the hospital acute sector because in aged care... I no longer feel safe in this sector. If I don’t make it, I will leave nursing altogether. Many of my colleagues have left and it’s a shame as we are very experienced and skilled in this area and very supportive of junior staff."

"I left the last aged care facility because Management decided to increase the workload of nurses by including food prep, cleaning and activities into our job description, simply to cut staff levels even further. I could not cope with the inability to provide adequate care to the residents. I no longer work in aged care and will never again while the issues remain the same."

"I am about to resign after nearly 30 years in Aged Care directly due to recent cuts in RN hours resulting in what I consider to be unsafe work conditions i.e. I feel that my practice is compromised."

"I worked in a dementia specific nursing home for 2.5 years as a PCA. The reason I left was due to management cutting staff, increasing workloads, limiting the ability to provide the best quality care that we wanted. Working in in-home (Community) care is better from a staffing perspective, but not without other issues, particularly OHS and repetitive heavy manual work such as 4 house cleanings in a day."
Finding and retaining the right people with the right characteristics, aptitudes, and skill-sets to work in the aged care sector is described in the terms of reference for the Aged Care Workforce Strategy Taskforce. The ANMF understands that defining the 'right' person with the 'right' fit will vary depending upon perspective (e.g. employer, employee, care recipient, or community member), broadly, however, a particular skill set is required to deliver quality care within the healthcare industry. These skills are particularly important within the aged care context where systemic industry problems are driving a decreased quality of care for residents and consumers and leading to poor worker attraction and retention.

An integrated review identified five areas required for the appropriate delivery of care in aged care nursing: ethical and attitudinal, interactional, evidence-based care, pedagogical, and leadership and development competence. Each of these are covered under the NMBA’s regulatory standards for registered and enrolled nurses, however no comparable regulatory standards exist for personal care workers. The ANMF believes these skills are equally necessary across all levels of care provision within the aged care sector.

Ethical dilemmas occur frequently within aged care facilities. A possible example could occur where policies and procedures enacted to ensure the overall wellbeing of an individual are in conflict with an individual’s personal preference for care. In this situation, a care giver is required to respect the privacy, individuality, and choice of the care recipient whilst ensuring that appropriate and evidence-based care is delivered in-line with established regulations and standards. These decisions must be managed at both the individual and collective level, where the dignity of one person must be respected whilst ensuring quality of life for all other individuals within a facility. This is achieved through an attitudinal willingness to understand and respect the feelings and needs of older people whilst maintaining disciplined and ethical decision-making.

Effective communication, interaction, and collaboration between and among staff, recipients of care, and their families is vital in aged care. Aged care staff must be capable of communicating respectfully and empathetically in often sensitive situations, potentially involving end-of-life care. This expectation also extends to working as a member of the broader care team; an environment in which communication skills are crucial to the successful delivery of quality care.

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38 Ibid [2]
39 Ibid [2]
94. Technical skill and current knowledge of evidence based best-practice is required for the delivery of care to residents. Aged care staff are often required to decide upon and deliver this care independently or under the direction of more senior or qualified staff. Successful delivery of this care requires an understanding of the individual receiving care and will incorporate proactive assessment of health and wellbeing.\textsuperscript{40}

95. Pedagogical competency is required by senior staff across all levels in supervising and educating less experienced staff to acquire and master new knowledge to drive best practice. This skill is also important when reassuring residents or family in care planning processes. Skill in education is an important tool in building trust and alleviating anxiety or fear.\textsuperscript{41} This skill is also particularly important in terms of supervising and training new staff and students on placement.

96. Competency in leadership is expected where aged care staff, particularly those in senior roles, are required to plan, organise and manage resources in often intense work environments. The requirement to lead is often derived from necessity and expectation.\textsuperscript{42} While registered nurses are often the best placed to lead care in residential aged care facilities, leaders do not necessarily hold managerial roles in aged care or hold a particular qualification. Opportunity for education and support in the development of leadership is often found to be lacking across the aged care industry and is a key area for further improvement.\textsuperscript{43}

97. The skills and abilities outlined above present the ANMF's view of the ideal requirements for work in the aged care sector. However, as stated earlier, the current conditions across the aged care do not promote, foster or develop the required skills and abilities for work in the sector. Employers have a duty to look after and support their staff and to engage in ongoing training to improve their skill and confidence to provide safe and effective care. However, this is currently not occurring across the sector, leading to a workforce which is not equipped, either in numbers or appropriate skills, to ensure safe and quality care for all elderly Australians. The next section of this submission examines, in greater detail, why this is the case.

**CHALLENGES IN ATTRACTING AND RETAINING AGED CARE WORKERS**

98. As stated above, the provision of safe and quality aged care in Australia demands a sufficient and suitably skilled workforce. The previous section in this submission outlined the current size and composition and noted the changes in the skills profile of the workforce over the last 15 years. These changes have resulted in a workforce which is insufficient to meet the current care needs of elderly Australians.\textsuperscript{44} A range of challenges in attracting and retaining aged care workers has been a major contributor to the current insufficiency of the aged care workforce.

99. The problems with attraction and retention of the workforce in the aged care sector are

\textsuperscript{40} Ibid
\textsuperscript{41} Ibid
\textsuperscript{42} Ibid
\textsuperscript{44} Willis E, Price K, Bonner R, et al, op.cit., 99-101
not new. The challenges, broadly outlined below, are well understood across the industry:

- low wages and poor conditions;
- inadequate staffing levels and workload issues;
- unreasonable professional and legal responsibilities;
- lack of career opportunities;
- stressful work environments;
- poor management practices; and,
- a poor perception of aged care in general.

100. Despite this understanding, governments and industry have simply failed to address these matters. Consequently, these issues continue to persist. These issues, and the reasons for them are outlined in detail in the next sections of this submission.

WAGES AND THE INDUSTRIAL LANDSCAPE IN AGED CARE

Industrial Overview

101. Workplace wages and conditions are key to attracting and retaining suitably skilled and qualified workers to the aged care sector. Unlike public and private sector health, the aged care sector is not as well developed industrially and this has affected wage and condition outcomes. Poor conditions and low wages also contribute to the perception that work in aged care is undervalued, under-appreciated and not respected. To attract and retain skilled and experienced staff into the aged care sector and enhance the workforce's capacity and capability to provide high quality care, wages and conditions must improve.

102. In a recent ANMF survey of members who have left or are thinking about leaving jobs in aged care, just over 44% (n = 341) participants indicated that "low wages" were a primary or contributing factor to their decision to leave. Among participants who currently work in aged care, just over 62% (n = 505) indicated "low wages" were a primary or contributing reason for considering leaving the sector. "Improved pay" (76% / n = 1,138) was the third most commonly selected factor that participants identified would influence them to continue to work in aged care or return to working in aged care behind "minimum staff to resident ratios" (78% / n = 1,165) and "more time with residents" (80% / n = 1,183). Below are selected quotes from members where they discuss the impact and experience of low wages in the sector:

"There has to be more money for wages for qualified staff that are compatible to gov sector. People can’t do the hard work with no financial benefits."

"I used to work in aged care full time. I left to work in the hospitals as nearly $22hr more – YES $22 an hour. The entire sector is a joke many of these places are beautiful to look at but it stops there. Having 34 years-experience in the sector they are all the same disgusting workloads, pitiful wages, lack of resources…"

"Every shift is a struggle, not enough staff, time or resources. Unpaid overtime has become a regular occurrence and management don’t care. We are constantly told to “work faster, work smarter”

"Instead of the government giving us as an industry a bad wrap all the time, provide us with the means as in wages and ratios to make the industry great again."
"We are under-valued, and this is reflective in our wages. I can apply for and work as a disability support worker/teacher aide in a position that is from only 0800-1330 Monday-Friday for double the rate I'm currently on now including the penalties i get now. The new position on base rate is more than my 75% penalty rate I get on a Sunday in aged care and I would have my weekends free! ..."

"I do an important job, we are responsible to make sure someone’s loved one is kept safe, feed, bathed, and given the care that every human has a right to. Yet care workers wage is less than a person the stack shelves [at a supermorket]! How’s is this right? The award rate needs to be looked at.”

"The owners of the Nursing Home are “crying poor” whilst making millions of dollars profit, and cutting wages, shifts & the standards of care. QLD nurses are paid the lowest of any State there needs to be standardisation of wages & conditions across all States in Australia.”

"I really would like to see something done; certainly better wages and more staff should be at the top of the list. Our elderly have given all their life and now should be better looked after.”

**Wage outcomes**

103. A report prepared for the Aged Care Workforce Strategy Taskforce\(^4\) analysed remuneration levels of PCW and nursing roles in the aged care sector comparing like for like roles from their pay database which contains remuneration data for 463 organisations nationally across all major industry sectors.

104. The remuneration measure used is “Fixed annual reward” (FAR) – base salary plus fixed allowances and benefits, plus employer superannuation and NFP gross up, but excludes short-term incentives. The data set out below is as at February 2018.

105. The key findings show that:

- PCWs are paid significantly below the market medium. PCWs are generally paid between the bottom 10% and bottom 25% of the “All Organisations market”.\(^5\)

- Nurses – overall the FAR of Nurses in aged care is lower than the median FAR of similar size roles in the "All Organisations market".\(^6\)

- Nurses at Hay Reference Levels, (job levels), 11 to 14 are paid between the 25\(^{th}\) percentile to the 50\(^{th}\) percentile of the All organisations market.

