

NFAW Submission to the Royal Commission into Aged Care Quality and Safety September 2019

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Authorisation

This submission has been authorised by the NFAW Board

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Endorsement

This submission has been endorsed by:

Equality Rights Alliance (ERA)
Women in Adult and Vocational Education (WAVE)
Women with Disabilities ACT (WWDACT)
Women With Disabilities Australia (WWDA)
Women With Disabilities Victoria

Background to this submission

This submission draws on several sources. In part it updates an analysis undertaken by NFAW in 2016 following the referral of the matter of the future of Australia's aged care sector workforce to a Senate Community Affairs References Committee for inquiry (referred to as the Senate workforce inquiry in this submission). The context much of that analysis drew on two main sources as well as the direct experience of NFAW members in different aspects of aged care policy and administration:

- The reports on the Aged Care Workforce compiled by the National Institute of Labor Studies at Flinders University (NILS) for the Commonwealth in 2007 and 2012. The findings of the 2016 NILS survey are now also available and accessible at <https://www.gen-agedcaredata.gov.au/Resources/Reports-and-publications/2017/March/The-aged-care-workforce,-2016>.
- The Stocktake of Commonwealth Funded Aged Care Workforce Activities, prepared for the Department of Social Services and released in August 2015.

The analysis also drew on several studies based on further analysis of NILS data:

A. Howe (2009) Migrant care workers or migrants working in long term care? A review of Australian experience. *Journal of Aging and Social Policy*. 21: 374-392.

A. Howe, D. King, J.M. Ellis, Y.D. Wells, Z. Wei & K. Teshuva. (2012). Stabilising the aged care workforce: an analysis of worker retention and intention. *Australian Health Review*, 36: 83-91.

D. King, Z. Wei and A. Howe. (2013). Worker satisfaction and intention to leave among direct care workers in community and residential aged care in Australia. *Journal of Aging and Social Policy*, 25:301–319.

A. Howe with P. Cotter (2014). Ageing in Australia's Indigenous and culturally diverse communities. Ch. 26 in G. Caplan (Ed). *Geriatric Medicine: An Introduction*. IP Communications, Sydney. 2014. Pp.384-410.

We have updated our analysis to take in a number of more recent developments, including:

- the 2017 Legislated Review of Aged Care (<https://agedcare.health.gov.au/reform/aged-care-legislated-review>)
- NFAW's February, 2017 submission to the Senate Finance and Public Administration References Committee on Gender Segregation in the Workplace and its Impact on Women's Equality https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/Gendersegregation/Submissions
- the NFAW Gender Lens on the Budget for 2018 (<https://www.nfaw.org/document-repository/gender-lens-on-the-budget>)
- Professor Sarah Charlesworth's submission to the Senate workforce inquiry (submission No 290) , Section 1: Adequacy of current modern award conditions for aged care workers https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Aged_Care_Workforce/Submissions
- Good Shepherd Australia's 2019 submission to the Senate Standing Committees on Community Affairs – Community Affairs References Committee's Inquiry into ParentsNext https://goodshep.org.au/media/2245/g sanz_parentsnext-inquiry-submission_20190201.pdf

- Commonwealth of Australia, Department of the Prime Minister and Cabinet, *Towards 2025 A Strategy to Boost Australian Women's Workforce Participation [Implementation Plan]*, (2017)
<http://womensworkforceparticipation.pmc.gov.au/sites/default/files/towards-2025-implementation-plan.pdf>

Principles underpinning our recommendations

A safe, high quality and sustainable aged care system is dependent on the workforce that delivers care.

This submission focuses measures that will enable the aged care workforce to grow and to adapt continuously, so that it can respond to current and emerging problems in the sector.

The principles underpinning our specific recommendations are:

- Social infrastructure is at least as important to national well-being as hard infrastructure. Treating social infrastructure as a cost and hard infrastructure as an investment distorts government decision-making and undermines the future of the sector.
- The aged care workforce is critical social infrastructure. At present there are significant shortages in aged care workforce, particularly in regional Australia and amongst higher skilled roles.
- Aged care infrastructure needs to be rebuilt. There is a need for a shift in focus from attributes of existing and potential workers to structural factors that underpin greater consistency across aged care and related caring sectors in levels of qualification and recognition of qualifications, in wages and in other working conditions. Uneven and fragmented reforms are counterproductive.
- Flexibility in aged care should not be focussed simply on filling rosters on a given day. Flexibility also requires the capacity to grow the sector and to respond to innovations to improve quality, such as mandated ratios of nurses to patients; accessible and effective complaints mechanisms for residents and family members, mandated unannounced inspections by those responsible for standards, and so on.
- Employees will enter and remain in the industry, embrace reform and sectoral change and invest time and money in new skills only if they are assured of a reliable employment foundation including stable and secure working conditions, a proper valuation of skill sets, and relevant, recognised and, wherever possible, portable training.
- A strong sector should not be built by passing the problems of casualisation, forced self-employment, and undervaluation of work on to other parts of the caring sector such as disability support.

Recommendations

This submission recognises, but does not address the critical and growing importance of specialised dementia care. About 50% of current aged care residents have dementia and that number will increase dramatically in the next decade or two.

The 21 recommendations made through this submission follow.

NFAW recommends:

A. The current composition of the aged care workforce

[1] that evidence be sought from the Aged Care Quality Agency on the extent of changes in staffing in line with increases in resident dependency and the removal of the high care/low care distinction. Analysis should also be undertaken of how many women/men complete nursing degrees in whole or part, are unable to obtain hospital registration, and who then find employment in aged care -- and whether the ability to get specific registration through the aged care stream would be a useful option.

[2] that the Commission give attention to the impact on the aged care workforce of shortages of professional and other staff in the service systems that support the delivery of residential and community aged care.

B. Future aged care workforce requirements

[3] that research be undertaken to clarify whether the replacement of casual by part-time work in the sector is masking the use of part-time provisions to produce an effectively casualised workforce at ordinary time rates by changing scheduled working hours at short notice and increasing hours at ordinary time rather than overtime rates.

[4] that the role of self-employed workers in the delivery of community care be closely monitored, especially in care packages operating on Consumer Directed Care models.

[5] that the Outcome Standards be reviewed with attention to recognition of the part that new technologies have to play in provision of high quality care; that measures be taken to promote the adoption of best practice information technology and assistive devices, particularly those which reduce injury; and that recurrent and capital expenditure on care technologies be monitored by the Aged Care Funding Authority. In our view it would be helpful to have a national policy on assistive devices and technologies in keeping with the international approaches to making AT available to all, both in Consumer Directed settings and institutional settings at an affordable rate.

C. Interaction of aged care workforce needs with employment in related sectors

[6] that steps be taken to achieve national consistency across the aged care, disability services, and other community services sectors in training and qualification levels, and in remuneration and work conditions; in particular, differences in recognition of workers performing domestic work in residential and community care need to be recognised. Consistency is also required for other aged care workers, including administrators, nurses, cooks, kitchen staff, cleaners et. al., in relation to their training and to underpin delivery of appropriate standards of quality aged care.

D. Challenges in attracting and retaining aged care workers

[7] that the Government work with employer and employee bodies to identify a range of strategies to enhance retention of new workers and promote continued workforce participation on the part of workers aged over 50, especially as the age at which women can access the Age Pension rises to 67, and that expansion of these initiatives be balanced by a review of strategies focused on recruitment.

[8] that minimum qualifications should be re/established, with consideration given to increasing levels to at least Certificate 4 and preferably diploma level. Priority should also be given to developing career pathways for workers who have obtained qualifications at Certificate 4 level and to reviewing the wide range of these qualifications to identify those which could be consolidated into a career path towards a further qualification in the formal tertiary education system. Consideration should be given to the future professionalisation of care work, similar to the trajectory that was taken by Nursing.

E. Factors impacting aged care workers

[9] NFAW endorses the recommendations of the Charlesworth submission that any future strategy for the aged care workforce needs to have at its heart a commitment to provide decent working conditions for the workers who provided aged care services. This not only has consequences for the attraction and retention of aged care workers but also is fundamental to providing high quality care that people need. To that end:

1. Consideration needs to be given by the federal government and the industrial parties to the proper valuing of frontline aged care work. Such valuing would 'unpack' and remunerate the complex skills and competencies required to undertake this work in both residential and community-based settings. In terms of home care, a useful starting point would be the conditions in the NSW Aging, Disability & Home Care (State) Award 2014. Under that award, which also provides for travel time, the skills classifications are quite detailed, providing concrete examples of the different levels of skills, including interpersonal and discretionary, required in home care work. Further, the NSW award recognises three levels of direct home care work rather than just two as under the SCHCDS Award.
2. There needs to be better regulatory protection for part-time workers to ensure that their entitlements are truly pro-rata those of full-time workers, not only in wages but also in working time conditions, consistent with Australia's obligations under ILO Convention 175 on Part-time Work ratified by the Australian government in 2011.
3. Minimum engagements need to be increased for casual home care workers. I note both the ACTU and the HSU have made claims for four hour minimum engagements for casual workers in the FWC's Modern Award Review process. This is consistent with current modern award conditions for casual manufacturing workers (Charlesworth & Heron 2012).
4. Travel time spent in travelling between clients by home care workers must be paid for by aged care services and funded by the federal government.

and NFAW further recommends that the Commission ask the Fair Work Commission for advice on the industrial relations arrangements that cover the aged care workforce, with special reference to trends in the application of Modern Awards in the sector, and identifying anomalies within the sector and between the aged care, disability and health sectors.

