

The Senate

Community Affairs
References Committee

Future of Australia's aged care sector workforce

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Secretariat

Ms Jeanette Radcliffe (Committee Secretary)

Mr Gerry McInally (Committee Secretary)

Ms Kate Gauthier (Principal Research Officer)

Ms Monika Sheppard (Senior Research Officer)

Dr Josh Forkert (Senior Research Officer)

Ms Cathy Nunn (Senior Research Officer)

Mr Tasman Larnach (Senior Research Officer)

Ms Megan Jones (Research Officer)

Ms Amelia Hurd (Graduate)

Ms Carol Stewart (Administrative Officer)

PO Box 6100

Parliament House

Canberra ACT 2600

Phone: 02 6277 3515

Fax: 02 6277 5829

E-mail: community.affairs.sen@aph.gov.au

Internet: www.aph.gov.au/senate_ca

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Substitute members

Senator Helen Polley for Senator Carol Brown (from 3 December 2015 to 9 May 2016)	Tasmania, ALP
Senator Helen Polley for Senator the Hon Don Farrell (from 15 September 2016 to 10 October 2016)	Tasmania, ALP
Senator Helen Polley for Senator Sam Dastyari (from 10 October 2016 to 20 June 2017)	Tasmania, ALP

Participating members for this inquiry

Senator Carol Brown (from 3 December 2015)	Tasmania, ALP
Senator Patrick Dodson	Western Australia, ALP
Senator the Hon Don Farrell (from 15 September 2016)	South Australia, ALP
Senator Stirling Griff	South Australia, NXT
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Senator Malarndirri McCarthy	Northern Territory, ALP
Senator Claire Moore	Queensland, ALP
Senator Helen Polley (to 3 December 2015)	Tasmania, ALP
Senator Dean Smith	Western Australia, LP

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACAR	Aged Care Approvals Round
ACAT	Aged Care Assessment Team
ACEBAC	Australian Centre for Evidence Based Aged Care
ACFA	Aged Care Financing Authority
ACFI	Aged Care Funding Instrument
ACIWAG	Aged Care Illawarra Action Group
Act	<i>Aged Care Act 1997 (Cth)</i>
ACTU	Australian Council of Trade Unions
ACWF	Aged Care Workforce Fund
AHMA	Australian Health Ministers' Advisory Council
AHP	Allied health professional
AIHW	Australian Institute of Health and Welfare
AiN	Assistant in Nursing
ALRC	Australian Law Reform Commission
AMA	Australian Medical Association
ANAO	Australian National Audit Office
ANMAC	Australian Nursing and Midwifery Accreditation Council
ANMF	Australian Nursing and Midwifery Federation
AQF	Australian Qualifications Framework
ASQA	Australian Skills Quality Authority
ATSI	Aboriginal and Torres Strait Islander
CALD	culturally and linguistically diverse

CDC	consumer directed care
CHSP	Commonwealth Home Support Programme
CN	Clinical Nurse
COAG	Council of Australian Governments
COTA	Council on the Ageing
CPD	Continuing professional development
ECCV	Ethnic Communities Council of Victoria
EEC	Senate Education and Employment References Committee
EEN	Endorsed Enrolled Nurse
EN	Enrolled Nurse
FECCA	Federation of Ethnic Communities' Councils of Australia
GNARTN	Greater Northern Australia Regional Training Network
GP	General practitioner
HACC	Home and Community Care programme
HARG	Health Ageing Research Group, La Trobe University
HCPP	Home Care Packages Program
LASA	Leading Age Services Australia
LGANT	Local Government Association of the Northern Territory
LGBTI	Lesbian, gay, bisexual, transgender and/or intersex people
MCCI	Multicultural Communities Council of Illawarra
MPS	Multi-Purpose Services program
NACA	National Aged Care Alliance
NACWCS	National Aged Care Workforce Census and Survey
NCC	National Code of Conduct for health care workers
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme

NFAW	National Foundation for Australian Women
NILS	National Institute of Labour Studies
NP	Nurse Practitioner
NRAS	National Registration and Accreditation Scheme for health practitioners
PAYG	Pay as you go
PCA	Personal care attendant
PCW	Personal care worker
RACF	Residential aged care facilities
RACGP	Royal Australian College of General Practitioners
RN	Registered nurse
RTO	Registered Training Organisation
VET	Vocational and Education Training

LIST OF RECOMMENDATIONS

Recommendation 1

5.14 The committee recommends that the aged care workforce strategy taskforce be composed of representatives of service providers, workforce groups, including nurses, care workers/personal care attendants, medical and allied health professionals, and others, and representatives of consumers and volunteers. Representatives of workers, care providers and consumers from regional and remote areas should also be included.

Recommendation 2

5.15 The committee recommends that the government, as a key stakeholder in aged care in terms of regulation, policy, intersections with other sectors and the coordination of government involvement, and as the key source of funding and revenue for the aged care sector, must be an active participant of the taskforce and must take ownership of those aspects of the workforce strategy that will require government intervention and / or oversight.

Recommendation 3

5.20 The committee recommends that the aged care workforce strategy include a review of existing programs and resources available for workforce development and support and ensure consideration of the NDIS Integrated Market, Sector and Workforce Strategy to identify overlapping issues and competitive pressures between the sectors and how they may be addressed.

Recommendation 4

5.25 The committee recommends that, as part of the aged care workforce strategy, the aged care workforce strategy taskforce be required to include:

- development of an agreed industry-wide career structures across the full range of aged care occupations;
- clear steps to address pay differentials between the aged care and other comparable sectors including the disability and acute health care sectors;
- mechanisms to rapidly address staff shortages and other factors impacting on the workloads and health and safety of aged care sector workers, with particular reference to the needs of regional and remote workers including provision of appropriate accommodation; and
- development of a coordinated outreach campaign to coincide with developments introduced through the workforce strategy to promote the benefits of working in the aged care sector.

Recommendation 5

5.28 The committee recommends that the aged care workforce strategy taskforce include as part of the workforce strategy a review of available workforce and related data and development of national data standards in a consultative process with aged care sector, and broader health sector and other relevant, stakeholders. Any nationally agreed data standards should enable comparison across and between related sectors where possible.

Recommendation 6

5.31 The committee recommends that the aged care workforce strategy include consideration of the role of informal carers and volunteers in the aged care sector, with particular focus on the impacts of both the introduction of consumer directed care and the projected ageing and reduction in these groups.

Recommendation 7

5.34 The committee recommends that the national aged care workforce strategy includes consideration of the role of medical and allied health professionals in aged care and addresses care and skill shortages through better use of available medical and allied health resources.

Recommendation 8

5.41 The committee recommends that the government examine the introduction of a minimum nursing requirement for aged care facilities in recognition that an increasing majority of people entering residential aged care have complex and greater needs now than the proportions entering aged care in the past, and that this trend will continue.

Recommendation 9

5.42 The committee recommends that the aged care workforce strategy include consideration of and planning for a minimum nursing requirement for aged care services.

Recommendation 10

5.43 The committee recommends that the government consider, as part of the implementation of consumer directed care, requiring aged care service providers to publish and update their staff to client ratios in order to facilitate informed decision making by aged care consumers.

Recommendation 11

5.48 The committee recommends that the government take immediate action to review opportunities for eligible service providers operating in remote and very remote locations to access block funding, whether through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program or through other programs. The committee further recommends that consideration be given to amending the 52 day limitation on 'social leave' for aged care residents living in remote and very remote aged care facilities.

Recommendation 12

5.49 The committee recommends that the Department of Health review the implementation of consumer directed care to identify and address issues as they emerge. Specific attention should be paid to any impacts on remuneration, job security and working conditions of the aged care workforce, and impacts on service delivery in remote and very remote areas, and to service delivery targeting groups with special needs, as identified in the Section 11-3 of the *Aged Care Act 1997*.

Recommendation 13

5.51 The committee recommends that the aged care workforce strategy ensure consideration of the service delivery context in which the workforce is expected to perform. The strategy should also include medium and long term planning for location- and culturally-specific skills, knowledge and experience required of the aged care workforce working with diverse, and dispersed, communities throughout Australia. This must specifically include addressing workforce issues specific to service delivery in remote and very remote locations.

Recommendation 14

5.55 The committee recommends that all recommendations of the Senate Education and Employment References Committee inquiry into the operation, regulation and funding of private vocational education and training (VET) providers in Australia be implemented.

Recommendation 15

5.57 The committee recommends that the aged care workforce strategy taskforce work with Australian Skills Quality Authority to establish nationally consistent minimum standards for training and accreditation.

Recommendation 16

5.59 The committee recommends that the aged care workforce strategy taskforce work with the Australian Nursing and Midwifery Accreditation Council (ANMAC) to establish aged care as a core part of the nursing curriculum, establish dementia skills training, and develop greater collaboration between the sector and nursing colleges to increase student placements in aged care facilities.

Recommendation 17

5.61 The committee recommends that the government and the aged care workforce strategy taskforce develop a specific strategy and implementation plan to support regional and remote aged care workers and service providers to access and deliver aged care training, including addressing issues of:

- the quality of training;
- access to training;
- on-site delivery of training;
- upskilling service delivery organisations to deliver in-house training; and
- additional associated costs relating to regional and remotely located staff.

This strategy should take account of consultation and analysis such as that undertaken through the Greater Northern Australia Regional Training Network (GNARTN).

Recommendation 18

5.62 The committee recommends that the government work with the aged care industry to develop scholarships and other support mechanisms for health professionals, including nurses, doctors and allied health professionals, to undertake specific geriatric and dementia training. To succeed in attracting health professionals to regional and remote areas, scholarships or other mechanisms should make provision for flexible distance learning models, be available to aged care workers currently based in regional and remote areas, and include a requirement to practice in regional or remote locations on completion of the training.

Recommendation 19

5.68 The committee recommends that the government examine the implementation of consistent workforce and workplace regulation across all carer service sectors, including:

- **a national employment screening or worker registration scheme, and the full implementation of the National Code of Conduct for Health Care Workers;**
- **nationally consistent accreditation standards;**
- **continuing professional development requirement;**
- **excluded worker scheme; and**
- **workplace regulation of minimum duration for new worker training.**

The regulation of the workforce must address:

- **historical issues impacting on employment of Aboriginal and Torres Strait Islander peoples; and**
- **ways to ensure the costs of this regulation are not passed on to workers.**

Chapter One

Introduction

1.1 The aged care sector has experienced the impacts of significant changes in recent years. These changes range from the ageing of the Australian population and the corresponding ageing of the workforce, the increased use of technology in service delivery, the increased complexity of health needs of individuals entering aged care, and the shift in policy approaches to aged care, with much service delivery now occurring at home to allow people to 'age in place' for longer rather than enter institutions at the first sign of age-related frailty. All of these developments are placing significant pressure on the aged care workforce.

1.2 At the same time, the funding model for aged care has shifted from a model where service delivery organisations were directly funded by government through 'block funding', to a market-based model, where consumers of services exercise greater control over how funding is spent. In this new approach, eligible individuals are largely able to choose for themselves what services they need and the organisations or individuals they wish to deliver those services, via the new Consumer Directed Care (CDC) model of service delivery.

1.3 A similar change to disability service funding, via the introduction of the National Disability Insurance Scheme (NDIS), has also seen impacts in the disability sector. In addition, the rollout of the NDIS adds to pressures on the aged care workforce as the need for more staff grows across both the disability and aged care sectors.

1.4 The focus of this inquiry has been to ensure scrutiny is also placed on the aged care service sector, which, like the disability service sector, is responsible for the direct care of vulnerable Australians. This inquiry was undertaken to review the current frameworks under which aged care providers recruit, train and retain their workforce, and to anticipate the impact of current and expected changes to the aged care service sector, and the workforce which will be needed to deliver those services in the years to come.

Terms of reference

1.5 The terms of reference for this inquiry are:

- a) the current composition of the aged care workforce;
- b) future aged care workforce requirements, including the impacts of sector growth, changes in how care is delivered, and increasing competition for workers;
- c) the interaction of aged care workforce needs with employment by the broader community services sector, including workforce needs in disability, health and other areas, and increased employment as the National Disability Insurance Scheme rolls out;
- d) challenges in attracting and retaining aged care workers;

- e) factors impacting aged care workers, including remuneration, working environment, staffing ratios, education and training, skills development and career paths;
- f) the role and regulation of registered training organisations, including work placements, and the quality and consistency of qualifications awarded;
- g) government policies at the state, territory and Commonwealth level which have a significant impact on the aged care workforce;
- h) relevant parallels or strategies in an international context;
- i) the role of government in providing a coordinated strategic approach for the sector;
- j) challenges of creating a culturally competent and inclusive aged care workforce to cater for the different care needs of Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups and lesbian, gay, bisexual, transgender and intersex people;
- k) the particular aged care workforce challenges in regional towns and remote communities;
- l) impact of the Government's cuts to the Aged Care Workforce Fund; and
- m) any other related matters.

Report structure

1.6 This report is divided into five chapters:

- **Chapter 1** provides a background to the committee's inquiry and an overview of the changing Australian aged care sector and the composition of the workforce. The chapter also reviews the role of government in developing workforce strategies.
- **Chapter 2** examines the changing environment in which the aged care workforce operates, including new service delivery models, increasing use of technology and the increasingly complex needs of people entering the aged care system.
- **Chapter 3** examines the challenges in attracting, training and retaining aged care workers.
- **Chapter 4** examines the increasing diversity of aged care users, and the associated challenges in regional and remote community service delivery, and the challenges faced by organisations in delivering a culturally competent service both in regional and urban locations.
- **Chapter 5** concludes the committee's consideration and makes recommendations for further consideration.

The changing aged care sector

1.7 The aged care sector is undergoing significant changes. The Australian population is ageing, and at the same time the aged care user cohort is becoming more diverse, with greater disparity in health status, disability, location, cultural and language needs, sexual orientation and gender identification. These changes are placing increasing pressure on the workforce not only to meet the overall increased numbers of aged care recipients, but to have the specialised skills needed to meet the increasing diversity of service needs. This following section will outline the key changes occurring in the aged care sector by overall population, and the diversity of specialised service needs.

Increasing aged care service users

1.8 As at 30 June 2016, 15 per cent of Australia's population was aged 65 years and over (3.7 million people) and 2 per cent were aged 85 years and over (488,000 people). By 2026, it is estimated that 18 per cent of the population will be aged 65 years and over (5.0 million people) and 2.3 per cent (644,000 people) will be 85 years and over.¹

1.9 By 2055, the proportion of Australians over 65 will increase to 22.9 per cent (8.9 million) of the total population.² The number of Australians receiving aged care is projected to increase by around 150 per cent over the next 40 years.³

1.10 In 2009-10, around 616 000 people aged 70 years or older received home and community care services (HACC).⁴

1.11 Between 1999 and 2011, the number of people moving into residential aged care in Australia increased by 25 per cent, with the largest growing group being those over 85 years of age. In 2014, 82 per cent of permanent aged care residents required high-level care.⁵

1.12 Department of Health data shows that in 2015-16:

- Over 1.3 million older people received some form of aged care:
 - More than 640,000 older people received home support through the Commonwealth Home Support Programme (CHSP);
 - 285,432 older people received support through the Commonwealth-State HACC program (Victoria and WA);
 - 56,852 people received residential respite care;

1 Department of Health, 2015-16 [Report on the Operation of the Aged Care Act 1997](#), 2016, p. 6.

2 Australian Government, *2015 Intergenerational Report*, March 2015, pp vii–viii.

3 Productivity Commission, *Caring for Older Australians*, Report No. 53, v.2, 2011, p. 2.

4 Productivity Commission, *Caring for Older Australians*, Report No. 53, v.1, 2011, p. xxvi.

5 Dr Deirdre Marie Anne Fetherstonhaugh, Director, Australian Centre for Evidence Based Aged Care, La Trobe University, *Committee Hansard*, 28 April 2016, p. 26.

- 88,875 people received care through a home care package;
- 234,931 people received permanent residential aged care.
- the average age on entry for new admissions to permanent residential aged care was 82.0 years for men and 84.5 years for women; and
- around 50 per cent of all residential aged care residents had a diagnosis of dementia.⁶

Aged care in rural and remote communities

1.13 The committee notes that there are particular challenges for the delivery of aged care in rural and remote areas. Thirty one per cent of older Australians live in inner and outer regional areas, and approximately 1.5 per cent of all Australians aged 65 years or older live in remote or very remote areas.⁷

1.14 The proportion of older Australians in aged care in rural and remote areas varies across the states and territories. In 2013–14, 30 per cent of people in permanent residential aged care were located in rural or remote areas: fewer than one per cent (0.7 per cent) in remote or very remote areas and 30 per cent in inner and outer regional areas.⁸ In New South Wales, Victoria, South Australia and Western Australia, fewer than 30 per cent of permanent aged care residents were in facilities in rural or remote areas; in Queensland the proportion was 35 per cent.⁹ In the Northern Territory and Tasmania, all people in permanent residential aged care were located in areas categorised by the Australian Bureau of Statistics as regional or remote areas.¹⁰

1.15 In remote and very remote areas, aged care service provision may be delivered by a very limited number of organisations, and in some cases by just one provider. Local government is a key aged care service provider in remote and very remote locations. For example, the MacDonnell Regional Council is the only provider of disability and aged care services in eight remote Aboriginal and Torres Strait Islander communities in Central Australia.¹¹

1.16 The Australian Institute of Health and Welfare (AIHW) has noted:

6 Department of Health, 2015-16 [Report on the Operation of the Aged Care Act 1997](#), 2016, pp. xiii-xiv.

7 Australian Institute of Health and Welfare, [Diversity in aged care](#), accessed 31 May 2017.

8 Australian Institute of Health and Welfare, [Diversity in aged care](#), accessed 24 May 2017.

9 30 per cent of people in New South Wales and Victoria; 35 per cent in Queensland, 23 per cent in South Australia and 17 per cent in Western Australia. Australian Institute of Health and Welfare, [Diversity in aged care](#), accessed 24 May 2017.

10 This reflects these jurisdictions' overall remoteness status, with no areas classified as *Major cities*. Australian Institute of Health and Welfare, [Diversity in aged care](#), accessed 24 May 2017.

11 Mr Rohan Marks, Director, Community Services, MacDonnell Regional Council, *Committee Hansard*, 26 October 2016, p. 1.

People who live in rural or remote areas face additional difficulties in accessing health and ageing related services. Rural and remote areas have fewer services available, particularly in close proximity to where people live, and the services that do exist may not be attainable, for example, due to cost or lack of transport. In addition, service providers in rural or remote areas face challenges in service provision: the costs of building and operating facilities are higher, and there are fewer skilled workers available.¹²

Aboriginal and Torres Strait Islander peoples in aged care

1.17 Aged care service delivery to Aboriginal and Torres Strait Islander peoples has differing challenges from mainstream service delivery, not only based on the need to deliver a culturally competent service, but also because the demographics, health profiles and locations of these service users differ significantly from the non-Indigenous population.

1.18 In 2014-15, 34 283 Aboriginal and Torres Strait Islander people accessed residential aged care (2 279), Home Care (2 214) and Home and Community Care (29 552), and 800 people accessed services through the Aboriginal and Torres Strait Islander Flexible Aged Care program. In 2015-16, Aboriginal and Torres Strait Islander peoples accessed the majority of residential places and home care packages in remote and very remote locations.¹³

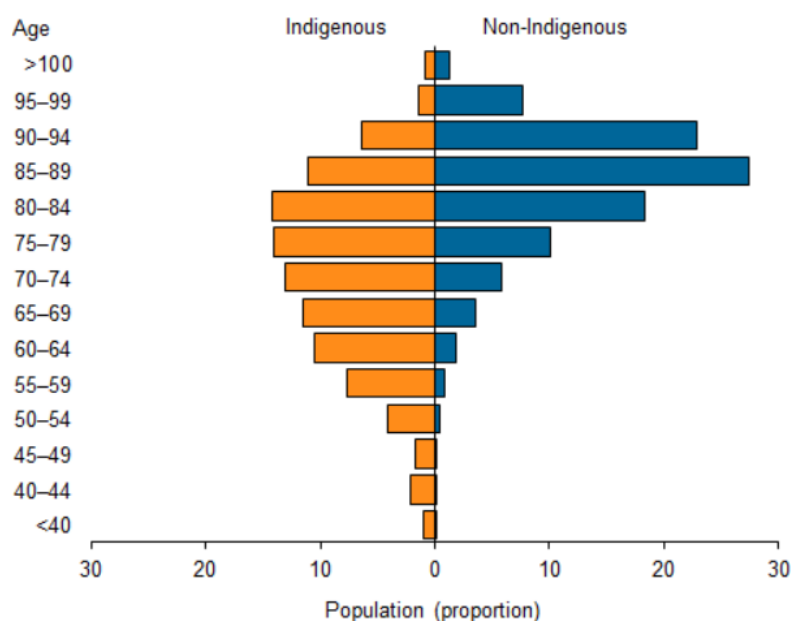
1.19 The committee notes that the age distribution of Aboriginal and Torres Strait Islander peoples in aged care differs from the non-Indigenous population, with a younger age structure and shorter life expectancy. The average life expectancy of the general population is about 73 years for women and 69 years for men. Due to generally poorer health, conditions associated with ageing may affect Aboriginal and Torres Strait Islander peoples earlier than non-Indigenous people. Owing to these factors, aged care planning includes the Aboriginal and Torres Strait Islander population aged 50 and over, rather than 70 and over as with the non-Indigenous population.

1.20 In general, the age profile of Aboriginal and Torres Strait Islander peoples in residential facilities was substantially younger than that of non-Indigenous people (Figure 1.1).

12 Australian Institute of Health and Welfare, [Diversity in aged care](#), (accessed 24 May 2017).

13 Australian National Audit Office, [Indigenous Aged Care](#), ANAO Report No. 53 of 2016/17, p 23.

Figure 1.1: People in residential aged care, by age group as a proportion of population by Indigenous status, at 30 June 2014.



Source: AIHW National Aged Care Data Clearinghouse. [Data table \(386KB XLS\)](#).

Source: Australian Institute of Health and Welfare, [Indigenous people in aged care](#) webpage, (accessed 23 December 2015).

1.21 In all groups aged under 85 years, Aboriginal and Torres Strait Islander peoples used residential aged care at higher rates than non-Indigenous people of the same age (Table 1.1).

Table 1.1: Age and sex specific usage rates for people in residential aged care by Indigenous status, at 30 June 2014 (per 1,000 population)

Age group	Indigenous Males	Indigenous Females	Indigenous Persons	Non-Indigenous Males	Non-Indigenous Females	Non-Indigenous Persons
<50	0.2	0.1	0.1	0.0	0.0	0.0
50-54	2.3	1.4	1.8	0.5	0.6	0.5
55-59	4.0	4.6	4.3	1.2	0.9	1.1
60-64	9.1	7.2	8.1	2.7	2.2	2.5
65-69	14.2	13.1	13.6	5.8	5.1	5.4
70-74	27.3	23.6	25.3	12.0	12.3	12.2
75-79	36.9	56.6	47.9	24.7	31.5	28.3
80-84	69.7	95.5	84.8	55.0	82.9	70.7
≥ 85	155.3	235.5	207.6	149.6	264.2	222.8
Total	1.7	2.3	2.0	4.7	10.3	7.5

Sources: AIHW National Aged Care Data Clearinghouse; ABS 2014 [1]. [Data table \(386KB XLS\)](#).

Source: Australian Institute of Health and Welfare, [Indigenous people in aged care webpage](#), (accessed 23 December 2015).

1.22 A higher proportion of Aboriginal and Torres Strait Islander aged care residents are located in remote or very remote facilities across Australia than non-Indigenous aged care residents. In New South Wales and Victoria, however, where

there are no aged care facilities in remote or very remote areas, all aged care residents are in urban or regional aged care facilities.¹⁴

Culturally and linguistically diverse (CALD) community in aged care

1.23 A key diversity challenge for the aged care sector is service delivery to CALD communities. As outlined below, the proportion of older Australians from CALD backgrounds is increasing, and, like Aboriginal and Torres Strait Islander peoples, they utilise aged care services differently to Australian-born aged care service users.

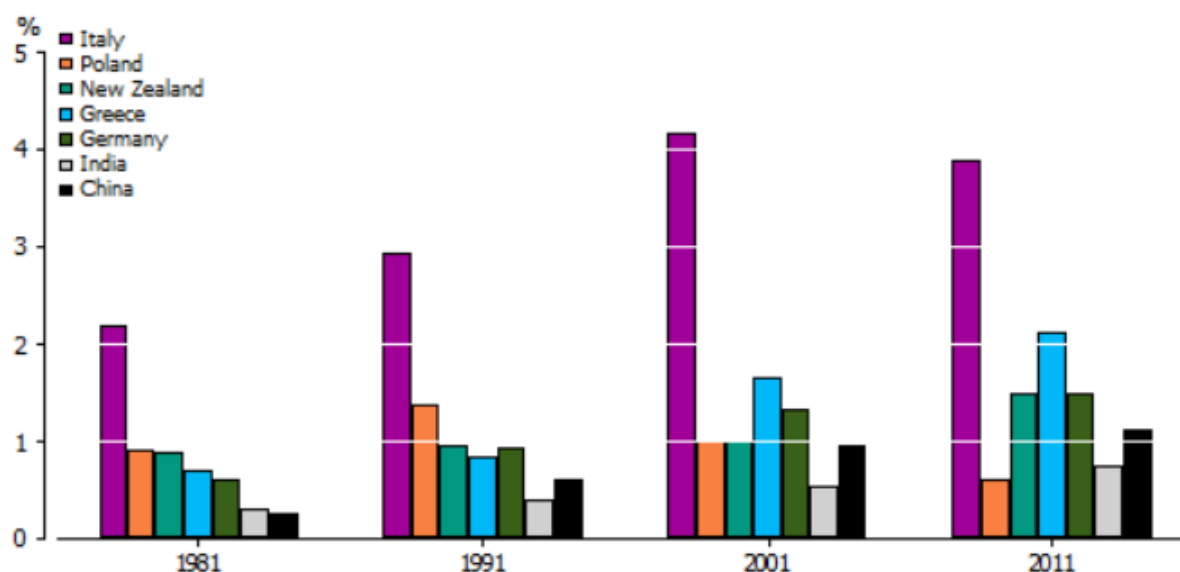
1.24 In 2011, 36 per cent of older Australians were born overseas, with 22 per cent from 'non-main English speaking countries'.¹⁵ The older population of Australia comes from a diverse range of countries, which is expected to continue into the future (Table 1.2). The Australian Bureau of Statistics examined the birthplace of the 0–64 age group in the 2011 Census and reported: older Australians are more likely to be born in Australia, many as second generation Australians the United Kingdom and Europe are becoming much less dominant sources of immigrants, with strengthening proportions from India and Sri Lanka, Lebanon, Vietnam, the Philippines, Malaysia, China, Hong Kong, South Africa, New Zealand and other countries in the region.¹⁶

14 Australian Institute of Health and Welfare, [Indigenous people in aged care](#) (accessed 23 December 2015).

15 Australian Bureau of Statistics, [Who are Australia's Older People?, Reflecting a Nation: Stories from the 2011 Census](#), 2012, (accessed 22 December 2015).

16 Australian Bureau of Statistics, [Who are Australia's Older People?, Reflecting a Nation: Stories from the 2011 Census](#), 2012, (accessed 22 December 2015).

Table 1.2: Older persons born overseas, countries of birth, 1981, 1991, 2001 and 2011(a)(b)



(a) Leading countries of birth, excluding Australia and the UK.

(b) Calculated as a proportion of the total population aged 65 years and over.

Source: Australian Bureau of Statistics, [Who are Australia's Older People?, Reflecting a Nation: Stories from the 2011 Census](#), 2012, (accessed 22 December 2015).

1.25 The number of older Australians from CALD backgrounds is expected to increase in future decades, in line with the overall increase in the older population. In a 2001 study, the Australian Institute of Health and Welfare forecast:

Between 2011 and 2026 the number of people aged 65 and over from culturally and linguistically diverse backgrounds is projected to increase from 653,800 to 939,800, a growth rate of 44% over the 15-year period. At the same time, the number of Australian-born people aged 65 and over is projected to increase by 59%. Older persons from culturally and linguistically diverse backgrounds are projected to account for 22.5% of the older Australian population at the beginning of the period, and 21.2% at the end.

Between 2011 and 2026 the proportion of the culturally and linguistically diverse background population that is aged 80 and over is projected to increase from 25.9% (compared with 27.5% for the Australian-born) to 28.7% (compared with 22.4% for the Australian-born). The older population from culturally and linguistically diverse backgrounds thus ends the projection period with a considerably older population profile than the Australian-born, having begun it with a considerably younger one.

The numbers for those aged 80 and over are projected to increase from 169,500 to 269,600 (a 59% increase compared with 29% in the Australian-born population). The proportion of people aged 80 and over who are from culturally and linguistically diverse backgrounds is projected to change

from 21.8% to 25.2%. By 2026, then, one in every four people aged 80 and over will be from culturally and linguistically diverse backgrounds.¹⁷

1.26 The cultural and linguistic diversity of older Australians is an important consideration in the planning and delivery of appropriate aged care services. Diversity may be reflected in a number of ways, such as:

- attitudes to the elderly, expectations of family care giving, roles of women and support groups, and beliefs about health and disability;
- beliefs, practices, religions, behaviours and preferences which can affect the propensity to use formal care services; and
- English language proficiency, which can affect access to information and services, communication of needs and participation in the wider community.¹⁸

1.27 As a result, the use of aged care services by older Australians from CALD backgrounds is different than that for many other older Australians, with variation across programs, age groups and countries of birth (Table 1.3). In general, people born in 'non-main English speaking countries' have higher usage rates of non-residential care.¹⁹

17 Australian Institute of Health and Welfare, [*Projections of Immigrants, People from culturally and linguistically diverse backgrounds, 1996–2026, Australia*](#), Department of Health and Aged Care, May 2001, p. xviii, (accessed 22 December 2015).