- Nurses at Hay Reference Levels 15 to 16 are paid below the 25\(^{th}\) percentile of the All organisations market.

- For nurses, incremental progression in salaries between levels are insignificant compared to the market implying that as the job progresses, it tends to fall behind the market for comparable higher-level jobs.

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\(^4\) Korn Ferry | Hay Group, Reimagining the Aged Care Workforce Report prepared for the Aged Care Workforce Strategy Taskforce Australian Government by Department of Health, 2018.

\(^5\) Korn Ferry | Hay Group, 97

\(^6\) Korn Ferry | Hay Group, 98
Comparison with specific industry markets:

106. The report found that care workers in aged care had an overall FAR that was significantly lower than in comparable markets and nurses were also lower. The report concluded:

107. "The findings of this remuneration benchmarking support the idea that remuneration might be a key obstacle in attracting the right talent to the aged care industry. ...."48

108. As highlighted above from the results of our recent survey, our members agree that poor wages are a considerable problem.

The role of Federal awards

109. While enterprise agreements are the predominant form of industrial regulation covering nurses and care workers in residential aged care, approximately 10% of facilities are award reliant.

110. In home and community care the level of award reliance is much higher due to the difficulty in organising this more fragmented workforce and the lack of enterprise bargaining in this area. The Nurses Award 201049 and the Aged Care Award 2010,50 together with the National Employment Standards, provide a minimum safety net of wages and conditions of employment for nurses and care workers.

111. The most recent process of award modernisation involved the review and rationalisation of more than 1500 awards into 122 industry or occupational awards.

112. For nurses and nursing employers it meant approximately 50 federal awards and 80 state awards were merged into a single occupational award covering all national system employers of registered nurses, enrolled nurses and assistants in nursing, however titled, except primary and secondary schools.

113. This process meant a reduction in wages and conditions for many employees in the aged care sector, particularly those previously covered by state awards where wages had been subject to work value increases and conditions periodically adjusted to reflect changes in community standards.

114. The second major modern award review, (the four-yearly review) commenced in 2014 and continues into 2019. While the four yearly review process has resulted in some beneficial improvements to the awards, it has not been concerned with reviewing minimum rates of pay or how those rates are set.

115. Award rates for nurses and care workers are substantially lower than public sector rates and are lower to varying degrees for nurses and care workers covered by enterprise agreements in non-public sector aged care.

48 Korn Ferry|Hay Group, 104
116. The low benchmark of award rates is a factor that influences poor enterprise bargaining outcomes in private profit and not for profit aged care.

117. Modern awards also play an important role in agreement making, providing the basis of the "better off overall test" under the Fair Work Act 2009. This requires employees covered by an agreement to be better off overall than they would under the relevant modern award. Awards are therefore important in providing a safety net for negotiating enterprise agreements.

118. Many award entitlements have monetary values set around base ordinary hour rates, for example shift penalties, overtime, weekend and public holiday rates and superannuation. Where base rates are low, all consequent rates are also low, thus compounding the impact of working in a sector that does not compare favorably with public sector health.

The role of enterprise bargaining

119. Currently, the vast majority of nurses and care workers' wages and conditions are established through the process of enterprise bargaining. It is almost universally the case that the ANMF is a bargaining representative in negotiations with the respective employers.

120. Excluding government aged care facilities, as at August 2019 there are approximately 754 federally registered agreements operating in the sector covering an estimated 2137 facilities. 87% of the agreements cover all nursing categories, including RNs, EN’s and AINs/PCWs. The remaining agreements cover nursing staff or care work staff only.

Agreement coverage

121. Agreement coverage varies across states and territories. For example, in Victoria 96% of
facilities are fully covered by agreements; 95% in NSW, 92% in Tasmania and 78% in Queensland. In South Australia coverage is more variable depending on classification. RNs and ENs are covered by 98% of facilities while only 43% of facilities are covered by an agreement for AIN’s/PCWs.

122. In the main, agreements are state based covering single employers and employees of a particular enterprise. A number of large providers, have multiple agreements covering employees in different states. This can result in different wages and conditions applying to employees working for the same employer and doing the same or comparable work.

123. There is a small number of agreements operating across two, three or more states or territories.

Wage outcomes in aged care enterprise bargaining

124. The ANMF produces a quarterly report\textsuperscript{51} on average wage data based on current and recently expired (or recently passed their nominal expiry date) agreements for key classifications including:

\begin{itemize}
  \item AIN/PCW;
  \item AIN/PCW certificate III;
  \item Enrolled Nurse and Registered Nurse Level 1 (or equivalent).
\end{itemize}

125. The data is provided on both state/territory and national level and compared with equivalent classifications in the respective public sector agreements/awards to identify the disparity in rates for each classification.

126. Nationally, and on average, the rates of pay for an RN level 1 sitting at the top of the structure are 15% or $216 per week less in aged care compared to public sector wages.\textsuperscript{52} This is calculated on the base rate of pay and does not take into account other wage based entitlements such as shift allowances, weekend penalties, qualification allowances and so forth, important to overall remuneration. As stated above, a low base rate impacts on the rate of other entitlements.

Aged Care Average wages data – August 2019

127. Bargaining outcomes are fragmented with varied wage rates both within and across the States and Territories and also across classifications.

128. The exception is NSW where a large percentage of the sector is covered by agreements based on two different templates negotiated with the industry bodies.

129. The average wages data below is indicative of wage levels for key classifications and shows the degree of variation between States/territories.

Rate ranges by classification:

<table>
<thead>
<tr>
<th>Classification</th>
<th>National average</th>
<th>Lowest</th>
<th>Highest</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIN/PCW entry</td>
<td>$22.29</td>
<td>$21.75</td>
<td>$23.58</td>
</tr>
</tbody>
</table>

\textsuperscript{51} Paycheck
\textsuperscript{52} Paycheck
Nurses Award rates of pay

130. Award rates of pay are extremely low. The Table below shows that for AINS/PCWs in particular, aged care agreement rates (on average) are only 6-8 percent above the Award. Rates for equivalent classifications in the public sector are 18 to 26% above the Award.

National average rates of pay compared to Nurses Award

<table>
<thead>
<tr>
<th>Classification</th>
<th>Public Sector</th>
<th>Aged Care</th>
<th>Nurses Award</th>
<th>% Diff public sector &amp; Nurses Award</th>
<th>% Diff Aged care &amp; Nurses Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIN entry</td>
<td>25.21</td>
<td>22.29</td>
<td>21.23</td>
<td>19%</td>
<td>5%</td>
</tr>
<tr>
<td>AIN top</td>
<td>26.26</td>
<td>23.32</td>
<td>21.99</td>
<td>19%</td>
<td>6%</td>
</tr>
<tr>
<td>Cert 3 entry</td>
<td>25.88</td>
<td>23.69</td>
<td>22.70</td>
<td>14%</td>
<td>4%</td>
</tr>
<tr>
<td>Cert 3 top</td>
<td>27.47</td>
<td>24.03</td>
<td>22.70</td>
<td>21%</td>
<td>6%</td>
</tr>
<tr>
<td>EN min</td>
<td>29.43</td>
<td>26.39</td>
<td>23.12</td>
<td>27%</td>
<td>14%</td>
</tr>
<tr>
<td>EN max</td>
<td>32.61</td>
<td>29.27</td>
<td>24.32</td>
<td>34%</td>
<td>20%</td>
</tr>
<tr>
<td>RN Level 1 entry</td>
<td>33.49</td>
<td>30.62</td>
<td>24.73</td>
<td>35%</td>
<td>24%</td>
</tr>
<tr>
<td>RN Level 1 top</td>
<td>44.49</td>
<td>38.43</td>
<td>29.72</td>
<td>50%</td>
<td>29%</td>
</tr>
</tbody>
</table>
131. While there is a high level of bargaining in the sector, the results have always been and remain patchy, and below most other sectors. The disparity in wage rates is compounded by less attractive conditions in relation to workload, leave and other entitlements.

132. This is a key factor in recruitment and retention of skilled staff in the sector and will remain the case until the substandard wages and conditions for all staff are addressed.

**Barriers to strong bargaining outcomes in aged care**

133. Bargaining in this sector has always been difficult and remains so today. From its inception in the mid 1990’s it has been a struggle to secure decent wages, wage increases and improved conditions for nurses and carers working in aged care through bargaining.

134. A number of factors, as outlined in detail below, contribute to the problem.

**High levels of part-time and casual employment**

135. As set out in paragraphs 29 and 39 the overwhelming majority of the direct care workforce in residential aged care is employed on a part-time or casual basis. The high proportion of part-time and casual staff in aged care contributes to the problems in bargaining in a number of ways. There is also reticence on the part of employers to give casual staff members permanent hours despite consistent employment, as a member told us in the 2019 ANMF National Aged Care Survey:

> “40 years-experience and training and paid less than a supermarket shelf stacker. Expectation to do heaps of (usually online tick and flick training) while not being given permanent hours after two years in my current workplace as a casual.”

136. Staff spend less time in the workplace and may do shift work that means they are not present when staff meetings or union meetings take place. It is difficult to organize when the workers time at the workplace is variable or irregular.

137. Employees engaged on either in casual employment or part-time employment are
vulnerable to losing shifts. This contributes to a reluctance to be vocal or active in the workplace. A member told us in our recent workforce retention survey:

"Food being served to residents was disgusting, when I complained I was labelled a troublemaker and had my hours cut"

**Female dominated workforce**

138. Historically, female dominated workforces are undervalued and have been less industrially organised than male dominated industries. This has resulted in long term, systemic undervaluing of work in female dominated industries - for example in child care, early childhood education and the disability sector. Aged care is no exception.