[10] that steps be taken to improve wages and conditions for aged care workers as a means of stabilising the workforce, with particular attention to

- ‘unpacking’ and remunerating the complex skills and competencies required to undertake this work in both residential and community-based settings
- improving regulatory protection for part-time workers to ensure that their entitlements are truly pro-rata those of full-time workers, not only in wages but also in working time conditions
- scrutinising management practices that shape conditions of employment offered to workers, given there is no unified system of training or recognised management qualification in the aged care sector.

[11] that the Commonwealth support the development of staffing models that take account of staff mix and resident dependency and promote take up of these models as best practice for optimal staffing.

F. Role and regulation of registered training organisations

[12] that terminology such as Certified Personal Care Worker and Certified Community Care Worker be adopted to designate workers with recognised training at least at Certificate 3 level in order to correct community perceptions that a large part of the aged care workforce is unskilled, to encourage providers to employ a trained workforce, and to give recognition to the workers themselves for their attainments. Wherever possible, nomenclature should be designed to harmonise terminology across the disability and aged care sectors.

[13] that steps be taken to standardise and regulate the aged care education and training workforce and the qualifications obtained from courses they deliver.

G. Government policies at the state, territory and Commonwealth level

[14] that

- providers of programs such as Newstart, ParentsNext, Job Assist et al be monitored to ensure that participants being steered into the aged care sector receive career counselling to ascertain their suitability for the sector and presented with other choices that may be available/more suitable for the applicant (NILS 201, 153), and
- awards and conditions for the aged care workforce be harmonised nationally to provide consistency across the sector and with related sectors, and to facilitate movement of workers between jurisdictions. We note that consistency does not mean reducing pay and entitlements through a lowest common denominator approach, which would not be in the best interests of those receiving care, of the industry’s employees, or of ongoing workforce attraction and recruitment. The sector requires a reliable employment foundation including a proper valuation of skill sets, stable and secure working conditions and relevant, recognised and, wherever possible, portable training.

H. Relevant parallels or strategies in an international context

[15] that the term ‘migrant workers’ not be used in discussion of the aged care workforce as in suggesting a group of temporary workers. It is a misnomer for overseas-born workers who join the aged care workforce after shorter or longer periods of residence in Australia, the majority of whom are or soon become permanent residents and Australian citizens.

I. Role of government in providing a coordinated strategic approach for the sector

[16] that the role of the Aged Care Workforce Advisory Committee be reviewed and that it be charged with identifying a small number of priorities for strategic action against the background of on-going, broad based workforce development activities. The new Aged Care Workforce Strategy itself should also pay attention to areas where people with disabilities might be employed in the Care economy. Targets could be considered in which the Aged sector could meet employment targets set under the National Disability Strategy 2020-2030.

J. Challenges of creating a culturally competent and inclusive aged care workforce

[17] that training for all aged care workers give attention to the 3 R's of recognition of, respect for and responsiveness to differences in cultural norms across the community, including gender norms, and that client preferences take precedent in cases of potential transgression of norms.

- Staff need to be highly proficient in English. While NFAW is not recommending that a particular IELTS score threshold be set, it must be more than basic.
- Consideration also needs to be given to aged care services that cater for specific ethnic groups. Many clients revert to their mother tongue with ageing, along with a focus on the cultural mores of their youth. There are some multicultural aged care providers; others for specific groups (incl. religious).

[18] that action be taken in Indigenous communities to develop the primary health care workforce alongside the aged care workforce to deliver a better balance of primary health care programs to tackle chronic illness as well as to provide aged care services and that the definition of the Indigenous target population for aged care be reviewed to ensure that is an accurate and appropriate basis for planning this range of services.

[19] that research should be taken into the particular needs of LGBTQI clients/residents to inform formal training of staff. While this is broadly relevant, it is important that staff from countries that regard homosexuality as unnatural or sinful be able to deliver appropriate and respectful care to LGBTQI clients/residents.

K. Particular aged care workforce challenges in regional towns and remote communities

[20] that the extent to which the impacts of geographic isolation on the aged care workforce can be moderated by organisational integration and outreach be taken into account in the development of service delivery models in rural and remote areas that strengthen and support workers in those areas, and that this strategy consider ways of bringing all services in these areas into such support networks. It is essential to ensure that workers are covered for travel costs in areas where distance and travel conditions result in high costs, and that these costs are not shifted to workers or clients in CDC and other user charging regimes.

L. Impact of the Government's cuts to the Aged Care Workforce Fund

[21] that workforce development activities give attention to funding and that a clear distinction be made between time-limited initiatives intended to achieve particular changes in the short term and initiatives that have to be continued over the longer term to sustain growth of the workforce and quality improvements.

Submission

The National Foundation of Australian Women, NFAW, is a non-politically aligned feminist organisation committed to examining the potentially differential impact of policies and their outcomes for men and women and whether the consequences of policies, intended or unintended adversely affect women.

The aged care workforce is an area of major policy interest to NFAW on four grounds:

1. Just on 90% of the aged care workforce are women, in both residential and community care. In common with many other sectors of the workforce dominated by women workers, a high proportion work part-time, making protection of working conditions and work-life balance a high priority.
2. The majority of recipients of care delivered by the aged care workforce are women, around 70% in both residential and aged community care, and the quality of care they receive is a direct product of the skills of the workforce.
3. Formal services are the major source of support for older people (aged 65 and over) in need of care. While only some 15% rely fully on formal services, four out of ten receive some formal services as well as having informal care, three out of ten rely on informal support alone, and the remaining 15% are in residential care.
4. Women account for a high proportion of informal care givers. While recognising the substantial contribution made by these carers, this submission does not address issues of support for informal carers, other than to stress that a sufficient and effective paid workforce has to be seen as complementing and supporting the role of carers and that carers should not be treated as an unpaid substitute for trained paid workers. Further, having to undertake undue caregiving should not impinge on women's capacity to enter or remain in the paid workforce. Volunteers should similarly be seen as complementing the paid workforce, not substituting for it.

A. The current composition of the aged care workforce

A.1 Ageing of the workforce

Concern has been expressed about the age structure of the aged care workforce: 60% are aged over 45 and 27% are aged 55 and over. These cross-sectional figures show that the aged care workforce is older than the female workforce as whole, due in part to aged care being a field that women tend to enter after the early years of childrearing.

The NILS data also shows that newly hired staff are younger. In residential care, 24% were aged 35-44; and close to 20% aged 25-34; and almost another 20% under 25. The age distribution of new hires was similar in community care, with 28% aged 35-44 and close to 15% between 25-34, but only some 10% aged 16-24. The differences between the cross-sectional view of all workers and new hires point to the importance of understanding the flow of workers into the aged care workforce and subsequent turnover.

Some of the differences in the profile of new hires in the residential and community care fields can be attributed to the more rapid growth of residential care in the years up to 2012 compared to limited growth of

community care, and the attraction of professional staff under age 30 into residential care compared to more limited growth of these opportunities in community care.

A.2 Trends in balance of nurses and non-nursing staff in residential care

NILS reported that the proportion of residential care workforce made up of registered and enrolled nurses (ENs) declined relative to the share made up of Personal Care Attendants (PCAs). Rather than being taken as indicating a reduced presence of skilled nurses, interpreting these figures needs to take account of the relative growth of both categories, growth in the number of residents, the ratios of staff to residents and changes in overall resident care needs. Some key features of these comparisons are:

- The PCA workforce grew faster than the resident population, resulting in a fall in the number of residents that each PCA had to care for, from 3.4 to 2.9.
- From 2003-2007, the nurse share fell from 21% to 16.8%, but the decline tapered to 2012 when the proportion was 14.7%.
- The number of residents to nurses increased slightly from 2007 to 2012, from 12.8 to 13.5 residents per nurse, and the ratio of residents to enrolled nurses remained stable at 17.

A major factor driving these shifts in the balance of nurses and ENs compared to PCAs was the Commonwealth approval and subsequent establishment of far more 'low care' beds which have a workforce dominated by PCAs. As the distinction between low and high care no longer applies in the approvals process, its effect on staffing should disappear. The increasing dependency of resident classifications and the single set of standards that now apply to all aged care homes should further remove this distinction and its effects on staffing.

Analysis should also be undertaken of how many women/men complete nursing degrees in whole or part, are unable to obtain hospital registration in consequence, and who then find employment in aged care. This in turn raises the question of whether the ability to get specific registration through the aged care stream would be a useful option.