18 Productivity Commission, [*Caring for Older Australians*](#), Inquiry Report No. 53, 28 June 2011, Vol 2 p. 246, (accessed 21 December 2015).

19 Australian Institute of Health and Welfare, [*Cultural and linguistic diversity measures in aged care, Working Paper*](#), 2014, p. 8, (accessed 22 December 2015).

Table 1.3: Use of selected aged care programs, by country of birth^(a) and age, 2010–11 (clients per 1,000 population)

Program	Overseas-born						Australian-born		
	Main English-speaking countries ^(b)			Non-main English-speaking countries					
	65–74	75–84	85+	65–74	75–84	85+	65–74	75–84	85+
HACC	73.5	266.9	469.7	101.5	296.2	511.1	111.8	322.9	482.5
ACAP	9.7	59.1	168.3	10.7	56.6	147.0	3.1	65.4	164.6
CACP ^(c)	2.3	13.8	43.6	3.3	18.0	49.9	3.9	15.7	39.6
EACH & EACHD ^(c)	1.1	3.6	10.3	1.1	4.6	12.7	1.1	3.5	7.4
Permanent residential care ^(c)	6.3	44.8	232.9	6.6	41.2	191.8	10.2	53.8	233.5

(a) Country of birth population data used for the calculation of rates are based on ABS data for 2010. The data were pro-rated from 2010 by 5-year age groups using 2011 total estimated resident population.

(b) Main English-speaking countries are the United Kingdom, Ireland, New Zealand, Canada, the United States of America and South Africa.

(c) Data for CACP, EACH, EACHD and permanent residential aged care are at 30 June 2011.

Note: Packaged care provided under CACP, EACH and EACHD was replaced with the Home Care Packages Program on 1 August 2013, for which data are not yet available.

Source: AIHW 2013c (AIHW analysis of unpublished data from the then DoHA Ageing and Aged Care data warehouse (October 2012); AIHW analysis of unpublished Aged Care Assessment Program data from then DoHA; AIHW analysis of the NSW HACC State Data Repository and the HACC MDS National Data Repository).

Source: Australian Institute of Health and Welfare, [Cultural and linguistic diversity measures in aged care](#), Working Paper, 2014, p. 8, (accessed 22 December 2015).

1.28 Some CALD communities receive aged care services from providers, who have tailored services to particular groups. However, the majority of older Australians from CALD backgrounds access mainstream aged care services.²⁰

Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) community in aged care

1.29 Many older LGBTI people have experienced discrimination over the course of their lives on account of their sexual orientation and/or gender identity. This discrimination can continue in aged care services, if older LGBTI Australians are not recognised and supported in policy and practice.

1.30 At present, there is no data on the number and distribution of older LGBTI Australians. However, it has been estimated that, in line with Australia's growing ageing population, the number of older LGBTI Australians aged 65 years and over is expected to reach 500 000 people by 2051.²¹

20 Productivity Commission, [Caring for Older Australians](#), Inquiry Report No. 53, 28 June 2011, Vol 2 p. 247, (accessed 21 December 2015).

21 GLBTI Retirement Association Incorporated and Curtin Health Innovation Research Institute, [Best practice guidelines, Accommodating older gay, lesbian, bisexual, trans and intersex \(GLBTI\) people](#), p. 2, (accessed 21 December 2015).

1.31 The 2016 Aged Care Workforce Survey found that:

- 11 per cent of residential aged care facilities cater for LGBTI residents; and
- of the 25 per cent of residential aged care facilities that cater for a specific ethnic or cultural group, 44 per cent cater for LGBTI residents.²²

1.32 There has been a significant increase in the proportion of home care and home support service providers providing specialised services who now also cater for LGBTI clients: in 2012, just one per cent of this group catered for LGBTI clients; in 2016, this had risen to almost 41 per cent.²³

Current composition of the aged care workforce

1.33 Just as the ageing population has changed in size and diversity, the demographics of the workforce have also been shifting.

1.34 The aged care workforce consists of a variety of employment types, including:

- paid direct care workers, including personal care workers and health care professionals;
- paid non-direct care workers, including managers and ancillary staff;
- agency, brokered or self-employed staff; and
- unpaid volunteers and informal carers.²⁴

1.35 Latest research shows that the aged care workforce is predominately female, has a higher than average median age, is largely employed on a permanent part-time basis, and is disproportionality represented by Personal Care Attendants (PCAs).²⁵

1.36 The main source of data on the aged care workforce is the National Aged Care Workforce Census and Survey (NACWCS), conducted by the National Institute of Labour Studies (NILS) at Flinders University, on behalf of the Australian Department of Health. The NACWCS is conducted every four years and collects comprehensive data on the profile of, and identifies prevailing trends in, the aged care workforce.²⁶

22 National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, p. 53.

23 National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, p. 119.

24 The Department of Health defines the aged care workforce as 'the formal workforce of the providers and services that offer Australian Government subsidised aged care through Home Support, Home Care Packages, residential aged care, veterans' home care and flexible care'. See: Department of Health, *Submission 293*, p. 5.

25 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, pp. xvii; 160 .

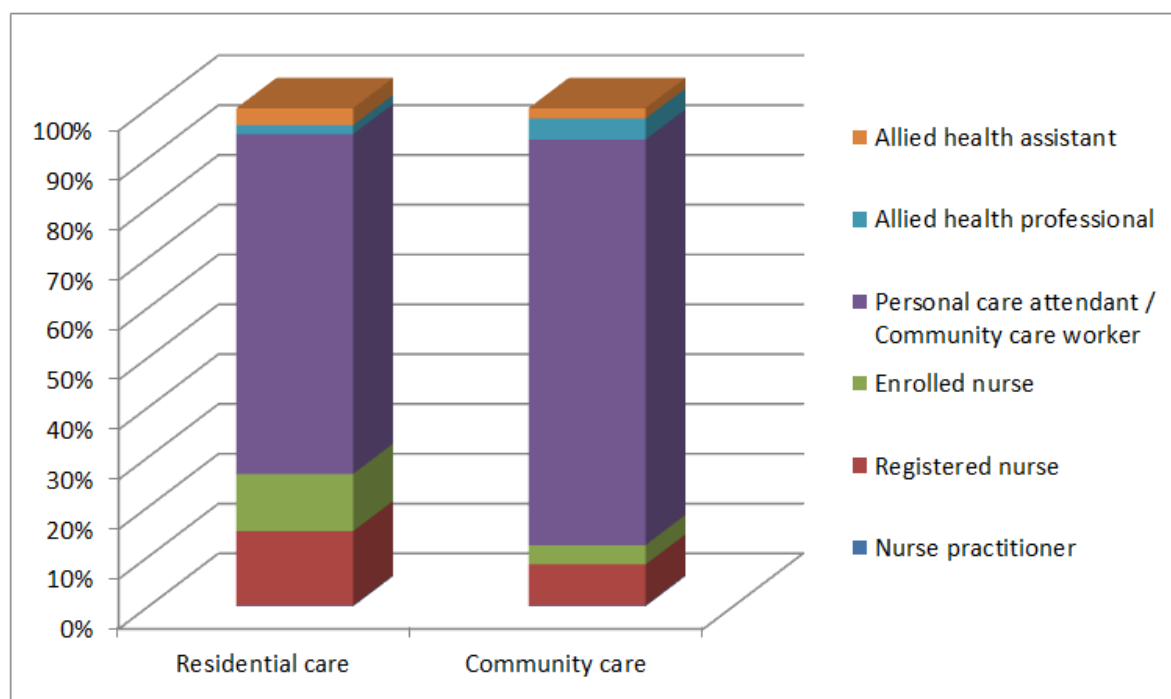
26 Previous reports were published in 2003, 2007 and 2012.

The Aged Care Workforce, 2016, published in March 2017, contains the most recent information and data.²⁷

Direct care workers

1.37 In 2016, there were an estimated 235 764 workers in residential care and 130 263 workers in home care and home support.²⁸ The majority of these workers were employed in direct care roles.²⁹

Figure 1.2: Direct care workforce, residential and community care, by occupational group, 2016



Source: National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, Department of Health, Table 3.2, Table 5.2.

1.38 Figure 1.2 shows that personal care attendants (PCAs)/community care workers (CCWs) are the largest occupational group in the home care and home support sector, representing nearly 84 per cent of workers.

1.39 Figure 1.2 also shows that, in 2016, PCAs constituted the majority of the residential direct care workforce, whereas Registered Nurses (RNs) and Enrolled

27 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health.

28 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 160.

29 The National Institute of Labour Studies defines the direct care workforce to include 'Nurse Practitioners (NP), Registered Nurses (RN), Enrolled Nurses (EN), Personal Care Attendants (PCA)/Community Care Workers (CCW), Allied Health Professionals (AHP) and Allied Health Assistants (AHA)'. See National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 158.

Nurses (ENs) constituted a comparatively small proportion. Since 2012, PCAs working in aged care have continued to increase both numerically and proportionally. In contrast, the proportion of nurses in residential aged care has declined.

1.40 Several submitters expressed concern that the number of qualified staff, particularly nurses, working in aged care is declining.³⁰ However, latest research appears to show that while the proportion of qualified nursing staff in residential direct care roles has remained relatively steady, their numbers (with the exception of ENs) have increased since 2012.³¹ The same trends have not been observed in the home care and home support sector however, with latest data showing that qualified nursing staff has declined numerically and proportionally since 2012.³²

Volunteers

1.41 Volunteers are significant contributors to the aged care workforce, with 83 per cent of residential facilities and 51 per cent of home care and home support outlets utilising volunteer staff. Several submitters argued that volunteers have a crucial role in the workforce, and that future challenges cannot be faced without their continued and increasing support.³³ The role, services provided by, and future challenges impacting volunteers is discussed in greater detail in chapter 2.

Allied Health Professionals

1.42 Allied Health Professionals (AHPs) represent a comparatively small proportion of the workforce (particularly in residential care).³⁴ Some submitters argued that AHPs are currently being underutilised, but will increasingly be required to meet the complex needs of older people in care.³⁵ The role of AHPs in helping to meet future workforce demands is discussed further in chapter 2.

30 See, for example: Australian Medical Association, *Committee Hansard*, 3 November 2016, p. 17; Palliative Care Nurses Australia, *Committee Hansard*, 3 November 2016, p. 27; Alzheimer's Australia, *Committee Hansard*, 3 November 2016, p. 28; NSW Nurses and Midwives' Association, *Committee Hansard*, 3 November 2016, p. 48.

31 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016, 2017*, Department of Health, Table 3.2, p. 13.

32 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016, 2017*, Department of Health, Tables 5.2, 5.3, p. 70.

33 See for example: Volunteering Tasmania, *Committee Hansard*, 31 October 2016, pp. 3-4, 6; Volunteering SA and NT Inc, *Committee Hansard*, 7 March 2017, p.34; Carers Australia, *Submission 269*, p. 3; Volunteering Victoria, *Submission 272*, p. 3; Australian Association of Gerontology, *Submission 217*, p.2.

34 See: Services for Australian and Remote Allied Health, *Submission 238*, p. 4-5.

35 See for example: Exercise and Sports Science Australia, *Submission 35*, p. [1]; Allied Health Professions Australia, *Submission 208*, p. 1; Occupational Therapy Australia, *Submission 282*; Services for Australian and Remote Allied Health, *Submission 238*, p. 4-5.

Characteristics of the aged care workforce

1.43 The average aged care worker is likely to be:

- female (88 per cent);
- older (49 years old); and
- located in a major city (around 2/3 of all workers).

1.44 Females represent the highest proportion of workers, accounting for 87 per cent in the residential care sector, and 89 per cent in the home care and home support sector in 2016. However, the proportion of males in the residential aged care workforce has grown from 7 per cent in 2007 to 13 per cent in 2016. The proportion of males in the home care and home support sector has not changed significantly since the collection of data began in 2007.³⁶

1.45 The latest iteration of the NACWCS found that the median age of the residential direct care age workforce has decreased from 48 years in 2012 to 46 years in 2016. However, the median age of home care and home support workers continues to grow, increasing from 50 years in 2012, to 52 years in 2016. Similar trends have also been observed for recently hired employees in both sectors.³⁷

1.46 Consistent with evidence received by the committee, the majority of the workforce is located in major cities, with about one third located in regional areas.³⁸

1.47 A substantial proportion of aged care workers are overseas-born. However, the overall proportion of the workforce born overseas has reduced since 2012 to 32 per cent and 23 per cent in residential and home care respectively. Despite this latest trend, the proportion of recently hired employees in the residential sector that are overseas-born has continued to increase.³⁹

1.48 By comparison, Aboriginal and Torres Strait Islander people account for a very small proportion of the workforce, representing around one to two per cent of the total workforce.⁴⁰

36 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 160.

37 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 160.

38 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 158.

39 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 160.

40 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 160.

The role of governments in aged care

1.49 The Australian Government's role in the provision of aged care services in Australia is in setting the regulatory framework and providing the majority of funding to support aged care providers.⁴¹

1.50 At the federal level, aged care is administered by the department and governed by the *Aged Care Act 1997* and associated *Aged Care Principles*.⁴² Aged care services in Australia are delivered by a range of not-for-profit (religious, charitable, and community) and for-profit organisations, and state/local government providers. The department provides funding to a large number of these providers through various funding packages.⁴³

1.51 The main programs funded by the department in the residential and community based care sector include:

- Residential aged care:
 - Permanent care: ongoing care in a residential aged care facility.
 - Respite care: temporary short-term care in a residential aged care facility.
- Community based care:
 - Commonwealth Home Support Program (CHSP): entry-level home-based support services.
 - Home Care Packages Programme: for more complex, coordinated and personalised home-based care.⁴⁴

1.52 Australian Government funding represents the highest proportion of revenue for aged care providers. In 2014-15, the Australian Government spent 15.2 billion on aged care.⁴⁵ In 2015-16, Australian Government expenditure on aged care was \$16.2 billion, of which \$11.4 billion was for residential aged care.⁴⁶

41 Department of Health, *Submission 293*, p. 10.

42 Department of Health, *Submission 293*, p. 7.

43 In 2014-15, the Australian Government's contribution to total revenue for aged care providers was: 65 per cent for residential aged care, 92 per cent for home care and 95 per cent for home support. See: Department of Health, *Submission 293*, p. 10.

44 Australian Institute of Health and Welfare, [Aged Care](#), (accessed 11 May 2017).

45 Department of Health, *Submission 293*, p. 10.

46 Department of Health, 2015-16 [Report on the Operation of the Aged Care Act 1997](#), 2016, p. xiii.

1.53 The majority of aged care providers across all types of care are not-for-profit organisations, with smaller proportions delivered by for-profit and state, territory and local governments.⁴⁷

1.54 In its 2017-18 Budget the Government announced that it will extend funding arrangements for the CHSP and Regional Assessment Services for a further two years.⁴⁸ More recently, the Government announced increased funding of \$649 million per year to provide an additional 9911 new aged care places in the 2016-17 Aged Care Approvals Round, with 2719 places reserved for services outside metropolitan areas. Of the total places being made available 75% are reserved for the development of new aged care services, including existing service providers establishing new dementia specific units. An additional \$64 million funding for capital grants is available to assist organisations establish new, or upgrade existing, facilities required to deliver their new aged care services.⁴⁹

Role of State and Territory governments

1.55 Under the 2011 Council of Australian Government's (COAG) *National Health Reform Agreement*, the Australian Government agreed to assume 'full funding, policy, management and delivery responsibility' for aged care services.⁵⁰ Separate agreements were negotiated with Victoria and Western Australia, where some home support services continue to be funded under the joint state/Commonwealth Home and Community Care (HACC) program, with plans to transition to the Commonwealth program at a later date.⁵¹

1.56 However despite the transition to full Commonwealth funding, it is clear from evidence received by the committee that state and territory governments continue to play an important role in the funding and delivery of aged care services.⁵²

1.57 For example, Queensland Health submitted that it provides 'about five per cent of residential aged care places, the majority of flexible community and residential aged care places...and a limited number of Home Care Packages and Commonwealth Home Support program services'.⁵³

47 In 2013-14, not-for-profit organisations accounted for 52 per cent of residential care, 69 per cent of home care and 74 per cent of home support aged care providers. See: Aged Care Financing Authority, [Report on the Funding and Financing of the Aged Care Industry](#), July 2015, p. xi.

48 Commonwealth of Australia, *budget Measures: Budget Paper No. 2 2017-18*, p. 123.

49 The Hon Ken Wyatt AM, Minister for Aged Care, [Media Release](#), 26 May 2017, (accessed 29 May 2015).

50 Council of Australian Governments, [National Health Reform Agreement](#), (accessed 12 May 2017).

51 See: Department of Health, [Commonwealth HACC Program](#), (accessed 12 May 2017).

52 See, for example: Queensland Government, *Submission 227*, p. 2.

53 Queensland Health, *Submission 227*, p. 2.

Role of local government

1.58 The committee received evidence that local governments play an important role in the delivery of aged care services, particularly in regional and remote areas.

1.59 The Local Government Association of the Northern Territory (LGANT) submitted that aged care services in remote Indigenous communities in the Northern Territory (NT) are provided under contract by a number of regional councils, which are 'cost sensitive' and rely on flexible funding arrangements to support their workforce.⁵⁴ LGANT noted that 'regional councils are well placed to provide a long term and accountable option for the delivery of Commonwealth programs and currently do so...'⁵⁵ At the committee's hearing in Darwin, LGANT suggested that regional councils, rather than for-profit providers are better placed to deliver aged care services in remote areas of the NT, as it is not generally viable for for-profit providers to deliver such services.⁵⁶

1.60 In Victoria, local government also has an important role as the main provider of community care through the HACC program.⁵⁷ Some Victorian local government agencies suggested that greater funding will be needed to assist with the transition of the HACC program to the Commonwealth from 2019.⁵⁸

Australian Government funded aged care workforce measures

1.61 This section examines the role government currently plays in funding and developing aged care workforce measures, and the role it should have in developing any future national strategy.

1.62 The Australian Government funds a range of measures to support the aged care workforce.⁵⁹

1.63 In 2015, the Australian Government commissioned the *Stocktake and analysis of Commonwealth funded aged care workforce activities*, which examined 54 workforce specific activities that received funding between 2011-12 and 2013-14. The stocktake found:

- the majority of Commonwealth funding was directed toward workforce training, education and upskilling;

54 Local Government Association of the Northern Territory, *Submission 241*, p. 1.

55 Local Government Association of the Northern Territory, *Submission 241*, p. 1.

56 Local Government Association of the Northern Territory, *Committee Hansard*, 25 October 2016, p. 18.

57 Municipal Association of Victoria, *Submission 268*, p. 1.

58 See, for example: Australian Services Union, *Submission 255*, p. 8; Municipal Association of Victoria, *Submission 268*, p. 3.

59 Since 2004, successive Australian governments have introduced a range of measures to develop the aged care workforce. Some of the major initiatives include the Living Longer, Living Better initiative, Aged Care Workforce Fund and the National Aged Care Workforce Strategy.

- consideration should be given to supporting workforce planning strategies, leadership development, regional and remote services, carers and volunteers; and
- program effectiveness needs to be better designed, measured, demonstrated and shared through evaluation with input from the aged care sector.⁶⁰

1.64 Some submitters expressed concerns about recent changes to the funding and structure measures for aged care, particularly the Aged Care Workforce Fund (ACWF).⁶¹

1.65 The ACWF was introduced in 2011 to provide a flexible funding pool for initiatives aimed at improving the quality of aged care, by developing the skills of the aged care workforce. The ACWF:

- provides access to training, education and other supports (such as scholarships for nurses and financial support for aged care providers to provide training places); and
- provides targeted training and development strategies for priority groups, including for Aboriginal and Torres Strait Islander peoples.

1.66 In 2015, the government announced that the ACWF would be combined with the Rural Health Outreach Fund and the Health Workforce Fund into a single Health Workforce Programme.

1.67 The department submitted that:

The merging of funds will enable the Government to develop and drive workforce change across the health and aged care sectors that will in turn benefit ageing Australians.

As part of the integration, Government support for aged care-specific workforce activities will be integrated into health workforce programs already available. In line with the Government's high prioritisation of Indigenous employment issues, it will continue to provide significant support and funding for workforce activities to provide access to health and aged care services for Australians in hard to reach areas, such as for Indigenous communities and in rural and remote areas.⁶²

1.68 The Aged Care Financing Authority (ACFA) noted that this change 'reflected an overall reduction in funding for these programmes across the forward estimates.'⁶³

60 Department of Health, [Stocktake and analysis of Commonwealth-funded aged care workforce activities](#), (accessed 12 May 2017).

61 Following announcements in the 2015-16 Budget the Aged Care Workforce Development Fund was redesigned to bring in 40.2 million dollars of savings over four years.

62 Department of Health, *Submission 293*, p. 23.

63 Aged Care Financing Authority, [Annual Report on the Funding and Financing of the Aged Care Sector](#), July 2016, pp. 52-3.

1.69 The committee received evidence from a wide range of groups across the sector, including local government, not-for-profit and for-profit aged care providers, and nurses and nursing unions concerning these changes. Many of these submitters expressed concerns about the reduction in funding for the ACWF, submitting that the ACWF has enabled them to provide education and training that they may not have been otherwise able to provide.⁶⁴

1.70 For example, the Local Government Association of the Northern Territory (LGANT) indicated that further reductions to the ACWF would have the following implications for remote and very remote aged care services and their workers:

- the ability to continue to provide services at a high level would be compromised;
- the ability to employ qualified staff would be further compromised;
- the ability for aged care clients to remain on country would be reduced, placing further pressures on residential facilities in regional centres; and
- services within communities would be compromised and potentially reduced, and clients' dependent on services which provide regular nutritious meals, water and personal care would be impacted.⁶⁵

1.71 Not-for-profit providers also expressed concerns regarding the streamlining and reduction of funding for the ACWF, and its impact on:

- ability of providers to support training for workers;⁶⁶
- development of palliative care and dementia care skills;⁶⁷
- support for workers in regional and remote areas.⁶⁸

1.72 Not-for-profit providers also noted the cap on fringe benefits tax exemptions and its impact on their ability to attract and retain workers.⁶⁹

1.73 In contrast, for-profit providers' main concern was the removal of the payroll tax subsidy and its impact on the ability of private providers to compete with not-for-profit providers.⁷⁰

64 See, for example: DutchCare, *Submission 179*, pp. 3 and 8.

65 Local Government Association of the Northern Territory, *Submission 241*, pp. 4-5.

66 See, for example: Leading Age Services Australia, *Submission 222*, p. 17; JewishCare Victoria, *Submission 109*, p. 6; Presbyterian National Aged Care Network, *Submission 190*, p. 7; DutchCare, *Submission 179*, p. 8; Baptist Care Australia, *Submission 219*, p. 9.

67 See, for example: Brightwater Care Group, *Submission 213*, p. 7; Palliative Care Nurses Australia, *Submission 188*, p. 9; Palliative Care Australia, *Submission 139*, pp. 2-3; Alzheimer's Australia, *Submission 180*, p. 3.

68 See, for example: LGANT, *Submission 241*, p. 4; Yass Valley Aged Care, *Submission 59*, p. 9.

69 See, for example: Health Workers' Union, *Submission 248*, p. 77.

70 See, for example: Aged Care Guild, *Submission 290*, p. 7.

1.74 Nurses and nursing unions expressed concern that the removal of the high/low care distinction for residential facilities may result in providers cutting RN staff.⁷¹ This change is expected to be particularly acute in NSW, where it is currently legislated that all high care facilities must have a RN on site at all times.⁷² This issue is discussed further in chapter 3.

Role of the Australian government in developing an aged care workforce strategy

1.75 During the inquiry the committee heard evidence that suggested the need for a national aged care workforce strategy to plan for and respond to future challenges facing the aged care sector.

1.76 The committee heard overwhelming support for a collaborative, strategic and targeted approach to the funding and design of a national aged care workforce strategy.

1.77 The committee received a vast array of evidence from groups across the aged care sector including not-for-profit and for-profit aged care providers, unions, nurses, medical professionals and allied health practitioners who considered that the Australian Government should:

- take responsibility and leadership for development of an aged care workforce strategy;⁷³ or
- work in consultation with the aged care sector to 'co-design' a strategy.⁷⁴

1.78 The National Aged Care Alliance (NACA), a national peak body of those in the aged care sector, were particularly supportive of a co-design approach to the development of a strategy. NACA recommended that the Australian Government:

...work with stakeholders to co-design a definitive workforce development strategy to ensure a sufficient future workforce to meet the service needs of health, aged care, disability and community service sectors (including in regional and remote areas). This strategy should work towards greater coordination across the social services sectors and should focus on recruitment, retention, education, development and remuneration to ensure the workforce needs of each of the sectors are met.⁷⁵

71 For example, the NSW Nursing and Midwives' Association expressed concern that the removal of the high/low care distinction 'will provide a window of opportunity for some aged care providers to reduce their overheads by removing RNs from their workforce'. See: NSW Nurses and Midwives' Association, *Submission 134*, pp. 30-31.

72 NSW Nurses and Midwives' Association, *Submission 134*, pp. 30-31.

73 See, for example: Combined Pensioners and Superannuants Association of NSW, *Submission 295*, p. 5; Health Services Union, *Committee Hansard*, 28 April 2016, p.8.

74 See, for example: COTA Australia, *Submission 283*, p. 1; Aged and Community Services Australia, *Submission 229*, p. 13; Leading Aged Care Services, *Submission 222*, p.15; Salvation Army Aged Care Plus, *Submission 183*, p. 8; Benevolent Society, *Submission 240*, p. 3; Catholic Health Australia, *Committee Hansard*, 3 November 2016, pp. 20, 21.

75 National Aged Care Alliance, *Submission 77*, p. 2.

1.79 COTA Australia, the national peak organisation representing older Australians, agreed with this approach, stating that a national strategy will only be effective 'if there is ownership of the development process by all stakeholders', noting:

It is not sufficient, as some in the sector have tended to do, to lay the primary responsibility on the federal government.⁷⁶

1.80 The Department of Health (department) views the Australian Government's role in the development of a workforce strategy as more of a 'facilitator', rather than a leader.⁷⁷ The department explained that the Australian Government's position on a national aged care workforce strategy is that it will support the sector in developing a strategy, but that it is ultimately the sector's responsibility:

Aged care employers are responsible, like any other employer, for assuring that their workforce needs are aligned with their business strategy, as an essential component of organisational governance.⁷⁸

1.81 In its submission, the department further commented that government will assist the sector in the development of a strategy 'by providing funding for a sector-run development process, including provision for consultation with all relevant parties'.⁷⁹

1.82 Consistent with these comments, the Government announced in its 2017-18 Budget that it will:

...provide \$1.9 million over two years from 1 July 2017 to establish and support an industry-led aged care workforce taskforce and contribute to the development of an aged care workforce strategy, including for regional and remote areas.⁸⁰

1.83 The department has explained that the taskforce will explore:

...short, medium and longer term options to boost supply, address demand and improve productivity for the aged care workforce.⁸¹

1.84 The department has also commented that the strategy 'will connect with the National Disability Insurance Scheme (NDIS) Integrated Market, Sector and Workforce Strategy', and that the taskforce will consult within the sector, but 'also engage with other sectors, including disability, education and employment'.⁸²

76 COTA Australia, *Submission 283*, p. 1.

77 Department of Health, *Submission 293*, p. 10.

78 Department of Health, *Submission 293*, p. 22.

79 Department of Health, *Submission 293*, p. 24.

80 Commonwealth of Australia, *Budget Measures: Budget Paper No. 2 2017-18*, p. 123.

81 Department of Health, [*Strengthening Aged Care – developing an aged care workforce strategy*](#), (accessed 25 May 2017).

82 Department of Health, [*Strengthening Aged Care – developing an aged care workforce strategy*](#), (accessed 25 May 2017).

1.85 The Government has not committed any additional funding for an aged care workforce strategy, but stated the measure will be funded 'from within the existing resources of the Department of Health'.⁸³

1.86 The funding forms part of a broader \$33 million dollar 'Boosting the Local Care Workforce' workforce initiative to:

...assist providers in rural, regional and outer suburban areas to provide the workforce required to meet the expected growth in the disability and aged care sectors arising from the introduction of the National Disability Insurance Scheme and an ageing population...⁸⁴

1.87 The department has stated that the initiative will create 'regional and specialist coordinators to assist NDIS and aged care providers to grow their businesses and employ more workers'.⁸⁵ The measure will be funded from within the existing resources of the Department of Health, and Department of Social Services, and is discussed in greater detail in chapter 4.

Committee view

1.88 The committee notes that all levels of government have an important role in aged care administration and expenditure, and providing funding and support to the sector.

1.89 The committee considers that federal, state and territory, and local governments have a role in assisting the sector to develop a national aged care workforce strategy.

1.90 The committee is pleased that the Government has announced a commitment to provide funding to assist to establish an industry-led aged care workforce strategy.

1.91 The committee notes it will be important to ensure that stakeholder consultation and engagement is properly organised to enable wide and meaningful input from those who may be affected by any changes included in a national workforce strategy.

Conduct of the inquiry

1.92 This inquiry was first referred by the Senate of the 44th Parliament for inquiry on 1 December 2015, with a reporting date of 30 June 2016. The inquiry lapsed at the dissolution of the Senate on 9 May 2016.

1.93 On 13 September 2016, the Senate of the 45th Parliament agreed to re-adopt the inquiry with a reporting date of 28 April 2017. On 20 March 2017, the Senate granted an extension of time for reporting until 21 June 2017.

83 Commonwealth of Australia, *budget Measures: Budget Paper No. 2 2017-18*, p. 123.

84 Commonwealth of Australia, *budget Measures: Budget Paper No. 2 2017-18*, p. 145.

85 Department of Health, [Strengthening Aged Care – developing an aged care workforce strategy](#), (accessed 25 May 2017).

Handling of submissions

1.94 During the first referral of this inquiry under the 44th Parliament, a total of 296 submissions were received, 98 from organisations and 198 personal accounts from individuals, showing the depth of concern with this issue from the general public.