139. The majority of the aged care workforce is female with an average age of 46. The combination of the factors above and the high proportion of part-time and casual work positions the aged care workforce as vulnerable to systemic issues. In addition, as females, many workers have caring responsibilities outside of work and rely on shift work to manage those responsibilities.

140. The 2012 Equal Remuneration Case in relation to the Social Community Health and Disability Award (SCHADS Award) resulted in uplift to award rates over a period of 8 years by between 23% and 45%. The female dominated work in aged care would have many comparable features to that of workers employed under the SCHADS Award and indeed some workers in aged care are covered by that award.

141. The Fair Work Act provides avenues to make application to lift award wages such as work value reviews, equal remuneration cases and arbitration, however, these are time consuming- taking many years in most cases, often difficult to access, costly and do not have guaranteed outcomes.

**Communication barriers**

142. There are a number of factors in relation to communication that serve as impediments to achieving improvements through enterprise bargaining. These include the factors described above for casual and part-time workers, particularly those on night or weekend shifts, who are not available for face-to-face meetings that are important for collective organisation.

143. The percentage of workers from culturally and linguistically diverse (CALD) backgrounds in aged care raises language as a barrier to effective bargaining. It is rare for employers to translate bargaining information into languages other than English.

144. Access to technology is also an issue. Many employees will not have access to a computer at work or at home and are therefore unlikely to have their own work email address. This makes organising to take industrial action and to communicate about agreement negotiations difficult.

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53 Equal Remuneration Case [2012] FWAFB 1000
145. Nurses and care workers are committed to the care of residents and care recipients. There is a strong cultural reluctance to take any action that may be seen to have a negative impact on residents.

146. Reluctance to bargain for enterprise agreements can also be influenced by employees' relationship with management. This is particularly the case in RACF's that operate on a small family business model where employees may have a strong sense of loyalty to the business and personal relationships with management.

147. In addition, nurses are required under the Health Practitioner Regulation National Law Act 2009 to meet professional standards of care. Where staffing levels are already at a minimum, the capacity to take industrial action without impacting care is severely limited.

148. Employers prevail on workers' commitment to the people for whom they care. It is a common experience for employees to be informed that if they reject a proposed enterprise agreement, the provider will face financial hardship and be forced to close. Employees feel compelled to accept low wage increases for fear of losing jobs or facilities becoming unviable.

149. In the ANMF National Aged Care Survey 2019, members told us:

"The volume of work is overwhelming and add to that the expectations of Residents and their families and what they expect you to do straightaway. There are not enough hours in the day, we are constantly told there is no more money for extra staff and the company is in dire financial straights if we do not keep to the set budget. We rely on ACFI funding to pay staff wages and the hours have recently been cut which puts more pressure on the staff left as we have to make up the shortfall. Is it ok to go to work everyday and feel that the only way forward is to quit and go elsewhere, the only thing that stops me is that we are one of the good places. I have lost count of the thousands of hours I have given of my own time to make sure that residents care is the best I can give. I know literally that I have made a difference or averted a crisis but it's tough. Aged care is the toughest job I have ever had and unless you have worked at the coal face you will never understand."

"Low wages with high expectations to provide clinical nursing care to our most vulnerable with the minimum of staffing each shift. We are told we have to provide 5 star service on a 1-star budget! I am still working in the industry because I genuinely care for those in my care and want to make their lives as happy and comfortable as I can."

150. The capacity to take industrial action to pursue claims is further limited by industrial laws that provide that any action that threatens the health and safety of the community can be ordered to cease. For instance the Fair Work Commission must make an order suspending or terminating protected industrial action for a proposed enterprise agreement if it is 'satisfied that the protected industrial action has threatened, is threatening or would threaten: to endanger the life, the personal safety or health, or the welfare, of the population or part of it'.

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54 Fair Work Act 2009 s424
Provider shortcomings

151. Employer expertise in bargaining is mixed and not all providers engage industry organisations to represent them in bargaining. Lack of expertise can contribute to slow and difficult bargaining and delay in the agreement approval process.

152. Agreement approval data collected by the Fair Work Commission shows that in 2018, there were 168 applications under s185 of the Fair Work Act to approve single enterprise agreements finalised in the aged care industry. Of these, less than 5% were able to be approved without an undertaking. This of itself is a disincentive to bargaining.

153. Providers rely in large part on Government funding to meet wage costs. However, neither the Government nor any funding authority representative is present at the bargaining table. This gives providers a 'cloak' to argue at the table that the funds they have available for wages is beyond their control or subject to pre-determined limits.

154. The lack of transparency and accountability with respect to funding of aged care and how those funds are expended by providers is a serious problem with respect to bargaining outcomes and more broadly.

Industrial strength of the workforce

155. Nurses in the public hospital sector are highly unionised and accustomed to the industrial process of collective bargaining and associated industrial action. Public sector employees are employed by one large employer and there is strength in numbers in bargaining.

156. The same is not the case for private for profit and not-for-profit aged care providers. For the reasons outlined above, union density in aged care is low and this reduces bargaining power. The predominance of care workers in aged care when compared to RNs and ENs is also a factor. Nurses have a strong industrial history and are likely in their careers to have experienced the benefits of collective activity. Care workers are more likely to have come from backgrounds that are not as well unionised and to be in insecure work. The impact is that where RNs and ENs are in the minority in a workplace, such as in many RACFs, their industrial capacity is reduced.

ANMF's efforts to combat the problems in bargaining outcomes in aged care

157. The ANMF's efforts to address these problems over a number of years include advocacy before federal and state industrial tribunals; where possible, industrial campaigns to support the bargaining process; submissions to Government reviews, inquiries and pre-budget submissions and broader political and community campaigns in response to widespread concern about the quality of care and workforce issues. The ANMF has consistently argued for wage parity with equivalent classifications in the public sector with a mechanism and dedicated funding to achieve this.

158. While employers have long maintained lack of funding is the problem, several Government initiatives to close the wages gap have not been passed on to nurses and

55Fair Work Commission, Agreement User Group-Common issues in agreement making, 8 March 2019
carers in the form of higher wages. In the 2002/2003 Federal budget, for example, $211.1 million was provided over 4 years to close the wages gap. Despite $110 million being dispersed over the next two years the wages gap doubled.

159. In the 2004/2005 Federal budget, $877.8 million over 4 years was allocated to assist aged care providers to pay “competitive wages”. While some conditions were attached, providers were not required to direct the additional funding into higher wages. Again there was no impact on reducing the wages gap.

160. In 2010 the Government allocated $132 million to an aged care sector workforce package, but none of this money was used to close the wages gap.

161. As recently as February 2019, the Federal Government allocated an addition $320 million to residential aged care providers. This money was provided without any requirement to improve wages or staffing numbers.

**Workforce supplement**

162. In 2013, the *Living Longer Living Better* aged care reforms provided up to 1.2 billion dollars to the residential and home care sectors to address workforce pressures through two programs: an Aged Care Workforce Compact and Supplement (the workforce supplement) and an Aged Care Workforce Development Plan. They were targeted at assisting providers to build the capacity of the workforce by increasing wages, improving conditions, and providing better training and career opportunities. The workforce supplement, specifically, was a measure designed to assist the sector to attract and retain skilled staff and was funded to enable employers to offer more competitive wages.

163. The aims of the workforce supplement were to improve the sector’s capacity to attract and retain a skilled and productive workforce and to provide funding to assist aged care providers deliver fair and competitive wages. Payment of the workforce supplement was linked to enterprise agreements, providing a transparent mechanism to ensure the additional funding met policy objectives – to improve wages and conditions of aged care workers.

**Workforce supplement payments and criteria:**

164. Eligible providers would receive additional funding based on a percentage of the basic daily subsidy amount as follows:

- 1% - 2013-14; 2% - 2014-15; 3% - 2015-16 and 3.5% - 2016-17.

165. Eligibility for additional funding:

In order to be eligible for additional funding, employers were required to undertake to either negotiate new enterprise agreements or vary existing enterprise agreements that included terms that gave effect to the following:

- At least a 1% additional wage increase on top of employer funded increases in each of 2013, 2014 and 2015 and a 0.5 increase in 2016;

- In addition, employers provide an annual employer-funded increase of at least 2.75% per annum or the Fair Work annual review increase, whichever is the higher;
• Agreement rates for AINs/PCWs and support staff be at least \(3\%\) above the Aged Care Award and agreement rates for ENs and RNs at least \(8.5\%\) and \(12.65\%\) above the Nurses Award respectively. This could be phased in over 3 years;

• Other workforce commitments to training and education, career structure and processes to support career development and workforce planning.

166. Providers with less than 50 places did not have to have an enterprise agreement but were required to meet the same terms and conditions per an undertaking with the Department of Health and Ageing.

167. The workforce supplement was introduced via the *Aged Care (Residential Care Subsidy Workforce Supplement Amount) Determination 2013* in June 2013. Following the federal election in September 2013, the Determination was repealed on 12 December 2013. This resulted in the entire program folding the \(1.2\) billion workforce supplement into ACFI via a one off \(2.4\%\) increase into the basic subsidy and the funds no longer being linked to improving wages and conditions for aged care staff.