NFAW recommends [1] that evidence be sought from the Aged Care Quality Agency on the extent of changes in staffing in line with increases in resident dependency and the removal of the high care/low care distinction.

Analysis should also be undertaken of how many women/men complete nursing degrees in whole or part, are unable to obtain hospital registration, and who then find employment in aged care -- and whether the ability to get specific registration through the aged care stream would be a useful option.

A.3 Supporting services workers

The aged care workforce does not operate in isolation but within the context of three main supporting services systems:

1. **Assessment, rehabilitation, restorative care and palliative care services** that support residential and community care services employ a wide range of professional staff in geriatric medicine, allied health, podiatry, dentistry, psychology, social work and related disciplines. Shortages of these staff have adverse

effects on clients and staff in residential and community care services as they compromise the support that can be provided to staff and clients and impose additional tasks on staff that may be beyond their

2. scope of practice. Availability of expert consultancy staff in all these areas needs to be addressed if the aged care workforce is to function optimally. Overcoming the shortage of placements for training is a starting point for addressing these concerns and increasing the availability of professional support staff for aged care in the longer term.
3. **Managerial and administrative staff** who are not employed in direct care account for about one third of the total aged care workforce. The non-direct care workforce includes domestic workers on one hand and administrative and management staff on the other. Performance of management has repeatedly been found to be a major determinant of satisfaction staff and turnover. There is no unified system of training or recognised management qualification in the aged care sector akin to those elsewhere in the health sector. Management training for entry to aged care and for promotion of existing staff is needed to address this gap.
4. **Domestic workers in residential and community care work are not equally recognised as part of the aged care workforce.** This issue is taken up below under C.3.

We cannot reach a conclusion as to whether multi-skilling across fields, such as through development of more generic training programs, would be desirable or whether it would fragment the workforce further. National consistency in training and qualification levels and in remuneration and work conditions across sectors is however required in order to expand the workforce in all these sectors quantitatively and enhance it qualitatively and not exacerbate competition for a limited workforce.

NFAW recommends [2] that the Commission give attention to the impact on the aged care workforce of shortages of professional and other staff in the service systems that support the delivery of residential and community aged care.

B. Future aged care workforce requirements, including the impacts of sector growth, changes in how care is delivered, and increasing competition for workers

It is beyond the scope of this submission to present projections of future workforce requirements, but three observations are made on potential impacts of changes in modes of care delivery:

B.1 Growth and general labour market conditions

The aged care workforce is growing at a faster rate than the workforce in general and this 'excess' growth itself contributes to shortages. The aged care workforce is also highly sensitive to general labour market conditions as many workers have skills that are readily transferrable to other service sectors, including sectors outside health and community services. Some of the changes in workforce shortages reported in the NELS 2007 survey, around the peak of the mining boom, and then in the 2012 survey, after the GFC, show these effects. These labour market effects need to be well understood so that factors affecting the aged care workforce are not misattributed to the sector when they arise from more general labour market conditions.

Even if a period of moderate labour demand in the economy overall were to persist, demand would continue at a stronger rate than in many other sectors, with the notable exception of health and disability support work, major competitors for similar kinds of workers. Rather than relaxing the need for a strong development strategy, the next 5 to 10 years should be seen as providing a window of opportunity to consolidate and strengthen aged care as a preferred field of employment.

B.2 Casualisation

Casualisation of the aged care workforce has been a growing concern. The NILS 2012 report showed that just under 20% of the residential aged care workforce and almost 30% of the community care workforce were employed on a casual or contract basis. These levels had remained stable over the period from the 2007 NILS survey. The 2016 survey showed a notable drop in casualisation. Ten per cent of the residential aged care workforce were casual or contract employees and 14 per cent of the home care and support workforce were casual or contract employees (NILS 2017, pp xvi-xvii). Over three-quarters of all residential direct care workers in 2016 were employed on permanent part-time contracts (78 per cent), with approximately 12 per cent on full time permanent and 10 per cent on a casual/contract arrangement. The corresponding percentages for 2012 were 72, 10 and 19, suggesting a considerable shift away from casual/contract arrangement in favour of permanent employment.

This development is on the face of it welcome. However, there are two concerns associated with an overwhelmingly permanent part-time workforce:

- Many employees in the sector would prefer more hours or full-time employment. The NILS 2016 survey found considerable underemployment in the sector: 30 per cent of residential and 40 per cent of home care and home support staff reported that they would prefer to work more hours than they do, and 9 per cent of residential workers and 16 per cent of home care and home support workers had more than one job (compared to 5 per cent of the whole Australian workforce) (NILS, 2016, 162).
- As with many other feminised awards, working time provisions provided for part-time employees in the sector can be used by aged care employers to produce an effectively casualised workforce at ordinary time rates. This is because employers can, with 'mutual agreement', both change the scheduling of those hours and increase employees' hours over their contracted part-time hours at ordinary time rather than overtime rates provided for in most male-dominated industry awards (see section E.1 below and Charlesworth & Heron 2012).

NFAW recommends [3] that research be undertaken to clarify whether the replacement of casual by part-time work in the sector is masking the use of part-time provisions to produce an effectively casualised workforce at ordinary time rates by changing scheduled working hours and increasing hours at ordinary time rather than overtime rates.

Beyond concerns about the terms and conditions of casual and part-time workers who are covered by award conditions, the prospect of the growth of self-employed care workers in conjunction with Consumer Directed Care and similar models raises even greater concerns about risks to workers and clients. One of these concerns is the split shift nature of the work for employees who are providing community care. When the care required is consumer-directed, there will be a need for split shifts, e.g. 2 hours in the morning and two hours in the late evening. A balance needs to be struck between an individual hiring support for sufficient hours to meet care needs and preventing exploitation of employees. In some cases the split shift work timetable actually suits the employee's lifestyle and/or family obligations; in others it can involve travelling and child care costs that offset any employment benefit.

Another risk associated with Consumer Directed Care and similar models is that of working excessive hours to earn an adequate income and increased injury to workers and clients. Indirect risks include an erosion of conditions with no accident and injury insurance, no holiday pay and no sick leave, and shifting costs such as transport to the worker.

There are also risks to clients, including the possibility of violence, abuse, exploitation and neglect that is unreported and not addressed because of the inherent power imbalance between the two parties. Risks to the client also include reduced quality of care and unscrupulous workers charging clients for services that are not delivered, of low quality or that are of no benefit to the client.

These paid services also undermine the recognition of the role of volunteers who provide companionship and other support in both residential and community services. Volunteer coordination funded through the Community Visitor Scheme¹ and the Commonwealth Home Support Program encourage providers to engage with volunteers and provide them with training and the necessary checks, liaison with families and with other service providers wishing to take on volunteers.

The workers most likely to set up small community care enterprises, in many cases one or two individuals, are also likely to have limited capacity to carry out the necessary administrative tasks associated record keeping and reporting, including taxation. The small scale of provision by self-employed workers is likely to see it remain at the margins of the formal system, but it is nonetheless a critical margin in terms of its impacts on workers and clients and the likelihood of creating further instability in the delivery of aged care. A particular risk is that central providers may withdraw the services they deliver to small communities and leave them to self-employed workers without any organisational support. Further comments on international experience with these trends are made under Section H.

NFAW recommends [4] that the role of self-employed workers in the delivery of community care be closely monitored, especially in care packages operating on Consumer Directed Care models.

B.4 Technology and assistive devices

NFAW is aware of the actual and potential impact of new information technologies (IT) and assistive devices (AD) on the delivery of care. These advances can have substantial benefits for clients, carers and staff, including reduction of injuries and increased independence. Take up of IT and AD appears uneven, however, and both are areas that warrant fuller recognition in the Aged Care Outcome Standards to ensure the standards reflect current best practice and that further advances are promoted through the work of the Aged Care Quality Agency and industry bodies. The extent of investment in cost effective technologies also warrants investigation and monitoring by the Aged Care Funding Authority.

Technology is an area where community-based workers and clients can miss out. The high cost of some special equipment such as lifting devices puts it out of the reach of many providers' budgets and the private resources of many clients. Even smaller items may prove too expensive if they incur on-going costs. The treatment of aids and equipment in Aged Care Packages remains a confused area; the experience of the NDIS shows that it is assisting clients with specialised equipment, but resources can be spread thinly.

¹ In Contrast the Community Visitor Programs, or Official Visitor Programs, in the disability sector can be either paid or volunteer programs, which function more as vehicles for quality control of services, with ability to do spot checks of residences, investigate matters, and inspect documents.



It is important to be aware of the tendency to overuse technology to monitor the movement of an individual in lieu of providing face-to-face care, or to send an alarm in the case of an individual's fall. CCTV and alarms can be seen as a form of Restrictive Practice when there is no part of the accommodation which is not under surveillance. It would be helpful to have a national policy on assistive devices and technologies in keeping with the international approaches to making AT available to all, both in Consumer Directed setting and institutional settings at an affordable rate.