1.95 In the second referral under the 45th Parliament, the committee resolved not to call for new submissions but to rely on submissions received during the 44th Parliament. All correspondence and evidence previously received for this inquiry has been made available to the new committee. An additional 13 submissions were received and accepted by the committee.

Public hearings

1.96 A total of 12 public hearings were held:

28 April 2016	Melbourne, VIC
27 September 2016	Perth, WA
28 September 2016	Bunbury, WA
25 October 2016	Darwin, NT
26 October 2016	Alice Springs, NT
31 October 2016	Launceston, TAS
3 November 2016	Canberra, ACT
23 February 2016	Townsville, QLD
6 March 2016	Wollongong, NSW
7 March 2017	Adelaide, SA
9 June 2017	Broome, WA
13 June 2017	Canberra, ACT

Chapter 2

Changing pressures on the aged care workforce

We know that the current aged-care workforce is older than the overall Australian workforce, and, like the population, is also ageing. We know that the current predictions indicate our aged-care workforce will need to grow by about 2 per cent annually, or triple from its current size, for the next 30 or so years to meet demand, notwithstanding technological innovation and changes to service delivery models.¹

2.1 The aged care sector is an industry currently facing significant changes which present great challenges, but also creates great opportunities. As the Australian population ages, there is expected to be exponential growth in employment opportunities. At the same time, service delivery is becoming more challenging due to changes in service delivery models to individualised home care services and increases in dementia and other complex care needs. To meet these challenges the aged care sector will need to be flexible and adopt new strategies to ensure provision of quality care.

2.2 The previous chapter provided some details on the current composition of the aged care workforce. This chapter examines:

- the adequacy of aged care workforce data in tracking and projecting workforce changes;
- the projected growth of the aged care workforce;
- the changing needs of older Australians;
- changes in service delivery models; and
- the challenges the sector is expected to face regarding skills mix and competition for workers from other sectors.

Adequacy of aged care workforce data

2.3 In order to develop sound strategies and policy around aged care it is crucial to have access to complete and accurate information and data. Any limitation in the data collected ultimately limits the extent to which that data can be used to inform policy.²

2.4 The committee heard evidence that the quality of aged care data currently collected is inadequate and has numerous areas of deficiency. Some submitters raised

1 Mr Trevor Lovelle, Chief Executive Officer, Aged and Community Services Australia, Western Australia, *Committee Hansard*, 27 September 2016, p. 1.

2 Professor Sara Charlesworth, *Submission 290*, p. 7.

particular concerns that current surveys and census reports do not adequately capture data on all sectors of the workforce.³

2.5 As mentioned in Chapter 1, the National Aged Care Workforce Census and Survey (NACWCS) is the main source of aged care workforce data and is widely acknowledged as one of the best sources, if not the best source, of aged care workforce data.⁴ Data is also available from other sources, including statistical collections maintained by the Australian Bureau of Statistics (ABS) and data sets created by the National Aged Care Data Clearinghouse.⁵

2.6 Professor Sara Charlesworth from RMIT University argued in her submission that data collected from both the NACWCS and ABS is deficient.⁶ Professor Charlesworth raised specific concerns that the workforce categories used by the ABS do not capture all home-based care workers, and that NACWCS data 'underestimates the proportion of casual and other non-standard employment arrangements'.⁷ Professor Charlesworth further argued that deficiencies in the workforce classification used by the ABS:

...limit the analysis of census and labour force data and the extent to which such data can be used to inform aged care workforce policy.⁸

2.7 Doctor Adrian Webster from the Australian Institute of Health and Welfare also commented:

...in terms of putting data together, one of the overriding challenges that we have is a relative lack of agreed data standards and collection mechanisms for monitoring the...aged care sector.⁹

2.8 The ABS submitted that the diverse range of industries and occupations engaged in aged care 'make it difficult to identify or define the current composition of the aged care workforce'.¹⁰

3 Professor Sara Charlesworth, *Submission 290*, p. 7; UnitingCare Australia, *Submission 256*, p. 17.

4 See, for example: Healthy Ageing Research Group, La Trobe University, *Submission 237*, p.3; Professor Sara Charlesworth, *Submission 290*, p. 7.

5 The National Aged Care Data Clearinghouse coordinates data collection from various agencies and departments: Australian Institute of Health and Welfare, [National Aged Care Data Clearinghouse](#), accessed 4 May 2017.

6 Professor Sara Charlesworth, *Submission 290*, pp. 7-9.

7 Professor Sara Charlesworth, *Submission 290*, pp. 7-9. The ABS' aged care workforce data is spread across a range of categories as defined by the Australian and New Zealand Standard Industrial Classification (ANZSIC) and Australian and New Zealand Classification of Occupations (ANZSCO). See: Australian Bureau of Statistics (ABS), *Submission 221*, p. 1.

8 Professor Sara Charlesworth, *Submission 290*, p. 7.

9 Dr Adrian Webster, Head of the Expenditure and Workforce Unit, Australian Institute of Health and Welfare, *Committee Hansard*, 3 November 2016, p. 57.

10 Australian Bureau of Statistics, *Submission 221*, p. 3.

2.9 For the purposes of this report, the committee has relied on the NACWCS, as the most widely accepted reputable source of aged care workforce data.

Committee view

2.10 The committee notes that deficiencies in aged care workforce data and a lack of nationally agreed standards makes it difficult to analyse the composition of the current workforce, and how that workforce may need to develop and adjust to meet future needs. The committee considers that the adequacy of aged care data collection needs to be addressed by data collection agencies and bodies, in order to have complete and accurate information concerning workforce trends and needs into the future.

Projected growth of the aged care workforce

2.11 It has been estimated that the aged care workforce will need to grow from around 366 000 to 980 000 by 2050 to meet the needs of the increasing numbers of older Australians accessing aged care services.¹¹ The committee heard evidence that Tasmania alone will require up to 4,000 additional workers by 2025 to meet future demand.¹²

2.12 *The Aged Care Workforce, 2016* report states 'the sector will need to respond [to increased demand], either by expanding its workforce or by increasing its productivity, or...a mix of the two'.¹³

2.13 However, NACWCS data shows that aged care providers are already experiencing skills shortages, particularly in residential aged care facilities, and remote and very remote areas.¹⁴

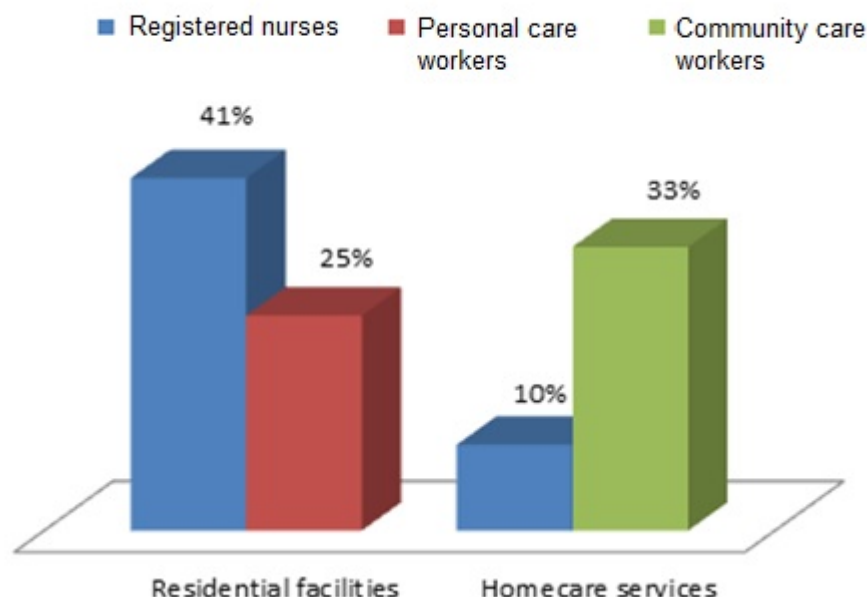
11 Department of Health, [Strengthening Aged Care – developing and aged care workforce strategy](#), (accessed 25 May 2017). See also: Productivity Commission, [Caring for Older Australians](#), Report No. 53, v.2, 2011, p. 354.

12 See for example: Aged and Community Services Tasmania, *Committee Hansard*, 31 October 2016, p. 8; and Primary Health Tasmania, *Committee Hansard*, 31 October 2016, p. 42.

13 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 54.

14 National Institute of Labour Studies, Flinders University, *The Aged Care Workforce, 2016*, 2017, Department of Health, p. 54.

Figure 2.1: Proportion of residential facilities and home care and home support outlets reporting skill shortages in 2016 (per cent), by occupation affected.



Source: National Institute of Labour Studies, Flinders University, *The Aged Care Workforce*, 2016, 2017, Department of Health, pp. 54, 119, 164.¹⁵

2.14 The most commonly reported reasons for the shortages in both sectors were 'no suitable applicants' and 'geographical location'.¹⁶

2.15 Submitters argued that in order for the aged care sector to grow to the levels required to meet future needs, it is crucial that:

- the industry attracts more young people, mothers returning to work, mature-aged persons (particularly males), migrants, and people looking for new career paths to the sector;¹⁷
- existing workers receive training to broaden their skill-sets; and¹⁸

15 63 per cent of residential facilities and 42 per cent of home care and home support outlets experienced skills shortages in 2016. Note, however, skills shortages in both sectors have reduced since 2012 (76 per cent of residential facilities and 49 per cent of home care and home support outlets reported shortages in 2012). See: National Institute of Labour Studies, Flinders University, *The Aged Care Workforce*, 2016, 2017, Department of Health, pp. 54, 119, 164.

16 80 per cent of residential facilities, and 72 per cent of home care and home support outlets reported 'no suitable applicants' as the cause for shortages in their facility or outlet, and 38 per, and 39 per cent of each sector respectively reported 'geographical location' as the cause for shortages. See: National Institute of Labour Studies, Flinders University, *The Aged Care Workforce*, 2016, 2017, Department of Health, pp. 55, 120.

17 See, for example: RDA Illawarra, *Committee Hansard*, 6 March 2017, p. 2; Leading Age Services Australia, *Committee Hansard*, 3 November 2016, p. 4; Hall and Prior Health and Aged Care Group, *Committee Hansard*, 28 September 2016, p. 22.

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- informal carers are supported to transition to the formal aged care workforce.¹⁹

Changing needs of older Australians

2.16 The needs of aged care patients are becoming more complex, with patients increasingly requiring specialised treatment in areas such as dementia and palliative care. The growing prevalence of older Australians with complex care needs is expected to place increased pressure and demand on aged care facilities and workers to provide quality and acute-care services.²⁰

2.17 Submitters suggested that the aged care workforce will need to broaden its skills and capabilities in order to assist older Australians with increasingly complex needs, such as:

- dementia and cognitive impairment;²¹
- mental illness;²²
- communication disorders;²³
- complex psychological situations;²⁴
- palliative care;²⁵ and
- Human Immunodeficiency Virus (HIV).²⁶

Dementia care

2.18 The number of older Australians living with dementia is growing, with the number of people with dementia predicted to increase from an estimated 342 800 in 2015 to 400 000 by 2020, and to about 900 000 by 2050.²⁷ Alzheimer's Australia, the

18 Healthy Ageing Research Group, La Trobe University, *Submission 237*, p. 6.

19 Carers Australia, *Submission 269*, pp. 10-11.

20 See, for example: Alzheimer's Australia, *Submission 180*, p. 2; The Bethanie Group Inc, *Committee Hansard*, 28 September 2016, p. 2.

21 See: Alzheimer's Australia, *Submission 180*, p. 4.

22 See: Australian Psychological Society, *Submission 142*, p. [1].

23 See: Healthy Ageing Research Group, La Trobe University, *Submission 237*, p. 25.

24 See: Australian Association of Social Workers, *Submission 236*, p. 4.

25 See: Palliative Care Australia, *Submission 139*, pp. 1-2.

26 See: Australian Federation of AIDS Organisations and National Association of People with HIV Australia, *Submission 106*, pp. 3-4; People Living with HIV Community Forum WA, *Submission 294*, pp. 3, 5.

27 In 2015 an estimated 342 800 Australians had dementia. In the same year, 10 per cent of Australians aged over 65, and 31 per cent aged over 85 had dementia. See: Australian Institute of Health and Welfare (AIHW), '[Dementia](#)', (accessed 9 May 2017).

peak body for providing support to people living with dementia, told the committee that 'dementia is one of the largest healthcare challenges facing Australia'.²⁸

2.19 Figures show that in 2013-14 more than 50 per cent of persons in Australian Government funded residential aged care facilities had dementia. Access Economics' modelling suggests a shortfall of carers for people with dementia as early as 2029.²⁹

2.20 Alzheimer's Australia expressed concern that decreases in the ratio of direct care staff and the proportion of qualified nursing staff:

...are already impacting on the quality of care offered to some of the most frail and vulnerable people in our community and that the situation has the potential to worsen in the future as demand pressure increases.³⁰

2.21 Alzheimer's Australia further commented:

Demand is growing at a faster rate than the supply of aged-care services. It seems inevitable that vulnerable, resource-intensive consumers, including people with dementia and especially those with more complex care needs, will lose out if we rely solely on market forces to drive access and quality.³¹

2.22 To overcome these issues, some submitters expressed support for the development and implementation of a national dementia strategy that builds on the *National Framework for Action on Dementia*.³²

2.23 In support of that approach, Alzheimer's Australia submitted:

This approach should be supported by government and by the aged care industry, and focus on achieving sustainable changes to practice which lead to better outcomes for people living with dementia.³³

Acute and Palliative care

2.24 As medicine advances and models of care change so that people are supported to stay in their homes longer, it is expected that the numbers of people entering residential care facilities at the acute care or palliative care stage will increase.³⁴

28 *Submission 180*, p. 4. See also, Alzheimer's Australia, *Committee Hansard*, 3 November 2016, p. 28.

29 Access Economics, [Making choices. Future dementia care: projections, problems and preferences](#), 2009, p. vi.

30 Alzheimer's Australia, *Committee Hansard*, 3 November 2016, p. 28.

31 Alzheimer's Australia, *Committee Hansard*, 3 November 2016, p. 28.

32 The *National Framework for Action on Dementia 2015-2019* was developed by Commonwealth, State and Territory governments to 'create a strategic, collaborative and cost effective response to dementia across Australia'. See: Department of Health, [National Framework for Action on Dementia 2015-2019](#) (accessed 9 May 2017).

33 Alzheimer's Australia, *Submission 180*, p. 3.

34 See, for example: Australian Medical Association, *Committee Hansard*, 3 November 2016, p. 15; Palliative Care Nurses Australia, *Committee Hansard*, 3 November 2016, p. 27.

2.25 The committee heard that this is already occurring, with a fundamental shift in the care requirements of older persons entering residential facilities already being observed. For example, Ms Joanne Christie from The Bethanie Group Inc. commented:

...five years ago, 70 per cent of our residents in residential would have been low care and 30 per cent were high care. Within five years that has flipped and 70 per cent were high care and 30 per cent were in low care.³⁵

2.26 Mr Stephen Midson from Palms Aged Care also told the committee about the increasing acute care needs of residential aged care clients:

...I have residents who come in and my worst has been a resident who lasted for 18 hours. They regularly live a lot shorter in an aged-care facility. They are far more acute. Their clinical needs are far greater than they were 20 years ago.³⁶

2.27 Palliative Care Australia, the peak national body for palliative care, expressed concerns about the capacity of aged care services to meet these increasingly high care needs:

People in receipt of aged care services increasingly have complex health care needs due to multiple chronic diseases; they will require long-term care including palliative care and end of life care. The complexity of their care needs is as high as people in acute hospitals and the trajectory of their care is long term and ultimately terminal. Yet, aged care services are often much less equipped in terms of staffing, funding and skills to provide high quality holistic care to these people, who are among the most vulnerable in our community.³⁷

2.28 To overcome these issues submitters suggested that the sector needs to provide greater workforce training in the area of palliative care to existing workers, and persons undertaking qualification courses in aged care.³⁸ For example, Palliative Care Nurses Australia Inc. submitted:

There is a need for mandatory integrated palliative care units of competency in the new generic aged care/disabilities Certificate III course, along with extended practice hours in new Certificate III and Individual Support to build confidence and competency for on-site facilitators.³⁹

2.29 Alzheimer's Australia also advocated for greater workforce training in complex care needs, stating:

35 Ms Joanne Christie, The Bethanie Group Inc, *Committee Hansard*, 28 September 2016, p. 4.

36 Mr Stephen Midson, Palms Aged Care, *Committee Hansard*, 23 February 2017, p. 4.

37 *Submission 139*, pp. 1-2.

38 See, for example: Alzheimer's Australia, *Committee Hansard*, 3 November 2016, p. 28; NSW Nurses and Midwives' Association, *Submission 134*, p. 21; Audiology Australia, *Submission 171*, p. 2; Vision Australia, *Submission 184*, p. 6; Australian College of Nursing, *Submission 285*, p.12.

39 Palliative Care Nurses Australia Inc., *Submission 188*, p. 3.

The future role of the aged care workforce will need to expand to include provision of respite, training and skills in the recognition of dying, grief, loss and bereavement support; skills in transitioning care, and most importantly, expertise in dementia care.⁴⁰

2.30 The need for greater training in the area of palliative care, and other areas more generally, is discussed further in Chapter 3.

Expectations around delivery and quality of services

2.31 Greater flexibility in delivery and quality of services which aged care patients expect to receive is also increasing. For example, Ms Patricia Sparrow from Aged and Community Services Australia noted:

...there is expectation in...older Australians around the needs and wants that they have with regard to the types of care that they will require, the types of services they will require, how and where that is delivered, by whom that is delivered and when that is delivered.⁴¹

2.32 Submitters said that the move toward consumer directed care (CDC) in particular has changed the expectations clients have of people providing care.⁴² For example, St Ives Home Care, argued that clients increasingly expect high quality care delivered by a single person:

...clients and consumers want to have an increased choice, and so they should, of who, when and what type of services they receive, and the ability and flexibility to chop and change these. They are expecting a more skilled workforce with a diverse skill set. They do not want to have somebody doing domestic services, somebody coming in to do their medication, somebody else coming in to do their personal care and somebody taking them to a social activity.⁴³

2.33 St Ives Home Care noted such changes in expectations, particularly the increasing scope of services workers are expected to deliver, creates training challenges for employers who will increasingly need to ensure their staff have the appropriately diverse mix of skills and capabilities to deliver such services.⁴⁴

Changes in service delivery

2.34 Australia's aged care system is currently undergoing significant reform with the introduction of CDC funding packages to support older Australians to receive care

40 Alzheimer's Australia, *Committee Hansard*, 3 November 2016, p. 28.

41 Ms Patricia Sparrow, Aged and Community Services Australia, *Committee Hansard*, 3 November 2016, p. 2.

42 See, for example: St Ives Home Care, *Committee Hansard*, 27 September 2016, p. 18; BaptistCare, *Committee Hansard*, 27 September 2016, pp. 26-27.

43 Ms Liza De Ronchi, St Ives Home Care, *Committee Hansard*, 27 September 2016, p. 18.

44 St Ives Home Care, *Committee Hansard*, 27 September 2016, p. 18.

at home or in the community.⁴⁵ These reforms were introduced in direct response to the Productivity Commission's inquiry into *Caring for Older Australians*, and are a significant change to historical models of service delivery for aged care in Australia.⁴⁶

2.35 This section examines the CDC model of care, challenges faced by the sector in implementing the model, and the impact the changing model of care is expected to have on demand for volunteers and informal carers.

Consumer directed care

2.36 CDC is designed to give more choice, flexibility and control to aged care consumers over the types of care and services they access and their delivery, including who delivers the services and when.⁴⁷ Following a successful pilot of the CDC model in 2010-11, changes were introduced so that from July 2015 all Home Care Packages are required to be delivered under CDC. This was a transitional period, where funding was still allocated to service providers under a pre-existing mechanism, the Aged Care Approvals Round (ACAR).

2.37 From February 2017, the full CDC model became operational. The key change arising from this is that Home Care Packages are no longer allocated to service providers but to assessed consumers, who are able to choose, and change, service providers.⁴⁸

2.38 These changes are consistent with comments made by the Department of Health (department), that the Australian Government's policy is to support 'consumer-driven, market-based system arrangements where customers have greater choice and control regarding the services they access'.⁴⁹

2.39 The committee heard varied responses from submitters regarding their level of support for the CDC funding model.

2.40 The Combined Pensioners and Superannuants Association of NSW were critical of the lack of information available for consumers, in particular as CDC is fully rolled out:

Presently, care recipients cannot make informed decisions about where they wish to receive care as the information necessary to make this decision is not available. The mandatory disclosure of staff ratios empowers care

45 The first phase of reforms included the introduction of the Commonwealth Home Support Programme (CHSP) and Home Care Packages Program (HCPP). Further changes in 2016 enabled the allocation of Home Care Packages to consumers, who can direct government funding to a provider of their choice. See: Department of Health, *Submission 293*, pp. 7-8.

46 See: Productivity Commission, *Caring for Older Australians*, 2011, <http://www.pc.gov.au/inquiries/completed/aged-care/report> (accessed 10 May 2017).

47 Department of Social Services, *What is Consumer Directed Care?*, https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/04_2015/what_is_consumer_directed_care_0_0.pdf (accessed 10 May 2017).

48 Department of Health, *Submission 293*, p. 8.

49 Department of Health, *Submission 293*, p. 7.

recipients to make better decisions about their care and also means that aged care providers will be incentivised to increase staffing levels.⁵⁰

2.41 Aged Care in Crisis (ACC) were also concerned about the approach to the development and implementation of CDC, which they submitted will not work in Australia for the following reasons:

- a. It fails to adequately recognise and take account of the vulnerability and incapacity of a large number of the aged citizens it expects to take control.
- b. It has tried to squeeze the empowerment of frail citizens into the free market belief system and the two are not really compatible.
- c. It has ignored the fact that the frail aged are part of a community and it is the community that relates to them and is ultimately responsible for and to them. The community gives their lives meaning. Community services are most successful when the community has ownership and responsibility and in the UK and Australia the community have largely been excluded.⁵¹

2.42 Volunteering Tasmania stated that the CDC model will make it very difficult to plan for and ensure a sustainable volunteer workforce in the aged care sector.⁵²

2.43 Aged and Community Services Australia expressed support for CDC, suggesting that aged care clients' expectations about the quality and delivery of their care are aligned with the CDC model:

...it is clear that today's aged care consumers (and those of the future) have higher incomes and higher expectations of material comfort and lifestyle choices. These changing expectations align to the policy direction towards consumer-directed care and in-home care.⁵³

2.44 However, several other submitters expressed concerns about the impact the CDC model of care may have on the composition of the workforce, including increased casualization of workers.

2.45 For example, Queensland Health submitted that CDC may create uncertainty for providers in terms of how they operate their staffing, and may lead employers to be 'less likely to want to make long-term employment decisions, potentially resulting in more part-time and more casualisation of services'.⁵⁴ Professor Sara Charlesworth of the Centre for Sustainable Organisations and Work at RMIT University said that the CDC mechanism may undermine the good intentions underlying the model 'by undercutting the employment conditions of aged care workers'.⁵⁵

50 Combined Pensioners & Superannuants Association of NSW, *Submission 295*, p. 16.

51 Aged Care Crisis Inc., *Submission 302*, Appendix B, p. 3.

52 Volunteering Tasmania, *Submission 56*, [p. 3].

53 Aged and Community Services Australia, *Submission 229*, p. 9.

54 Mr Graham Kraak, Queensland Health, *Committee Hansard*, 23 February 2017, p. 12.

55 Professor Sara Charlesworth, *Submission 290*, p. 3.

2.46 Some submitters also suggested that while CDC offers more flexible funding arrangements, it can also be a disincentive to attract people to the aged care workforce because it creates limited opportunity for long-term permanent employment.⁵⁶

Challenges for regional and remote providers

2.47 The committee heard evidence from several Aboriginal and Torres Strait Islander representative bodies and service providers who argued that CDC is not culturally appropriate for Aboriginal and Torres Strait Islander peoples.⁵⁷ These submitters suggested that CDC funding models, due to their individualistic nature, are not compatible with Aboriginal culture.⁵⁸

2.48 Some submitters also raised concerns that CDC is not appropriate for remote communities, as it presumes the existence of multiple service providers from which to choose, which is generally not the case in remote areas.⁵⁹ Additionally, the generally smaller numbers of people accessing services, and the additional costs of delivering services in remote locations, have not been factored in to CDC modelling. This is placing pressure on existing service providers who have indicated that there is a great degree of uncertainty about how services can continue to be provided in remote locations under the new service delivery model.⁶⁰

2.49 For these reasons, some submitters argued that block funding is more flexible and appropriate for people in regional and remote communities. In addition, it was argued that greater access to the National Aboriginal and Torres Strait Islander Flexible Aged Care Program would provide much needed assistance to regional and remote providers that may continue to face difficulties in accessing funding through the CDC model.⁶¹

56 See, for example: Local Government Association of the Northern Territory, *Committee Hansard*, 25 October 2016, pp. 16, 18, 19.

57 See, for example: Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, *Committee Hansard*, 3 November 2016, pp. 47; Indigenous Allied Health Australia, *Committee Hansard*, 3 November 2016, p. 46-47; Northern Regional Aboriginal and Torres Strait Islander Corporation, p. 18, 22; Ngaanyatjarra Health Service, *Committee Hansard*, 26 October 2016, p. 8; Central Desert Regional Council, *Committee Hansard*, 26 October 2016, p. 15.

58 See, for example: Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, *Committee Hansard*, 3 November 2016, p. 47; Indigenous Allied Health Australia, *Committee Hansard*, 3 November 2016, p. 46-47.

59 See, for example: Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, *Committee Hansard*, 3 November 2016, p. 42.

60 See for example: Mr Rohan Marks, Director, Community Services, MacDonnell Regional Council, *Committee Hansard*, 26 October 2016, p. 3.

61 See, for example: Western Desert Nganampa Walytja Palyantjaku Aboriginal Corp, *Committee Hansard*, 7 March 2017, p. 8; Central Dessert Regional Council, *Committee Hansard*, 26 October 2016, p. 15.

2.50 However, the department did not share these concerns, suggesting to the committee that challenges with the CDC model in remote communities relate to providers' capacity, rather than the model of care.⁶²

2.51 The challenges faced by regional and remote providers in regard to CDC are discussed further in Chapter 4.

Volunteers and informal carers

2.52 Several submitters raised concerns that the shift towards consumer based care 'will place further stress on an already stretched sector' and will lead to greater demand on the unpaid workforce.⁶³

2.53 The committee heard that there are five volunteers for every paid worker in the not-for-profit sector, at a value of about \$290 billion per annum.⁶⁴ In 2016, 23 537 volunteers provided 114 987 hours of care to older Australians in residential facilities.⁶⁵

2.54 In its submission, Carers Australia noted concerns, that as Australia's population ages, the number of informal carers will decline.⁶⁶ A 2015 report commissioned by Carers Australia found that over the next ten years, the demand for informal carers is expected to 'significantly outstrip its supply'.⁶⁷

2.55 Submitters also raised concerns about how moves to CDC will impact the way volunteers interact with clients.⁶⁸ For example, Mrs Evelyn O'Loughlin from Volunteering SA & NT Inc submitted:

...the moral and psychological equation in consumer-directed care will change in aged care in relation to how volunteers will work with clients. We do not have any experience to know how that may change – whether it will put off people volunteering, whether we can actually have the same types of volunteering roles, whether people still want volunteers.⁶⁹

2.56 At the committee's Launceston hearing, Mr Donald Coventry from Volunteering Tasmania relayed to the committee the importance of ensuring volunteers are included in workforce planning discussions:

62 Department of Health, *Committee Hansard*, 3 November 2016, p. 30.

63 See for example: Volunteering Victoria, *Submission 272*, p. 1; and Volunteering SA & NT Inc, *Committee Hansard*, 7 March 2017, p. 37.

64 Mrs Evelyn O'Loughlin, Volunteering SA & NT Inc, *Committee Hansard*, 7 March 2017, p. 34.

65 National Institute of Labour Studies, Flinders University, *Committee Hansard*, 7 March 2017, Table 4.21, p. 64.

66 Carers Australia argues that to compensate for the decline in informal carers, older Australians will 'have a greater reliance on the formal care sector'. See: Carers Australia, *Submission 269*, p.4.

67 Deloitte Access Economics, [*The economic value of informal care in Australia in 2015*](#), p. iii.

68 See for example, Volunteering SA & NT Inc, *Committee Hansard*, 7 March 2017, p. 36.

69 Mrs Evelyn O'Loughlin, Volunteering SA & NT Inc, *Committee Hansard*, 7 March 2017, p. 37.

As we seek to understand the challenges that the aged-care sector will face in coming years, it is crucial that volunteering be at the forefront of these discussions. Organisations will need to give as much consideration to how they plan and manage their volunteer workforce into the future as they will their paid workforce.⁷⁰

Committee view

2.57 The committee is concerned to note evidence of impacts on aged care workers and service providers in regional and remote areas, where there is a lack of choice of supply of services for consumers, and where workers and service providers are faced with a smaller and more dispersed client base, higher per-client costs and less certainty of demand than would be the case in urban settings.

2.58 The committee has some concerns that the planned roll out of CDC to residential aged care services may not yet sufficiently account for or enable planning in relation to informal carers and volunteers, who currently play such a critical role in aged care service delivery.

2.59 The committee is concerned that while changes in the aged care sector will place additional pressures on informal carers and volunteers, it is also projected that this unpaid workforce, which provides critical support in the aged care sector, will diminish over time as they too age and are in need of assistance.