168. The workforce supplement was the first time government funding to improve the wages of the aged care workforce was guaranteed to be passed on to staff. However, the incoming Government's shift in policy saw the funding allocated to the workforce supplement simply reabsorbed into general funding for providers with no tangible improvement for workers' wages.

*Examples of cases run by the ANMF in Federal and State industrial tribunals*

169. The following section provides a brief overview of specific examples of the ANMF's efforts to address the wages gap in the aged care sector.

170. 1999/2000: An application to the then Australian Industrial Relations Commission (AIRC) to make an Award covering nurses in aged care in Victoria following a successful application by the ANMF to terminate the bargaining periods in relation to approximately 356 aged care employers. The AIRC awarded a \(15\%\) increase, phased in over three years from 2000 to 2002 primarily citing the need to address recruitment and retention issues due to higher rates of pay in other sectors, particularly the public sector.

171. The ANMF made a similar application in the Northern Territory following unsuccessful attempts to bargain with aged care employers resulting in a similar outcome of \(15\%\) phased in over 3 years.

172. In 2005 the ANMF made an application to insert a new classification structure and wage rates for *Assistants in Nursing (Aged Care) in the Nurses Private Employment (ACT)* Award 2002 resulting in recognition of the Certificate III qualification and increases for all AIN levels in line with the rate in the Queensland State Award (see below).

173. Similarly, in state jurisdictions, the ANMF has successfully sought improvements to aged care nursing classification structures and rates of pay on work value grounds. For example, in 2002, the Queensland Industrial Relations Commission inserted a new classification structure for AINs, ENs and a revised structure for RNs (Nurses' Aged Care Award State).
174. Following proceedings in the New South Wales Industrial Relations Commission commencing in 2003 and concluding in 2005, increases in rates of pay for all nursing classifications totalling 23% were awarded on “special case” and work value grounds. (The first two increases of 6% and 5% were by consent; the Commission awarded another two increases of 6% effective in March 2005 and 2006). (Nursing Homes &c., Nurses’ (State) Award 2003).

Award Review process:

175. Improvements achieved in NSW and Qld State Awards were lost in the Award Modernisation process where over 100 Federal and State nursing awards were consolidated into a new occupational award for nurses and midwives - the Nurses Award 2010. This process required the Commission to use the relevant principal federal award as the starting point for drafting modern awards. As a result, gains made in the NSW and Qld State jurisdictions were not adopted and were phased out in the transitional provisions included in all modern awards.

Linking funding to wage outcomes

176. The above examples, in particular the lost opportunity to improve wages in aged care through the workforce supplement, illustrate that it is essential for providers to be held accountable for the funding they receive. Funding must be allocated and acquitted in a transparent manner and must be tied to the provision of care. The ANMF will deal with this issue in detail in a future submission.

PROBLEMS CONFRONTING AGED CARE WORKERS

Inadequate staffing levels and workload stress

177. Through the National Aged Care Survey 2019 members told the ANMF of the difficulties they face working in aged care. The concerns voiced by members are predominantly attributable to a lack of adequate staffing levels and skills mix.

178. ANMF members report that they feel stressed, overworked, undervalued and ‘treated as numbers’. They also report that on many occasions the care needs of their clients are missed because they don’t have time to provide adequate care. In addition to the impact on quality of care, members’ own health and safety is put at risk when staffing levels and skills mix are inadequate.

179. The ANMF submission ‘Aged Care in the Home’ sets out members’ concerns related to working in home and community aged care. The themes of experiencing workload stress, lack of staff and support, unreasonable demands, lack of appropriately skilled workforce and lack of time to care are elaborated upon in that submission.

180. The ANMF submission ‘Aspects of Care in Residential, Home, Flexible Aged Care Programs, Rural and Regional Issues for Service Delivery of Aged Care, And Quality of Life for People

56 ANM.0002.0001.0001
57 Ibid p0011-0014
Receiving Aged Care while focussing on quality of care, also highlights the stress and concern members experience in the workplace.

181. Members responses to the National Survey summarise those concerns:

"I do not know of any other work where there is such high responsibilities and stress to staff. There is a huge physical work load and documentation workload, emotional demands from residents, their families, expectations are beyond acceptable, the Royal commission needs to focus on how to gain and retain good staff, who love and care for their residents and to value their contribution, not make life harder, having to prove we do it all perfectly. People are getting sicker from the stresses imposed, when the workplace should be a happy, caring environment that fulfils residents' needs, values staff and is a joy to work at."

"I love my work. It’s my passion, but to not be able to provide the best care possible to these vulnerable people who deserve this breaks my heart. My facility is amazing, and we do a great job but can only do this in a rushed, stressful environment due to staffing levels. Fix this and more nurses will want to join the aged care sector. A pay rise to meet the same rate as hospital-based nurses would also attract. We do this job not for the pay but for the caring empathetic people we are and our love of the elderly. Basic needs cannot be met effectively, and this has to change! ..."

**Role Substitution/Scope Creep**

182. A growing body of national and international research and evidence clearly demonstrates that inadequate levels of qualified nursing staff lead to an increase in negative outcomes for those in their care, which results in increased costs. In the acute setting, the implementation of safe mandated minimum staffing has been shown to prevent adverse incidents and outcomes, reduce mortality and prevent readmissions thereby cutting health care costs. It is widely agreed that the same improvements could be achieved in the aged care sector.

183. However, rather than look to the benefits of better utilisation of qualified nurses, there is increasing discussion in the aged care sector about educational requirements for care workers, particularly around expansion of their roles and potential increases to the scope of activities they currently perform. Many of these proposed activities sit well within the existing practice of enrolled nurses and registered nurses. Not only would it be wasteful and unnecessary to attempt to expand the activities of care workers when suitable other workers already exist, it would be profoundly unsafe.

184. As referred to in paragraph 17 above, it is apparent over the last decade, that there is an ongoing reduction in the percentage of the aged care workforce made up of RNs and ENs. At the same time, the number of care workers is increasingly making up a greater percentage of the workforce.

185. The ANMF acknowledges the work and skills of care workers and that they are an essential part of the workforce. However, the ANMF is opposed to the replacement of registered nurses and enrolled nurses with care workers where the work requires the skills and knowledge of either a registered nurse or an enrolled nurse.

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58 ANM.0005.0001.0001
186. Registered nurses are responsible and accountable for making decisions about who is the most appropriate person to perform an activity that is in the nursing plan of care. The registered nurse is required to complete a comprehensive assessment of the person receiving the care and identify if the nurse or non-nurse being delegated the care is competent and safe to do so. Registered nurses are also then required to provide adequate supervision.

187. The current environment in aged care is such that nurses, particularly registered nurses, frequently feel compromised in their efforts to meet their professional and legal obligations as set out by their regulatory authority. The environment is frequently incongruent with nurses' regulatory requirements and registered nurses are understandably deeply frustrated.

188. Inadequate staffing levels and workloads compounded by unreasonable (and even potentially unlawful) requests from employers to direct care staff to undertake tasks for which they may not possess the skills, leave many nurses feeling vulnerable and at risk of personal regulatory consequences.

189. The ANMF's concern therefore, is that by reducing the number of nurses in the aged care workforce, resident and consumer care is being compromised. Member responses to the ANMF National Survey illustrate the problem:

**Question: What are the issues you are most concerned about?**

"Unqualified staff giving medications - only EEN or RN should be giving medications. Management twist or misinterpret laws or regulations involved for medication management and train AINs or PCWs to give medications out to all residents in Aged Care Facilities."

"The ratio of RN to EN is not high enough. ENs are making decisions and liaising with Doctors & family over matters for which they are not educationally prepared."

"Care Workers should not be allowed to give medicine in Aged Care or Disability - that is what EN's are for."

"We now have to cook meals, wash dishes, clean rooms and other areas, do the residents laundry entertain them, as well as personal care, pressure area care, and dressings, deal with behaviours, and safely administer medications."

"Supervision/Reporting lines are not correct e.g. RNs are having to report to EN Clinical managers and PCAs are overseeing the completion of nursing assessments for ACFI Funding purposes."

"Upper management counted as staff on the floor. It's not true; they will not help on the floor."

"The number of unqualified carers being given the ability to give medications. Whilst ENs and RNs have to pay for this privilege yearly and do Continued Education to maintain registration, it's scary that this is allowed to happen."

"Medication Management-Personal Care Workers work beyond their scope of practice, dangerous life-threatening medications i.e. Schedule 8 drugs, Anticoagulant Medications and Psychotropic Medications in Dose administration Aids given out by PCWs. Who performs invasive procedures like Insulin and Enema administration when no RN?"

190. The ANMF is particularly concerned about the erosion of the role of ENs. Both the
statistics about workforce proportion and the anecdotal evidence supports the argument that providers are electing to engage less qualified staff to perform work that should be done by qualified nurses. It is hard not to view this trend as an effort in cost cutting by providers that comes at the expense of quality of care. As one member told us in the 2019 ANMF National Aged Care Survey:

"Staff hours and numbers were cut so much we were not able to take our breaks and always left work late [residential aged care facility] and still we were struggling to attend to the cares of all the high care residents. Not being able to answer a buzzer quick enough resulted in residents soiling themselves and losing their dignity OR trying on their own without assistance and falling and breaking bones. It broke my heart and I had to move to another nursing home."