NFAW recommends [5] that the Outcome Standards be reviewed with attention to recognition of the part that new technologies have to play in provision of high quality care; that measures be taken to promote the adoption of best practice information technology and assistive devices, particularly those which reduce injury; and that recurrent and capital expenditure on care technologies be monitored by the Aged Care Funding Authority. In our view it would be helpful to have a national policy on assistive devices and technologies in keeping with the international approaches to making AT available to all, both in Consumer Directed settings and institutional settings at an affordable rate.

C. Interaction of aged care workforce needs with employment in related sectors

The evidence of which we are aware suggests that interaction between the aged care sector and the broader community services, disability and health sectors occurs in specific segments of the total workforce. Interaction is shaped by the markedly greater representation of nurses in the aged care workforce and the greater share of aged care that is delivered in residential settings whereas the greater part of disability care is delivered in home and community settings by a workforce with a diverse mix of generalist personal and home care workers and specialist staff working with different client groups.

The Commission needs to look at how equality of qualification and training requirements across the aged and disability sectors could be beneficial to both sectors. In the long term, career pathways in the Caring Industry need to be considered with the possibility of transferability between the two sectors. At present, the disability sector, with the opportunities offered through the NDIS, is probably more likely to attract personal care workers. In the long term (by 2040), there will be a large number of NDIS participants in the 50+ age group, whose existing disabilities become more complex and who acquire new disabilities associated with ageing. This may mean that the workforce 'bleeds back' to the aged care sector.

As in the disability sector there needs to be greater focus on home-based care and parallel reduction of institutional care.

C.1 Nursing staff

The main area of interaction is between nursing staff in the acute and aged care sectors. Salary differentials that have been a major disincentive to nurses working in the aged care sector were to be addressed through the allocation of funding in the Aged Care Workforce Strategy announced in 2012 under the Living Longer, Living Better package. Progress with this strategy overall is unclear and the impact of the redirection of the Aged Care Workforce Fund is taken up in section L below.

C.2 Personal and home care staff

Interaction between non-nursing staff appears most likely between disability services and community aged care, but even here segmentation of the workforces may limit mobility. This segmentation may be because of



distinctive skill sets required in each sector, with different training pathways in TAFE and on the job training, and the focus of employers on one area of service delivery. The report of the survey of 116 Registered Training organisations (RTOs) conducted as part of the Stocktake of Commonwealth funded aged care initiatives noted that while it was recognised that aged care and disability workers require a common set of core skills, close to 60% of RTOs considered that the differences in other areas meant that training should remain specialised for each area rather than being fully combined into one qualification. The need is for consistency in training in different areas, not uniformity.

Most aged care providers deliver residential or community care, and only a minority operate both, sometimes in conjunction with other services such as retirement accommodation or disability services. Just on 20% of community care providers also delivered residential care and only some 10% of residential aged care providers also provided community care; public sector providers were more likely to operate both residential and community services, but they comprise only a small segment of the sector overall and providers operating in both fields were dominated by not-for-profit providers.

It should be noted that there is considerable diversity among providers operating across fields, ranging from large organisations in the for-profit and not-for-profit sectors operating across states, to small Multi-Purpose Services operating in outer regional and remote areas. It is evident that the workforce needs of these different providers are equally diverse. Most disability providers are not involved in aged care, and where major organisations do operate in both sectors, these services are usually clearly differentiated in administration, finance and operations. The exception has been home care services delivered through the former Home and Community Care Program, but even these were a relatively small component of services delivered to clients with disabilities, and delivery arrangements are changing as these services move into either the Commonwealth Home Support Program or the National Disability Insurance Scheme. It would be good if policy settings minimised this segmentation.

C.3 Different recognition of domestic workers in residential and community care

Workers providing domestic support in home care, mainly in cleaning and related tasks, are recognised as part of the community care workforce and a high proportion have Certificate 3 training. This is not the case in residential care, yet similar workers provide support services such as cleaning and meals preparation. These support staff are essential to ensuring that personal care and nursing staff are engaged in delivering care and not deflected to performing other tasks.

Competition for staff in this area has prompted a range of responses from workers and providers in community care. Workers who want more hours may pick up shifts with other providers, and in-home community workers may opt to work in preferred jobs in social support or personal care if they are available and Certificate 4 is not required. Some providers are trialling use of commercial cleaning firms to meet the shortfall, but the experience of workers from these firms in other settings such as hotels or after hours in offices may not fit them well to work in clients' homes. While possibly providing immediate solutions, none of these responses is building this segment of the aged care workforce.

Maintaining the conditions of these generally low paid workers across community and residential care is essential to provide a strong base for both the residential and community care sectors and ensure that conditions of direct care workers and support staff are not eroded.

NFAW recommends [6] that steps be taken to achieve national consistency across the aged care, disability services, and other community services sectors in training and qualification levels, and in remuneration and work conditions; in particular, differences in recognition of workers performing domestic work in residential



and community care need to be recognised. Consistency is also required for other aged care workers, including administrators, nurses, cooks, kitchen staff, cleaners et. al., in relation to their training and to underpin delivery of appropriate standards of quality aged care.

D. Challenges in attracting and retaining aged care workers

D.1 Relative shortages and underemployment of available workers

Underemployment of available workers appears widespread, with one third of workers in all categories in both residential and community care reporting that they wanted more hours of work. Increasing their hours is a main means by which workers can increase their total pay. This underemployment suggests that part of the answer to workforce shortages lies in the hands of employers and management and points to the need for providers to develop internal solutions as much as for further recruitment efforts to attract workers to the sector.

In some cases of underemployment we may be seeing employer decisions not to reach the number of hours where the superannuation guarantee must be paid. Some workers may have multiple employers and scarcely get any CSG paid.

D.2 Drivers of turnover

In 2016 around 9 per cent of home care and home support direct care workers were actively seeking work at the time of the 2017 NILS survey, which was largely unchanged from 2012 (8 per cent). Four per cent intended to leave aged care, with a subset of those intending to retire.

Among those actively seeking work reasons related to the personal circumstances of employees (e.g. the need to move house, find work closer to home or fulfil caring responsibilities) accounted for around 45 per cent of the main reasons given for leaving a job by PCAs, 35 per cent by ENs, 26 per cent by RNs, and 36 per cent by allied health (AH) workers. These proportions had changed very little compared to the 2007 and 2012 surveys and reflect the ways in which paid work is embedded in the broader context of family responsibilities and in the household decisions about where the family live and work (for these mostly female workers in their middle age).

Other key reasons for leaving their last aged care job reported to the 2016 survey were related to conditions in the workplace. Two reasons stood out as being consistently cited across occupational groups. First—which has implications for job design and training pathways—was the desire to find more challenging work (RNs 15 per cent, ENs 12 per cent, and 16 per cent for AH workers). The second was ‘to get the shifts or hours desired’ (strongest for PCAs with 18 per cent). This is consistent with the finding that while 56 per cent of residential aged care workers did not wish to change their working hours, the remaining 44 per cent would have preferred a change.

These findings point to a need to give more attention to retention of workers than just recruitment and to recognise that different strategies will be needed to retain new entrants to the field vis-à-vis prolonging participation of those who have been in the sector for some time. As well as training, the former are likely to include meeting workers’ preferred hours of work and flexible arrangements for achieving a positive work-life balance for younger workers with dependents. The latter are likely to include scope for increased or full-time

hours, followed by flexible arrangements for transition to retirement and reducing physical demands on older workers.

While better screening and assessment might reduce entry of workers who have very short stays in the sector, this is a small group and may be hard to reduce further. Focusing on retention of those who intend to stay is likely to yield better results.

Retention issues are also addressed in section G below.

NFAW recommends [7] that the Government work with employer and employee bodies to identify a range of strategies to enhance retention of new workers and promote continued workforce participation on the part of workers aged over 50, especially as the age at which women can access the Age Pension rises to 67, and that expansion of these initiatives be balanced by a review of strategies focused on recruitment.

D.3 Career pathways

Different groups of workers have different pathways for entry into the aged care workforce and progression to more skilled levels. Findings from NILS 2012 on paid work prior to entry to the aged care sector, qualifications and current studying are summarised in Box 1 below. As well as summarising entry and flows into aged care work, the shaded boxes highlight three pathways for progression from PCA and CCW jobs to higher skill jobs, one current and one potential.

Although relatively few members of the workforce had no previous paid work experience, offering opportunities for training and placements may be particularly effective in attracting women with no paid workforce experience into the aged care workforce. Most workers had prior paid work experience outside aged care, suggesting that efforts to attract workers seeking a job change or to re-enter the workforce may have more success than attempts to make aged care an entry level job, especially for younger workers.

There are notable features of these three pathways of entry and progression:

- One current and quite distinctive pathway is identified for PCA and CCWs who are studying health courses. These are most likely student nurses and include international students for whom work experience assists in obtaining Permanent Residence. While adding to the nursing workforce and other categories of health care workers, these students may not necessarily remain in aged care.