Skills mix

2.60 The committee heard evidence that the skills mix of the aged care workforce must broaden in order to meet future needs. In particular, submitters highlighted the importance of ensuring that the direct care workforce has an appropriate mix of skilled workers, including personal care workers, nurses, allied health practitioners and medical professionals. To achieve this, submitters suggested that the industry needs to attract more young people, migrants, mothers returning to work, mature-aged workers, and people looking for new career paths to the sector.⁷¹

Personal care workers and nurses

2.61 Some submitters expressed concerns that the ratio of personal care workers is increasing at the expense of specialised skilled staff, particularly nurses.⁷² The New South Wales Nurses and Midwives' Association submitted that less than one third of direct care workers in residential and community aged care are registered or enrolled nurses: 'This means the majority of direct patient care in these areas will be delivered by unregulated workers.'⁷³

70 Mr Donald Coventry, Volunteering Tasmania, *Committee Hansard*, 31 October 2016, p. 3.

71 See, for example: RDA Illawarra, *Committee Hansard*, 6 March 2017, p. 1.

72 See, for example: Australian College of Nursing, *Submission 285*, p. 9; National Seniors, *Submission 278*, p. 6.

73 New South Wales Nurses and Midwives' Association, *Submission 134*, p. 9.

2.62 Ms Lee Thomas, Federal Secretary of the Australian Nursing and Midwifery Federation stated that:

currently members are saying to us that it is not uncommon for one registered nurse and a couple of assistants in nursing to be looking after up to 150 residents. That is not uncommon, unfortunately.⁷⁴

2.63 Queensland Health commented that there has been a 'de-professionalisation'⁷⁵ of the workforce as the number of nurses working in residential aged care facilities has declined and numbers of PCWs has increased:

...the number of registered nurses and, to a lesser extent, the number of enrolled nurses have reduced over a number of years. They have been replaced with personal care workers, many of whom have a certificate III in aged care...⁷⁶

2.64 Submitters expressed concerns that this 'de-professionalisation' of the workforce has diminished the quality of care provided and led to poorer outcomes for residents.⁷⁷

2.65 The committee also received evidence that there is a need for more specialist nurses, who can provide care and support to older Australians with dementia.⁷⁸

Medical professionals

2.66 Medical professional bodies expressed concerns that health care professionals may be excluded from workforce planning.⁷⁹ In particular, the Royal Australian College of General Practitioners (RACGP) submitted that general practitioners (GPs) will play an increasingly important role in supporting older Australians to remain at home or in the community. The RACGP recommended that initiatives to encourage GPs to work in aged care should be explored to ensure older patients can access GP care in the community and during transitions between care settings.⁸⁰

2.67 The Australian Medical Association (AMA) also submitted that medical practitioners are 'central to the provision of quality care for older people' and

74 Ms Lee Thomas, Federal Secretary, Australian Nursing and Midwifery Federation, *Committee Hansard*, 31 October 2016, p. 10.

75 The term 'de-professionalisation' was used by Queensland Health in its submission to describe the overall lowering of the skill level of the aged care workforce. See: Queensland Health, *Submission 227*, p. 3.

76 Mr Graham Kraak, Queensland Health, *Committee Hansard*, 23 February 2017, p. 14.

77 See, for example: Palliative Care Nurses Australia, *Committee Hansard*, 3 November 2016, p. 27; Alzheimer's Australia, *Committee Hansard*, 3 November 2016, p. 28; NSW Nurses and Midwives' Association, *Committee Hansard*, 3 November 2016, p. 48.

78 Australian College of Nursing, *Submission 285*, p. 11.

79 See, for example: Australian Medical Association (AMA), *Submission 210*; Royal Australian College of General Practitioners (RACGP), *Submission 281*; Australian Association of Gerontology, *Submission 217*.

80 RACGP, *Submission 281*, p. 8.

suggested that more funding to support medical services to integrate with aged care services and will improve residents' access to medical care and lead to a more efficient health system.⁸¹

2.68 The AMA and other submitters argued that greater integration of GPs into the aged care sector would make the system more efficient as it would help to prevent more expensive health services downstream, such as hospital admissions.⁸²

Allied health professionals

2.69 The committee received evidence from allied health groups, including dietitians, speech pathologists and occupational therapists that expressed concerns that allied health professionals (AHPs) are currently underutilised in the aged care sector.⁸³

2.70 At its Melbourne hearing, the committee heard from a range of allied health organisations, who all supported greater integration of allied health services with aged care services and more support for older Australians to access allied health services.⁸⁴ Organisations representing older Australians with specific health conditions such as sight and hearing disabilities, also supported greater utilisation and integration of AHPs to meet their needs.⁸⁵

Committee view

2.71 The committee notes concerns that nurses, medical professionals and AHPs are currently underutilised in the aged care sector. The committee agrees that nurses, medical professionals and AHPs present an opportunity to help fill current workforce gaps, and that there is a need for greater integration of AHPs, in particular, into the aged care sector.

Competition for workers with other sectors

Competition between sectors

2.72 Several submitters expressed concerns that the projected increases in the aged care sector will result in competition for workers in other sectors who share similar

81 Australian Medical Association, *Submission 210*, p. 2.

82 Australian Medical Association, *Committee Hansard*, 3 November 2016, p. 15; Anglicare Australia, *Committee Hansard*, 3 November 2016, p. 21; Australian College of Nursing, *Committee Hansard*, 3 November 2016, p. 53.

83 See, for example: Dietitians Association of Australia, *Submission 83*.

84 See, for example: Speech Pathology Australia, Allied Health Professions Australia, Australian Psychological Society, Dietitians Association of Australia, *Committee Hansard*, 28 April 2016, pp. 39-50.

85 See, for example: Guide Dogs Australia, Blind Citizens Australia, Vision 2020 Australia, Audiology Australia, *Committee Hansard*, pp. 39-50, 51-56.

skill sets.⁸⁶ This competition is expected to be particularly acute with the disability sector following the full roll out of the National Disability Insurance (NDIS) scheme. For example, the Presbyterian National Aged Care Network submitted:

The immediate impact of the growth of the NDIS is increased competition for staff working in frontline roles.⁸⁷

2.73 Yass Valley Aged Care Ltd noted that such competition is already being observed in regional areas of Australia.⁸⁸

2.74 Increased competition for workers is predicted to lead to increased labour costs and shortages of workers.⁸⁹ As discussed earlier in this chapter, a large proportion of residential facilities and home care and home support outlets are already experiencing skills shortages.

2.75 National Disability Services (NDS) expressed particular concern about the existing shortage of allied health professionals in both the disability and aged care sectors. NDS highlighted that 'innovation in workforce roles and utilisation, including greater sharing of staff across sectors' could help to alleviate allied health practitioner shortages.⁹⁰

2.76 Aged and Community Services Australia agreed that the similar skill sets of aged care and disability care workers presents opportunities for innovation, such as the development of collaborative care arrangements.⁹¹

2.77 Queensland Health commented that while the NDIS will 'drive a lot more movement to the sector where they believe that they will receive the best remuneration and the best support mechanisms and the best employment conditions' it also has the potential to expand the workforce pool and create opportunities for training and care arrangements across both sectors:

There is a degree of commonality between both that we should not see as a competition but see as an opportunity to actually build a more agile workforce that potentially can move between both sectors.⁹²

86 See, for example: National Institute of Labour Studies, Flinders University, *Committee Hansard*, 7 March 2017, p. 42; Aged and Community Services Australia, *Submission 229*, 11; Australian Institute of Health and Welfare, *Committee Hansard*, 3 November 2016, p. 56. The Department of Health has predicted that by 2019-20 the number of aged and disability carers will increase by 18.5 per cent, and the number nurse support and personal care workers will grow by 15.1 per cent. See: Department of Health, *Submission 293*, p. 50.

87 Presbyterian National Aged Care Network, *Submission 206*, p. 5.

88 Yass Valley Aged Care Ltd, *Committee Hansard*, 6 March 2017, p. 32.

89 Aged and Community Services Australia, *Submission 229*, p. 11.

90 National Disability Services, *Submission 277*, p. 5.

91 Aged and Community Services Australia, *Submission 229*, p. 11.

92 Mr Graham Kraak, Queensland Health, *Committee Hansard*, 23 February 2017, p. 12.

Competition within the sector

2.78 Submitters also expressed concerns about competition for workers within the aged care sector, particularly competition between the public sector and not-for-profit sector.⁹³

2.79 Port Augusta City Council described to the committee their experience competing with the public sector for workers, stating:

We have continuing issues attracting and retaining qualified staff particularly – registered nurses and enrolled nurses – mainly due to the fact that we are competing with the local hospital and Port Augusta prison. Public sector employees are paid at higher rates and also have the benefit of more attractive salary-sacrificing options here in Port Augusta.⁹⁴

2.80 Scope Home Access also described their difficulties competing with government for allied health workers:

...with allied health workers, our real problem in recruiting, irrespective of whether it is rural, remote, regional or metro, is trying to compete with government salary levels...We just cannot meet those salaries unless we have plenty of access to salary sacrifice and opportunities to provide conditions that would be different from the government jobs that are out there.⁹⁵

2.81 Yass Valley Aged Care Ltd agreed with these concerns, submitting that the 'pay differentials between aged care and acute care nursing staff' makes it difficult to compete for young nurses entering the health sector.⁹⁶

Committee view

2.82 The committee is concerned about the increased pressure the rollout of the NDIS is predicted to have on competition for skilled workers. The committee considers that there is potential for the aged care and disability sector to invest in new innovations to share workers across these sectors, such as creating a combined workforce pool and establishing collaborative care arrangements.

93 See, for example: The Salvation Army Aged Care Plus, *Submission 183*, p. 4; Presbyterian National Aged Care Network, *Submission 190*, p. 3; Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 1; Scope Home Access, *Committee Hansard*, 7 March 2017, p. 12.

94 Mrs Anne O'Reilly, Port Augusta City Council, *Committee Hansard*, 7 March 2017, p. 1.

95 Ms Anne Reeve, Scope Home Access, *Committee Hansard*, 6 March 2017, p. 12.

96 Yass Valley Aged Care, *Committee Hansard*, 6 March 2017, p. 32.

Chapter 3

Attracting, training, and retaining aged care workers

...to ensure quality care, aged care services must have adequate numbers of skilled, qualified staff committed to providing person-centred care. The workforce must have appropriate education, training, skills and attributes to provide quality care for older people, including people with dementia, who frequently have complex care needs. To attract and maintain the right workforce, equitable pay conditions and appropriate career paths will be needed.¹

3.1 As Australia's aged population continues to grow, demand for aged care workers will also grow. This creates opportunities for people looking to pursue a career in aged care, but also creates challenges for the sector in attracting, training and retaining a sufficient workforce. Indeed these challenges are already being faced across the sector with providers reporting skills shortages and significant difficulties recruiting and retaining appropriately qualified staff. In order to meet future needs it will be crucial for the sector to adapt and adopt strategies that will ensure it is able to attract and retain a highly skilled and well trained workforce.

3.2 This chapter examines:

- the key challenges in attracting and retaining workers to the aged care sector;
- staffing ratios in residential aged care facilities; and
- the adequacy of training provided by Registered Training Organisations (RTOs).

Key challenges in attracting and retaining workers

3.3 As discussed in Chapter 2, the aged care workforce needs to grow by about two per cent annually in order to meet future demand. However, evidence received by the committee indicates that the aged care sector is already struggling to attract and retain skilled workers. This presents significant challenges for the sector in developing its workforce now and into the future.

3.4 Submitters argued that the key challenges in attracting and retaining workers arise from:

- poor sector reputation;²
- poor working conditions, including high client-staff ratios;³

1 Professor Graeme Samuel, Alzheimer's Australia, *Committee Hansard*, 3 November 2016, p. 29.

2 See, for example: Mrs Anne O'Reilly, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 5; Occupational Therapy Australia, *Committee Hansard*, 25 October 2016, p. 1; Mr Graham Kraak, Queensland Health, *Committee Hansard*, 23 February 2017, p. 11.

- a lack of career paths and professional development opportunities;⁴ and
- low rates of remuneration⁵.

3.5 These challenges are particularly acute for care providers in regional and remote areas of Australia, which submitters suggested experience additional 'challenges in accessing the necessary workforce to provide services to older Australians living in these areas'.⁶ The particular challenges faced by regional and remote care providers are discussed in Chapter 4.

Reputation

3.6 The committee heard that the poor reputation and perceptions of the aged care sector are major barriers to recruiting and retaining newly qualified graduates and people looking for work in the health and community sectors.

3.7 Professor Melanie Birks from James Cook University described to the committee the negative perceptions around aged care work:

...there is a perception that aged care nursing is less glamorous than nursing in the acute care sector. This perception is fed by a belief that nurses working in an aged-care setting require a lower skill set than those working elsewhere, and often there is this perception...that nurses who work in aged care work there because they could not get another job in another setting.⁷

3.8 These perceptions appear to develop early, with many nursing students indicating that they do not view aged care as an attractive career choice.⁸

3.9 For example, the Healthy Ageing Research Group (HARG) from La Trobe University submitted that undergraduate and graduate nurses generally prefer not to work in aged care settings.⁹ Some submitters attributed such preferences to a lack of

3 See, for example: Mr Tim Jacobson, Health Services Union, *Committee Hansard*, 28 April 2016, p. 9.

4 See, for example: Queensland Heath, *Committee Hansard*, 23 February 2017, p. 11; Northern Regional Aboriginal and Torres Strait Islander Corp., *Committee Hansard*, 23 February 2017, p. 19; Palms Aged Care, *Committee Hansard*, 23 February 2017, p. 2; MacDonnell Regional Council, *Committee Hansard*, 26 October 2016, p. 2; Southern Cross Care for Facility Pearl Supported Care, *Committee Hansard*, 25 October 2016, p. 10.

5 See, for example: MacDonnell Regional Council, *Committee Hansard*, 26 October 2016, p. 2; Southern Cross Care for Facility Pearl Supported Care, *Committee Hansard*, 25 October 2016, p. 10; Occupational Therapy Australia, *Committee Hansard*, 25 October 2016, p. 12; Anglicare Australia, *Committee Hansard*, 3 November 2016, p. 21; NSW Nurses and Midwives' Association, *Committee Hansard*, 3 November 2016, p. 54.

6 Aged and Community Services Australia, *Submission 229*, p. 2.

7 Professor Melanie Birks, James Cook University, *Committee Hansard*, 23 February 2017, p. 46.

8 See, for example: Professor Melanie Birks, James Cook University, *Committee Hansard*, 23 February 2017, p. 46; Healthy Ageing Research Group, La Trobe University, *Submission 237*, p. 8.

9 Healthy Ageing Research Group, *Submission 237*, p. 8.

exposure to aged care practice in clinical placements and poor understanding of aged care as a complex specialist environment.¹⁰

3.10 Benetas, a not-for-profit aged care provider in Victoria, submitted that 'the reputation of the Aged Care sector needs to be repositioned'.¹¹ Aged Care Illawarra Action Group (ACIWAG) agreed, submitting that aged care work needs to be promoted as highly skilled and rewarding, with multiple opportunities for career advancement.¹² Services for Australian Rural and Remote Allied Health (SARRAH) suggested a marketing campaign that highlights the benefits of working in aged care, would assist to attract a workforce, particularly in regional and remote areas.¹³

3.11 These and other submitters argued that Government has an important role in assisting to reposition the reputation of aged care within the health and community services industry.¹⁴ ACIWAG suggested that government and industry should work together to increase the profile of aged care by building on the work already being undertaken by ACIWAG in a regional context:

ACIWAG has responded to the competition for workers through the kinds of marketing collateral developed, a vibrant social media presence and the conduct of an annual Careers Expo for the sector. This work at a regional level could be greatly enhanced if supported by government initiatives that reinforced its key messages.¹⁵

3.12 However, submitters also noted the importance of ensuring that the sector attracts the 'right' type of workers.¹⁶ Submitters argued that people not only require the appropriate subject matter knowledge and practical competencies to be suited to work in aged care, but must also possess the necessary soft skills required by the

10 See, for example: Dementia Training Study Centres, *Submission 76*, p. 3.

11 Benetas, *Submission 78*, p. [2].

12 Aged Care Illawarra Workforce Action Group, *Submission 148*, p. [2].

13 Services for Australian Rural and Remote Allied Health, *Committee Hansard*, 3 November 2016, p. 13.

14 See for example, Benetas, *Submission 78*, p. [2]; Aged Care Illawarra Workforce Action Group, *Submission 148*, p. [2].

15 At a regional level ACIWAG has been working to 'enhance community awareness about the Aged Care sector and improve its visibility in the community' through the Illawarra Regional Workforce Planning Strategy for the Aged Care Sector. The strategy involves a wide range of promotional activities, including production of promotional material, conducting career expos, promoting government programs and using social media platforms to advance the aged care sector. See: Aged Care Illawarra Workforce Action Group, *Submission 148*, p. [2].

16 Illawarra Forum, *Submission 212*, p. [7].

work.¹⁷ Such soft skills include communication, empathy, and ability to work as a member of a team.¹⁸

3.13 For example, Jewish Care Victoria submitted that some people only choose to work in aged care because they are unable to find work elsewhere:

There is a cohort of those drawn to do a Certificate III in aged care because they cannot find jobs in their preferred field or their qualifications (obtained overseas) are not recognised in Australia...These workers are often frustrated and demotivated doing roles that they deem 'beneath them' due to the poor perception of aged care work. This sometimes has ramifications in terms of the quality of care they provide...¹⁹

Committee view

3.14 The committee notes the concerns raised by aged care workers and providers about the poor reputation attached to working in the aged care sector, and the impact this has on attracting and retaining workers in the sector.

3.15 The committee also notes some of the innovative approaches being taken to try to change the negative image of the aged care industry.

3.16 The committee further notes that, underlying this negative image, are some key workforce factors outlined below, that, if addressed, would also help to change how potential aged care workers view the industry.

Working conditions

3.17 The aged care sector is generally associated with poorer working conditions than comparable areas of the health and community services sector.²⁰

3.18 The committee heard evidence from several nurses and personal care workers who described aged care as an unhappy and stressful environment in which to work due to:

- high resident to staff ratios, resulting in high workload pressures;²¹
- low registered nurses to personal care attendant ratios;²²
- working longer hours to cover staff shortages;²³ and

17 See, for example, Dr Richard Curtin, Public Policy Consultant and Visiting Fellow, Australian National University, *Submission 168*, p. 11; Dr Michael Bauer, Australian Centre for Evidence Based Aged Care, La Trobe University, *Committee Hansard*, 28 April 2016, p. 28.

18 See, for example: Dr Richard Curtin, *Submission 168, Attachment one*, p. 11; Department of Health, *Submission 293*, p. 51.

19 Jewish Care Victoria, *Submission 109*, p. 4.

20 Healthy Ageing Research Group, La Trobe University, *Submission 237*, p. 10.

21 See, for example: Name withheld, *Submission 10*, p. 2; Name withheld, *Submission 66*, p. 2.

22 See, for example: Ms Marilyn Murray, *Submission 39*; Name withheld, *Submission 224*, p. 3.

23 See, for example: Name withheld, *Submission 81*, p. 1; Name withheld, *Submission 161*, p. 2; Name withheld, *Submission 257*, p. 1.

- an increase in strenuous activity, and workplace injury (related to an increase in complex care needs).²⁴

Workload pressures

3.19 The committee received evidence that direct care workers are managing workloads that are unsustainable, leading to compromised professional standards and quality of care, as well as adverse impacts on workers.

3.20 Nurses working in aged care expressed particular concern about their ability to manage workloads as well as supervise other staff. For example, the Queensland Nurses' Union submitted that as the numbers of RNs on shift at any one time has declined, increased workloads have been placed on remaining RNs to supervise a greater number of carers, diminishing RNs ability to provide quality care to patients.²⁵

3.21 The Australian Nursing and Midwifery Federation (ANMF) included in its submission short statements from some of its members who described the workload pressures for nurses in residential care:

I am still unable to leave my section in the morning between 6-7am as there is no staff member to supervise the section, if I ask for help from another staff member then that staff member will be leaving their section unattended and they also will not be able to complete their round compromising resident care.

I am unable to safely complete my clinical responsibilities to residents. One section upstairs is not safe for only one staff member to work there, the residents are highly confused/delirious and are at high risk for falls. Wanderers, aggressive and physically abusive toward staff and other residents, they are mostly needing two staff to assist with care, and there is only one staff member to look after them all.²⁶

3.22 Mrs Sonya Peck, an RN and member of the ANMF also explained to the committee at its Launceston hearing, the immense workload pressures and competing priorities nurses in residential facilities face:

As registered nurses we look after up to 36 patients per wing. From the time the nurses hit the floor they are running to have their handover, count medications, get their pill rounds started, and do their wound care and direct staffing care. They are just the general aspects. You also have admissions. For example, in the last few weeks we have had seven new admissions to one wing. It really did put a great deal of extra workload onto the registered nurses to complete all the paperwork in a timely manner and to get the ACFI funding assessments started. It also took time away from direct

24 See, for example: Presbyterian National Aged Care Network, *Submission 190*, p. 4; Healthy Ageing Research Group, La Trobe University, *Submission 237*, p. 10; Mr Tim Jacobson, Health Services Union, *Committee Hansard*, 28 April 2016, p. 9; Doctor Jodi Oakman, La Trobe University, *Committee Hansard*, 28 April 2016, p. 14.

25 Queensland Nurses' Union, *Submission 215*, p. 4.

26 Australian Nursing and Midwifery Federation, *Submission 225*, p. 22.

patient care, because you only have so many hours to do that care and then you have to move on to your paperwork...

Nurses do not take breaks. They are unpaid for their half-hour meal breaks and very rarely do any of our nurses take it, because they cannot get through their workloads. The cuts at the moment are also impacting on our work. We are having to do extra pain management – to make sure our residents are not in pain, we have added massages which the physios were doing – and that is an extra 40 minutes plus a day that can be added into the nurses' time...Most of the residents do not finish on time; most of the nurses are rostered off dayshift to finish at 2.45 but you can still see the bulk of them sitting there from 3.30 to 4 o'clock completing paperwork and patient care. They are not paid for that time – it is not authorised overtime – but they are not willing to walk away and leave care, even though they may be directed to hand it over. The next shift is also extremely busy. We cannot do all the work we are expected to do in our time frame. Sometimes you are actually threatened with disciplinary action if you do not complete what is expected of you on your shift. They are not giving you new strategies on how to fit this workload in.²⁷

Workplace health and safety

3.23 The incidence of workplace injuries has increased as the needs of patients have become more complex and workload pressures have risen. For example, the Health Services Union (HSU) told the committee that physical injury rates, such as back, neck and shoulder injuries, are high, but that mental health issues are also increasing, largely due to high workload and stress related issues.²⁸

3.24 The HARG noted that residential work in particular is recognised as being physically and emotionally demanding, which can lead to risks to employee health and wellbeing. Such risks may include development of work-related musculoskeletal disorders, low job satisfaction and poor health.²⁹

3.25 In its submission the Health Workers Union (HWU) noted that it has represented members who have sustained injuries and musculoskeletal disorders from aged care work. While manual handling aids are available to avoid such injuries, the HWU suggested they are not being widely utilised because there are insufficient staff to help operate the devices, causing workers to lift and transport patients without proper supports.³⁰

27 Mrs Sonya Peck, Australian Nursing and Midwifery Federation, *Committee Hansard*, 31 October 2016, p. 11.

28 Mr Tim Jacobson, National Assistant Secretary, Health Services Union, *Committee Hansard*, 28 April 2016, p. 9.

29 Healthy Ageing Research Group, La Trobe University, *Submission 237*, p. 10.

30 Health Workers Union, *Submission 248*, pp. 46-47.

3.26 The HWU also noted that it has received reports from its members that some clients also direct verbal and physical abuse toward staff, which can also lead to injury.³¹

3.27 The New South Wales Nurses and Midwives' Association (NSWNMA) echoed these concerns, submitting that:

Over 90% of 'aged care workers had been subject to some form of aggression from residents so it is unsurprising that workers are not only demotivated to work in aged care, but quickly seek alternative employment in lower risk environments.³²

3.28 An example of the injuries and abuse workers in aged care facilities may experience was provided by Ms Jude Clarke, a delegate of United Voice, at the committee's hearing in Perth:

My injuries over the years – I have had broken wrists from residents grabbing on, saying, 'No I don't want to be moved. I don't want to shower. I'm not going to eat,' so they grab your wrists. Your wrists get pretty tender after a while, so I have had both wrists broken quite a few times. I have my arm pulled out of its socket and ribs taken off the front and back by that injury. That took me two years to come back from...

...I have been stabbed with scissors. I have been stabbed with forks. I have been pushed, punched, kicked, had hair pulled out...That is the risk that we take every day when we are out on the floor.³³

3.29 Professor Yvonne Wells, Coordinator at the HARG, told the committee that the working environment in aged care facilities, particularly the physical and emotional demands of the work, impacts staff attrition, attraction and retention, and provision of quality of care.³⁴

Committee view

3.30 The committee is concerned at the evidence presented to it in relation to poor working conditions and threats to workers' health and safety, which the committee has heard are impacted by issues including insufficient staffing levels and the need for existing staff to cover staff shortages. These issues in turn impact on the quality of care, and contribute to the poor reputation of the industry.

3.31 The committee considers poor working conditions an urgent matter given the impacts on the need to grow and sustain the aged care workforce and on the ability of staff to deliver a standard of care expected by the community.

31 Health Workers Union, *Submission 248*, pp. 46.

32 NSW Nurses and Midwives Association, *Submission 134*, p. 19.

33 Ms Jude Clarke, United Voice, *Committee Hansard*, 27 September 2016, p. 50.

34 Professor Yvonne Wells, Healthy Ageing Research Group, *Committee Hansard*, 28 April 2016, p. 13.

Lack of career paths

3.32 Lack of clear career paths and opportunities for professional development were cited by various submitters as disincentives for people to work and stay in the aged care sector.³⁵ This was felt across a broad range of skill levels, from personal care workers through to nurses and allied health professionals.³⁶

3.33 For example, JewishCare Victoria submitted:

Career paths are not well defined or articulated for most aged care workers and there is an inconsistent approach within the industry for career and succession planning that feeds into a public perception of a 'dead end' career.³⁷

3.34 The Quality Aged Care Action Group Incorporated also argued that 'there is no career pathway in aged care', and suggested that workers are not rewarded for seeking to enhance their qualifications:

Those workers who do gain extra qualifications in palliative care or gerontology do not get any extra pay, even if they achieve post graduate qualifications. We want to encourage expert knowledge in aged care but we don't reward or value it.³⁸

3.35 Doctor Linda Isherwood, Research Fellow at the National Institute of Labour Studies commented that qualitative research and interviews of nurses and personal care workers in aged care showed that workers 'did not feel there were sufficient career pathways once you were in aged care' and were keen to upskill and assume more responsibility, such as supervisory roles or more clinical responsibility.³⁹

3.36 The NSWNMA agreed, submitting that many workers are passionate about working in aged care, but 'feel stifled in their roles due to a lack of a structured career pathway and very few nurse practitioner and/or leadership opportunities'.⁴⁰ Ms Brenda Oganyo from United Voice also told the committee that 'there is zero progression for the personal-care workforce within the industry'.⁴¹ One of the biggest challenges for aged care workers in respect of career progression appears to be the lack of 'expert roles' which they can strive to progress towards.⁴²

35 See, for example: Mrs Hazel Gordon, Wattle Hill Lodge Inc, *Committee Hansard*, 28 September 2016, p. 30.

36 See, for example: Mrs Hazel Gordon, Wattle Hill Lodge Inc, *Committee Hansard*, 28 September 2016, p. 30.

37 JewishCare Victoria, *Submission 109*, p. 4.

38 Quality Aged Care Action Group Incorporated (QACAG Inc), *Submission 182*, p. 4.

39 Doctor Linda Isherwood, National Institute of Labour Studies, Flinders University, *Committee Hansard*, 7 March 2017, p. 46.

40 NSW Nurses and Midwives' Association, *Submission 134*, p. 20.

41 Ms Brenda Oganyo, United Voice, *Committee Hansard*, 27 September 2016, p. 51.

42 NSW Nurses and Midwives' Association, *Submission 134*, p. 20.

Mechanisms to address lack of career paths

3.37 Queensland Health suggested that a career structure in aged care would help to attract more workers to the sector. Queensland Health explained to the committee the career structure that it currently has in place:

We have nurse unit managers, clinical nurse consultations and registered nurses providing clinical support. They are also linked into hospitals and can access the clinical services that are needed. The aged care industry does not have that. I think those are the sorts of things that would make the aged-care sector a bit more of an attractive service to come to.⁴³

3.38 Representatives of James Cook University agreed that a career structure for aged care workers would make the sector more attractive for people who want to pursue a career in nursing. Ms Jennifer Davis suggested a model which offers a graduate entry program into aged care, and pathway opportunities into higher qualification, such as upskilling to a nurse practitioner.⁴⁴

3.39 The Australian Council of Trade Unions (ACTU) were also supportive of establishing a career structure for the sector, suggesting that pathway options to undertake specialised training, such as in dementia or palliative care, mentoring new entrants and graduates and developing career pathways linked to wage progression should all be examined as options.⁴⁵

3.40 The Department of Health (department) has stated that consideration of initiatives to establish career opportunities for people in the aged care sector is a matter for service providers and the industry to manage, and further that:

The department's view is that setting minimum standards and having lots of rules about how people should be employed and what mix and all those sorts of things actually creates some problems due to the diversity of what may be required by a small community-based provider in a remote community versus a large commercial provider in an urban centre. So there is not a one-size-fits-all model here.⁴⁶

Committee view

3.41 The committee notes that career paths in the aged care sector are not clearly defined, and play a role in the inability of the sector to attract and retain staff. While some providers rely on their own career structure initiatives to attract workers, there is an inconsistent approach within the industry to career planning and succession, with other providers offering limited or no career and development opportunities.

43 Mr Graham Kraak, Queensland Health, *Committee Hansard*, 23 February 2017, p. 13.

44 Ms Jennifer Davis, James Cook University, *Committee Hansard*, 23 February 2017, p. 48.

45 Australian Council of Trade Unions, *Submission 254*, p. 4.

46 Ms Catherine Rule, Acting Deputy Secretary, Department of Health, *Proof Committee Hansard*, 13 June 2017, p. 3.

3.42 The committee commends those providers who have established their own career structures and continuing professional development models for their staff. The committee agrees that such models should be explored to identify best practice models that could be replicated nationally across the industry.