191. At the same time, RNs are being increasingly utilised to perform administrative and management functions with less direct resident or consumer care and RN numbers being reduced. The following responses from the ANMF National Survey illustrate the concerns:

**Question: Do you think the ratio of registered nurses to other care staff in your facility are adequate?**

"Many RN duties have been removed from direct patient contact which impairs residents' health assessment and timely and adequate treatment."

"Often on an afternoon shift a EN will be designated to be in charge of the whole facility, with access to an on-call RN. Even when the EN objects to this situation they are not listened to."

"Not enough care staff for resident needs. Push by management to reduce RN's although high care residents who need RN's."

"When the role of the RN is purely clinical then yes. However the RN is frequently required to attend to duties which are outside the scope of clinical practice. This leaves Care staff to frequently work without adequate supervision. Also RN's are regularly replaced by EN's with the EN expected to perform the duties of a RN. This is often as a result of not enough RN's on staff. Management claim that there are very few who are suitable looking for employment for many reasons."

"I work in the facility of 120 residents with 2 RN on the floor which not safe at all to provide care. PC's made to administer medications to residents because RN is too busy doing administrative workload."

"Care staff are doing medication rounds which can sometimes include wound management, etc. They work under instruction from an RN or EN but are independent whilst doing the round. I believe they are not adequately trained or skilled to be handling Medications and that job should be done by someone who is skilled in that area. We are carers not nurses. The longer we allow this practice to continue the more of a "norm" it will become. It is a money-making exercise that is not in the best interest of the community it serves."

"I think this is adequate only because a lot of facilities allow enrolled nurses or carers to do registered nurse jobs."

"I have a fairly high level of RN compared to other sites but I believe any lower would be dangerous. I am often put under pressure to reduce the number of RN and told that if I reduced the RN numbers I could have more care staff. My counter argument is why would I replace clinical
expertise with a Cert III? And if I did then the difference would be very obvious in the Clinical Indicators. I must admit I am running out of energy to keep having this argument and to constantly justify why I have the number of RN on the floor that have. They are currently working at 1 RN:40 Residents in AM, 1 RN:64 Residents in the PM and 1 for 128 at night. They are also supported with EN with 3 EN per AM & PM shift. Any slimmer would be very substandard and extremely dangerous.”

“Using EN’s to replace RN’s and get away with it.”

“Registered nurses extremely overworked and no one to cover sick leave. Have to use ENs and PCAs to fill gaps and also seriously over work RNs.”

“Unqualified staff having to do RN work such as meds in dementia and sometimes high care unit.”

192. The Korn Ferry report found ‘Overall, there is a significant scope creep in nursing roles - they are treated as a ‘jack of all trades’. This creates significant issues in role clarity for nurses leading to ‘burnout’ and ultimately their exit from the aged care industry.29

193. The effects of inappropriate role substitution or ‘scope creep’ include:

- Increased risk of medication error
- Increased risk of missed care
- Decrease in the delivery of safe and quality care
- Greater delay in identifying health concerns of residents and consumers
- More unnecessary hospital admissions
- Unreasonable workload pressure and stress
- Job dissatisfaction
- Undervaluing the profession.

Workplace violence and aggression

194. Experiencing violence and aggression from residents and their family members is disturbingly common for workers in aged care.

195. In 2018, the NSW Nurses & Midwives’ Association collaborated with Dr Jacqui Pich of the University of Technology, Sydney to conduct an extensive survey of nurses and midwives in NSW looking at their exposure to patient related violence and aggression. The survey asked about all forms of violence, including sexual harassment as experienced by nurses and midwives from patients, relatives and visitors to health services. It did not look at violence between colleagues at work. The findings formed the report ‘Violence in Nursing and Midwifery in NSW: Study Report (the Pich report)60.

196. The survey attracted responses from 3,416 participants, working in all areas of nursing and midwifery across the public sector (78%), private sector (16%) and not for profits (7%). Reflective of gender representation in the industry, 87% of respondents were women. 16% of respondents identified as working in aged care. The findings referred to

56 Korn Ferry Hay Group, 38
below are overall findings, but indicate that experiencing violence in the workplace is a significant issue in aged care.

197. Of the total number of participants surveyed, 47% reported experiencing an episode of violence in the previous week and 80% in the 6 months prior to completing the survey. Of the respondents in aged care 79% had experienced violence in the 6 months prior to completing the survey.61

198. The report looked at the type of violence experienced in the previous 6 months. Verbal or non-physical violence was the most common type of violence reported, with 76% of participants experiencing an episode. Of those participants who had experienced verbal or non-physical violence, 25% had experienced sexually inappropriate behaviour.

199. Nearly, 25% of participants reported physical abuse/violence in the previous 6 months. Of those participants 13% experienced inappropriate sexual conduct and 2% - or 35 individuals- had experienced sexual assault.

Impact of violence

200. The Pich report examines the consequences of episodes of violence.

201. 28% of participants reported they had suffered a physical or psychological injury as a result of an episode of violence. Nearly a third of those sought medical attention and over a third took time off work ranging from the remainder of a shift to over a year.

202. Some participants elaborated by saying they ended up resigning, were forced into retirement or took random days off when too distressed to work. The impact of violence can be highly detrimental to the working lives of nurses and midwives in terms of time away from work. Absence from work also impacts on colleagues, management of services and care of patients and health care recipients.

203. The Pich report also identifies the emotional consequences of experiencing violence at work. These can range from long term psychological harm to feelings of unhappiness, powerlessness, fear, anxiety, shame and guilt.

204. This extract from the Pich report shows the range of detrimental effects that can be experienced:

4.4.1 Emotional response

Participants reported a range of ongoing emotional responses following an episode of violence, some of which indicated negative coping strategies, for example "increase in use of alcohol or other substances/medications". A number of the responses were long-term in nature, including those linked to Post Traumatic Stress Disorder (PTSD), for example "weight loss/gain", "nightmares and flashbacks" and "altered sleep patterns". PTSD itself was selected as a response by 8% of participants. In addition some responses impacted

61The Pich Report, 35
the nursing practice of participants, for example “withdrawal from people/situations” and “fear/anxiety re future episodes” (Table 18). \(^{62}\)

205. The report identifies that in addition to the impact on the individual there is a clinically adverse outcome for health care recipients as well. Participants reported a withdrawal not only from an offending individual but were more likely to experience a lack of empathy for patients generally. A loss of ability to empathise and interact with patients is detrimental to the overall ability to provide care.

206. With reference to other studies, Dr Pich concludes that nurse ‘burn out’ leads to a lack of joy in providing care and spending less time with patients whom they perceive as abusive. ‘Thus the negative effects of patient related violence extend to the workplace and can lead to difficulties with the recruitment and retention of nurses, decreased productivity and efficiency, increased absenteeism and fewer resources for nurses.’\(^{63}\) There is a cost flow on to the recruitment and retention of nurses and workers compensation claims.

207. Participants were asked to rank a number of staffing issues from highest to lowest in terms of the risk of potential violence they perceived them to have. The responses related to the numbers of staff, the experience and skill of staff and workload. \(^{64}\)

Table 30: Staffing-specific factors (ranked)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Factor (n = 1895)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inadequate staffing</td>
</tr>
<tr>
<td>2</td>
<td>Workload and time management</td>
</tr>
<tr>
<td>3</td>
<td>Inadequate skills mix</td>
</tr>
<tr>
<td>4</td>
<td>Lack of staff skills to manage episodes of violence</td>
</tr>
<tr>
<td>5</td>
<td>Nursing practice and attitudes of individual nurses</td>
</tr>
<tr>
<td>6</td>
<td>Inadequate communication with patients and relatives, friends or visitors e.g. about waiting times</td>
</tr>
<tr>
<td>7</td>
<td>Lack of training e.g. in de-escalation techniques, restraint, dementia care</td>
</tr>
<tr>
<td>8</td>
<td>Professional communication issues e.g. handover/documentation</td>
</tr>
</tbody>
</table>

208. The Pich report noted that the negative effects of patient-related violence can lead to difficulties with recruitment and retention, decreased productivity and increased absenteeism and fewer resources for nurses.\(^{65}\) It identifies the cultural problem of assuming experiencing violence is part of the job and therefore is not reported nor acted upon.\(^{66}\)

209. These issues are highlighted in the following member response to the 2019 ANMF National survey:

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\(^{62}\) The Pich Report 49-50
\(^{63}\) Ibid 71
\(^{64}\) Ibid 59
\(^{65}\) Ibid 71
\(^{66}\) Ibid 72
“Despite the negative images which broadcast on media, I do get to know the people who are absolutely dedicated to deliver the best possible quality care to the elderly. But when we get misunderstood, we get abused too (and we are asked not to make a big fuss so we all tend to put up with it), sometimes by the families and sometimes the violence comes from residents themselves. These days, aged care facilities accept more residents with mental illnesses, ranged moderate to severe. Dementia is not an exemption. They can be quite full on, requires lot of 1:1 to de-escalate their behaviours. However, we never get enough support. The recommendations from the offsite mental health services never consider the levels of staffing and resources, most of the suggestions are general but unrealistic. Imagine if you under pressure of everything, over time, you will lose your compassion... till the day you can handle no more, then you will leave the industry.”

210. Improved staffing levels and skills mix will reduce the risk of violence in aged care workplaces and consequently reduce recruitment and retention difficulties.