BOX 1: Pathways into and progression in the aged care workforce

	Nurses		PCAs		CCWs	
	No paid work	<10%	No paid work	<15%	No paid work	~10%
	Acute Care	~50%				
Paid work prior to aged care	Other health/care	~20%	Health/Care	~20%	Health/Care	20%
	Other	~20%	Other	~65%	Other	70%
	None post school	<5%	None post school	15%	None post school	~15%
Qualifications held*	Nursing non-degree only	15%	Certificate 3	~75%	Certificate 3	~70%
	Degree	~80%	Certificate 4	20%	Certificate 4	20%
			Other aged care	15%	Other aged care	25%
	Not studying	87%	Not studying	75%	Not studying	80%
	Studying	13%	Studying	25%	Studying	20%
Progression			Aged Care	~6%	Aged Care	7%
			Health (Nursing)	15%	Health (Nursing)	3%
			Other	~4%	Other	10%

* Figures refer only to health and aged qualifications.

Figures for PCAs and CCWs add to more than 100% as many held more than one qualification, such as Cert. 3 and 4. Some workers in all 3 groups also held other qualifications in addition to those shown.

- A potential pathway can be identified among PCAs and CCWs who are undertaking Certificate 4 or other training. The majority of these workers reported that they were studying to improve skills for their current job or similar reasons and only a small proportion were interested in promotion. Most of these workers are likely to remain in their present roles in the aged care workforce and scope for developing career pathways to nursing or management positions remains untested.
- Realising this potential will require a variety of strategies as only small numbers of workers may be interested in or able to pursue career pathways at different life stages and with other commitments. Over time however, a steady flow through these pathways would build on experience and could lead to significant cumulative outcomes.
- Consolidating the current proliferation of qualifications and training is a prerequisite to developing career pathways for those already working in aged care and enhancing retention in the sector. Rather than

relying on individual providers to take these steps, action needs to be taken with the tertiary education sector to develop nationally standardised formal qualifications.



Work in the aged care sector for many carers is precarious, considered low skilled and is relatively low paid. Minimum qualifications should be re/established, with consideration given to increasing levels to at least Certificate 4 and preferably diploma level. Consideration should also be given to the future professionalisation of care work, similar to the trajectory that was taken by Nursing.

NFAW recommends [8] that minimum qualifications should be re/established, with consideration given to increasing levels to at least Certificate 4 and preferably diploma level. Priority should also be given to developing career pathways for workers who have obtained qualifications at Certificate 4 level and reviewing the wide range of these qualifications to identify those which could be consolidated into a career path towards a further qualification in the formal tertiary education system. Consideration should be given to the future professionalisation of care work, similar to the trajectory that was taken by Nursing.

Factors impacting aged care workers

E.1 Industrial relations, awards and enterprise agreements

NFAW has repeatedly pointed out in its *Gender Lens* analysis of the annual Budget that the undervaluation of caring work continues to underwrite Budget savings at the expense of those who work in the feminised caring sector (NFAW Gender Lens 18, 121). These assumptions have fed into funding models and have also played a role in shaping current awards. Award terms and conditions are particularly important to those employed in the aged care and other caring industries because of factors affecting unionisation of employees and the lack of access to enterprise agreements in those industries.

The adequacy of current modern award conditions for aged care workers is not just a matter of equity, it is also a matter of future economic growth and the future of the aged care workforce. NFAW strongly recommends to the Commission's attention the following analysis of award arrangements affecting the aged care workforce by Professor Sarah Charlesworth, quoted here at length:

Under the Fair Work Act 2009, the 10 National Employment Standards industry or occupation specific modern awards' set down the so-called 'safety net' of minimum employment conditions for most Australian employees. The Aged Care Modern Award and the Social Community Home Care and Disability Services (SCHCDS) Modern Award provide the regulation that specifically sets the minimum employment standards to which employees working as personal care workers in residential aged care or as home care workers in community-based aged care are entitled.

There are some significant limitations to this regulation:

- The award provisions, which include provisions for working time and skill classifications and rates of pay, do not provide any protection for the growing numbers of so-called 'self-employed' aged care workers.
- As with many other feminised awards, working time provisions provided for part-time employees can be used by aged care employers to produce an effectively casualised workforce at ordinary time rates. This is because employers can, with 'mutual agreement', both change the scheduling of those hours and increase employees' hours over their contracted part-time hours at ordinary time rather than

overtime rates provided for in most male-dominated industry awards (see Charlesworth & Heron 2012).

- Even for employees, both awards offer poorer working time protections than other feminized industries, including ‘flexible’ part-time work conditions and inadequate skills classifications. There are particular issues faced by part-time home care workers who, while entitled to agreed guaranteed minimum hours, can have their schedules altered where clients cancel services.
- In Australia, to date there has been no work value exercise taken in relation to frontline aged care work. While the vast majority of occupations covered under the SCHCD award won wage increases because of the 2012 SACS equal pay decision, home care workers were excluded from any increases in the Equal Remuneration Order as they had not been covered by the equal pay claim (Macdonald & Charlesworth 2013). This may provide a perverse incentive to move disability support workers onto the home care worker classifications with the gradual merging of the aged care and disability care in-home care workforces.
- In both awards, the lack of detail in skill classifications can impact on the pay rates to which a worker is entitled. For example a distinction between a personal care worker grade 1 and grade 2 in the Aged Care Award is that the former is required to perform work with a limited level of accountability or discretion while the latter is required to exercise a medium level of accountability or discretion (Schedule B). Nor do the classifications on which pay is based recognise the skills or the competencies required to actually ‘do’ aged care work. For example in the SCHCDS Award, the skills descriptors for home care employees level 1 merely state under ‘interpersonal skills’ that ‘Positions in this Level may require basic oral communication skills and where appropriate written skills, with clients, members of the public and other employees’ while the level of interpersonal skills for a level 2 home care employees is described as ‘Positions in this Level require oral communication skills and where appropriate written skills, with clients, members of the public and other employees. Such descriptions do not capture the highly complex relational nature of aged care work, which clearly requires high-level interpersonal skills.
- Under the SCHCDS Award there is no provision for travel time. This is utterly extraordinary and reflects a fundamental failure by the industrial relations system and by the federal government to recognise home care work as ‘work’. It is hard to imagine another occupation where the travel time that was integral to undertaking the job was not paid for. This issue has been recently highlighted both via research and in subsequent action taken by the New Zealand and UK governments. A NZ Human Rights Commission Inquiry into the Aged Care Workforce (NZHRC 2012) and subsequent advocacy, including a legal case bought by the Public Service Association (PSA), led to the NZ government agreeing to provide funding that time spent by aged care workers traveling between clients is remunerated <http://www.health.govt.nz/new-zealand-health-system/claimsprovider-payments-and-entitlements/between-travel-settlement>. Likewise in the UK, the Kingsmill Review (http://www.yourbritain.org.uk/uploads/editor/files/The_Kingsmill_Review_-_Taking_Care_-_Final_2.pdf0, and in particular the research evidence of Dr Shereen Hussein (see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262269/131125_Social_Care_Evaluation_2013_ReportNov2013PDF), found that by not paying for travel time many social care employers were paying workers less than the legal minimum wage. As a result the British government has now made it clear that travel time between clients *is* working time, which must be remunerated accordingly (<https://www.gov.uk/minimum-wage-different-types-work/overview>).

- Under the SCHCDS Award, casual home care workers are entitled to only one hour minimum engagement. Disability support workers are entitled to 2 hours with other social and community services employees entitled to 3 hours. Not surprisingly there is some evidence that under the NDIS there have been attempts to reclassify casual disability service employees providing in home care as home care workers. Indeed the reduction of the minimum hours engagement for casual disability support workers to one hour as for home care workers is already the subject of employer claims under the current Modern Award Review being conducted by the Fair Work Commission.
- Enforcement of minimum labour standards in a highly feminised industry, with significant casual and part-time employment, low unionization, and a high concentration of migrant workers is very difficult. This is exacerbated by the gendered assumptions about the value of aged care work embedded in inadequate funding by the federal government and in the work practices of many aged care providers who do not provide sufficient time or staffing to allow workers to complete the work they have been allocated within paid hours.