Remuneration

3.43 Aged care workers, both skilled and semi-skilled, are paid significantly less than similarly qualified workers in comparative sectors. The wage disparities between the aged and acute care sector, for example, cause many nurses and PCAs to feel undervalued and underpaid in their roles.⁴⁷

3.44 Submitters highlighted the low rates of remuneration as one of the key barriers to recruiting and retaining workers in the aged care sector.⁴⁸

Nurses and personal care workers

3.45 Individuals and organisations submitted that the remuneration rates for nurses and personal care workers in aged care are:

- less than wages paid in the health and disability sectors for equivalent roles;⁴⁹ and
- not reflective of the value and responsibility of the work.⁵⁰

3.46 Remuneration for nurses in the aged care sector is significantly lower than for nurses working in the acute care sector. The committee received evidence that RNs and ENs are paid about 100 dollars less per week in aged care than acute care.⁵¹ The wage disparity between the two sectors creates significant difficulties for aged care providers to compete for nurses, and undervalues the important work of nurses in aged care.

3.47 For example, the ANMF commented that the low remuneration levels undervalue aged care work:

47 Australian Nursing and Midwifery Federation, *Submission 225*, p. 19.

48 See, for example: Catholic Care Wollongong, *Committee Hansard*, 6 March 2017, p. 9.

49 See, for example: Healthy Ageing Research Group, La Trobe University, *Submission 237*, p. 7; Australian Council of Trade Unions, *Submission 254*, p. 3; Queensland Nurses' Union, *Submission 215*, p. 9.

50 See, for example: Quality Aged Care Action Group, *Submission 182*, p. 4; Australian Nursing and Midwifery Federation, *Submission 225*, p. 18; Mr Tim Jacobson, Health Services Union, *Committee Hansard*, 28 April 2016, p. 7; Professor Sara Charlesworth, RMIT University, *Committee Hansard*, 28 April 2016, p. 19; Professor Melanie Birks, James Cook University, *Committee Hansard*, 23 February 2017, p. 49.

51 Doctor Ann Harrington, School of Nursing and Midwifery, *Committee Hansard*, 7 March 2017, p. 43. See also, WA Primary Health Alliance, *Committee Hansard*, 28 September 2016, p. 12. The Australian Nursing and Midwifery Federation also submitted that the wage difference between a full time registered nurse level 1 in the public sector compared to residential aged care is 200 dollars, or 15 per cent per week calculated on a base rate. See: Australian Nursing and Midwifery Federation, *Submission 225*, p. 19.

The pay for the majority of aged workers, both skilled and semi-skilled, simply does not reflect the nature of the work and the level of responsibility required nor does it value the importance of providing the best care possible to Australia's frail elderly.⁵²

3.48 The NSWNMA agreed that aged care work is undervalued stating that aged care workers are paid significantly less than people working in other sectors that require comparatively lower skills and training:

...across all comparable types of jobs people at the checkout get paid better than assistants in nursing; people who are supervising a small division get paid better than an assistant in nursing with a certificate III who is termed a team leader.⁵³

3.49 Unions and employee representatives have raised concerns that the changing aged care sector will adversely impact on the pay and conditions of aged care sector workers. For example, unions have noted that in the scheduled 4 yearly reviews of the Aged Care and Social, Community, Home Care and Disability Services Industry awards by the Fair Work Commission, which are currently under way, some employer groups have made submissions seeking to:

remove the requirement for a regular pattern of hours. In other words, a part-time employee, if they are successful with their award change, would only need to be given a minimum number of hours that is less than 38 but could be expected to work fluctuations on that, week-in week-out, day-in day-out, without considering the needs of that worker and their own caring needs or family responsibilities.⁵⁴

3.50 Further, Professor Sara Charlesworth of the School of Management at RMIT University argued that the introduction of CDC is being used by employer groups to argue for further eroding aged care workers' entitlements:

Aged Care Employers (ACE) argued in a submission to the Fair Work Commission that ACTU claims for some improvement of conditions for casual and part-time workers 'all run contrary to CDC in that they all reduce flexibility, increase regulation, increase costs and put significant barriers in the way of CDC'.⁵⁵

3.51 The committee has also heard about the growth in 'zero hour contracts', which seem to be increasingly used by aged care service providers instead of permanent, regular work contracts. United Voice, a union which represents a range of employee groups in the aged care sector, including personal carers, gardeners, cooks and cleaners, submitted that:

52 Australian Nursing and Midwifery Federation, *Submission 225*, p. 18.

53 Mr Brett Holmes, NSW Nurses and Midwives' Association, *Committee Hansard*, 3 November 2016, p. 54. See also: Mrs Anne O'Reilly, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 2.

54 Mr Robert Moore, Assistant State Secretary, Health Services Union Tasmania Branch, *Committee Hansard*, 31 October 2016, p. 19.

55 Professor Sara Charlesworth, *Submission 290*, p. 4.

Such contractual arrangements provide workers with no guaranteed weekly hours and thus no guaranteed weekly income. The employer is not obliged to provide the worker with any minimum working hours, and the worker is not obliged to accept any of the hours offered.⁵⁶

3.52 The committee heard that the impact of these kinds of contractual arrangements on both employees and the quality of care available to aged care service users can be significant. For employees, it can mean a high degree of uncertainty about income and hours to be worked, which in turn affects the ability to manage financial affairs and plan, placing 'particular strains on families'.⁵⁷ For people accessing aged care services, Professor Sara Charlesworth argued that:

Good quality care in both residential and community-case based settings requires a stable workforce, adequate staffing and an appropriate staff mix, as well as working conditions that allow workers the time to develop and maintain care relationships with the elderly and importantly to use their skills.⁵⁸

Allied health and medical professionals

3.53 The committee also received evidence from allied health and medical professionals that the aged care sector is not an attractive career choice due to the low rates of pay.⁵⁹

3.54 For example, at the committee's Melbourne hearing, the Royal Australian College of General Practitioners told the committee that general practitioners (GPs) receive higher pay when working in a clinic compared to an aged care facility, with estimates that 50 per cent of the work of GPs in residential care is unfunded.⁶⁰ The wage disparity between clinical and residential care, means that aged care work is often a last choice for AHPs and GPs.

Mechanisms to improve remuneration

3.55 To overcome issues regarding remuneration, submitters supported a strategic approach whereby the Australian Government works together with industry to develop a strategy to improve remuneration in the aged care sector.⁶¹ For example, Leading Aged Services Australia (LASA), a peak body for service providers, suggested that

56 United Voice, *Submission 247*, pp. 15-16.

57 Mr Robert Moore, Assistant State Secretary, Health Services Union Tasmania Branch, *Committee Hansard*, 31 October 2016, p. 23.

58 Professor Sara Charlesworth, *Submission 290*, p. 4.

59 Ms Jaci Armstrong, Guide Dogs Australia, *Committee Hansard*, 28 April 2016, p. 53.

60 Dr Beres Wenck, Royal Australian College of General Practitioners, *Committee Hansard*, 28 April 2016, pp. 34-35.

61 Australian Nursing and Midwifery Federation, *Submission 225*, pp. 19, 21; Australian College of Nursing, *Submission 285*, p. 16.

government should work with stakeholders to co-design a workforce strategy that includes a focus on remuneration.⁶²

3.56 The ANMF suggested that any future remuneration measure would need to ensure wage parity with the health and disability sector and be able to respond to indexation:

A mechanism which ensures the aged care sector achieves and maintains wage parity with the acute care sector must be developed. Such a mechanism must respond to changes in wage rates and accommodate an effective indexation system that provides employers with adequate funds when wage rises are negotiated. It must also incorporate a transparent and accountable process/framework.⁶³

3.57 IRT Group and the ACTU also suggested that portability of entitlements, such as accrued leave, would encourage mobility in the industry and help to attract people to the sector.⁶⁴

3.58 Submitters suggested that low remuneration is intrinsically linked to insufficient funding, and that government needs to increase funding in order for the sector to improve remuneration.⁶⁵

Committee view

3.59 The committee notes the inconsistency between the pay and conditions enjoyed by acute health care and disability workers compared to those available in the aged care sector. The committee also notes that aged care remuneration is often lower than less skilled jobs, or those with less responsibility, in other sectors.

3.60 The committee is concerned that pay and conditions for workers in the aged care sector are becoming more uncompetitive with other sectors. The committee considers that the move to 'zero hour' contracts, which are intended to provide flexibility for aged care service providers, but which have the impact of further marginalising aged care sector workers, is making the industry a less attractive alternative for workers.

3.61 Remuneration in the aged care sector will clearly affect the ability of the sector to grow to meet the needs of the ageing population.

Lack of funding

3.62 Several aged care providers argued that their ability to attract and retain workers would be enhanced if they received greater funding which would make them

62 Leading Aged Services Australia, *Submission 222*, p. 8.

63 Australian Nursing and Midwifery Federation, *Submission 225*, p. 21.

64 IRT Group, *Committee Hansard*, 6 March 2017, p. 21; Australian Council of Trade Unions, *Submission 254*, p. 4.

65 See, for example: Palms Aged Care, *Committee Hansard*, 23 February 2017, p. 2; Palm Island Aboriginal Shire Council, *Committee Hansard*, 23 February 2017, p. 25; Australian Council of Trade Unions, *Submission 254*, p. 3.

more competitive.⁶⁶ Submitters expressed concerns that reductions in funding to the for-profit sector, in particular, has increased competition for workers, and hindered their ability to attract a workforce.⁶⁷

3.63 For example, at the committee's Bunbury hearing, Hall and Prior Health and Aged Care Group told the committee that the loss of payroll tax funding for for-profit providers has made it harder to compete for staff with not-for-profit providers, such as churches and charities who can utilise tax deductibility status for salary-sacrificing options which reduce wage costs.⁶⁸

3.64 Juniper also told the committee that the successive reductions in funding across a range of programs have impacted their ability to support staff to seek to 'improve their skills, knowledge and qualifications'.⁶⁹ At the committee's hearing in Broome, Mrs Raelene Siford, the Executive Manager, Residential, at Juniper told the committee that:

The funding that is allocated to aged care is really designed around services that operate in the metro or rural areas of Australia. It certainly does not take into account costs associated with the remoteness of services in the Kimberley. A number of examples of those costs are employing staff. The cost of transferring them from a metro site to the country can be up to \$12,000 just to get them up there. That is the cost of flights, transferring their furniture—all their goods and chattels—and you do not have that cost in the metropolitan areas or the rural areas. But there is no recompense designed to meet the needs of the Kimberley for anything like that in the funding models.⁷⁰

Committee view

3.65 The committee acknowledges concerns that reductions in funding have impacted the sector's ability to recruit and retain workers, and offer higher rates of remuneration.

3.66 The committee notes that the Government committed in its 2017-18 Budget to provide funding to assist providers in rural and regional areas, in particular, to grow their workforce. The committee is of the view that this is an important first step to addressing the impact previous reductions in funding have had on the sector.

66 See, for example: Ms Joanne Christie, The Bethanie Group Inc, *Committee Hansard*, 28 September 2016, p. 1.

67 Mr Graeme Prior, Hall and Prior Health and Aged Care Group, *Committee Hansard*, 28 September 2016, p. 25.

68 Mr Graeme Prior, Hall and Prior Health and Aged Care Group, *Committee Hansard*, 28 September 2016, p. 25.

69 Mrs Margaret Antonucci, Juniper, *Committee Hansard*, 27 September 2016, p. 9.

70 Mrs Raelene Siford, Executive Manager Residential, Juniper, *Proof Committee Hansard*, 9 June 2017, p. 2.

Staffing ratios

3.67 Several submitters expressed concerns that the ratio of registered nurses, personal care attendants and clients leads to poor quality of care and stressful working conditions. To overcome this issue, some submitters supported the introduction of mandatory staffing ratios.

3.68 However, the committee also heard evidence from a number of submitters who were not supportive of mandated staffing ratios, mostly because they considered it would not resolve issues and would impose unnecessary regulatory burden and expense on the sector.⁷¹

3.69 The committee understands that mandated staff ratios in the aged care sector are not currently government policy.

3.70 ⁷²This section examines the various arguments presented to the committee for and against government regulation of mandatory minimum staffing ratios in aged care.

Mandated staffing ratios: the case for

3.71 Some submitters supported the introduction of mandatory staffing ratios due to concerns that staff and clients are not adequately supported. In particular, the committee heard that there are not enough nurses in some facilities to provide appropriate medical care.⁷³

3.72 The ACTU was supportive of mandated ratios on the basis it would improve the quality of care delivered, and reduce unsafe work practices:

We are concerned that high [patient to staff] ratios are creating unreasonably high workloads, leading to unsafe work practices that compromise both patient and carer safety. Consideration should be given to requiring aged care providers to publish minimum staff/patient ratios which, which will enable older Australians to make informed choices about their care and support.⁷⁴

3.73 The ANMF suggested that mandated ratios would lead to better outcomes for patients, and reduce health costs, as has been observed in the acute care sector:

In the acute setting, the implementation of safe mandated minimum staffing has been shown to prevent adverse incidents and outcome, reduce mortality and prevent readmissions thereby cutting health care costs. It is widely

71 See, for example: Jewish Care Victoria, *Submission 109*, p. 4.

72 Ms Catherine Rule, Acting Deputy Secretary, Department of Health, *Proof Committee Hansard*, 13 June 2017, p. 1.

73 See, for example: Name withheld, *Submission 117*, p. 1; Name withheld, *Submission 260*, p. 1; Name withheld, *Submission 66*, p. 1; Australian Council of Trade Unions, *Submission 254*, p. 3; Australian Nursing and Midwifery Federation, *Submission 225*, p. 23; Australian Medical Association, *Committee Hansard*, 3 November 2016, p. 13; Combined Pensioners & Superannuants Association of NSW Inc, *Submission 295*, p. 15.

74 Australian Council of Trade Unions, *Submission 254*, p. 3.

agreed that the same improvements could be achieved in the aged care sector.⁷⁵

3.74 The HWU agreed, submitting that the aged care sector should have mandated staff-to-patient ratios as is the case in comparable health and community sectors, such as hospitals and child care centres.⁷⁶

3.75 The committee also received evidence from some submitters that mandated staffing ratios would assist to retain workers who can become too stressed by high workload pressures, and consequently choose to leave aged care for sectors with better working conditions.⁷⁷

Mandated staffing ratios: the case against

3.76 The committee received evidence from several aged care providers who did not support mandatory staffing ratios. Providers argued that ratios could stifle innovation. Providers also suggested that mandatory ratios are incompatible with consumer directed care which is expected to change the role of rostering and service provision to be customer, rather than industry led.⁷⁸

3.77 For example, LASA, submitted that a mandatory staff ratio is a 'blunt instrument' that does not take into account changing care needs or acknowledge the broad-ranging skills of the workforce.⁷⁹

3.78 JewishCare Victoria agreed stating that it does not support mandated staffing ratios as it considers quality 'care is achieved through adequate training and competency...and not through additional staff'.⁸⁰

Alternative model: mandated minimum nursing numbers

3.79 An alternate approach to mandated staffing ratios is mandatory minimum nursing numbers.

3.80 Prior to July 2014, all designated 'high care' facilities in NSW were required to have an RN on duty at all times. Following changes to Commonwealth legislation which resulted in the removal of that requirement, the NSW Government agreed to maintain mandated minimum nursing requirements for facilities formerly designated

75 Australian Nursing and Midwifery Federation, *Submission 225*, p. 23.

76 Health Workers Union, *Submission 248*, p. 43.

77 See for example, Health Workers Union, *Submission 248*, p. 43; Queensland Nurses' Union, *Submission 215*, p. 12.

78 See, for example: Resthaven, *Submission 140*, p. 6; HammondCare, *Submission 209*, p. 4; JewishCare Victoria, *Submission 109*, p. 4.

79 Leading Aged Services Australia, *Submission 222*, p. 10.

80 JewishCare Victoria, *Submission 109*, p. 4.

as 'high care'.⁸¹ In October 2015, an inquiry into RNs in NSW nursing homes, conducted by the NSW General Purpose Committee No. 3, recommended that the requirement for all aged care facilities to have a RN on duty at all times be reintroduced in legislation, and extended to all facilities with residents with high care needs.⁸²

3.81 Submitters to the NSW inquiry highlighted the success mandatory minimum nursing requirements have had in NSW in ensuring the provision of quality care, and improving health outcomes for patients.⁸³

3.82 Ms Jan Barham MLC, former Chair of the General Purpose Committee No. 3, submitted to this inquiry that the mandatory nursing requirement should be implemented across the Commonwealth.⁸⁴

3.83 Ms Jennifer Davis from James Cook University was supportive of establishing a mandatory minimum nursing requirement, stating that if the Commonwealth government does not introduce mandated ratios it should:

At least establish a minimum...It does not necessarily have to dictate numbers, as such, but I think there needs to be an established minimum where you can actually demonstrate that there has been someone with a critical clinical eye who knows the clients and what their health needs are.⁸⁵

3.84 The NSWNMA was also supportive of the viewpoint that residential aged care facilities should be required to have nursing staff rostered at all times.⁸⁶

3.85 A representative of the Health Services Union (HSU) indicated support for an examination of ratios or some other means to ensure appropriate staffing levels in residential aged care facilities:

There are a couple of different models, and ratios is certainly one that I think has some merit, because we are seeing a severe lack of staff in residential aged care, and we would certainly support a model that would see better and safer staffing.⁸⁷

81 The removal of the distinction between high and low care from the *Aged Care Act 1997* in July 2014 rendered the NSW requirement under the *Public Health Act 2010* to have a RN in 'high care' facilities at all times inoperable, as it applied to 'high care' facilities as defined by the *Aged Care Act*. See: NSW Nurses and Midwives' Association, *Submission 134*, p. 30; Ms Jan Barham MLC, *Submission 245*, p. [4].

82 NSW Legislative Council, General Purpose Standing Committee No. 3, *Registered nurses in New South Wales nursing homes*, recommendation 7, pp. 77-78.

83 NSW Legislative Council, General Purpose Standing Committee No. 3, *Registered nurses in New South Wales nursing homes*, pp. 69-70.

84 Ms Jan Barham MLC, *Submission 245*, pp. [3] and [5].

85 Ms Jennifer Davis, James Cook University, *Committee Hansard*, 23 February 2017, p. 49.

86 NSW Nurses and Midwives' Association, *Submission 134*, p. 7.

87 Mr Robert Moore, Assistant State Secretary, Health Services Union Tasmania Branch, *Committee Hansard*, 31 October 2016, p. 18.

3.86 The committee heard that the Australian Health Ministers' Advisory Council (AHMAC) agreed in February 2017 to ask the government to consider, in its development of a single aged care quality framework, 'the inclusion of a standard that requires that clinical care provided in residential aged care be best practise and provided by a qualified clinician'.⁸⁸

3.87 The Australian Law Reform Commission (ALRC) in its recent report commissioned by the Attorney General, *Elder Abuse – A National Legal Response*, made the following recommendation:

Recommendation 4-7 The Department of Health (Cth) should commission an independent evaluation of research on optimal staffing models and levels in aged care. The results of this evaluation should be made public and used to assess the adequacy of staffing in residential aged care against legislative standards.⁸⁹

Committee view

3.88 The committee is concerned that the ratio of workers to patients in some aged care facilities is too low and risks compromising the quality of care delivered.

3.89 The committee acknowledges concerns expressed by residential care providers that mandatory staffing ratios may not resolve current issues and could stifle innovation and impose greater regulatory burden and expense on the sector. The committee also acknowledges, however, the AHMAC agreement to consider a clinical care standard in its development of the aged care quality framework and more particularly the ALRC recommendation to evaluate optimal levels of care and make use of and publish the results of this analysis.

3.90 The committee considers that a compromise position may be to mandate a minimum number of nurses working at any one time and that there should be a registered nurse present at all times. The committee considers such an approach may be less burdensome for employers than mandating a nurse-to-patient ratio.

3.91 The committee notes that the sector may require additional funding and support from governments in order to meet such a mandatory minimum requirement.

3.92 The committee also considers that a mandated requirement for residential aged care facilities to publish their staff to client ratios should be explored.

Training personal care workers

3.93 Training for personal care workers is provided by Australia's vocational and education training (VET) system and delivered by registered training organisations (RTOs). Students can gain aged care specific qualifications through VET including Certificate III in Aged Care and Certificate IV in Aged Care.

⁸⁸ Ms Amy Laffan, Assistant Secretary, Department of Health, *Proof Committee Hansard*, 13 June 2017, p. 1.

⁸⁹ Australian Law Reform Commission, [*Elder Abuse – A National Legal Response*](#), ALRC Report 131, May 2017, p. 11.

3.94 This section examines the quality of training currently provided to personal care workers (PCWs), areas for improvement, and the potential for greater regulatory oversight including the establishment of a national register of workers and setting of mandatory minimum training standards.

Quality and consistency of training

3.95 Many submitters expressed concerns that VET training programs do not adequately equip PCWs with the necessary theoretical and practical skills and knowledge for work in the aged care sector.

3.96 Key concerns expressed by submitters regarding the quality and consistency of training programs included:

- inconsistency of program quality across RTOs;
- varying length of programs offered by RTOs with some being too short to develop adequate skills and experience;
- non-compliance with national training standards;
- limited work placement opportunities in aged care offered during training; and
- lack of training on dementia and palliative care.

Consistency of training

3.97 The committee heard that the quality and consistency of training provided by RTOs varies considerably, with courses varying in length, entry requirements, and opportunities for on-the-job training:

In the various RTOs, courses range from four weeks to six months full-time. There is no national consensus on what is an acceptable time frame, and many RTOs unfortunately have little or no practical experience embedded into that certificate in aged care.⁹⁰

3.98 Many submitters expressed concerns that the length of courses provided by some RTOs are inadequate to ensure students receive the level of training in skills and competencies required to work in the aged care sector. The NSW Nurses and Midwives' Association also raised concerns about 'training delivered online with no safety checks on how much they have learnt or whether they can apply learning to practice'.⁹¹ The concern in relation to aged care training delivered online was echoed by the Western Australian Primary Health Alliance.⁹²

3.99 A 2013 report by the Australian Skills Quality Authority (ASQA), the national regulator for Australia's VET sector, found that 70 per cent of RTOs who offered a Certificate III in Aged Care ran the course for a period of less than one year,

90 Miss Stacey Kafkakis, Gratis Recruitment, *Committee Hansard*, 7 March 2017, p. 14.

91 NSW Nurses and Midwives' Association, *Submission 134*, p. 25.

92 Ms Krystal Laurensch, Aged Care Representative, Regional Clinical Commissioning Committee, WA Primary Health Alliance, *Committee Hansard*, 28 September 2016, p. 10.

despite the fact the Australian Qualifications Framework (AQF) guidelines set a benchmark of one to two years as an appropriate course length for a Certificate III.⁹³

3.100 The Australian Centre for Evidence Based Aged Care (ACEBAC) at La Trobe University submitted that there is 'a lack of standardised education' in the aged care sector. ACEBAC further noted that despite the fact that there are national standards for these courses, 'there can be a great deal of variance in delivery standards between training organisations and States' resulting in 'large differences in skills and knowledge between workers'.⁹⁴

3.101 Many submitters highlighted concerns that some RTOs do not provide students with the necessary skills to work in aged care, resulting in many graduates not being job ready.⁹⁵ For example, Jewish Care Victoria noted:

Experience has shown that quality and job readiness of personal care workers varies from RTO to RTO. Those RTOs with more stringent selection criteria seem to provide workers better suited to an aged care environment. Acceptance into a course should be made on genuine desire to work in the industry...⁹⁶

3.102 The Salvation Army Australia (Aged Care Plus) also noted concerns that 'many Certificate III holders come with little or no knowledge of critical topics like manual handling, infection control and basic understanding of what personal care involves'.⁹⁷

3.103 A number of witnesses and submitters have indicated that service providers do not hire people who have obtained their Certificate III through certain RTOs:

We are targeting relationships with [training] providers that we have confidence in because they provide the right levels of training, and we are eliminating a number of providers out of our employment where we can. I know that there has been a lot of work done around cert III training into improving that standard, but we are still getting people applying or coming to do work experience with us who have only just got the piece of paper, and we are then expected to teach them.⁹⁸

93 The same report found that over 'one-third of RTOs offered the Certificate III in Aged Care in less than 15 weeks'. Australian Skills Quality Authority, [*Training for aged and community care in Australia*](#), p. xi.

94 Australian Centre for Evidence Based Aged Care, *Submission 174*, p. [1].

95 Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 1; Wami Kata Old Folks Home Inc, *Committee Hansard*, 7 March 2017, p. 2; Gratis Recruitment, *Committee Hansard*, 7 March 2017, p. 14; Resthaven Inc, *Committee Hansard*, 7 March 2017, p. 14.

96 Jewish Care Victoria Inc., *Submission 109*, p. 4.

97 The Salvation Army Australia (Aged Care Plus) *Submission 183*, p. 6.

98 Mrs Linda Jackson, Manager of People and Risk, Hall and Prior Health and Aged Care Group, *Committee Hansard*, 28 September 2016, p. 21; see also: Mrs Deanna Maunsell, Manager, Aged and Disability, Catholic Care Wollongong, *Committee Hansard*, 6 March 2017, p. 11; Ms Jenny Semple, Chief Executive Officer, Southern Migrant and Refugee Centre, *Committee Hansard*, 28 April 2016, p. 58.

3.104 Catholic Care in the Illawarra region in New South Wales argued that a national standard that meets the needs of the industry is desirable, as in the current system 'there are some RTOs that have only a nine-week program and they may as well have just cut it off from a Weet-Bix box'.⁹⁹

3.105 The committee notes that a number of the concerns highlighted by submitters were also raised in ASQA's 2012 inquiry into aged care VET courses.¹⁰⁰ Many submitters supported the implementation of ASQA's recommendations to improve VET quality training in its 2013 report of that inquiry (see Box 1.1).

Box 3.1 – ASQA review of aged and community care VET training courses

In 2012, ASQA initiated a review of aged and community care VET training programs. The key findings of the review set out in its 2013 report included:

- training programs offered by RTOs are 'largely too short' and do not include sufficient time for 'satisfactory skills development';
- RTOs delivering high-quality programs face unfair competition from RTOs offering cheaper, shorter programs;
- most RTOs offering training were not compliant with the national standards; and
- RTO leadership and staff had poor knowledge and understanding of the national standards.¹⁰¹

Representatives from ASQA told the committee at its Melbourne hearing that there has been 'good progress' on addressing the review's 10 recommendations, including revisions to the VET training courses for aged care and introduction of workplace requirements.¹⁰² However, ASQA remains concerned that around 25 per cent of courses offered are 'still too short for people to get properly skilled' and that no changes have been made to minimum course length requirements.¹⁰³

Compliance with national training standards

3.106 Under section 22 of the *National Vocational Education and Training Regulator Act 2011*, it is a condition of registration for RTOs to comply with the VET

99 Mrs Deanna Maunsell, Manager, Aged and Disability, Catholic Care Wollongong, *Committee Hansard*, 6 March 2017, p. 11.

100 Australian Skills Quality Authority, *Training for aged and community care in Australia*.

101 Australian Skills and Quality Authority, *Opening statement and report*, 2016, p.3 (tabled 28 April 2016).

102 Ms Bronwen Griffiths, Australian Skills and Quality Authority, *Committee Hansard*, 28 April 2016, p. 72.

103 Mr Christopher Robinson, Australian Skills and Quality Authority, *Committee Hansard*, 28 April 2016, p. 70.

quality framework, including the national training standards.¹⁰⁴ The purpose of the standards is to ensure that training programs delivered by RTOs 'meet the requirements of training packages or VET accredited courses'.¹⁰⁵

3.107 The ASQA's 2013 report, found that 87.7 per cent of RTOs offering aged and community care training were not compliant with at least one of the training standards.¹⁰⁶

Committee view

3.108 The committee is deeply concerned that the significant issues associated with the provision of aged care workforce training are undermining, the development of the aged care workforce, and will continue to do so until they are addressed.

3.109 The committee is concerned by evidence that RTOs are providing inconsistent standards of training and that many RTOs are offering programs that are too short to ensure students gain the necessary skills and practical training to ensure they are job ready.

3.110 The committee acknowledges that quality rather than duration of courses is paramount, but considers that the length of some courses offered is far too short to cover all the necessary skills and competencies required for aged care work. The committee is particularly concerned by reports that some RTOs are offering courses that range from as little as four weeks, which falls well below the AQF guidelines.

3.111 The committee considers that greater regulatory oversight of RTOs in regard to the duration, curricula, and on-the job-training for courses they offer is urgently required. The committee is of the view that current national training standards do not go far enough to achieve this, and more needs to be done to ensure that RTOs are providing quality training to give students the best possible training and work outcomes.

Changes to regulatory framework

3.112 The VET system is regulated by the Commonwealth, state and territory governments through the Council of Australian Governments (COAG) Industry and Skills Council.¹⁰⁷ VET training packages are developed and approved by the Australian Industry and Skills Committee.¹⁰⁸

104 The latest iteration of the national training standards was agreed to by the Council of Australian Governments (COAG) on 26 September 2014 – the [Standards for Registered Training Organisations \(RTOs\) 2015](#). See: Australian Skills and Quality Authority, [Standards for Registered Training Organisations \(RTOs\) 2015](#), (accessed 23 May 2017).

105 Australian Skills and Quality Authority, *Standards for Registered Training Organisations (RTOs) 2015*.

106 Australian Skills Quality Authority, *Training for aged and community care in Australia*, p. ix.

107 Department of Education and Training, [About the Skills Sector](#), (accessed 18 May 2017).

108 Department of Education and Training, [Australian Industry and Skills Committee](#) (accessed 18 May 2017).

3.113 As mentioned, the ASQA is responsible for registering RTOs, monitoring compliance with national standards and investigating quality concerns.¹⁰⁹ In Victoria and Western Australia these roles are undertaken by the Victorian Registration and Qualifications Authority and the Training Accreditation Council Western Australia.