PERCEPTIONS OF AGED CARE AND CULTURAL VIEWS OF ELDERLY PEOPLE

211. The Aged Care Workforce Taskforce examined how the community and the industry itself views aged care.67 Indeed, as Professor John Pollaers poignantly remarked:

“A matter of care is for all Australians, because the way we care for our aging is a reflection of who we are as a nation. How we care says who we are.”68

212. The Report of the Taskforce, A Matter of Care, outlines how the aged care sector has become increasingly aligned with a consumer-centric style of market. Consumer expectations and preferences for aged care have changed (and will continue to change) along with broader beliefs about ageing itself. People desire increased choice and autonomy and have expectations regarding safe, consistent, and high-quality care. Person-centred care is also a strong priority for many.

213. The many reports of quality and safety issues in the aged care sector, both prior to and heard by the present Commission have led many people to regard the aged care industry, its providers and its workforce, to be failing those who engage with aged care services as either care recipients or family and loved ones of those in aged care. These are not isolated cases, and while all instances have involved individual staff and providers, the sheer number and distribution of concerns and complaints regarding the safety, appropriateness, and quality of aged care in Australia points to an ongoing systemic crisis.

214. Working in aged care has been described as being negatively perceived. An analysis of the perceptions of people who work in aged care including care managers, nurses, carers, domestic staff, and speech pathologists revealed four key themes that were common across all groups;69 working in RACFs is personally rewarding and challenging;

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68 Ibid.
relationships and philosophies of care directly impact service provision; staff morale and resident quality of life; a perceived lack of service-specific education and professional support impacts service provision, and; service provision in RACFs should be seen as a specialist area. The authors called for aged care providers to work collaboratively with staff to address these issues and continue to advocate for the recognition of RACFs as a specialist service area.

215. The negative perceptions around working in aged care are not new nor are they an exclusively Australian phenomenon.\textsuperscript{70,71,72,73,74} Indeed, aged care nursing has suffered from a poor image due to perceptions regarding lower status in comparison to more technical fast-paced acute care environments and concerns regarding funding, staff levels, and quality of care.\textsuperscript{75,76}

216. Nurse participants in a study examining the experiences of working in aged care revealed that nurses felt concerned about de-skilling, role clarity and accountability and felt that aged care nursing is being devalued and is emotionally and physically draining. These feelings are amplified by challenges related to poor staff-skill mix, high staff turnover, poor retention and instability of key roles as well as the number of junior and inexperienced staff needing support and supervision.\textsuperscript{77}

217. While perceptions regarding working in aged care may not be positive – which appears to largely be related to awareness of the systemic challenges and problems that appear to be prevalent in many countries’ aged care sectors, undergraduate nurses themselves have largely positive attitudes, perspectives, and perceptions regarding older people and working with older people.\textsuperscript{78} These attitudes however, do not appear to be fixed, as another study found that working in aged care was the least desirable career choice for graduating nurses which appeared to be driven by socialising factors within the education process, negative clinical experiences, and ageist biases within the broader community.\textsuperscript{79}
218. The Aged Care Workforce Taskforce noted that in Australia, there is a prevalent and negative societal attitude towards ageing, which is viewed as a problem and a burden. Death and dying are also negatively perceived. The Taskforce recommended that a social change campaign must be deployed as a matter or priority to reframe caring and to promote the workforce.80

219. Based upon the Taskforce’s workshops and community consultations, perceptions that ageing and caring for the aged is a burden are described to be built upon:

- past experiences of families and carers;
- highly negative portrayals of ageing and aged care in the media and public discourse;
- lack of understanding of the aged care system and available supports, and;
- inherent fears and frustrations with aging and death.81

220. The Taskforce linked these negative perceptions with partly why the aged care sector struggles to attract new workers and why current workers feel undervalued and even persecuted by the community.

221. Ageism can be described to manifest in multiple ways; negative attitudes towards older people, old-aged and the ageing process; discrimination or unfair treatment of older people; and, the implementation of policies or practices that reinforce or perpetuate negative stereotypes of older people.82 As with other forms of discrimination (e.g. sexism, racism, homophobia) ageism can have significant detrimental impacts upon peoples’ health and wellbeing. In a broad sense, widespread ageism may perpetuate a culture and society where older people are not valued or treated fairly.83 Where negative stereotypes of older people are common and where the care of older people is not typically considered important or meaningful. In a narrower sense, there is evidence that shows that the experience of ageism on the individual is also powerful and detrimental, especially upon mental health.84

222. Negative perceptions of ageing, death, and dying may also be held by older people themselves and may also be related to poorer physical and mental outcomes.85 A systematic review of 28 observational studies found that the way that older people (60 years and older) perceive ageing is related to their health and functioning across multiple domains; memory and cognitive performance, physical and physiological performance, medical conditions and outcomes, care-seeking, self-rated health, quality of life, and

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80 Ibid [1]
81 Ibid.
84 Ibid. [6]
death. Across each domain, more negative ageing perceptions were related to poorer health and functioning. The comprehensive account of the relationship between older adults’ aging and their health appeared to indicate the possibility of a bi-directional relationship between perceptions of ageing and health where older peoples’ negative attitudes towards ageing could predict or influence their health and be explained by their experiences of health and wellbeing across the above domains. Factors that appeared to be related to negative perceptions of ageing among older people included:

- Perceptions that one’s own health was poorer than others
- Attributions of illness to old age
- Lower quality of life (particularly among people with dementia)
- Better recall memory performance
- Poor vision
- Difficulties with activities of daily life (including instrumental activities)
- Greater dependency on assistance
- Decreased physical functioning
- Presence of multiple co-morbid conditions (but not a single chronic condition)
- Tremors/shaking (not associated with disease)
- Dementia (in terms of psychosocial loss)
- Greater number of medical appointments
- Greater number of days off work due to illness
- Less regular exercise and physical activity
- Poorer medication adherence
- Poorer diet, sleep and rest
- Reduced health care seeking
- Risk of shortened survival (greater mortality risk)

223. Factors related to positive perceptions of ageing among older people included:

- Better self-rated health
- Psychological wellbeing
- Higher health status
- Better quality of life (including among RACF residents)
- Better vision and hearing
- Physiological performance (ability to walk further)
- Less physical performance deterioration
- Less difficulty and need for assistance with activities of daily living
- Higher functional health status
- Slower rates of decline in activities of daily living
- Higher rates of exercise and physical activity
- Lower mortality risk

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224. Assessing the above factors that either increase and/or explain more negative attitudes towards ageing (and conversely reduce and/or explain these negative attitudes) provides a range of practical and actionable interventions that may be implemented with older people within and outside RACFs in order to improve health and wellbeing as well as their own attitudes towards the ageing experience.

**EFFECTIVE RECRUITMENT AND RETENTION**

225. Despite being a complex and specialised area, aged care continues to be regarded as something of a 'poor cousin' within the broader context of the health system in which the majority of nurses traditionally work. This is not just because of the poor wages and working conditions as outlined extensively above, or just as critically, because of the significant professional difficulties encountered by nurses and, increasingly, care workers working in the sector, but also because of the lack of adequate preparation for aged care work and professional career opportunities in the aged care sector.

**Theoretical preparation**

226. Aged care is a multifaceted specialty area that requires expertise, education, experience, and a significant suite of skills to effectively, efficiently, and safely deliver care to a cohort of the population that is particularly frail, vulnerable, and at high risk of complications from all aspects – pharmacological (higher incidence of side-effects and interactions), nurse-sensitive adverse events (for example, urinary tract infections, chest infection, pressure injuries), acute deterioration and general decline (from worsening chronic conditions and/or additional acute illnesses), and accidents (falls in particular).

227. We need to continue to prepare nurses of the future for this sector, through education and destigmatisation. The ANMF recommends that, as identified in our previous submissions, aged care specific theory and practice in pre-registration programs for both registered and enrolled nurses, including dementia care and palliative care, could be improved. This would equip graduates better for work in the sector and enhance care delivery for people in aged care.

**Clinical learning**

228. Equally important as the inclusion of sufficient aged care specific theory in educational programs is ensuring quality clinical placements in aged care settings for students of degree and diploma programs. The ANMF’s education submission, referenced earlier in this submission, examines the importance of quality clinical placements for nursing students and the key factors required to achieve this. When quality placements are provided, they effectively prepare students, as beginning or novice practitioners, for the workplace. However, we are frequently provided with feedback regarding the lack of quality of aged care placements.

229. One of the key issues is the lack of staff, particularly in residential aged care facilities. The staff is insufficient in number, and often skill, to provide adequate preceptorship to students. Too often, there are no nurses available to provide supervision and support, or to encourage and foster reflective practice. The environments, also frequently, are not

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87 ANM.0003.0001.0005 & ANM.0004.0001.0008-9.
conducive to learning and do not promote positive learning cultures. In addition, also too often, we hear from members that aged care placements tend to focus on foundational or basic care rather than allow students to appreciate the complex nature of the specialty.

230. Students who experience these negative conditions are unlikely to choose aged care as a specialty once they graduate.

231. In addition to their studies, students of nursing may gain employment in aged care prior to the completion of their degrees or diplomas. This may be one way of gaining early exposure to the sector. However, as with clinical placements, members report to us that if their experience is a negative one, they are very unlikely to seek permanent employment in the sector.

Transition to the workforce

232. Another important element in attracting and retaining nurses and care workers in the aged care workforce is ensuring effective transition from the educational environment into the workforce. When the features of effective transition, as outlined in the ANMF’s education submission, are in place the new graduate is provided with the opportunity to consolidate their learning and establish themselves as a competent practitioner. There are however, few examples of where graduate transition is done well in the aged care sector.