Any future strategy for the aged care workforce needs to have at its heart a commitment to provide decent working conditions for the workers who provided aged care services. This not only has consequences for the attraction and retention of aged care workers but also is fundamental 'to providing high quality care that people need' (ITUC 2016: 31). To that end:

1. Consideration needs to be given by the federal government and the industrial parties to the proper valuing of frontline aged care work. Such valuing would 'unpack' and remunerate the complex skills and competencies required to undertake this work in both residential and community-based settings. In terms of home care, a useful starting point would be the conditions in the NSW Aging, Disability & Home Care (State) Award 2014. Under that award, which also provides for travel time, the skills classifications are quite detailed, providing concrete examples of the different levels of skills, including interpersonal and discretionary, required in home care work. Further, the NSW award recognises three levels of direct home care work rather than just two as under the SCHCDS Award.
2. There needs to be better regulatory protection for part-time workers to ensure that their entitlements are truly pro-rata those of full-time workers, not only in wages but also in working time conditions, consistent with Australia's obligations under ILO Convention 175 on Part-time Work ratified by the Australian government in 2011.
3. Minimum engagements need to be increased for casual home care workers. I note both the ACTU and the HSU have made claims for four hour minimum engagements for casual workers in the FWC's Modern Award Review process. This is consistent with current modern award conditions for casual manufacturing workers (Charlesworth & Heron 2012).
4. Travel time spent in travelling between clients by home care workers must be paid for by aged care services and funded by the federal government. Significantly, the 2016 NILS report found that 70 per cent of all outlets paid for their staff's travel time and 46 per cent paid a petrol/depreciation allowance for work-related transport costs (p. 162). This was the first time that the report collected data on the allowances paid to home care and home support workers, such as travel time between care appointments, which is currently not included in the modern award for the sector.
5. Specific attention needs to be paid to aged care employer compliance with minimum labour standards and the enforcement of those standards by the Fair Work Ombudsman. While the practical enforcement of employment conditions in relation to in-home care presents some specific challenges,



these challenges need to be urgently addressed with the shift of aged care provision towards community-based care.

NFAW endorses the recommendations of the Charlesworth submission and further recommends [9] that the Commission ask the Fair Work Commission for advice on the industrial relations arrangements that cover the aged care workforce, with special reference to trends in the application of Modern Awards in the sector, and identifying anomalies within the sector and between the aged care, disability and health sectors.

E.2 Pay, conditions and preferred work arrangements

There is a history of undervaluation of work in the aged care sector which is in turn underpinned by an undervaluation of social infrastructure vis-a-vis hard infrastructure. The annual budget net operating and capital expense reporting treats spending on infrastructure as an investment, even when the financial returns are implausible, but spending on social infrastructure, such as child care, aged care or vaccines, as a cost. Yet such spending increases productivity and growth for current and future generations, partly by increasing the number of women in the workforce (Elson, 2017).

Total pay remains the single area of marked dissatisfaction in the aged care workforce and interactions of structural and management factors are identified as contributing to this outcome. The 2017 Legislated Review of Aged Care found (at para 10.120) that

Low pay is consistently identified as a concern by all stakeholders. Worker satisfaction with pay is low, and the rates of increase in the sector do not appear to be addressing the problem. I note ACFA's [the Aged Care Financing Authority's] work that indicates provider viability and financial performance have improved.² The sector now needs to develop a workforce strategy that translates some of this positive capability into improved wages and conditions for its employees.

Pay rates and hours worked are inextricably linked and both contribute to total pay, and as a substantial proportion of workers have reported wanting to work more hours, attention is required to unresponsive management practices that fail to make optimal use of the available workforce. Permanent part-time work is the most common and highly preferred basis of employment, but not as a cover for casualised employment practices. Working preferred total number of hours and preferred, stable rosters, are major factors in worker retention and satisfaction, in part because they enable workers to balance financial commitments and work-life responsibilities.

Permanent part-time work is the most common and highly preferred basis of employment, reported by over 70% of the total residential care workforce and 60% of the total community care workforce. While most employers provide preferred terms of employment to most of their workers, NILS has identified dissatisfaction with work conditions where employers impose hours that are longer than scheduled norms, and/or unexpected variations to hours or location of work.

While both workers and employers value a degree of flexibility, any measures to increase flexibility must protect conditions for permanent part-time workers who should receive pro-rata fulltime terms and conditions. Such protections will play an important part in retaining and attracting workers who might otherwise move to jobs in other services, not just in other health and community sectors but outside these sectors altogether to areas such as retail and hospitality.

² ACFA, 2016, *Fourth report on the funding and financing of the aged care sector*, p. 58.

NFAW recommends [10] that steps be taken to improve wages and conditions for aged care workers as a means of stabilising the workforce, with particular attention to

- ‘unpacking’ and remunerating the complex skills and competencies required to undertake this work in both residential and community-based settings
- improving regulatory protection for part-time workers to ensure that their entitlements are truly pro-rata those of full-time workers, not only in wages but also in working time conditions
- scrutinising management practices that shape conditions of employment offered to workers, given there is no unified system of training or recognised management qualification in the aged care sector.

E.3 Staffing ratios

The underlying principle of the Aged Care Standards is that the skills of workers and staffing levels should be appropriate to the clients’ care needs and the complexity of care being delivered. Simple staffing ratios are now widely regarded as blunt tools for capturing the interaction of these factors and ensuring effective provision and use of staff. Two steps can be taken to develop more effective tools.

1. The 2016 NILS survey estimated staffing ratios (obtained by dividing the total number of direct care workers by the total number of operational places across all facilities) as 0.78, nearly unchanged from 2012 when it was 0.77. To the extent possible this data should be mined to establish existing ratios of different categories of staff to residents in residential aged care homes to identify normative ratios, the extent of variation above and below these norms and factors associated with these variations
2. More complex staffing models that take account of staffing mix and client dependency are now being developed and applied on a limited scale in the sector. The Aged Care Funding Instrument provides nurse managers with information on funding available for the mix of residents in a home, and in conjunction with this knowledge, staffing models can enable development of rosters that ensure all staff are allocated to the times and tasks that optimise delivery of care in accord with resident care plans and available funding. Further work on these models should provide a basis for developing best practice in staffing that takes account of the roles of different staff and responsibilities within their scope of practice. By identifying the staff mix that is most appropriate to meeting client needs, use of these approaches can also promote effective teamwork and leadership.

NFAW recommends [11] that the Commonwealth support the development of staffing models that take account of staff mix and resident dependency and promote take up of these models as best practice for optimal staffing.

F. Role and regulation of registered training organisations, including work placements, and the quality and consistency of qualifications awarded

F.1 Access to affordable training

NFAW member group Women in Adult and Vocational Education (WAVE) have emphasised the need for access to affordable training that results in an accredited qualification that is recognised across the sector. The cost of training poses a real barrier for some potential workers interested in aged care, or for workers already in the workforce but with no or limited training. Women with no or very low earned income are not able to participate in training that would give them an accredited qualification at Certificate 3 or above unless it is fully subsidised. These potential workers need to be provided with support to assess their suitability before

taking on training to ensure they have a clear understanding of aged care work. They also need written information and time to make their decision.

The formal TAFE system is best placed to offer such training, and at the same time can deliver workplace English training to those who need this additional training. As discussed below, English language training is critical to enabling workers from different cultural and linguistic backgrounds to enter the aged care workforce in mainstream services as well as services for special needs groups.

All training courses need to have a component that increases workers' knowledge of the use of a basic range of assistive technologies, so that these can be supplied and used to maximise independence of individuals.

F.2 Proliferation of training providers

The proliferation of training providers and relaxation of regulation has resulted in very varied outcomes for both workers and providers. Workers lack standard qualifications across the sector and providers have no real way of understanding what qualifications obtained from diverse providers, including on-the-job and provider training, mean in terms of workers' competencies.

As the basic qualification in community aged care, Certificate 3 must include basic occupational health and safety training and standards for relationships with clients, such as not accepting gifts. The varied content and standard of Certificate 3 training is a major cause of concern.

The only uniform requirement across the whole of the aged care workforce is for police checks, and having up to date police checks is given close attention in standards monitoring in residential care. There are however gaps in coverage of past history of all workers, for example, New Zealanders who can enter Australia freely, and as police checks apply at the time the worker joins the aged care workforce, they do not provide a guarantee against future offences. At the same time, minor offences recorded many years previously may exclude some otherwise suitable workers from seeking employment in aged care.

F.2 Recognition of Certified workers

As well as addressing the quality and consistency of qualifications, there is a need to recognise TAFE level qualification to demonstrate to the community that this segment of the workforce is not unskilled and as a means of expressing the value of these workers. In the US and elsewhere, non-nursing residential care workers are titled *Certified* Nurse Assistants or similar in recognition of the para-professional qualifications they hold. Fully 75% of the Australian community care workforce are Community Care Workers and two thirds of these CCWs overall have certificate level qualifications, mainly Certificate 3 in aged care (48%) and Certificate 3 in Home and Community Care (20%). A considerable share of those without such qualifications are undertaking study towards them. It seems unlikely that in any other field would such a high proportion of the paid workforce have this level of qualification but be widely viewed as 'unskilled'.

Standardisation of qualifications is a prerequisite to recognition that is a first step towards registration.

NFAW recommends [12] that terminology such as Certified Personal Care Worker and Certified Community Care Worker be adopted to designate workers with recognised training at least at Certificate 3 level in order to correct community perceptions that a large part of the aged care workforce is unskilled, to encourage providers to employ a trained workforce, and to give recognition to the workers themselves for their attainments. Wherever possible, nomenclature should be designed to harmonise terminology across the disability and aged care sectors.