3.114 Submitters supported more 'nationally consistent' training standards for RTOs. Some submitters offered suggestions on how to improve the existing regulatory framework, including:

- review of quality and accreditation processes for RTOs and training courses;¹¹⁰
- consideration of student outcome and feedback in ASQA audits of VET courses;¹¹¹
- public reporting by government on effectiveness of training programs;¹¹² and
- increased role for industry in ASQA auditing process (such as development of 'companion manuals' for auditors).¹¹³

3.115 Some of these same suggestions and concerns were raised during an inquiry by the Senate Education and Employment References Committee (EEC) in 2015 (see Box 1.2).

109 See: Australian Skills Quality Authority, *About ASQA*, <https://www.asqa.gov.au/about> (accessed 18 May 2015).

110 Australian Human Rights Commission, *Submission 243*, p. 4; Catholic Health Australia, *Submission 211*, p. 3.

111 See, for example: HammondCare, *Submission 209*, pp. 10-11; Southern Migrant Resource Centre, *Submission 38*, p. 3.

112 Australian College of Nursing, *Submission 285*, p. 16.

113 Australian Nursing and Midwifery Federation, *Submission 225*, p. 26.

Box 3.2 – Education and Employment References Committee – VET inquiry

In October 2015, the EEC reported on its inquiry into the operation, regulation and funding of private VET providers. The EEC made 16 recommendations aimed at reforming the VET sector, including:

- ASQA conduct a review of RTOs to ensure they are complying with national standards, enforce adherence to the AQF learning standards, and remove non-compliant RTOs as VET FEE-HELP providers; and
- ASQA be given the 'powers to take swift and strong action' against RTOs 'found to be providing inadequate training to their students'.¹¹⁴

In response to the EEC's report, the government noted that the key concerns had already been addressed through a range of reforms to the VET sector introduced throughout 2015, including:

- introducing new standards for RTOs
- providing a further 68 million dollars to fund ASQA
- introducing the National Training Complaints Hotline and supporting the Australian Competition and Consumer Commission's investigation into complaints; and
- measures to strengthen the VET FEE-HELP scheme.¹¹⁵

National registration and minimum training standards

3.116 As noted above, PCWs do not have regulated minimum training requirements or ongoing professional development obligations, and are not subject to a registration or licensing system. The lack of quality oversight of PCWs means that consumers, families and employers cannot be sure that a prospective PCW is suitable for employment or to provide care to a loved one.¹¹⁶

3.117 To ensure greater oversight of the unregulated PCW many submitters supported the introduction of national minimum training standards and requirements for continuing professional development (CPD), and establishment of a national register of PCWs.

Minimum training standards

3.118 As Australia's ageing population grows and clients' care needs become more complex, it is expected that pressure and demand for quality training, particularly in

114 See recommendations 6 and 11. Education and Employment References Committee, *Final Report – Recommendations, Getting our money's worth: the operation, regulation and funding of private vocational education and training (VET) providers in Australia*, October 2015.

115 See: Coalition Senators' Minority Report, *Getting our money's worth: the operation, regulation and funding of private vocational education and training (VET) providers in Australia*, October 2015. See also: Department of Employment, *VET FEE-HELP REFORMS*, <https://www.education.gov.au/vet-fee-help-reforms> (accessed 24 May 2017).

116 Australian Nursing and Midwifery Federation, *Submission 225*, p. 22.

the areas of dementia and palliative care, will only increase. However, quality of training is hindered by the fact there is no national minimum standardised training requirements for aged care.

3.119 The committee heard overwhelming support for nationally consistent training standards.¹¹⁷ For example, the ACEBAC submitted that there is a major need for 'standardisation of education requirements and clearly defined competencies' for each level of worker in the aged care sector.¹¹⁸

3.120 Submitters argued that standardised training, particularly of the practical components of aged care courses, would ensure graduates have received the same level of training and are work ready.¹¹⁹

3.121 The ANMF recommended in its submission that minimum training standards for PCWs 'should be linked to the Australian Qualifications Framework and include a requirement for a recognised level of training to at least Certificate III level'.¹²⁰

3.122 The Corporation of the City of Port Augusta suggested that training standards and CPD requirements could be linked to a national register of carers.¹²¹

National register of personal care workers

3.123 Some submitters suggested that a system of registration, similar to the National Registration and Accreditation Scheme (NRAS) for health care workers, would increase accountability of workers and provide an important safeguard for consumers against abuse.

3.124 For example, the NSWNMA submitted that a registration system would improve quality safeguards and raise standards of care.¹²²

3.125 The Aged Care Guild also argued that a national register would improve administrative efficiencies for employers by providing easily accessible background checks and employer reviews.¹²³ Ngaanyatjarra Health Service agreed suggesting that a review mechanism, such as a website where employers can provide comments about

117 See, for example: RDA Illawarra, *Committee Hansard*, 6 March 2017, p. 6; Catholic Care Wollongong, *Committee Hansard*, 6 March 2017, p. 11; and Yass Valley Aged Care Ltd, *Committee Hansard*, 6 March 2017, p. 33.

118 Australian Centre for Evidence Based Aged Care, *Submission 174*, p. [1].

119 Southern Cross Care for Facility Pearl Supported Care, *Committee Hansard*, 6 March 2017, p. 11.

120 Australian Nursing and Midwifery Federation, *Submission 225*, p. 23. The ANMF estimated that around 30 per cent of assistants in nursing and personal care workers do not have formal aged care qualifications.

121 Mrs Anne O'Reilly, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 4.

122 NSW Nursing and Midwifery Association, *Submission 134*, p. 23. See also: Association of Private Nursing Services, *Submission 189*, p. 4; Australian Nursing and Midwifery Federation, *Submission 225*, p. 22.

123 Mr Cameron O'Reilly, Aged Care Guild, *Committee Hansard*, 3 November 2016, p. 5.

an individual contractor's performance, would assist employers to recruit adequately qualified and reliable staff.¹²⁴

3.126 Mrs Anne O'Reilly, Director of Community Services at the Corporation of the City of Port Augusta, also suggested that a national register would capture undesirable workers who may otherwise 'slip through' the gaps, and boost the accountability and standing of the PCW workforce:

...there are some workers that do go from facility to facility. You can try and do background checks. We all do our criminal history assessments and check with referees but we all know that there are people who can slip through the gap in that process as well. Secondly, I also think that it may be an opportunity to give some more credence to personal care attendants if there was some training and some continuing professional development attached to that to try and improve the standing of personal caring carers in the workforce community'.¹²⁵

3.127 St Ives Home Care agreed that a national register would improve quality safeguards and help to ensure patients are cared for by well performing workers.¹²⁶

3.128 These views were also reflected in the ALRC report, *Elder Abuse – A National Legal Response*, which recommended that 'unregistered aged care workers who provide direct care should be subject to the planned National Code of Conduct for Health Care Workers'.¹²⁷

3.129 Other submitters did not support a national register of carers, suggesting that the National Code of Conduct (NCC), and various state codes of conduct, for unregistered health care workers is sufficient to regulate the PCW workforce.¹²⁸

3.130 For example, Aged and Community Services Australia argued that a national register is not required as 'there are sufficient checks, balances and measures in place to ensure that quality aged care is delivered'.¹²⁹

3.131 The NCC was approved by the Council of Australian Government (COAG) Health Council in April 2015. The NCC does not impose minimum training standards

124 Ngaanyatjarra Health Service, *Committee Hansard*, 26 October 2016, p. 7. See also: St Ives Home Care, *Committee Hansard*, 27 September 2016, pp. 19 and 21.

125 Mrs Anne O'Reilly, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 4.

126 Ms Liza Michelle De Ronchi, St Ives Home Care, *Committee Hansard*, 27 September 2016, pp. 19 and 21.

127 Australian Law Reform Commission, [*Elder Abuse – A National Legal Response*](#), ALRC Report 131, May 2017, p. 11.

128 See, for example: Ms Emma Patton, Leading Age Services Australia, *Committee Hansard*, 3 November 2016, p. 5. New South Wales, South Australia and Queensland have established Codes of Conduct for unregistered health practitioners.

129 Mr Trevor Lovelle, Aged and Community Services Australia, *Committee Hansard*, 27 September 2016, p. 2. See also: Leading Age Services Australia, *Committee Hansard*, 3 November 2016, p. 5.

or CPD requirements. It is the responsibility of states and territories to implement the NCC.¹³⁰

3.132 However, the Aged Care Guild (ACG), which represents private providers, submitted that the NCC does not go far enough to ensure aged care workers are adequately trained and 'would not meet the requirements and full intent of a national registration process'.¹³¹

3.133 The ALRC report, *Elder Abuse – A National Legal Response*, has recommended the introduction of a new serious incident response scheme for aged care, with oversight from an independent body with investigative powers, and a national employment screening process which would be based on relevant incidents under the new serious incident response scheme, criminal record checks and relevant disciplinary proceedings or complaints.¹³²

Committee view

3.134 The committee notes the same issues around training standards and registration for personal care workers were examined in depth in relation to the disability service sector during the committee's 2015 inquiry into violence, abuse and neglect of people with a disability.¹³³ Three key recommendations were made in that report regarding national workforce and workplace regulation of the disability service sector:

- Establishment of a scheme to ensure national consistency in disability worker training;
- Establishment of a disability worker registration scheme, including requirements for ongoing professional development; and
- A national approach to State, Territory and Commonwealth service delivery accreditation programs.¹³⁴

3.135 The committee is of the view that the same recommendations must apply to the aged care sector, to ensure that consistent standards are met across both sectors which are responsible for the direct care of vulnerable Australians.

130 See: Council of Australian Government Health Council, *A National Code of Conduct for health care workers*, 2015.

131 Aged Care Guild, *Submission 220*, p. [8].

132 Australian Law Reform Commission, [*Elder Abuse – A National Legal Response*](#), ALRC Report 131, May 2017, pp. 10-11.

133 Community Affairs References Committee, [*Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability*](#), November 2015.

134 See recommendations three, four and five.

Training nurses and health professionals

3.136 The committee heard concerns that training courses for nurses, medical professionals and allied health practitioners do not include adequate experience and exposure to the aged care system.

3.137 For example, Doctor Deirdre Fetherstonhaugh, Director of the ACEBAC, told the committee at its Melbourne hearing that of the six Victorian universities that offer an undergraduate degree in nursing, only one of those offers a unit on aged care nursing as part of the degree.¹³⁵

3.138 Many submitters representing nurses, medical professionals and allied health professionals supported the introduction of initiatives to give students the opportunity to rotate through aged care placements during training, together with placement opportunities for graduates.¹³⁶

3.139 For example, the Australian Medical Association submitted:

Offering appropriate and accredited medical training places in aged care facilities would educate the next generation of doctors about caring for the aged as part of routine medical practice. These places need to be supported by appropriate incentives.¹³⁷

3.140 The Australian Nursing and Midwifery Accreditation Council (ANMAC), is the independent accrediting authority responsible for developing accreditation standards for nurses and midwives. Doctor Jo-Anne Rayner, Senior Research Fellow at the ACEBAC, suggested to the committee that ANMAC should have a role in ensuring that aged care becomes a core subject of the curricula for undergraduate nursing degrees.¹³⁸

3.141 At the committee's Wollongong hearing, the committee received evidence from representatives of TAFE Illawarra and IRT Group; both of which have developed training and placement initiatives to ensure students can gain experience in aged care.

3.142 For example, Ms Belinda Mackinnon from TAFE NSW described to the committee TAFE Illawarra's workforce development initiatives, including the Young@Heart Program, which is specifically targeted at encouraging young people to undertake training in aged care, and various partnership initiatives with universities that are aimed at building educational pathways into careers in aged care.¹³⁹

135 Dr Dierdre Fetherstonhaugh, Australian Centre for Evidence Based Aged Care, La Trobe University, *Committee Hansard*, 28 April 2016, p. 27.

136 Australian Medical Association, *Submission 210*, p. 5; NSW Nursing and Midwives' Association, *Submission 134*, p. 8; Royal Australian College of General Practitioners, *Submission 281*, p. 10; Allied Health Professions Australia, *Submission 208*, p. 4.

137 Australian Medical Association, *Submission 210*, p. 5.

138 Dr Jo-Anne Rayner, Australian Centre for Evidence Based Aged Care, La Trobe University, *Committee Hansard*, 28 April 2016, p. 28.

139 Ms Belinda Mackinnon, TAFE NSW, *Committee Hansard*, 6 March 2017, p. 16.

3.143 IRT Group also explained some of its training and development initiatives that are provided by the IRT College (a RTO operated by IRT Group), such as a school based apprenticeship and trainee program under which students have to complete a minimum of 700 hours of paid employment, and a pathways program that is in partnership with the University of Wollongong.¹⁴⁰

Committee view

3.144 The committee acknowledges concerns that current training courses for the medical profession do not offer adequate practical training in aged care.

3.145 The committee is of the view that a nationally consistent curriculum for aged care specific courses should be considered for people who wish to specialise in this area, and that a general overview course of aged care should be included in all general nursing degrees to increase exposure to the sector. The committee also considers that it is crucial that nursing students are given greater opportunities to undertake placements in aged care.

3.146 The committee considers that ANMAC, as the national accreditation body, should take a lead in developing and implementing such reforms.

140 Mr Campbell McGlynn, IRT Group, *Committee Hansard*, 6 March 2017, p. 17. The committee also had a site visit at IRT College, where it had the opportunity to learn about and see in practice some of the College's training initiatives.

Chapter 4

Diversity in aged care

4.1 The Australian population is becoming more diverse and this is reflected in the increasing proportion of aged care service users with special needs and preferences. The *Aged Care Act 1997* defines 10 groups of people as 'people with special needs' for whom there is additional consideration in the planning and delivery of appropriate aged care services.

4.2 'People with special needs' include people from Aboriginal and Torres Strait Islander communities, people from culturally and linguistically diverse (CALD) backgrounds, people who live in rural or remote areas, and lesbian, gay, bisexual, transgender and intersex (LGBTI) people.¹

4.3 Chapter 1 outlined the diversity of the population accessing aged care services and listed some of the challenges facing the mainstream aged care sector. This chapter will highlight the particular challenges in relation to creating a culturally competent and inclusive aged care workforce to cater for the different care needs of Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups, people living in rural or remote areas, and lesbian, gay, bisexual, transgender and intersex people.

Aboriginal and Torres Strait Islander aged care

We need to investigate how we provide appropriate aged care for Indigenous older people and in doing so we need to be encouraging Indigenous people to be participating in the aged care workforce. There must be provision for the education, support and a career structure so Indigenous aged care workers can guide and teach non-Indigenous peoples how to be culturally competent in working with Indigenous older people.²

4.4 The government funds a number of programs which assist in providing aged care services to Aboriginal and Torres Strait Islander peoples. These programs include the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, which funds organisations to provide flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander peoples close to their home and/or community, primarily in rural and remote areas.³

4.5 The National Aboriginal and Torres Strait Islander Flexible Aged Care Program includes a quality framework, which is based on two principles: cultural

1 Section 11.3 of the [Aged Care Act 1997](#).

2 Dr Maree Bernoth, *Submission 249*, p. 3.

3 Department of Social Services, [Residential and Flexible Care Program, National Aboriginal and Torres Strait Islander Flexible Aged Care Program \(NATSIFACP\), Guidelines Overview](#), October 2015, p. 7, accessed 15 February 2016. The program currently funds 29 aged care services, with the majority located in remote or very remote locations. The program is administered outside of the *Aged Care Act 1997*.

safety and continuous quality improvement.⁴ The quality framework sets out the requirements to achieve effective staff recruitment and retention to ensure that service user needs are met, including ensuring that services are provided by appropriately skilled staff who have an understanding of the cultural needs of the key stakeholders, including service users.⁵

Changing service delivery

It has been very difficult for us, in a sense, and I understand why the government has done what they have done and removed it as bucket funding and now it is individual. But for us as a family unit, as a community, if one is sick at the minute then we all chip in to raise them up to get them better, whereas now we are having to say, 'I am sorry, Auntie, but your budget does not allow it.'⁶

4.6 Submitters and witnesses to this inquiry have expressed concern that the national move to consumer directed care (CDC), and the introduction of a centralised access point to aged care services, will adversely impact on the delivery of services to regional and remote predominantly Aboriginal and Torres Strait Islander communities.

4.7 In Townsville, the Northern Regional Aboriginal and Torres Strait Islander Corporation, which delivers aged care and disability services to Aboriginal and Torres Strait Islander peoples in the area, indicated that the move to a centralised portal and phone line for individuals to be assessed for access to aged care services had created a barrier for the service and for their clients. Prior to the introduction of My Aged Care, the Corporation, and clients, could access the one Townsville-based Aboriginal and Torres Strait Islander Aged Care Assessment Team (ACAT) member directly to address issues; now, however, all transactions with the department must go through the centralised portal:

Now, again, everything has to go through My Aged Care. We have lost that connection between the multidisciplinary team and the consumer. This is all consumer directed, but for us it is actually not working. It is removing that connection that we have all had, and we have built that over a number of years. So it is quite difficult.⁷

4.8 This view has been echoed by service providers in their input to the 2017 performance audit of the Department of Health (department) and the Australian Aged Care Quality Agency by the Australian National Audit Office (ANAO), which found

4 Department of Health and Ageing, [*National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Quality Framework*](#), 2011, accessed 15 February 2016.

5 Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Flexible Aged Care Program, Quality Framework*, 2011, p. 22.

6 Miss Krys Fischer, Care Coordinator, Northern Regional Aboriginal and Torres Strait Islander Corporation, *Committee Hansard*, 23 February 2017, p. 22.

7 Miss Krys Fischer, Care Coordinator, Northern Regional Aboriginal and Torres Strait Islander Corporation, *Committee Hansard*, 23 February 2017, pp. 22-23.

that the centralised My Aged Care web portal and call centre can be a barrier to accessing aged care services for Aboriginal and Torres Strait Islander peoples, both in terms of cultural appropriateness and, for those living in remote and very remote locations, where access to communication technologies and the internet is limited or unavailable.⁸

4.9 Similarly, a Northern Territory service provider stated that the introduction of My Aged Care and CDC had led to a decline in service levels to aged care clients, as the administrative burden created diverted resources away from direct care:

To give you an example, previously our programs had one person in Alice Springs overseeing them. We now have four people, which is because of the complexities of budgeting, costings, interacting with My Aged Care—all those sorts of things. That is all money that does not go towards service delivery.⁹

4.10 The Chief Executive Officer of the Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation raised concerns that the CDC model is not compatible with providing services to a small number of people, and particularly when that small group may, for example, need to relocate temporarily to another community, taking the funding with them:

For example, in Mount Liebig, where there are currently about 10 old people, the staffing for that service is a full-time coordinator who is responsible for everything about that service and a few part-time community employees working a few hours a day...If a few of those old people decide that they need to go to Kintore for sorry business for a month, they take their packages with them. We are concerned that there may be a position where you actually have not got the money to pay the staff on the ground.¹⁰

4.11 The Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation and the MacDonnell and Central Desert regional councils all indicated that block funding, such as that available, for example, under the Aboriginal and Torres Strait Islander Flexible Aged Care Program, is a more appropriate funding model for remote and geographically-dispersed service delivery, where the costs of

8 Australian National Audit Office, [*Indigenous Aged Care*](#), ANAO Report No. 53 of 2016/17, pp.27-28.

9 Ms Katie Snell, Manager, Aged and Disability Services, Central Desert Regional Council, *Committee Hansard*, 26 October 2016, p. 16.

10 Ms Sarah Brown, Chief Executive Officer, Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation, *Committee Hansard*, 7 March 2017, pp. 7-8.

service provision, and attracting and providing professional development for staff, are higher than in less remote locations.¹¹

4.12 The MacDonnell Regional Council, which has attempted to apply for funding under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, recommended that

the funding model for remote Indigenous services needs to reflect the operating environment. Allocations to the NATSI Flexi program need to be sufficient to allow many providers that are currently operating within this context, and under CDC, to transition over to the NATSI Flexi program, to ensure these providers do not exit the sector, which is a real risk at the moment.¹²

4.13 The ANAO performance audit of Indigenous aged care examined the National Aboriginal and Torres Strait Islander Flexible Aged Care Program in the broader context of aged care service delivery to Aboriginal and Torres Strait Islander peoples, finding that the program is a more cost effective and viable model for residential aged care service delivery in remote and very remote locations, however, 'the majority of Flexible Program recurrent funding for residential aged care is allocated to services in major cities and inner regional areas'.¹³

4.14 The ANAO recommended that the Department of Health:

(a) provide an opportunity for eligible existing Indigenous-focused aged care service providers, which are not currently funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, to access the available funding under this scheme; and

(b) apply a consistent assessment process to ensure that places allocated through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program align with service provider capacity and are targeted to those service providers who will generate the greatest community benefit.¹⁴

4.15 The National Foundation for Australian Women (NFAW) and Catholic Healthcare Wollongong also expressed concern that additional costs associated with

11 Ms Sarah Brown, Chief Executive Officer, Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation, *Committee Hansard*, 7 March 2017, pp. 8; Mr Rohan Marks, Director, Community Services, MacDonnell Regional Council, *Committee Hansard*, 26 October 2016, p. 3; Ms Katie Snell, Manager, Aged and Disability Services, Central Desert Regional Council, *Committee Hansard*, 26 October 2016.

12 Mr Rohan Marks, Director, Community Services, MacDonnell Regional Council, *Committee Hansard*, 26 October 2016, p. 2.

13 Australian National Audit Office, [*Indigenous Aged Care*](#), ANAO Report No. 53 of 201617, p. 29.

14 Australian National Audit Office, [*Indigenous Aged Care*](#), ANAO Report No. 53 of 201617, p. 35.

service provision in a regional or remote area, for example, the cost of transport and travel, are not accounted for in the CDC model.¹⁵

4.16 The department indicated that some remote and/or Aboriginal and Torres Strait Islander service providers have successfully implemented CDC. The department stated that it has established the Service Development Assistance Panel (SDAP) to assist service providers who may be experiencing difficulties, in relation to:

- clinical care;
- quality standards;
- governance models; and
- business systems or business planning.¹⁶

4.17 The ANAO performance audit found that aged care service providers were not necessarily aware of the SDAP service and further commented that:

there would be benefit in Health better ensuring funding was targeted towards building financial management and governance capacity within organisations, rather than supplementing financial losses that are likely to persist unless changes in organisational culture and skills are made. Raising awareness of the availability of SDAP funding, and ensuring that funding was conditional on entities building financial management and governance capacity, could result in a more equitable and targeted allocation of SDAP funding.¹⁷

Committee view

4.18 The committee considers that the Government should review the implementation of CDC and consider alternative models where it is clear that CDC is not working, particularly in remote and very remote locations. The committee further notes the challenges to access presented by the implementation of a centralised access point to aged care services, which equally need to be addressed. Alternative models of funding and other support to services operating in remote and very remote locations also need to encompass attracting, maintaining and supporting aged care workers.

4.19 The committee notes the ANAO performance audit findings that the Aboriginal and Torres Strait Islander Flexible Aged Care Program has been effective in delivering culturally appropriate access to aged care services for Aboriginal and Torres Strait Islander peoples. The committee considers that this program should be expanded, and greater opportunities made available for eligible Indigenous-focused services to access the program.

15 National Foundation for Australian Women, *Submission 105*, p. 22; Mrs Deanna Maunsell, Manager, Ageing and Disability, Catholic Healthcare Wollongong, Committee Hansard, 6 March 2017, p. 14.

16 Ms Rachel Balmanno, First Assistant Secretary, Department of Health, *Committee Hansard*, 3 November 2016, p. 65.

17 Australian National Audit Office, [*Indigenous Aged Care*](#), ANAO Report No. 53 of 2016/17, p. 37.

4.20 The committee considers it essential to ensure that services delivered to Aboriginal and Torres Strait Islander peoples are accessible, do not present barriers to access, and are culturally appropriate and appropriately resourced, and take into account the specific challenges for service providers and aged care workers operating in remote and very remote locations.

Aboriginal and Torres Strait Islander workforce

4.21 The 2016 Aged Care Workforce Survey found that about one per cent of workers in residential direct care are Aboriginal and Torres Strait Islander people, a proportion which has not changed since the previous survey in 2012.¹⁸

4.22 The survey found that of these, 81 per cent were personal care attendants (PCAs), about 10 per cent were registered nurses, 7 per cent were enrolled nurses and 2 per cent were allied health workers. The survey noted that Aboriginal and Torres Strait Islander workers are more likely than the overall residential direct care workforce to be PCAs, rather than enrolled or registered nurses, or allied health professionals.¹⁹

4.23 The survey did not cover the reasons for this difference; however, it did note that the proportion of Aboriginal and Torres Strait Islander nurses had increased from 12 per cent in 2012 to 17 per cent in 2016, and the proportion of Aboriginal and Torres Strait Islander PCAs had fallen from 85 per cent to 81 per cent.²⁰

4.24 There are challenges in finding and retaining Aboriginal and Torres Strait Islander workers in the aged care industry. The 2015 *Stocktake and Analysis of Commonwealth-funded Aged Care Workforce Activities* report indicated that consultations undertaken as part of the stocktake revealed that a lack of culturally appropriate training specifically targeted to Aboriginal and Torres Strait Islander peoples wishing to enter or remain in the aged care sector was reported to be a 'significant impediment to the attraction, recruitment and retention of this workforce group'.²¹

4.25 Some issues relate to circumstances which disproportionately affect Aboriginal and Torres Strait Islander peoples' capacity to engage in the workforce. For example, a representative of the aged care service provider, Australian Unity, stated

18 National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, p. 19.

19 National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, p. 19.

20 National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, p. 19.

21 Health Outcomes International, [*Stocktake And Analysis Of Commonwealth Funded Aged Care Workforce Activities: Final Report*](#), Department of Social Services, 2015, [p. 50].

that many aged care workers are required to have a driving licence, as a car and licence are requirements of the roles.²²

4.26 Leading Age Services Australia stated that key challenges for engaging Aboriginal and Torres Strait Islander workers are at the commencement of employment in the sector:

It is at the entry point, supporting the completion of initial training and shifts that presents a barrier. The age services industry are looking to other industries to learn from their successes.²³

4.27 One aged care facility in a remote location initially had an Aboriginal workforce who were replaced by a non-Aboriginal and non-English speaking background workforce upon a change of ownership, which presented significant difficulties for the residents:

Using this kind of workforce has really skewed being able to care adequately for the clients. The Indigenous workers who were there did not feel safe working there any longer—but now you have the residents, who cannot leave. We need to be asking those workers why they left and what it would take for them to come back. What does this organisation need to have to be safe?²⁴

4.28 Situations like these suggest that a cornerstone to ensure continuity in culturally appropriate care for Aboriginal and Torres Strait Islander peoples accessing aged care as users, is to better source, train and support Aboriginal and Torres Strait Islander peoples to enter the aged care workforce:

If we look at the patterns of ageing and the demographics of our Aboriginal and Torres Strait Islander populations, our workforce needs into the future, to 2030, are really critical now around planning and how we support, resource and invest in models that work for Aboriginal and Torres Strait Islander people as we live longer.²⁵

4.29 Australian Unity's Aboriginal Home Care service has developed an Aboriginal workforce strategy. The key objectives of this strategy include:

...attracting and retaining our Aboriginal workforce, building capabilities and career pathways for our Aboriginal workforce and improving Aboriginal cultural competency across the company. The themes include:

22 Ms Kelly Chatfield, Manager, Aboriginal Business Development, Australian Unity, *Committee Hansard*, 6 March 2017, p. 39.

23 Leading Age Services Australia, *Submission 222*, p. 16.

24 Ms Annie Farthing, Member, Services for Australian Rural and Remote Allied Health, *Committee Hansard*, 3 November 2016, p. 17.

25 Ms Donna Murray, Chief Executive Officer, Indigenous Allied Health Australia, *Committee Hansard*, 3 November 2016, p. 40.

working collaboratively with internal and external business partners to create a supportive cultural environment and promoting staff engagement.²⁶

4.30 CRANaplus, a peak organisation for professional remote health workers that provides education, support and professional services to workers in health and related sectors, discussed how it addresses the education needs of remote health care workers, particularly those working in Aboriginal and Torres Strait Islander communities:

One of our things is that we take education out to the remote area workforce. That has been one of our greatest successes—that we acknowledge the context of your practice is different. You cannot try and make a metropolitan model fit out there, so you have to be adaptable and take the education out to the workforce out there. That has been very successful from our organisation's perspective.²⁷

4.31 Services specifically available to support the aged care workforce in delivering services to Aboriginal and Torres Strait Islander peoples include:

- Indigenous Remote Service Delivery (IRSD) traineeships—National Partnership on Indigenous Economic Participation.²⁸
- Culturally appropriate and targeted training for the Aboriginal and Torres Strait Islander aged care workers employed in eligible aged care services.²⁹
- Remote and Aboriginal and Torres Strait Islander Aged Care Service Development Assistance Panel.³⁰
- Activities under the Dementia and Aged Care Services Fund, including training and individual support for Aboriginal and Torres Strait Islander service providers in rural and remote Australia.³¹

4.32 While there are a number of options available via the department for service providers to develop the skills and knowledge of aged care workers delivering services to Aboriginal and Torres Strait Islander peoples, the ANAO performance

26 Ms Kelly Chatfield, Manager, Aboriginal Business Development, Australian Unity, *Committee Hansard*, 6 March 2017, p. 37.

27 Ms Gerardine Marie Malone, Director, Professional Services, CRANaplus, *Committee Hansard*, 7 March 2017, p. 37.

28 Under this program, up to 80 traineeships are offered annually in business management for Aboriginal and Torres Strait Islander people in aged and primary health care facilities.

29 Under this program, Northern Territory based Registered Training Organisations were funded to deliver culturally appropriate, skills-based aged care training on-site in 59 communities across the Northern Territory and two communities in Western Australia.

30 The Panel provides expert assistance and advice to providers across care delivery, quality delivery, governance, business management, financial management and project management to eligible aged care services.