233. Too often, members report that they are unsupported, there are few formal or structured programs to guide their transition and development as a new practitioner and they are frequently exposed to environments that are dangerously understaffed placing new graduates at unreasonable professional and personal risk. It is unlikely that many newly graduated nurses would choose to remain working in such environments.

Career progression

234. As identified earlier in this submission, there are limited opportunities for career progression and development for nurses in the aged care sector, particularly when compared to the public health sector but also when compared to the private acute sector. Some opportunities are available for progression to management and there may be some opportunities for progression into education, and clinical education. There are however, few opportunities for nurses to progress as clinical specialists or experts and very few career structures available in the sector to support this progression.

235. An exception is the potential for nurses to progress to a nurse practitioner (NP) role. In aged care settings, nurse practitioners have an important role in providing support and direction to registered nurses and enrolled nurses in the complex care needs and chronic disease management of residents such as diabetes, respiratory conditions, urinary conditions, and cardiac disease. More importantly they provide timely intervention to prevent unnecessary admission to tertiary health care facilities.

236. ANMF members have identified that having a NP within their residential facility has not only improved care through direct care delivery but also through the NP providing support and education for nurses and care workers. Members have further identified that the NP’s presence can empower them to improve care delivery in facilities where clinical governance structures are lacking.
237. However, as above, opportunities for this progression are also limited. There are significant barriers for nurses wishing to become NPs, including lack of workplace support, education costs, and the lack of permanent job opportunities following formal endorsement as a nurse practitioner. These issues are examined in detail in the ANMF’s education submission.

238. Investing in increasing the nurse practitioner workforce and enabling innovation in models of care, is key to meeting the projected demand arising from the substantially increased proportion of complex care for older people in both residential aged care and home care. In addition, the nurse practitioner workforce has the potential to deliver significant cost savings.

Why nurses choose to work in and stay in aged care

239. A small Canadian study was conducted to better understand the factors that attract registered nurses to gain employment and remain working in the aged care sector. The study found that despite perceptions that working in aged care was an unattractive choice in comparison to working in a hospital, participant nurses appeared to often choose to work in aged care due to convenience. Organisational characteristics and environment including support for professional education and training, flexible working arrangements, as well as the caring relationship between staff and residents were significant factors regarding remaining in aged care.

240. While some participants described deciding to work in aged care due to difficulty finding employment in other sectors, others explained their specific interest in geriatric nursing and long-term care were major factors for selecting aged care as an employment area of choice. The authors recommended that marketing positive aspects of working in aged care, particularly opportunities regarding developing caring relationships with residents and their families, professional development opportunities, and job flexibility may improve the attraction and retention of registered nurses in the aged care sector.

241. Similar positive factors regarding working in aged care as a registered nurse were also identified in another Swedish study of perceptions of working in RACFs. The three key categories around nurses’ experiences of working in aged care included establishing long-term relationships with residents and families, nursing beyond technical skills and utilising a broader and more complex skillset regarding the provision of holistic, person-centred care, and balancing independence with loneliness due to the relatively lower numbers of other registered nurses and higher ratios of clients.

242. In the Australian context, altruism appeared to be a primary motivator for deciding to work with older people and people with dementia. A large Australian study with 3,983
nurse participants identified and examined key issues and factors affecting retention of qualified nurses who care for older people and persons with dementia in Australian acute, subacute, community and residential health-care settings. The following emerged as key recommendations for improving the recruitment and retention of nurses in aged care and are focused upon bolstering decision-making among nurses and improving workplace focus and structures:

- Involve nurses in system change plans, implementation strategies and evaluation of change on patient outcomes.
- Consistently consult with nursing staff on policy, procedures and care practices.
- Allow nurses more autonomy to run their departments and nursing budgets.
- Enable nurses to employ their diagnostic and clinical skills and to make judgments about nursing care.
- Create formal avenues to acknowledge nursing expertise within teams.
- Create partnerships among different health settings to promote reciprocal nurse secondment to transfer necessary skills, expert knowledge and new ideas.
- Create innovative working environments that involve nurses in quality projects and research.
- Provide education and supervision in patient and person-centred care.
- Provide structured support and mentoring for new graduates employed in the organisation.
- Maintain appropriate numbers of qualified nurses at the bedside as direct-care providers, mentors and supervisors.
- Facilitate staff development in clinical and management areas for qualified nurses.
- Support positive staff/resident interaction through the adaptation of existing resident documentation to facilitate the recording of strengths/abilities as opposed to deficits.
- Facilitate access to the Internet for educational purposes, information sharing and clinical assurance on current methods of best practice.

243. These features are all too often absent from Australia's aged care system.

**Why nurses and care workers are leaving or considering leaving the aged care workforce**

244. Retention of staff in aged care is a significant concern with respect to ensuring the aged care workforce's capacity and capability to provide high quality care and support and good quality of life for care recipients.

245. This submission identifies low wages, workload stress and violence and undervaluing of both the work and workforce in aged care as concerns for those working in aged care. Lack of support transitioning into the workforce and opportunities for career development are also issues of concern. The combined effects of inadequate staffing levels and skills mix all impact on the ability of those working in aged care to deliver the care they wish to offer both personally and professionally. This leads to 'burnout' and disillusionment in working in the aged care sector.
246. The ANMF conducted a short survey between 17-23 September 2019 asking members if they had left aged care altogether, changed employers or were thinking of leaving aged care or their current employer. Key outcomes of the survey and member responses are outlined in the section below. A more detailed analysis of the survey results will be provided to the Royal Commission at a later date.

**ANMF Aged Care Survey – Have you left or are you thinking of leaving aged care?**

247. Over 2000 responses were received, with approximately 41% of respondents working in private residential for profit facilities and 43.5% in not for profit private residential care.

248. Just over 1900 members responded to the question below. The answer tells us 40% (n=775) of respondents have left their aged care employer or the aged care sector entirely. 771 members told us why they had left. See tables A and B below.

**Table A**

Q7 Have you left your aged care employer or the aged care sector entirely?

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes (left aged care entirely)</td>
<td>23.38%</td>
</tr>
<tr>
<td>Yes (my previous employer, but still in aged care)</td>
<td>17.07%</td>
</tr>
<tr>
<td>No (I am still working at the same job in aged care)</td>
<td>59.55%</td>
</tr>
</tbody>
</table>
Table B

Q8 If you left a previous aged care employer or stopped working in aged care entirely, why did you leave? (you can select more than one)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not enough time to deliver appropriate care</td>
<td>76.65%</td>
</tr>
<tr>
<td>Not enough staff</td>
<td>62.50%</td>
</tr>
<tr>
<td>Not enough nurses</td>
<td>59.17%</td>
</tr>
<tr>
<td>Restructuring (cutting hours and/or shifts)</td>
<td>29.83%</td>
</tr>
<tr>
<td>Redundancy</td>
<td>9.84%</td>
</tr>
<tr>
<td>Low wages</td>
<td>44.23%</td>
</tr>
<tr>
<td>Excessive workloads</td>
<td>34.31%</td>
</tr>
<tr>
<td>Concerns with management</td>
<td>32.47%</td>
</tr>
<tr>
<td>Better job offer somewhere else</td>
<td>21.82%</td>
</tr>
<tr>
<td>Health and safety concerns (for yourself or other staff)</td>
<td>21.01%</td>
</tr>
<tr>
<td>Bullying or harassment</td>
<td>41.12%</td>
</tr>
<tr>
<td>Concern for the residents</td>
<td>55.04%</td>
</tr>
<tr>
<td>Personal reasons</td>
<td>9.86%</td>
</tr>
<tr>
<td>I feel undervalued</td>
<td>46.69%</td>
</tr>
<tr>
<td>Other reasons (please specify)</td>
<td>23.37%</td>
</tr>
</tbody>
</table>

249. For those respondents who had not left, 72.5% (n=1,125) are considering leaving with nearly 50% of those considering leaving aged care altogether. 813 respondents responded as to the reasons they are considering leaving. See tables C and D below.

Table C

Q9 Are you considering leaving your employer or aged care entirely?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes - I am thinking of leaving my employer</td>
<td>23.56%</td>
</tr>
<tr>
<td>Yes - I am thinking of leaving aged care entirely</td>
<td>46.98%</td>
</tr>
<tr>
<td>No - I am not thinking of leaving job</td>
<td>27.47%</td>
</tr>
</tbody>
</table>
Table D

Q10 If you are considering leaving, what are the main reasons why? (you can select more than one)

Not enough time to deliver appropriate care: 81.30%
Not enough staff: 82.36%
Not enough nurses: 97.93%
Restructuring (cutting hours and/or shifts): 35.92%
Redundancy: 1.23%
Low wages: 62.12%
Excessive workloads: 83.27%
Concerns with management: 54.74%
Better job offer somewhere else: 7.50%
Health and safety concerns (for yourself or other staff): 44.53%
Bullying or harassment: 32.72%
Concerns for the residents: 49.04%
Personal reasons: 6.15%
I feel undervalued: 58.79%
Other reasons (please specify): 16.27%

In the survey, members were asked if they would return to aged care if improvements were made across a range of areas. Overwhelmingly, of the 1,483 who answered the question, more time with residents, minimum staff to resident ratios and improved pay were the factors that would influence their consideration. See Table E below.
Table E

Q11 Would you consider working in aged care again / or continue working in aged care if the following improvements were made: (you can select more than one)