F.3 The aged care education and training workforce

Aged care educators and trainers provide essential support to the aged care workforce. After growth of training in the formal tertiary education system in the late 1980s through the 1990s, there has since been considerable proliferation of training providers. The increasing involvement of independent education and training businesses is a particular cause for concern in the absence of effective regulation. Increases in employer-delivered training is also a cause for concern; while it may enhance the workforce for the employer, it may not provide workers with skills that will be recognised by other employers and across the sector.

Regulating the aged care education and training workforce and standardising the courses offered would lead to recognition of approved providers. This measure is a correlate of standardising qualifications obtained by workers. Two means to this end are:

1. ensuring that funding for education and training goes only to education and training providers who deliver recognised qualifications, and
2. recognising only authorised or approved training in monitoring the relevant Standards Outcomes in all aged care services.

NFAW recommends [13] that steps be taken to standardise and regulate the aged care education and training workforce and the qualifications obtained from courses they deliver.

G. Government policies at the state, territory and Commonwealth level which have a significant impact on the aged care workforce

In its 'Towards 2025: An Australian Government strategy to boost women's workforce participation' the Government set out employment projections to November 2020 showing that the health care and social assistance industry (78.3% women) was on track to make the largest contribution to employment growth, increasing by 16.4%. The disability sector workforce – which intersects with aged care services—was also estimated to more than double to meet the demand of the full National Disability Insurance Scheme (NDIS) by 2020.

Demographic changes, the associated demand for aged care workers, and the sex segregation of the workforce between them will see that these employment trends continue. In terms of policy drivers, recent Government policy has focused on employer incentives to take on temporary trainees and interns at reduced or no wages. Supply measures were summarised in the Government's strategy document as 'reforms to welfare payments that better assist recipients to participate in the labour force, prevent lengthy absences from the labour market and reinforce self-reliance through work' (Strategy, 25).

In practice these measures involved tightening and reducing tax transfers and access to income support, thus 'encouraging' women into the labour market while enabling wage growth to remain suppressed (2018 Gender Lens, 117-118; ; Good Shepherd Australia's submission to the Senate Standing Committees on Community Affairs – Community Affairs References Committee's Inquiry into ParentsNext https://goodshep.org.au/media/2245/g sanz_parentsnext-inquiry-submission_20190201.pdf).

Consistent with these drivers, the government's job training providers are reported to be pushing their clients into aged care because it is a growth area irrespective of their qualifications or interests. Analysis is required to obtain data re women/men enrolling in aged care related courses through VET providers, including those who enrol/are employed via programs such as Newstart, ParentsNext, Job Assist et al, where participants often have little or no career counselling to ascertain suitability for the sector and other choices that may be

available/more suitable for the applicant (NILS 201, 153). NFAW is aware of at least one Sudanese engineer now working as a personal care attendant who loathes it.

This practice is exacerbated by the ongoing skills shortage in the aged care sector that has been in place for almost a decade and is now escalating. Despite the number of recent inquiries and reviews in the sector, measures to increase its actual attractiveness as a source of employment have been thin on the ground, especially following the cancellation of the March 2012 Workforce Supplement following the change of Government in 2013. The 2016 NILS National Aged Care Workforce Census and Survey reported, not surprisingly, that

Negative perceptions of aged care work as an occupation of low pay and status remain. Given the need for the expansion of the aged care workforce, this issue must be addressed. (NILS 2016, pp xviii, 132)

The 2017 Legislated Review of Aged Care similarly found that part of the image problem is clearly pay (para 10.125), and further that ‘the modest wage growth in the aged care sector is consistent with my observation that recent policy on wages in the sector has not narrowed the wages gap between aged care and other sectors’ (180). Given economy-wide low wage growth, this continued wages gap should be concerning. As aged care is now almost entirely a Commonwealth responsibility, it should be expected that government address workforce attraction issues including pay, casualisation, minimum hours, transport costs (identified in E1 above) and the adequacy and consistency of awards.

NFAW recommends [14]

- that providers of programs such as Newstart, ParentsNext, Job Assist et al be monitored to ensure that participants being steered into the aged care sector receive career counselling to ascertain their suitability for the sector and presented with other choices that may be available/more suitable for the applicant (NILS 201, 153), and
- that awards and conditions for the aged care workforce be harmonised nationally to provide consistency across the sector and with related sectors, and to facilitate movement of workers between jurisdictions. We note that consistency does not mean reducing pay and entitlements through a lowest common denominator approach, which would not be in the best interests of those receiving care, of the industry’s employees, or of ongoing workforce attraction and recruitment. The sector requires a reliable employment foundation including stable and secure working conditions, a proper valuation of skill sets, and relevant, recognised and, wherever possible, portable training.

H. Relevant parallels or strategies in an international context

While there are opportunities to learn from overseas experience and to adopt and adapt models of care developed in other countries, a number of caveats need to be noted.

H.1 International standing of the Australian aged care system

First and foremost, Australia’s aged care system is highly regarded internationally. Major characteristics of the system as a whole that are consistently noted are that

- it is a coherent national system,
- it spans residential and community care, and in community care especially avoids the division between ‘health care’ and ‘social care’,

- it provides equity of access taking account of assessed client care needs and consistent means testing
- there is a high degree of national coverage of services, and
- it is cost effective, in line with the Australian health care system.

Another feature is the strength of the not-for-profit sector compared to the US and increasingly the UK where the major roles of central and local governments have given way to private providers with a less prominent not-for-profit or third sector.

H.2 Exceptional or typical models?

Many of the actual or proposed importations of overseas experience come from small scale, innovative projects. It is often difficult to know if these innovations have been taken up more widely in the other country, and if so, whether the same conditions for such spread apply in Australia. In particular, transfer of models from Scandinavian countries needs to take account of the much higher taxation rates that apply in those countries and the very different social insurance schemes that cover social services.

Even the only major import into the Australian aged care system, namely Consumer Directed Care (CDC), is characterised by great variation in models between countries and changes over time. Of particular note in relation to the workforce are reports from both UK and Japan that document rapid growth of independent providers spawned by CDC. While appearing to develop a more flexible workforce claimed to be more responsive to consumer needs, many of these private enterprises were very small scale and short-lived, and did not have the workforce to sustain delivery of significant amounts of care of a stable quality. There is also a risk of proliferation of services offering 'soft' services such as companionship and telephone support that may not enhance client well-being, but which clients and their families are pushed to engage and pay for.

These kinds of small enterprises may appear to offer a solution to the high overheads reportedly taken out of Package funding with the introduction of CDC in Australia, commonly around 30% but higher in some instances. The question that arises here is whether the share of overheads associated with worker benefits are in fact directed to those benefits, and why overheads should be so much higher than for services operating in the Commonwealth Home Support Program.

H.3 Migrant workers

Aged care workforces in many countries include 'migrant workers'. Many of these workers are temporary residents who have migrated with an intention of finding work in aged care, in some cases with qualifications in their own country. Others with transitory migration status who have obtained employment in the sector often work under poor conditions.

It is important to distinguish these 'migrant workers' from 'migrants who happen to be working in aged care' in Australia. Migrants working in aged care in Australia have been recruited from the population at large, and in many respects are little different to overseas born workers in other sectors of the economy, or to their Australian-born counterparts in the aged care workforce. Most have been here for many years and are citizens. There is little evidence of aged care being a point of entry to employment for recently arrived migrants. The practices of job network agencies in some areas of high unemployment of attempting to place new arrivals in jobs in nearby residential aged care homes is an exception.

Periodic provider interest in recruiting workers overseas has proved short-lived and has not been pursued as barriers have been recognised in areas such as recognition of qualifications in aged care, costs of sponsored migration, and retention of workers post arrival.

Issues of ensuring a culturally competent and inclusive workforce are discussed further below in Section J.

NFAW recommends [15] that the term ‘migrant workers’ not be used in discussion of the aged care workforce as in suggesting a group of temporary workers. It is a misnomer for overseas-born workers who join the aged care workforce after shorter or longer periods of residence in Australia, the majority of whom are or soon become permanent residents and Australian citizens.

I. Role of government in providing a coordinated strategic approach for the sector

I.1 Commonwealth leading role

The Commonwealth has taken a strong, leading role in aged care since the early 1980s, and all responsibility for aged care funding was effectively assumed by the Commonwealth in 2015. Only the Commonwealth is in a position to provide the lead required to develop a nationally coordinated workforce strategy and take steps to implement it.

In contrast, two factors limit the capacity and likelihood of the sector itself developing a coherent workforce strategy. First, the extent to which management practices underlie a number of workforce difficulties demonstrates the inability of the sector to take action on the scale required. Second, the Stocktake report indicates considerable uncertainty in the sector about where responsibility for workforce planning should lie. Both these factors mean that Commonwealth action is required to bring sector views together to develop a strategy that is agreed across provider and employee groups, and that is consistent with wider training and workforce development trends in related sectors.