31 Department of Health, *Submission 293*, p. 31.

audit of Indigenous aged care found that providers are not necessarily aware that such programs and supports exist.³²

Committee view

4.33 The committee notes that there are specific challenges in providing appropriate training, professional development and secure employment opportunities in the aged care sector in regional and remote locations, including in Aboriginal and Torres Strait Islander communities.

4.34 There is a need to ensure that ongoing challenges in providing appropriate professional development and employment opportunities to Aboriginal and Torres Strait Islander aged care workers, and to those workers providing services to Aboriginal and Torres Strait Islander communities, are addressed.

4.35 The committee considers that these issues cannot be addressed in isolation, and cannot be addressed by the aged care industry alone, but as part of a broader re-examination of aged care service delivery in remote and very remote locations and to Aboriginal and Torres Strait Islander peoples.

CALD aged care sector

4.36 As discussed in chapter 1, the population of Australia is becoming more diverse in cultural and linguistic background, and as the CALD community age, are taking up aged care services in greater numbers, and their differing needs are placing new challenges on the workforce.

National Ageing and Aged Care Strategy for People CALD Backgrounds

4.37 The 2012 *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds* supports the aged care sector to deliver care that is appropriate and sensitive to the needs of older Australians from CALD backgrounds.³³

4.38 The Strategy is based on five principles and sets out six broad goals and associated actions to be achieved by the Department of Health and Ageing (now the Department of Health) in the period 2012–2017, including:

- CALD input positively affects the development of ageing and aged care policies and programs that are appropriate and responsive (Goal 1);
- monitor and evaluate the delivery of ageing and aged care services to ensure that they meet the care needs of older people from CALD backgrounds, their families and carers (Goal 4); and

32 Australian National Audit Office, [*Indigenous Aged Care*](#), ANAO Report No. 53 of 2016/17, p. 9.

33 Department of Health and Ageing, *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*, 2012, p. 3, accessed 15 February 2016.

- enhance the CALD sector's capacity to provide ageing and aged care services (Goal 5).³⁴

4.39 The Department of Health has submitted that the strategy includes coverage for workforce issues, including 'resources to support consumers and providers'.³⁵

Partners in Culturally Appropriate Care

4.40 An organisation in each state and territory is funded to assist aged care providers to deliver culturally appropriate care to older people from CALD backgrounds (Partners in Culturally Appropriate Care (PICAC) organisations). The PICAC organisations conduct a range of activities—such as training, information sessions, workshops and resource development—to achieve three primary outcomes:

- more aged care services delivering culturally appropriate care to older persons from CALD communities;
- older people from CALD communities having increased access to culturally appropriate residential and community based aged care services; and
- older people from CALD communities having greater capacity to make informed decisions about residential and community based aged care.³⁶

4.41 The Department of Health has submitted that PICAC organisations: provide culturally appropriate training to staff of aged care services, disseminate information on high quality aged care practices and support the aged care service providers to develop new culturally appropriate services including clusters, ethno-specific and multicultural aged care services.³⁷

Building capacity for the aged care needs of CALD communities

4.42 The Department of Social Services has developed a number of resources to support CALD communities with emerging aged care needs to establish aged care services.³⁸

4.43 In the 2014 Budget, the Government announced \$20 million funding to support the provision of culturally appropriate aged care services in Western Sydney: \$10 million over three years to the Lebanese Muslim Association; and \$10 million over two years to the Maronite and other Arabic speaking Christian communities.³⁹

34 Department of Health and Ageing, *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds*, 2012, pp 12–17, (accessed 23 December 2015).

35 Department of Health, *Submission 293*, p. 29.

36 Department of Health, *Ageing and Aged Care, People from diverse backgrounds* webpage, <https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/older-people-their-families-and-carers/people-from-diverse-backgrounds> (accessed 16 December 2015).

37 Department of Health, *Submission 293*, p. 29.

38 Department of Social Services, [People from diverse backgrounds](#), accessed 15 February 2016.

39 Australian Government, [Budget measures: budget paper no. 2: 2014–15](#), 2014, p. 190, (accessed 3 December 2015).

4.44 Mr Christopher Lacey, General Manager, Multicultural Communities Council of Illawarra (MCCI), emphasised the diversity of people accessing aged care:

In our region at the time of the 2011 census there were about 8,039 people who were aged 70-plus and were born overseas. Of these, around 2,400 people needed assistance with core activities, 1,800 of those people were living alone and about 2,300 of those people spoke English 'not well or not at all'.⁴⁰

4.45 To address the needs of these people, of the 52 staff (approximately 30 FTE positions) employed by MCCI, around 70 per cent are bilingual:

For us, this is a very significant capability requirement. To be able to deliver culturally-appropriate care to CALD communities, we need workers who can speak a range of different languages. It is a key component of who we are as a business.⁴¹

4.46 The Ethnic Communities' Council of Victoria (ECCV) stated that the feedback they had received from members indicated that:

Bilingual aged-care workers trained in ethno-specific and multicultural agencies have invaluable expertise in facilitating the access of seniors from non-English-speaking backgrounds to the service systems.⁴²

4.47 The ECCV expressed particular concern about the lack of availability of culturally appropriate services and resources in rural and regional towns and areas.⁴³

4.48 Another concern raised, in relation to aged care workers from CALD backgrounds, was the assumption that these workers do not need training in culturally appropriate aged care services:

For instance, here in Melbourne we know that all aged-care facilities in the western and southern regions have residents who prefer to speak a language other than English. We also know that staff are not provided with initial training or professional development, as was outlined, in how to carry out the work that provides the services in a culturally inclusive way.⁴⁴

4.49 Further, the Centre for Cultural Diversity and Ageing referred to the lack of bilingualism in Australia as an additional factor impacting on the ability to provide culturally appropriate aged care services:

40 Mr Christopher Lacey, General Manager, Multicultural Communities Council of Illawarra, Committee Hansard, 6 March 2017, p. 10.

41 Mr Christopher Lacey, General Manager, Multicultural Communities Council of Illawarra, Committee Hansard, 6 March 2017, p. 10.

42 Mrs Marion Lau, Deputy Chairperson, Ethnic Communities' Council of Victoria, *Committee Hansard*, 28 April 2016, p. 57.

43 Mrs Marion Lau, Deputy Chairperson, Ethnic Communities' Council of Victoria, *Committee Hansard*, 28 April 2016, p. 57.

44 Ms Ljubica Petrov, Manager, Centre for Cultural Diversity in Ageing, *Committee Hansard*, 28 April 2016, p. 62.

That is something that I think needs to be explored in the future, because we need more bilingual people who will meet the diversity of language needs in the aged-care sector.⁴⁵

4.50 To this end, the Federation of Ethnic Communities' Councils of Australia (FECCA) has recommended, given the evidence available on the increasing cultural diversity of the aged population requiring care, the development of an Aged Care Workforce Cultural Diversity Management Strategy.⁴⁶

4.51 FECCA submitted that this strategy should address the following areas:

- ways to attract CALD workers to employment in aged care services; methods for improving the retention of culturally competent aged care workers, including but not limited to workers from CALD backgrounds;
- attracting aged care workers to rural and regional areas;
- implications for interface between the National Disability Insurance Scheme (NDIS) and aged care system; and
- strategies to enhance cultural competency of the aged care workforce, as part of increasing the capability of the sector to meet the needs of older people from CALD backgrounds.⁴⁷

4.52 The call for a specific strategy was echoed by a number of submitters and witnesses.⁴⁸

CALD people in the aged care workforce

4.53 The 2016 Aged Care Workforce Survey found that 32 per cent of the total residential care workforce were born overseas, and 40 per cent of recent hires in residential care were migrant workers; and 23 per cent of the PAYG home care and home support direct care workforce were born overseas.⁴⁹

4.54 The 2016 survey asked residential aged care facilities to identify the benefits of engaging people from CALD backgrounds. Responses indicated that 84 per cent found a benefit in the opportunity to enhance cross-cultural understandings and activities; and 37 per cent indicated that employing people from CALD backgrounds was important for developing networks into particular communities.⁵⁰

45 Ms Ljubica Petrov, Manager, Centre for Cultural Diversity in Ageing, *Committee Hansard*, 28 April 2016, p. 62.

46 FECCA, *Submission 205*, p. 2.

47 FECCA, *Submission 205*, p. 2.

48 See for example: National Foundation for Australian Women, *Submission 105*; Resthaven Incorporated, *Submission 140*; Alzheimer's Australia, *Submission 180*; Brightwater Care Group, *Submission 213*; Aged Care Guild, *Submission 220*; Aged & Community Services Australia, *Submission 229*.

49 National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, pp. xvi, 10.

50 National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, p. 45.

Committee view

4.55 The ageing population is clearly culturally diverse, and so too is the workforce providing care to those in need of either in home or residential aged care services.

4.56 The committee acknowledges the challenges and opportunities in delivering culturally aware aged care and the need for the aged care workforce to be prepared effectively to deliver culturally appropriate care.

National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy

4.57 The 2012 *National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy* is designed to enable better education, care and support for older LGBTI Australians in aged care. The strategy is intended also to help workers to understand any differences between their personal values or beliefs and appropriate and inclusive workplace behaviour and practice.⁵¹

4.58 The strategy has six strategic goals and associated actions that are the outcomes to be achieved by the Department of Health and Ageing (now the Department of Health) from 2012 to 2017, including:

- LGBTI people will experience equitable access to appropriate ageing and aged care services (Goal 1);
- the aged care and LGBTI sectors will be supported and resourced to proactively address the needs of older LGBTI people (Goal 2);
- ageing and aged care services will be supported to deliver LGBTI-inclusive services (Goal 3);
- LGBTI-inclusive ageing and aged care services will be delivered by a skilled and competent paid and volunteer workforce (Goal 4);
- LGBTI communities, including older LGBTI people, will be actively engaged in the planning, delivery and evaluation of ageing and aged care policies, programs and services (Goal 5); and
- LGBTI people, their families and carers will be a priority for ageing and aged care research (Goal 6).⁵²

4.59 The Department of Health submitted that the strategy includes coverage of workforce issues, including 'resources to support consumers and providers'.⁵³

51 Department of Health and Ageing, [*National Lesbian, Gay, Bisexual, Transgender and Intersex \(LGBTI\) Ageing and Aged Care Strategy*](#), 2012, p. 3, accessed 15 February 2016.

52 Department of Health and Ageing, [*National Lesbian, Gay, Bisexual, Transgender and Intersex \(LGBTI\) Ageing and Aged Care Strategy*](#), 2012, pp 12–17, (accessed 21 December 2015).

53 Department of Health, *Submission 293*, p. 31.

Review of strategy implementation

4.60 In 2013, the National LGBTI Health Alliance convened the Second National LGBTI Ageing and Aged Care Roundtable, to review implementation of the strategy. Four recommendations were made:

- update VET qualifications with LGBTI competencies;
- include LGBTI with special needs/diversity outcomes in all aged care standards and linked to accreditation;
- include LGBTI within the Survey of Ageing, Disability and Carers and in all government research; and
- ensure workplace inclusion strategies for aged care organisations.⁵⁴

LGBTI workers in the aged care workforce

4.61 There is no data available on the number or proportion of people working in the aged care sector who identify as LGBTI, which makes it challenging to obtain information about LGBTI people working, or seeking employment in, the aged care workforce.

4.62 The National LGBTI Health Alliance has submitted that a significant issue affecting LGBTI people who wish to work in the aged care sector is the ability of faith-based organisations providing aged care services to discriminate in the hiring of workers under Section 37 of the *Sex Discrimination Act 1984*:

The exemption to the SDA undermines the ability of faith-based organisations to create an LGBTI-inclusive service and decreases the confidence that LGBTI consumers have in these organisations to deliver inclusive care. Furthermore, the blanket nature of the exemption disadvantages faith-based providers that do not want to be exempted from anti-discrimination laws.⁵⁵

4.63 The National LGBTI Health Alliance argues that this is a significant issue, given that '[in] 2015-16 faith-based organisations provided 24.4% of residential care places and 31.9 % of operational home care places in Australia'.⁵⁶

4.64 A member of the Legislative Council of New South Wales, Ms Jan Barham MLC, also indicated in her submission the inconsistency introduced through amendments to the *Sex Discrimination Act* in 2013 that prohibit discrimination against LGBTI people seeking aged care services, but which allows discrimination against LGBTI aged care workers.⁵⁷

54 National LGBTI Health Alliance, [*2nd National Lesbian, Gay, Bisexual, Transgender and Intersex Ageing and Aged Care Roundtable*](#), August 2014, (accessed 21 December 2015).

55 National LGBTI Health Alliance, *Submission 308*, p. [2].

56 National LGBTI Health Alliance, *Submission 308*, p. [3].

57 Ms Jan Barham MLC, *Submission 245*, p. [6].

4.65 The Alliance has argued that this matter should be addressed either through repeal of the relevant section enabling the discrimination to occur, or to narrow the definition of what kinds of occupation and work the exemption can apply to:

Under this option, a faith-based provider would be able to lawfully discriminate when hiring a chaplain but it would not allow discrimination against other staff (e.g. cleaners).⁵⁸

Committee view

4.66 The committee has heard evidence that indicates that aged care providers and other stakeholders including the government have worked to help accommodate and cater for LGBTI people accessing aged care services. This includes more services specifically catering for LGBTI people.

4.67 The committee is concerned, however, that more could be done to address discrimination faced by LGBTI workers in the aged care industry and seeking to enter the industry. While aged care facilities are no longer able to exclude potential residents and clients because of their LGBTI status, the same does not apply to LGBTI workers.

Regional and remote aged care sector

4.68 Earlier in this report, it was noted that about a third of the population of Australia aged 65 and over live in regional and remote locations, and that there is considerable diversity amongst this population.

The aged care workforce in regional and remote Australia

4.69 Recent data shows that just over one third of the residential aged care workforce, and 40 per cent of the community care aged care workforce, is employed in regional and remote areas. For both groups of aged care workers, the majority of those working outside major cities are located in regional areas, with fewer than two per cent of residential care workers, and just over four per cent of community care workers, located in remote or very remote areas.

58 National LGBTI Health Alliance, *Submission 308*, p. [4].

Table 4.1: Distribution of residential direct care workforce and home support direct care workforce (per cent) by location, 2016.

Location*	Residential care ¹	Community Care ²
Major cities	64.6	59.7
Inner regional	23.4	18.9
Outer regional	10.3	17.0
Remote	1.2	3.5
Very remote	0.5	0.6

Source: 1. National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, p.50; 2. National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, p. 112.

*Australian Bureau of Statistics remoteness area categories.

4.70 The data from the recently released *2016 National Aged Care Workforce Census and Survey* indicates that there has been little change in the geographical distribution of workers in residential aged care over the past 5 years. Due to changes in the method of defining categories, data on community care workers cannot be compared with previous surveys.

4.71 Geographical location was nominated by aged care service providers who completed the survey as the second highest factor causing skills shortages, with lack of available suitable applicants being the leading cause of skills shortages.⁵⁹ The *2016 National Aged Care Workforce Census and Survey* also found that vacancies, especially for registered nurses in residential care facilities, take longer to fill in remote and very remote areas.⁶⁰

Aged care workforce challenges in regional and remote communities

Being in a semi-regional area we have the issue of trained staff – that is probably our biggest problem – and the cost of training, and also the availability of young people coming through⁶¹

4.72 Delivering aged care services is particularly challenging in regional and remote communities.⁶² The *2016 National Aged Care Workforce Census and Survey*

59 National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, p. 55.

60 National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, p. 58.

61 Ms Julie Cooper, Executive Officer, Bess Home and Community Care Inc, *Committee Hansard*, 28 September 2016, p. 1.

shows that there are difficulties in both attracting and retaining aged care workers in the sector, and that there are also skills shortages which aged care providers struggle to address. The survey also shows that these difficulties are more pronounced in regional and remote areas.⁶³

4.73 A lack of community level coordination of services across related health, disability and aged care services and agencies also impacts on peoples' access to services in remote locations. Dr Kate Smith, a Research Fellow at the University of Western Australia who has been conducting research into ageing in the Kimberley region for around 15 years, suggested that greater collaboration across sectors at a local level may be of use in addressing access to services, including allied health care workers.⁶⁴

4.74 There is concern that where there currently is coordination of services, the introduction of CDC and the move to introduce greater competition between service providers may result in a 'weakening of that kind of collaborative, coordinated delivery of services'.⁶⁵ This is particularly critical when, due to limited service availability in remote and very remote locations, aged care service providers often deliver services for young people who have a disability. This places an additional requirement on those services, and their staff, to possess an appropriate level of training and skills to meet the differing needs of a broad client base. Finding and retaining staff to meet this additional need adds to the challenges facing service providers in regional and remote locations.⁶⁶

4.75 The Aged Care Funding Agency (ACFA) has found that aged care providers in regional and remote areas generally have higher cost pressures and lower financial results and 'face a high level of workforce 'churn' and challenges in recruiting and retaining staff'.⁶⁷ In discussing these issues, Aged and Community Services Australia noted that there are additional challenges for the aged care workforce in rural and remote communities:

62 See: Yass Valley Aged Cares, *Submission 59*; CRANaplus, *Submission 1*; Rural Health Workforce Australia, *Submission 133*; Services for Australian Rural and Remote Allied Health (SARRAH), *Submission 238*; Australian College of Rural and Remote Medicine, *Submission 251*; National Rural Health Alliance, *Submission 296*.

63 National Institute of Labour Studies, Flinders University, *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016*, Department of Health, 2017, p. xvii.

64 Dr Kate Smith, Research Fellow, University of Western Australia, *Proof Committee Hansard*, 9 June 2017, p. 32.

65 Mr Robert McPhee, Deputy Chief Executive Officer, Kimberley Aboriginal Medical Services, *Proof Committee Hansard*, 9 June 2017, p. 15.

66 Mr Robert McPhee, Deputy Chief Executive Officer, Kimberley Aboriginal Medical Services, *Proof Committee Hansard*, 9 June 2017, p. 15.

67 Aged Care Funding Agency (ACFA), *Financial Issues Affecting Rural and Remote Care Providers*, February 2016, p. 57.

Aged care services in rural and remote Australia are experiencing particular challenges in accessing the necessary workforce to provide services to older Australians living in these areas.⁶⁸

4.76 Further, aged care service providers can also struggle to maintain consistent funding in order to engage staff. This is particularly an issue for remote and very remote services with a small client base. One example raised during this inquiry is that of the limitation on 'social leave' of up to 52 nights per year for aged care residents, after which government funding for the aged care place ceases. This can impact on aged care service providers in remote locations where Aboriginal or Torres Strait Islander residents may need to visit their home communities for cultural purposes, and who may exceed the 52 day limit.⁶⁹

4.77 Health Workforce Australia explained that these extra and well-documented challenges include:

- distance from family and friends;
- feelings of professional and/or personal isolation;
- lack of employment opportunities for partners;
- lack of preferred schooling opportunities for children;
- lack of professional development opportunities;
- lack of local community amenities (eg. theatre, restaurants, etc.);
- higher workloads and on-call hours; and
- poor workplace infrastructure.⁷⁰

4.78 The section below will look at two key challenges particularly relevant to regional and remote aged care workforce: attracting and retaining workers and lack of training.

Attracting and retaining workers

4.79 There are two distinct forms of challenges facing aged care providers in attracting and retaining aged care workers in regional and remote areas. The first are challenges that are specific to rural and regional areas, and the second are general challenges faced by the industry that are made more acute by the regional and remote location. For example, workers in regional and remote areas may face challenges in finding and being able to afford adequate housing and transport close to work, a challenge raised by Bess Home and Community Care Inc.⁷¹

68 Aged and Community Services Australia, *Submission 229*, p. 2.

69 Dr Kate Smith, Research Fellow, University of Western Australia, *Proof Committee Hansard*, 9 June 2017, pp. 31-32.

70 Health Workforce Australia, *Submission 133*, p. 23.

71 Ms Julie Cooper, Executive Officer, Bess Home and Community Care Inc, *Committee Hansard*, 28 September 2016, p. 9.

4.80 The issue of attracting particularly professional staff to regional and remote locations was highlighted by aged care service providers, including Bethanie Care:

Where we find it difficult currently – and I can only see it getting worse in the future – is when you are looking at professional staff, such as registered nurses and in particular allied health: physiotherapists, OTs and those sorts of people. They are very hard to attract to regional areas.⁷²

4.81 Some submitters suggest that due to the difficulties in attracting staff, regional and remote providers rely on agency (temporary) staff to fill vacancies, which can adversely impact on the costs of running services (including where temporary staff must be brought in to cover a vacancy), the quality of care provided and cohesiveness of workplace culture.⁷³

4.82 Some aged care providers stated the difficulty of attracting or retaining workers related to the lack of opportunities in regional and remote areas.⁷⁴

4.83 It is clear that while there are challenges in attracting suitably skilled and qualified staff to work in the aged care sector in regional and remote areas, there are also challenges in making use of the existing potential workforce in regional areas. Ms Nicky Sloan, Chief Executive Officer, Illawarra Forum Inc., informed the committee that, '[d]espite unemployment in our region – we do have significant unemployment across the region – we struggle to attract the workforce that we need.'⁷⁵

4.84 While the aged care sector, along with the health sector in general, is expanding in the Illawarra region of New South Wales, stakeholders are also trying to find ways to 'broaden the profile of the aged care sector,' to attract younger people and also men into the sector.⁷⁶

4.85 The available workforce in the Wollongong and Illawarra region of New South Wales has in recent times been affected by the loss of job opportunities in other industries, but aged care providers have found that the sector is not seen, and in many cases is not, an attractive industry for many workers moving out of other, higher paid, industries, a point raised by Catholic Care:

Especially in Wollongong, we did a lot of work with members leaving BHP and looking for a new place to work, and there was just not the

72 Ms Joanne Christie, Chief, People and Culture, The Bethanie Group Inc, *Committee Hansard*, 28 September 2016, pp. 1-2.

73 Illawarra Forum, *Submission 212*, p. 8.

74 See for example: Mrs Hazel Gordon, Facility Manager, Wattle Hill Lodge Inc, *Committee Hansard*, 28 September 2016, p. 28.

75 Ms Nicky Sloan, Chief Executive Officer, Illawarra Forum Inc, *Committee Hansard*, 6 March 2017, p. 2.

76 Mr David Muscio, Project Officer, RDA Illawarra, *Committee Hansard*, 6 March 2017, p. 1.

competitiveness in wages for that to sustain them to work full time in the aged-care industry.⁷⁷

4.86 In Port Augusta, South Australia, the Port Augusta City Council is a provider of two residential aged care facilities and provided evidence to the inquiry that a key issue in relation to attracting and retaining registered and enrolled nurses, is the competition with other services, including the local hospital and the Port Augusta prison. This is because '[p]ublic sector employees are paid at higher pay rates and also have the benefit of more attractive salary-sacrificing options here in Port Augusta.'⁷⁸

4.87 Competition with other sectors was raised by a number of submitters, as there are often more attractive conditions available in the acute health sector, services associated with the National Disability Insurance Scheme, and other services, including those provided through Multi-Purpose Services (MPS). The MPS Program, a joint Commonwealth-state/territory initiative, provides 'integrated health and aged care services to small regional, rural and remote communities,' and was recently provided with additional funding of \$8.5 million.⁷⁹

4.88 The Multi-Purpose Services Programme (MPS) is a joint initiative of commonwealth, state and territory governments to provide integrated health and aged care services for some small rural and remote communities: 'It allows services to exist in regions that could not viably support stand-alone hospitals or aged care homes'.⁸⁰

4.89 MPSs receive funding from the Commonwealth for the delivery of aged care services, with the relevant state or territory government providing funding for a range of health services.

4.90 The National Foundation for Australian Women is supportive of the collaborative approach underpinning the MPS program:

The development of Multi-Purpose Services 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.⁸¹

4.91 Another key issue for Port Augusta is the challenge of finding suitably qualified staff, particularly personal care attendants. The committee heard that the use

77 Mrs Deanna Maunsell, Manager, Aged and Disability, Catholic Care Wollongong, *Committee Hansard*, 6 March 2017, p. 9.

78 Mrs Anne O'Reilly, Director, Community Services, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 1.

79 The Hon. Ken Wyatt, MP, Assistant Minister for Health and Aged Care, '[\\$8.5 Million in Additional Funding for Aged Care Services in Regional, Rural and Remote Australia](#)', *Media Release*, 24 January 2017.

80 Department of Social Services, [Ageing and Aged Care, Multi-Purpose Services Programme](#), accessed 16 February 2016.

81 National Foundation for Australian Women, *Submission 105*, p. 22.

of agency staff presented challenges, especially covering additional costs such as travel and accommodation for staff brought in from other locations, for which no additional funding is available, as the City is not eligible for any supplementation. The City of Port Augusta indicated that 'being a regional centre there is no acknowledgement of those higher costs in relation to staffing'.⁸²

4.92 To address these issues, the City of Port Augusta established a training program in partnership with a local training provider (TAFE SA), and accessed funding through the Regional Development Australia Far North program funding.⁸³

4.93 The Illawarra Regional Workforce Planning Strategy for the Aged Care Sector recommended a strategy to 'enhance community awareness about the Aged Care sector and improve its visibility in the community'. It does this by producing promotional material, conducting Career Expos, promoting government programs such as Young at Heart with TAFE and using social media platforms to advance aged care and the broader community and disability services sectors.⁸⁴

4.94 The committee heard that another issue aged care service providers is the move to CDC, which presents a challenge for regional but particularly remote and very remote aged care providers and workers alike:

The thing is: a marketised model is probably not going to work very well in regional and remote areas where you do not have the demand. It just does not work. Maybe the goal in these regional areas is not to have a choice of multiple, different providers but to have real and meaningful control over your care and the way it is delivered.⁸⁵

Lack of training

4.95 Further to the training issues considered in chapter three, the committee notes that there are several training related challenges specific to regional and remote aged care providers and workers.

4.96 The quality of training was raised on a number of occasions throughout the inquiry, with a number of submitters and witnesses identifying inconsistencies in the quality of training available as contributing to the challenges of maintaining an appropriately qualified and skilled aged care workforce.

4.97 In particular, submitters stated that service providers in regional or remote locations can find it difficult to source good quality local training providers to cover the full range of training required by staff working in the aged care sector. For

82 Mrs Anne O'Reilly, Director, Community Services, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 1.

83 Mrs Anne O'Reilly, Director, Community Services, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 1.

84 Aged Care Illawarra Workforce Action Group, *Submission 148*, p. [2].

85 Ms Ellis Blaikie, Senior Policy Adviser, Combined Pensioners and Superannuants Association, *Committee Hansard*, 3 November 2016, p. 39.

example, in the Illawarra region, Catholic Care Wollongong indicated that 'there is a vast difference between different RTOs in the Illawarra.'⁸⁶

4.98 The prohibitive costs of either bringing trainers on-site or sending staff to a major centre to undertake training is another key issue affecting the aged care workforce in regional and remote areas. Port Augusta City Council stated that:

We also experience difficulties in relation to training of staff in that it costs more to hold training on site here in Port Augusta due to travel and accommodation for trainers and the increased cost of sending staff to Adelaide for training purposes. What we found previously was that not all certificate III qualified staff were job ready on employment.⁸⁷

4.99 Ms Sarah Brown, Chief Executive Officer, Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation, submitted that services should have flexibility to provide their own training:

In my experience, giving aged-care coordinators of staff on the ground some skills to train the support staff is much more sustainable. It means that education and training support is happening all the time and it is not from a for-profit company, where they are coming in for a couple of days and they have got no real idea of the culture of the place or the cultural priorities.⁸⁸

4.100 Where training is not available locally, there can be considerable costs involved in getting staff to the location of training and covering their shifts while they are away. This was highlighted by Bess Home and Community Care Inc., an organisation which operates in regional Western Australia:

The main bulk – I would say 99.9 per cent – of the training that is offered is always around the Perth area. If you want to put some staff through, say, medication training, half of your workforce goes up to Perth. So you have to pay for the course and their accommodation and we do not have the staff backup to cover them.⁸⁹

4.101 Some aged care providers have developed innovative solutions to the challenge of providing appropriate training to aged care workers, or people seeking to enter the industry, through partnerships with training providers. Hall and Prior Health and Aged Care Group implemented a training program in Albany, Western Australia, in partnership with the Chamber of Commerce and Industry and what is now called the Great Southern Institute of Technology. This training program:

86 Mrs Deanna Maunsell, Manager, Aged and Disability, Catholic Care Wollongong, *Committee Hansard*, 6 March 2017, p. 11.

87 Mrs Anne O'Reilly, Director, Community Services, Corporation of the City of Port Augusta, *Committee Hansard*, 7 March 2017, p. 2.

88 Ms Sarah Brown, Chief Executive Officer, Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation, *Committee Hansard*, 7 March 2017, p. 11.

89 Ms Cara Kekkula, Manager, Bess Home and Community Care Inc, *Committee Hansard*, 28 September 2017, p. 3.

garner[ed] attention because we won a national award for it, but it was a real solution to a real problem of how to manage older people with high and complex care needs in a regional centre by staff, who, up to then, had not been adequately trained to meet those care needs.⁹⁰

4.102 The impact of changes in policy direction or support by government can be significant. For example, the funding that had supported this successful partnership between Hall and Prior Health and Aged Care Group, Great Southern Institute of Technology and the Chamber of Commerce and Industry in Albany was removed or substantially reduced.⁹¹

4.103 Submitters highlighted the need for greater cooperation between Commonwealth, state, territory and local governments across health, disability and aged care services in regional and remote areas to take advantage of the economies of scale and scope.⁹²

4.104 The Australian College of Rural and Remote Medicine recommends that the committee explore opportunities for 'cooperative management' of Commonwealth, state, territory and local government funded aged care resources in regional and remote communities.⁹³

4.105 In 2015, the government undertook an examination of Commonwealth-funded aged care workforce activities. The analysis covered activities implemented over a three year period from 2011–12 to 2013–14.