<table>
<thead>
<tr>
<th>Improvement</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum staff to resident ratios</td>
<td>78.56%</td>
</tr>
<tr>
<td>More registered nurses</td>
<td>61.02%</td>
</tr>
<tr>
<td>More enrolled nurses</td>
<td>44.10%</td>
</tr>
<tr>
<td>More carers</td>
<td>71.68%</td>
</tr>
<tr>
<td>Improved management</td>
<td>92.51%</td>
</tr>
<tr>
<td>More to care hours/shifting</td>
<td>92.42%</td>
</tr>
<tr>
<td>Improved pay</td>
<td>76.74%</td>
</tr>
<tr>
<td>More training opportunities</td>
<td>66.84%</td>
</tr>
<tr>
<td>Improved health care, dementia care, and personal care for residents</td>
<td>69.93%</td>
</tr>
<tr>
<td>More time with residents</td>
<td>79.77%</td>
</tr>
<tr>
<td>Improved occupational health and safety</td>
<td>39.92%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>12.74%</td>
</tr>
</tbody>
</table>

Members provided hundreds of comments in response to an open question as to why they were considering leaving or had left aged care. Below is a snapshot of those comments, including an appeal to this Royal Commission:

I hope members of royal commission have worked in aged care system to get to know the real world - to get real picture of the excessive workload and how to provide holistic care to real human beings not dummies, who have multiple co morbidities. It’s easier to pick on multiple issues regarding care given but it’s quite difficult to deliver that care when we have 2 carers to almost 20 residents and one RN who is also a supervisor, to oversee 115 residents and that RN has to follow her own duty statement which includes 2 meds rounds in any wing of approx 15 residents and do warfarin and 2 rounds of reg DDA, on top of that attend to emergencies, falls, consult with doctors and families, attend to care plans, Do 20 set of neuro one as 2-3 falls are expected in a day...... list is endless and it’s never enough after staying back for 30 mins to an hour on average without getting paid, we walk out of door thinking I didn’t have time to provide emotional support to that resident today. It’s equal to looking after dummies but unfortunately our elderly are expected to compromise with the system because system knows they are helpless... and we are letting the system take advantage of them. I have worked in different aged care companies and they are all less or more same when it comes to staffing ratios. If people are serious to do something for aged care- come and work with us for at least a month, not for a day or week. You won’t have to do surveys or listen to us, because you’ll know by then what it means to work in aged care. Thank you for taking time to read my experience who has worked as RN for 8 years looking after elder people. Please share it with good people who wants to make a positive change.
I think after 10 years I have reached burn out. Working with violent dementia residents, going home black and blue but management won’t address the issues. We are bottom of the food chain as PCA and that’s exactly how it feels. Time to find something where I feel like I’m valued. Kids working on the checkouts at the supermarket get paid more per hour and have way less responsibilities.

I left aged care to pursue my studies as a registered nurse. At the time I was a PCA, but now as a qualified nurse I wouldn’t go back due to the incredibly hard and unsafe workload. In hospitals we have ratios luckily, which is why I stay in the hospital system and wouldn’t return to aged care until safe ratios and staffing are in place.

My job was my life I loved my job. The home was under new management. We had approx 24 residents per ward. At least half on each ward were hoist lifts. Only 2 carers per ward. 3 staff morning and 2 in the afternoon. I was afternoon shift. Management were cutting staff back to 1 carer per ward. We were expected to leave our ward to assist another ward in hoist lifts with inactive residents. The food so cut back in the evening to an extent residents went hungry to bed. As these cut backs were happening they had to cut staff. I took voluntary redundancy. This was not a caring job any longer. Broke my heart to leave after 30 yrs.

I went to Donut King the other day. There were 4 staff serving and making donuts. I manage 100 residents with the same number of staff and deal with all aspects of care.....you do the maths.

Aged care culture is terrible and needs drastic change to get experienced nurses back. Low pay untrained staff. Bad management and complex needs of residents have all formed the perfect storm for very poor aged care reform is badly needed.

I felt my registration was at risk.

It’s all about the money, not the resident or resident care, it’s disgusting, the residents deserve so much more. I hope positive change happens soon from this enquiry, it’s heartbreaking what is happening.

Aged care nurses are often talked about as inadequate or not educated enough; however, our clinical skills and decision making processes have to happen so rapidly because time for sick old people is not factored into our daily workload at all. Our decisions are often made without the support that would be available for acute presentations. Aged care nurses also cop the blame when doctors are unwilling to listen or act on the information they are provided with. Aged care needs to be brought into the light and considered as the specialty it is. I am developing an immense knowledge of medications and interactions. I have held a necrotic toe (after it fell off) in my hand; packed a half a finger deep sinus wound. Been the company and comfort for the dying. Cried on the way home, cried at home, showered and gone back to work again.

Across all sectors and specialties, nurses need to have some more darn respect for each other; then the world sees us as united and not blaming one another for the parts of life that are way beyond our control.

As a Manager, I had no Admin Officer for the first 18 months of employment. No RN1 for the first 2 years, no support from Senior Management, but a brilliant team who I was able to upskill. I was on call 24/7... and I mean 24 hours 7 days per week! My last call was at midnight on a Friday night when a newly certificated PCA had a death. He was working with an agency PCA and I spent about 4 hours on the phone, talking him through final care, trying to contact the family, debriefing him, trying to contact the Regional Manager as was required when we had a death. At 4 am I went to bed, knowing that on Saturday I had to do the payroll or my staff did not get paid, and check and submit ACFIs my new graduate RN1 had completed so we could receive funding. Welcome to my world. I want to return as an RN1 on the floor but no one will employ me because of my qualifications and experience. I have three degrees... all education and aged care related. My specialty is dementia care.
CONCLUSION

252. Many of the factors that attract people to nursing in aged care can also contribute to retaining nurses in the profession. Aged care providers have a substantial influence, as do governments, on retention of nurses. Workplace conditions, manageable workloads, legislated nurse to residential staffing and skills mix, fair, reasonable and comparable remuneration, safety and quality standards, and positive practice environments are all examples of factors which assist retention of nurses.

253. Another important factor of nurse retention has been identified as early career preparation, support and provision of opportunities, job satisfaction\(^92\) and ongoing professional development opportunities. Supporting new graduates to transition to practice in aged care is critical to retaining nurses and ensuring a sustainable nursing workforce into the future.

254. When nurses are empowered to practice in accordance with the standards of the profession it increases work satisfaction and retention of the nursing workforce.\(^93\) Job satisfaction is linked to opportunity and support,\(^94\) effective, supportive and productive working relationships, access to education, effective clinical support and focused mentoring.\(^95\)

255. The leadership and culture of an organisation also plays a central role in retention. Features of effective leadership include providing a motivational influence, being respectful and acting with integrity, role modelling, ability to resolve conflict, nurturing others by mentoring and coaching, developing staff by facilitating learning, and empowering staff.\(^96\)

256. Working autonomously is important to many nurses, particularly those with experience. While there is potential for considerable autonomy for nurses, this is rarely realised outside the nurse practitioner role, and not always then; when combined with significant accountability, this can be a driver for people to leave the aged care sector or even the profession.

257. The ANMF submits that in order to enhance the aged care workforce’s capacity and capability to provide high quality care and support good quality of life to care recipients and make the aged care sector a more attractive and rewarding place to work the following must occur as a matter of priority:

a. Wage outcomes for aged care workers must be improved to match public sector wages.

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\(^{92}\) Applebaum O; Fowler S; Fiedler N; Osinubi O; Robson M (2010). The impact of environmental factors on nursing stress, job satisfaction, and turnover intention. *Journal of Nursing Administration,* 40 (7-8): 323-8.


b. The aged care sector should be supported to overcome the systemic barriers to achieving wage parity and improved working conditions.

c. Safe work practices and design must be promoted.

d. Government funding of aged care must be transparent and accountable.

e. Both Government and providers must demonstrate accountability with respect to funding allocated to wages.

f. Funding must be linked to quality of care outcomes and determined through an evidence-based methodology.

g. The aged care sector must be supported and promoted through policy and funding as an essential and valued part of the health sector. This is achieved through education pathways, transition to the workforce and career development.

h. Positive cultural perceptions of aging and elderly people and those who care for them must be promoted.

i. The currently unregulated aged care workforce must become subject to minimum education and training standards and be regulated to ensure delivery of quality and safe care.

258. Most importantly, minimum staffing ratios (numbers) and skills mix (type) must be legislated (made law) in residential aged care, in accordance with the ANMF’s project, i.e. a national average of 4.3 hours of care per day with a skills mix of 30% RN/20% EN/50% Care workers.

259. These mandated requirements should be implemented in accordance with the Plan (Aged care ratios make economic sense)97.

260. Finally, the ANMF directs the Commission’s attention to the Commonwealth Government’s view on workforce needs and skills mix. It is as follows:

“Government’s view is that aged care providers are best able to determine their workforce needs and staff skill mixes. This is because the relationship between staffing and aged care homes and the quality of the care provided is complex.”

(See letter from Senator The Honourable Richard Colbeck to Ms Beth Mohle, Secretary, Queensland Nurses and Midwives’ Union dated 20 September 2019. Annexed and marked ANM.0013.0004.0001.)

261. The ANMF utterly rejects that view as inconsistent with the experience of residents, their families, nurses, care workers, doctors, academic studies and the overwhelming evidence before the Commission. It is deeply troubling and underscores the importance of the Royal Commission’s work.

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97 ANM.0001.0001.3341