I.2 Reinvalidate a coherent workforce strategy

Two major Aged Care Workforce Strategies have been implemented over the last decade, the first from 2005 and the second from 2012 as part of the Living Longer Living Better package.

The recent stocktake reports that \$427m was allocated to a diversity of projects under the 2012 Strategy, but the findings show an imbalance between the types of activity, considerable duplication and a lack of integration across areas. It is evident that while most projects were useful, they remained isolated and the Strategy lacked any effective means of generating change across the sector as a result of any or all of the projects funded.

The stocktake was supported by the Aged Care Workforce Advisory Group and this body needs to be charged with identifying priorities for action to inform the development of a new Aged Care Workforce Strategy that will achieve more effective and sustainable outcomes across the sector. Without critical review, it is likely that separate initiatives will continue but with little sustained outcome.

The new Aged Care Workforce Strategy should also pay attention to areas where people with disabilities themselves might be employed in the Care economy. Targets could be considered in which the Aged sector could meet employment targets set under the National Disability Strategy 2020-2030 (under development).

Other measures are addressed in section G above.

NFAW recommends [16] that the role of the Aged Care Workforce Advisory Committee be reviewed and that it be charged with identifying a small number of priorities for strategic action against the background of on-going, broad based workforce development activities. The new Aged Care Workforce Strategy itself should also pay attention to areas where people with disabilities might be employed in the Care economy.



Targets could be considered in which the Aged sector could meet employment targets set under the National Disability Strategy 2020-2030.

J. Challenges of creating a culturally competent and inclusive aged care workforce

Many measures have been taken over the last three decades to develop services that are responsive to the needs of aged care clients from culturally and linguistically diverse backgrounds. The recent Stocktake showed that a third of funding for workforce initiatives was attributed to this area.

There has been a shift from initiatives in the mid 1980s-1990s that focused on providers seeking to match workers and clients of common backgrounds, to the development of a culturally competent workforce in which workers of all backgrounds are equipped to deliver care to clients of all backgrounds. Notwithstanding the leading role taken by ethno-specific providers in raising awareness of cultural dimensions of aged care, this shift has been driven by four other factors:

- recognition that the majority of clients of diverse backgrounds receive care through mainstream services;
- recognition that the majority of workers from diverse backgrounds provide care to clients who were born in Australia and for whom English is their only language;
- changes in the cultural backgrounds of the cohorts now reaching advanced old age and of workers which mean that while matching clients and workers remains a central strategy, it only applies to a part of the total client population and workers; and
- acknowledgement that workers from different backgrounds work alongside others whose only language is English and that there is a need for good communication both ways between workers as well as with clients.

Responses to these factors call for three emerging strategies to be advanced.

- ensuring English proficiency of all aged care workers by linking English language classes to aged care training on an as need basis for potential workers;
- acculturation training of workers from different backgrounds caring for clients from the majority population; and
- increasing awareness of differences in gender norms for workers and clients from different generations as well as different cultures.

Staff need to be highly proficient in English. While NFAW is not recommending that a particular IELTS score threshold be set, it must be more than basic.

Cultural awareness is even more important. NFAW is aware both directly and anecdotally of problems that have arisen in centres with very high levels of CALD staff. There is growing recognition of diversity in gender and cultural norms across the community as well as between generations, and workers need to be equipped to recognise and respect the differences that are likely to be found among the clients they care for. In cases where norms may be transgressed, such as a very old woman rejecting provision of personal care by a young male worker, client preferences should take precedence.

The other side of the story is hostility to CALD staff by clients and families who are bigots. Staff need protection from prejudice.

NFAW recommends [17] that training for all aged care workers give attention to the 3 R's of recognition of, respect for and responsiveness to differences in cultural norms across the community, including gender norms, and that client preferences take precedent in cases of potential transgression of norms.

- Staff need to be highly proficient in English. While NFAW is not recommending that a particular IELTS score threshold be set, it must be more than basic.
- Consideration also needs to be given to aged care services that cater for specific ethnic groups. Many clients revert to their mother tongue with ageing, along with a focus on the cultural mores of their youth. There are some multicultural aged care providers; others for specific groups (incl. religious).

With reference to meeting the care needs of the Indigenous population, recent research has challenged the view of 'premature ageing' and indicates that the need for many is for primary health care services to provide early interventions in areas of chronic illness such as heart disease and diabetes. A workforce with relevant training is not only required but has been shown to be feasible in community health programs delivered through services controlled by Indigenous community groups in metropolitans as well as regional areas. These programs need to be expanded rather than directing Indigenous clients to aged care services.

In the process, the definition of the Indigenous target population for aged care services on the basis of the population aged 50 and over should be reviewed to provide an accurate and appropriate basis for calculating workforce and service needs in primary care and aged care. The gap between life expectancy of Indigenous and other Australians is significantly affected by much higher death rates among young Indigenous adults. Around this age group, there have been improvements in Indigenous infant mortality and life expectancy at later ages. The latter trend needs to be recognised in aged older care planning.

NFAW recommends [18] that action be taken in Indigenous communities to develop the primary health care workforce alongside the aged care workforce to deliver a better balance of primary health care programs to tackle chronic illness as well as to provide aged care services, and that the definition of the Indigenous target population for aged care be reviewed to ensure that is an accurate and appropriate basis for planning this range of services.

There has been little research into the particular needs of LGBTQI clients/residents. NFAW is aware of cases in which people are experiencing discrimination based on their sexuality 40 years after they attended their first pride march. This correlates with the employment of staff from countries that regard homosexuality as unnatural or sinful.

NFAW recommends [19] Research should be taken into the particular needs of LGBTQI clients/residents to inform formal training of staff. While this is broadly relevant, it is important that staff from countries that regard homosexuality as unnatural or sinful be able to deliver appropriate and respectful care to LGBTQI clients/residents.

Flexibility of service delivery needs to be recognised across all types of aged care service to enable couples requiring care to co-habit, in the same room, in rooms in close proximity etc. and funding should be made available to enable appropriate beds to be purchased.

K. Particular aged care workforce challenges in regional towns and remote communities

K.1 Roles and responsibilities of major providers

There is a need for a clearer understanding of the structure of aged care services in rural and remote areas in developing and delivering effective workforce strategies. The case of Northern Territory is typical of outer regional and remote areas in other states. In 2016 the 102 separate aged care services in the Northern Territory were operated by just 34 providers, with three groups having a major role:

- One provider, Australian Regional and Remote Community Services Limited, operated 27 services. Formerly known as Frontier Services, ARRCs operated as a unit of Uniting Care Queensland, with Uniting Care being the largest aged care provider in the country.
- Another 30 services were operated by six Local Governments as part of their wider community services. Together with ARRCs, these six Local Government providers accounted for almost 60% of services in the NT, a very different picture to 102 separate services.
- Another 15 services were operated by Indigenous controlled organisations that also had some collective structure and oversight.

Organisational links between services in each of these groups could be expected to give them very different capacities in workforce management and development. The development of Multi-Purpose Services (MPS) in rural and remote areas has demonstrated a model that has supported multi-disciplinary workforces in many MPS that would not be viable in separate services in small communities. These approaches are critical to supporting employment of women in rural and remote communities and achieving benefits to the wider community by way of the social stability this can bring. It is essential to ensure that workers are covered for travel costs in areas where distance and travel conditions result in high costs, and that these costs are not shifted to workers or clients in CDC and other user charging regimes.

NFAW recommends [20] that the extent to which the impacts of geographic isolation on the aged care workforce can be moderated by organisational integration and outreach be taken into account in the development of service delivery models in rural and remote areas that strengthen and support workers in those areas, and that this strategy consider ways of bringing all services in these areas into such support networks. It is essential to ensure that workers are covered for travel costs in areas where distance and travel conditions result in high costs, and that these costs are not shifted to workers or clients in CDC and other user charging regimes.

L. Impact of the Government's cuts to the Aged Care Workforce Fund

Experience with the Aged Care Workforce Fund demonstrates the need for attention to possible unintended consequences of workforce measures that may hinder take-up in the short term and longer-term sustainability.

Take up of the Supplement as originally announced was limited by two factors: conditions attached to the Supplement in relation to enterprise bargaining were not well accepted in the field and there was also concern that providers would be left with unfunded increased in wages bills when the Supplement period ended. The \$1.5bn funding was redirected to the general pool of aged care funding in the 2014 Budget, when the Government announced that the industry had been consulted to ensure funding was distributed in a more flexible and targeted way, with minimal regulatory burden without jeopardising the viability of aged care services. All programs previously eligible for the Workforce Supplement should have benefitted from this redirection.

One lesson evident from this experience is the need to distinguish short term funding that is aimed at facilitating adjustment in the short term from funding that is expected to lead to longer term and continuing workforce expansion and enhancement.

NFAW recommends [21] that all workforce development activities give attention to funding and that a clear distinction be made between time-limited initiatives intended to achieve particular changes in the short term and initiatives that have to be continued over the longer term to sustain growth of the workforce and quality improvements.