4.106 A key finding of the government's *Stocktake and Analysis of Commonwealth-Funded Aged Care Workforce Activities* report was that: 'Consideration should be given to developing specific strategies in respect of the workforce in regional and remote areas.'⁹⁴ This finding was based on analysis which showed that only around 3.7 per cent of Commonwealth funded aged care workforce activities, and 7.9 per cent of funding, were listed as specifically for regional, rural and remote service provision.⁹⁵

4.107 Recognition of the specific characteristics and challenges of remote service delivery will be needed in developing any strategy to strengthen the aged care workforce in remote locations. For this reason the NFAW recommends that:

90 Mrs Jennifer Grieve, General Manager Health and Care Services WA, Hall and Prior Health and Aged Care Group, *Committee Hansard*, 28 September 2016, pp. 21-22.

91 Mrs Jennifer Grieve, General Manager Health and Care Services WA, Hall and Prior Health and Aged Care Group, *Committee Hansard*, 28 September 2016, pp. 22.

92 Yass Valley Aged Care, [Submission 59](#), p. 11; Australian College of Rural and Remote Medicine, [Submission 251](#), p. 4.

93 Australian College of Rural and Remote Medicine, [Submission 251](#), p. 4.

94 Health Outcomes International, [Stocktake And Analysis Of Commonwealth Funded Aged Care Workforce Activities: Final Report](#), Department of Social Services, 2015, [p. 6].

95 Health Outcomes International, [Stocktake And Analysis Of Commonwealth Funded Aged Care Workforce Activities: Final Report](#), Department of Social Services, 2015, [p. 6].

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.⁹⁶

4.108 The Greater Northern Australia Regional Training Network (GNARTN), a cross-jurisdictional network funded by the government has been developing an issues paper on the aged care workforce in the Northern Territory. Mr Robert McPhee of the Kimberley Aboriginal Medical Service, a member of the GNARTN, told the committee that the issues paper, part of a series, has identified around 12 recommendations relating to aged-care workforce issues in northern Australia. Mr McPhee informed the committee that the completed issues paper will be submitted to the government for consideration.⁹⁷

Committee view

4.109 The evidence presented during this inquiry confirms the findings of the ACFA report and the *2016 National Aged Care Workforce Census and Survey*. The issues of high turnover and recruitment and retention of staff have been consistent themes for aged care service providers outside of major urban centres.

4.110 There are particular needs for training the aged care workforce for regional and remote areas that will need innovative approaches, most likely across aged and disability care and the health sector.

4.111 The recently announced National Aged Care Workforce Strategy will need to address the particular needs of regional and remote service delivery, particularly in the context of CDC, and work in collaboration with stakeholders to arrive at locally relevant and workable solutions to challenges facing particular regions or communities.

4.112 The taskforce should consider work already undertaken by the Greater Northern Australia Regional Training Network (GNARTN) in its issues paper on aged care workforce issues in the Northern Territory.

Concluding committee view

4.113 The committee acknowledges the particular challenges facing aged care workers and service providers in delivering services to a diverse and geographically dispersed ageing population. As part of this inquiry, the committee has had the opportunity to visit and see first-hand, and to hear compelling evidence from, these service providers, aged care workers and other stakeholders. Their message has been clear: there is a need for a more tailored, flexible approach to aged care service delivery, particularly in remote and very remote areas.

96 National Foundation for Australian Women, *Submission 105*, p. 22.

97 Mr Robert McPhee, Deputy Chief Executive Officer, Kimberley Aboriginal Medical Services, Proof Committee Hansard, 9 June 2017, p. 7.

4.114 Aged care service providers delivering services to Aboriginal and Torres Strait Islander communities, particularly in more remote locations and often as the sole provider, are struggling to adapt to the CDC model, indicating a need for review and change. The committee notes that the government has programs available to assist workers and service providers. However, the evidence from this inquiry shows that some aged care service providers are either unable to access these programs or are unaware of their existence. In some cases, the available support programs do not address the particular needs of the aged care service providers and/or their workforce.

4.115 Equally, service providers delivering services to CALD and LGBTI people are facing difficulties delivering training to prepare and develop the skills of aged care workers in maintaining culturally appropriate care, and in the case of LGBTI workers, of ensuring equitable access to employment.

Chapter 5

Conclusion and recommendations

5.1 The aged care sector in Australia is undergoing significant growth and change. Factors contributing to this include:

- the growth in the ageing population, and projections of a significant rise in the proportion of people aged 65 and over;
- increasing diversity in the ageing population;
- greater complexity of healthcare needs in those accessing aged care;
- significant changes to aged care service delivery and the impact of new technologies; and
- growth and change in other sectors, in particular, the disability care sector with the roll out of the National Disability Insurance Scheme (NDIS).

5.2 The government has placed considerable focus on establishing the NDIS and establishing a user determined model for disability service delivery, which it has also introduced into the aged care sector as the 'consumer directed care' (CDC) model. It is the view of this committee that, in doing so, there has not been sufficient focus on the unique challenges associated with aged care service delivery and with the changing aged care sector. This is particularly evident in relation to regional and remote services and service delivery to diverse communities.

5.3 The committee is concerned to ensure that service delivery changes, and other ongoing challenges facing the aged care sector, receive sufficient focus and support from government.

5.4 The committee has heard that the aged care workforce will need to grow by two per cent per year to accommodate demand for services, yet there is no clear plan in place as to how this will be achieved. The committee also heard that ageing Australians living in remote or very remote locations, and the service providers and workers delivering services to them, cannot rely on the CDC model of service delivery alone to provide an appropriate level of care.

5.5 The aged care workforce, which is the focus of this inquiry, is being significantly affected by ongoing issues with pay and conditions. Workers often struggle to secure competitive pay and conditions, relevant and timely training, and have fewer career and advancement opportunities than may be available in other comparable sectors. They also face, in the changing aged care sector, greater insecurity as the model of service delivery changes. For regional and remote workers, these challenges are felt more acutely, particularly in relation to training and professional development, and insecurity in the face of the introduction of CDC.

5.6 There are four key themes that arose during the inquiry:

- the need for an integrated sector-wide workforce development strategy;

- the need for improved training;
- the need for further workforce and workplace regulation; and
- the particular challenges facing the aged care workforce in remote communities.

Aged care workforce development strategy

5.7 Throughout this inquiry, there has been an almost universal call for a workforce strategy that should be developed by key stakeholders in the aged care sector, including service providers, representatives of workers, consumers, their carers, and government.

5.8 The committee welcomes the government's announcement to commit resources to support the establishment of an industry-led taskforce to develop a national aged care workforce strategy. The committee also notes the aim of the taskforce to explore short-, medium-, and long-term options to address supply, demand and productivity issues for the aged care workforce.

5.9 In establishing and setting the direction for the workforce strategy taskforce, the following issues have been identified during this inquiry that should be addressed:

- taskforce composition;
- interaction with the NDIS Integrated Market, Sector and Workforce Strategy;
- workforce issues including wages and conditions, career structures, development opportunities and succession planning;
- deficiencies in data;
- the role of informal carers and volunteers;
- the role of medical and allied health professionals;
- mandatory minimum nursing requirement; and
- the challenges of service delivery to a diverse, and geographically dispersed, population.

Taskforce composition

5.10 The committee considers that the aged care taskforce must be representative of all stakeholders in the aged care sector. The composition of the taskforce should include representation from across the full range of service providers (public (state, territory and local government), for-profit, not-for-profit, urban-based, remote and very remote), workforce representatives from across the spectrum of aged care sector employment categories, including nurses, care workers/personal care attendants, medical and allied health professionals, and others, and representatives of consumers and volunteers.

5.11 The committee notes that the government regulates, sets the policy direction for and is the main source of funding and revenue in the aged care sector. The committee considers that the government has a responsibility to ensure that the aged care sector responds to workforce challenges in a way that will make best use of the

considerable public funding that supports and underpins the aged care sector. The government should be more than a mere 'facilitator' for an industry-led response to the aged care workforce challenges.

5.12 Given that the strategy must be developed within the broader context of aged, disability and health care delivery, the government must play a key role in the development of the workforce strategy to ensure the proper alignment of policy and outcomes across different sectors, where this will achieve better service delivery, value for public expenditure and address workforce shortage issues. These are not matters that the aged care industry can or should be required to achieve on its own, or even with government facilitation. This is something that requires active participation and leadership from government.

5.13 The committee believes it will be important to take an holistic approach to the National Aged Care Workforce Strategy, to ensure that all levels of government, consumers and related stakeholders are appropriately consulted in the development and implementation of the Strategy.

Recommendation 1

5.14 The committee recommends that the aged care workforce strategy taskforce be composed of representatives of service providers, workforce groups, including nurses, care workers/personal care attendants, medical and allied health professionals, and others, and representatives of consumers and volunteers. Representatives of workers, care providers and consumers from regional and remote areas should also be included.

Recommendation 2

5.15 The committee recommends that the government, as a key stakeholder in aged care in terms of regulation, policy, intersections with other sectors and the coordination of government involvement, and as the key source of funding and revenue for the aged care sector, must be an active participant of the taskforce and must take ownership of those aspects of the workforce strategy that will require government intervention and / or oversight.

Interaction with NDIS Integrated Market, Sector and Workforce Strategy

5.16 The committee has heard the concerns raised by the aged care sector that providers will progressively lose staff to disability service providers, and particularly so in regional and remote areas. The committee also notes that the government has recognised the similarities in the kinds of work undertaken, skills and knowledge required to provide aged care and disability services.

5.17 Evidence presented to the committee indicates that while many stakeholders welcome moves to better coordinate care across different sectors, for example, the disability sector, there are concerns that aged care policy, programs and funding may be at risk as a result of this move, which may see a shift of focus (and potentially resources) away from aged care service provision.

5.18 The committee further notes the 2017-18 Budget announcement of \$33 million over three years to increase the supply of aged care and disability workers in rural, regional and outer suburban areas, with funding drawn from the Department of Health and Department of Social Services.

5.19 The committee considers that the aged care workforce strategy must be developed within the broader context of aged, disability and health care delivery. It should include review and consideration of existing programs and resources available, and refer to the NDIS Integrated Market, Sector and Workforce Strategy. The strategy must consider the opportunities that arise from overlapping workforce issues for the aged care and disability sectors, as well as the competitive pressures that are now beginning to emerge.

Recommendation 3

5.20 The committee recommends that the aged care workforce strategy include a review of existing programs and resources available for workforce development and support and ensure consideration of the NDIS Integrated Market, Sector and Workforce Strategy to identify overlapping issues and competitive pressures between the sectors and how they may be addressed.

Workforce issues

5.21 The committee notes the evidence of poor working conditions in the aged care sector, including comparatively lower pay than other similar sectors, lack of sector-wide career structures, difficulties for workers in accessing development opportunities and concerns over workplace health and safety issues. The committee considers these matters that affect many individuals in the aged care sector, and which can also impact on the quality of care delivered, require urgent attention and should be a primary focus of the workforce strategy.

5.22 The committee is concerned that pay and conditions for workers in the aged care sector are now becoming more uncompetitive with other sectors with the move to 'zero hour' contracts, which are intended to provide flexibility for aged care service providers, but which have the impact of further marginalising aged care sector workers and making the industry a less attractive alternative for workers.

5.23 The reputation of the aged care sector as a career choice for workers has been recognised by the industry as a significant barrier to attracting and maintaining staff. The committee considers that addressing the key workforce issues will go some way to rehabilitating the reputation of the industry; however, industry and other stakeholders also have a role in developing a more positive image of the industry.

5.24 The committee commends the work being undertaken by the sector to improve the image of the aged care sector, and considers the aged care workforce strategy as an important means of broadening these efforts across the whole sector.

Recommendation 4

5.25 The committee recommends that, as part of the aged care workforce strategy, the aged care workforce strategy taskforce be required to include:

- **development of an agreed industry-wide career structures across the full range of aged care occupations;**
- **clear steps to address pay differentials between the aged care and other comparable sectors including the disability and acute health care sectors;**
- **mechanisms to rapidly address staff shortages and other factors impacting on the workloads and health and safety of aged care sector workers, with particular reference to the needs of regional and remote workers including provision of appropriate accommodation; and**
- **development of a coordinated outreach campaign to coincide with developments introduced through the workforce strategy to promote the benefits of working in the aged care sector.**

Deficiencies in data

5.26 The committee acknowledges the work undertaken by the National Institute for Labour Studies (NILS) at Flinders University in ongoing surveys of aged care service providers and the aged care workforce, and considers it essential that this work should continue into the future. The committee notes, however, the limitations of the data available in relation to aged care and aged care service delivery. The lack of nationally agreed standards enabling the collection and analysis of the composition of the workforce across all relevant occupation groups needs to be addressed.

5.27 The committee considers it essential that the aged care taskforce review the workforce and other industry data available and ensure it meets the industry's needs for planning (and reporting) purposes. It is also necessary to ensure that data review and development enables comparisons between sectors, for example, the disability and acute health sectors.

Recommendation 5

5.28 The committee recommends that the aged care workforce strategy taskforce include as part of the workforce strategy a review of available workforce and related data and development of national data standards in a consultative process with aged care sector, and broader health sector and other relevant, stakeholders. Any nationally agreed data standards should enable comparison across and between related sectors where possible.

Informal carers and volunteers

5.29 The committee acknowledges the role of informal carers and volunteers in the provision of aged care services. The committee has heard that there is some concern that the CDC model introduced to aged care does not sufficiently account for, or enable planning in relation to, informal carers and volunteers.

5.30 The committee considers the convening of the taskforce to develop an aged care workforce strategy an excellent opportunity to consider the role of informal carers and volunteers and the issues and challenges for these very important groups

within the context of the changing sector, and changes in the composition and size of these groups over time.

Recommendation 6

5.31 The committee recommends that the aged care workforce strategy include consideration of the role of informal carers and volunteers in the aged care sector, with particular focus on the impacts of both the introduction of consumer directed care and the projected ageing and reduction in these groups.

Medical and allied health professionals

5.32 The committee has heard evidence that allied health and medical professionals are underutilised in the aged care sector, particularly in rural and remote areas.

5.33 The committee agrees allied health and medical professionals need to be better integrated into the aged care sector. The committee considers that the proposed national aged care workforce strategy provides an opportunity to examine the current state of medical and allied health professional involvement in the aged care sector and opportunities to address care and skill shortages through better use of available medical and allied health resources.

Recommendation 7

5.34 The committee recommends that the national aged care workforce strategy includes consideration of the role of medical and allied health professionals in aged care and addresses care and skill shortages through better use of available medical and allied health resources.

Mandatory minimum nursing requirement

5.35 The committee is concerned that the ratio of workers to clients in some residential aged care facilities is too low, leading to the risk of compromising the quality of care delivered. It can also detract from the appeal of working in the aged care sector for many potential employees, and can lead to exit from the sector.

5.36 The committee notes the concerns expressed by residential care providers that mandating staff to patient ratios may not be the best solution to this challenge, and considers that mandating a minimum number of registered nurses working at any one time may be a more appropriate regulatory requirement. The committee also notes advice from the Department of Health that while a mandated staff to client ratio is not currently government policy, the government has been asked by the Australian Health Ministers' Advisory Council to consider, as part of the development of the single aged care quality framework, the inclusion of a standard that requires that clinical care provided in residential aged care be best practise and provided by a qualified clinician.

5.37 The committee also notes the findings of the Australian Law Reform Commission (ALRC) report on elder abuse commissioned by the Attorney General, which recommends that the government commission an independent evaluation of

research on optimal staffing models and levels in aged care, and most importantly, make use of the evaluation findings to assess the adequacy of current arrangements.

5.38 The committee considers that such an evaluation must be undertaken in close consultation with all industry stakeholders, including aged care workers and service users and consider the costs and benefits of a range of options for better ensuring appropriate levels of clinical care in aged care facilities and services, how best to implement any agreed approach, and monitoring and evaluation of outcomes.

5.39 The committee also considers that a mandated requirement for residential aged care facilities to publish their staff to client ratios should be explored, given the shift to consumer directed care. Publication of such information is appropriate in order to assist consumers to make informed choices in their aged care planning.

5.40 The committee notes that any regulatory requirement imposed on aged care service providers may require additional funding and support from governments in order to meet the requirement.

Recommendation 8

5.41 The committee recommends that the government examine the introduction of a minimum nursing requirement for aged care facilities in recognition that an increasing majority of people entering residential aged care have complex and greater needs now than the proportions entering aged care in the past, and that this trend will continue.

Recommendation 9

5.42 The committee recommends that the aged care workforce strategy include consideration of and planning for a minimum nursing requirement for aged care services.

Recommendation 10

5.43 The committee recommends that the government consider, as part of the implementation of consumer directed care, requiring aged care service providers to publish and update their staff to client ratios in order to facilitate informed decision making by aged care consumers.

Challenges of service delivery to a diverse, and geographically dispersed, population

5.44 The committee considers that the aged care workforce strategy must take into account the context within which service delivery occurs, and the location- or culturally-specific skills, knowledge and experience that may be required of the workforce delivering those services. In particular, the strategy should recognise and address the particular challenges for attracting, retaining and training staff in remote communities, including issues in relation to housing, security, transport and remuneration.

5.45 The committee considers that a 'one size fits all' approach, as is being rolled out through the implementation of the CDC model in aged care, is problematic. This is particularly evident in the remote and very remote locations the committee has had the

opportunity to visit and see first-hand as part of this inquiry. The committee has heard compelling evidence from service providers, aged care workers and other stakeholders of the need for a more tailored, flexible approach to aged care service delivery.

5.46 Aged care service providers delivering services to Aboriginal and Torres Strait Islander communities, particularly in more remote locations and often as the sole provider, are struggling to adapt to the CDC model, not through an unwillingness to try, but because this model is not appropriate to remote circumstances. In this context, a degree of uncertainty and concern over the ongoing viability of these services is adding to the existing challenges of attracting and retaining workers in remote locations. It is clear that more needs to be done to engage with and assist aged care workers and service providers operating in remote and very remote locations.

5.47 The committee notes that the government has supports and programs available to assist workers and service providers, but the evidence from this inquiry is clear: there are aged care service providers unable to access these services, or unaware of their existence. In some cases, the existing supports and programs intended to assist aged care providers do not meet their needs. The committee considers that these issues must be reviewed and addressed as a matter of priority.

Recommendation 11

5.48 The committee recommends that the government take immediate action to review opportunities for eligible service providers operating in remote and very remote locations to access block funding, whether through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program or through other programs. The committee further recommends that consideration be given to amending the 52 day limitation on 'social leave' for aged care residents living in remote and very remote aged care facilities.

Recommendation 12

5.49 The committee recommends that the Department of Health review the implementation of consumer directed care to identify and address issues as they emerge. Specific attention should be paid to any impacts on remuneration, job security and working conditions of the aged care workforce, and impacts on service delivery in remote and very remote areas, and to service delivery targeting groups with special needs, as identified in the Section 11-3 of the *Aged Care Act 1997*.

5.50 The committee considers it essential to ensure that services delivered to Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, and lesbian, gay, bisexual, transgender and intersex peoples, are accessible, do not present barriers to access, and are culturally appropriate and appropriately resourced.

Recommendation 13

5.51 The committee recommends that the aged care workforce strategy ensure consideration of the service delivery context in which the workforce is expected to perform. The strategy should also include medium and long term planning for location- and culturally-specific skills, knowledge and experience required of the

aged care workforce working with diverse, and dispersed, communities throughout Australia. This must specifically include addressing workforce issues specific to service delivery in remote and very remote locations.

Improved training

5.52 The committee is concerned by evidence there is considerable inconsistency in the quality, scope and suitability of aged care programs offered to students. Of particular concern is that some RTOs are offering courses that fall below the Australian Qualifications Framework (AQF) guidelines and standards. The committee notes that this means that some students are not attaining the necessary skills and practical training to commence work in the aged care sector.

5.53 The Committee notes the October 2015 Education and Employment References Committee inquiry into the vocational and education training (VET) sector, which made 16 key recommendations. Some recommendations were implemented by government, but not all. Key recommendations yet to be implemented include:

- Establishment of a scheme to ensure national consistency in disability worker training;
- Establishment of a disability worker registration scheme, including requirements for ongoing professional development;
- A national approach to State, Territory and Commonwealth service delivery accreditation programs; and
- ASQA maintain a close scrutiny of and give priority to the aged care training sector.

5.54 The same issues raised in the 2015 Education and Employment References Committee inquiry continued to be raised in this inquiry, specifically in relation to aged care training.

Recommendation 14

5.55 The committee recommends that all recommendations of the Senate Education and Employment References Committee inquiry into the operation, regulation and funding of private vocational education and training (VET) providers in Australia be implemented.

5.56 The committee notes the Australian Skills Quality Authority evidence that around 25 per cent of courses offered are still too short for people to get properly skilled and that no changes have been made to minimum course length requirements.

Recommendation 15

5.57 The committee recommends that the aged care workforce strategy taskforce work with Australian Skills Quality Authority to establish nationally consistent minimum standards for training and accreditation.

5.58 The committee notes the evidence that nursing courses do not have an aged care component as core curriculum, and there is a lack of dementia-skills training and that very few student nurses seek aged care facility placements during training.

Recommendation 16

5.59 The committee recommends that the aged care workforce strategy taskforce work with the Australian Nursing and Midwifery Accreditation Council (ANMAC) to establish aged care as a core part of the nursing curriculum, establish dementia skills training, and develop greater collaboration between the sector and nursing colleges to increase student placements in aged care facilities.

5.60 The committee is concerned at the particular challenges facing the aged care workforce in regional and remote areas in accessing appropriate training and professional development. It is clear that regional and remote aged care service providers often struggle to find appropriately trained workers, and that they also face difficulties in accessing affordable and suitable training opportunities for their staff, given the additional costs involved with travel, accommodation, temporary replacement staff, or in attracting trainers to more remote places to deliver training on-site.

Recommendation 17

5.61 The committee recommends that the government and the aged care workforce strategy taskforce develop a specific strategy and implementation plan to support regional and remote aged care workers and service providers to access and deliver aged care training, including addressing issues of:

- the quality of training;
- access to training;
- on-site delivery of training;
- upskilling service delivery organisations to deliver in-house training; and
- additional associated costs relating to regional and remotely located staff.

This strategy should take account of consultation and analysis such as that undertaken through the Greater Northern Australia Regional Training Network (GNARTN).

Recommendation 18

5.62 The committee recommends that the government work with the aged care industry to develop scholarships and other support mechanisms for health professionals, including nurses, doctors and allied health professionals, to undertake specific geriatric and dementia training. To succeed in attracting health professionals to regional and remote areas, scholarships or other mechanisms should make provision for flexible distance learning models, be available to aged care workers currently based in regional and remote areas, and include a requirement to practice in regional or remote locations on completion of the training.

Workforce and workplace regulation

5.63 The committee notes the concerns raised by aged care service providers and worker representatives that the absence of some form of registration of workers can have significant impacts, including on the cost and quality of care delivered in the aged care sector, and on the well-being of aged care workers.

5.64 The committee also notes the support for an examination of what might be the best approach in relation to workplace and workforce regulation, noting the concerns raised that any costs of regulation not unfairly burden aged care workers.

5.65 In examining aged care worker registration or other means of regulation, consideration must be given to ensuring that any restrictions on employment in the aged care sector are relevant and appropriate. In particular, the committee considers that historical criminal offences should be considered in employment decisions but should not automatically rule out a person's employment in the sector. The implementation of recommendations in the ALRC report on elder abuse in relation to the establishment of national employment screening for aged care workers and the establishment of a new serious incident response scheme, may help to ensure that appropriate and relevant factors are considered in the employment of aged care workers. The ALRC has also recommended that unregistered aged care workers be subject to the planned National Code of Conduct for Health Care Workers.

5.66 The committee notes the recommendations made during the committee's 2015 inquiry into violence and abuse against people with disability, regarding the regulation of the disability sector workforce and workplaces.

5.67 The committee further notes the work being done under the NDIS on care worker regulation. The committee believes that to enforce regulation and oversight in the disability sector but not in aged care, when there is growing workforce overlap, increases the risk to consumers in an unregulated aged care sector, where portions of the workforce might migrate to avoid scrutiny. The committee therefore considers that there is a need for aged care regulation to be at least consistent with that in the disability and acute health care sectors.

Recommendation 19

5.68 The committee recommends that the government examine the implementation of consistent workforce and workplace regulation across all carer service sectors, including:

- **a national employment screening or worker registration scheme, and the full implementation of the National Code of Conduct for Health Care Workers;**
- **nationally consistent accreditation standards;**
- **continuing professional development requirement;**
- **excluded worker scheme; and**
- **workplace regulation of minimum duration for new worker training.**

The regulation of the workforce must address:

- **historical issues impacting on employment of Aboriginal and Torres Strait Islander peoples; and**
- **ways to ensure the costs of this regulation are not passed on to workers.**

Concluding remarks

5.69 The committee has been continuously impressed by the dedication, passion and commitment of aged care workers and service providers operating in a very challenging and changing environment.

5.70 The committee particularly commends the individuals and organisations it has met on its visit to the Kimberley region of Western Australia, upon whom the delivery of services in remote communities depends.

Senator Rachel Siewert

Chair

APPENDIX 1

Submissions and additional information received by the Committee

Submissions

- | | |
|-----------|------------------------------------|
| 1 | CRANApplus |
| 2 | Name Withheld (plus an attachment) |
| 3 | Ms Sue Tettmann |
| 4 | Confidential |
| 5 | Confidential |
| 6 | Name Withheld |
| 7 | Ms Angela Gifford |
| 8 | Name Withheld |
| 9 | Mr Rod Wyber |
| 10 | Name Withheld |
| 11 | Confidential |
| 12 | Confidential |
| 13 | Confidential |
| 14 | Confidential |
| 15 | Confidential |
| 16 | Confidential |
| 17 | Confidential |
| 18 | Ms Marian Gedye |

19	Confidential
20	Confidential
21	Name Withheld
22	Confidential
23	Name Withheld
24	Confidential
25	Name Withheld
26	Confidential
27	Confidential
28	Confidential
29	Name Withheld
30	Confidential
31	Confidential
32	Confidential
33	Confidential
34	Name Withheld
35	Exercise and Sports Science Australia
36	Confidential
37	Confidential
38	Southern Migrant and Refugee Centre
39	Ms Marilyn Murray
40	Name Withheld
41	Confidential

42	Name Withheld
43	Confidential
44	Confidential
45	Confidential
46	Ms Carmel Egan
47	Confidential
48	Confidential
49	Confidential
50	Confidential
51	Confidential
52	Confidential
53	Confidential
54	Confidential
55	Name Withheld
56	Confidential
57	Confidential
58	Confidential
59	Yass Valley Aged Care Ltd
60	Confidential
61	Confidential
62	Confidential
63	Confidential
64	Confidential

65	Volunteering Tasmania
66	Name Withheld
67	Confidential
68	Ms Debra Ireland
69	Name Withheld (plus a supplementary submission)
70	Confidential
71	Confidential
72	Confidential
73	Confidential
74	J. Zubevich, E. Rogers and J. Lindley
75	Confidential
76	WA Dementia Training Study Centre
77	National Aged Care Alliance
78	Benetas (Anglican Aged Care Services Group)
79	Name Withheld
80	Ms Sheri Lochner
81	Name Withheld
82	Name Withheld
83	Dietitians Association of Australia
84	Confidential
85	Confidential
86	Confidential
87	Confidential

88	Name Withheld
89	Confidential
90	Confidential
91	Confidential
92	Confidential
93	Name Withheld
94	Name Withheld
95	Confidential
96	Confidential
97	Confidential
98	Name Withheld
99	Confidential
100	Confidential
101	Confidential
102	Confidential
103	Confidential
104	Australian Indigenous Doctors Association; Congress of Aboriginal and Torres Strait Islander Nurses and Midwives; Indigenous Allied Health Australia; and National Aboriginal and Torres Strait Islander Health Workers Association (plus nine attachments)
105	National Foundation for Australian Women (plus an attachment)
106	Australian Federation of AIDS Organisations; and National Association of People with HIV Australia
107	Confidential
108	Volunteering SA and NT

109	Jewish Care Victoria
110	Confidential
111	Name Withheld
112	Confidential
113	Name Withheld
114	Confidential
115	Name Withheld
116	Confidential
117	Name Withheld
118	Confidential
119	Confidential
120	Name Withheld
121	Confidential
122	Confidential
123	Name Withheld
124	Name Withheld
125	Confidential
126	Name Withheld
127	Confidential
128	Confidential
129	Name Withheld
130	Ethnic Communities' Council of Victoria
131	Confidential

132	Name Withheld
133	Rural Health Workforce Australia
134	NSW Nurses and Midwives' Association
135	Confidential
136	Confidential
137	Confidential
138	Confidential
139	Palliative Care Australia
140	Resthaven Inc
141	Name Withheld
142	Australian Psychological Society
143	Confidential
144	Confidential
145	Confidential
146	Dr Sharon Mackenzie
147	Health Care Consumers Association of the ACT Inc
148	Aged Care Illawarra Workforce Action Group
149	Name Withheld
150	Confidential
151	Confidential
152	Confidential
153	Confidential
154	Confidential

155	Confidential
156	Name Withheld
157	Name Withheld
158	Confidential
159	Name Withheld
160	Confidential
161	Name Withheld
162	Confidential
163	Confidential
164	Name Withheld
165	Mr Des Hartree
166	Name Withheld
167	Name Withheld
168	Dr Richard Curtain (plus an attachment)
169	Australian Blindness Forum
170	Centre for Cultural Diversity in Ageing
171	Audiology Australia
172	Ms Joanne Russell
173	Dr John Flynn and Ms Sandra O'Kane
174	Australian Centre for Evidence Based Aged Care
175	Confidential
176	Ms Judi Walker
177	Name Withheld

178	Australian Institute of Health and Welfare
179	DutchCare
180	Alzheimer's Australia
181	Ms Lea McCulloch
182	Quality Aged Care Action Group Inc
183	Salvation Army Aged Care Plus
184	Vision 2020 Australia
185	Mrs Kasia Bail and Mr Laurie Grealish
186	Ms Jacqueline Holloway
187	Australian College of Nurse Practitioners
188	Palliative Care Nurses Australia Inc
189	Association of Private Nursing Services
190	Presbyterian National Aged Care Network
191	Confidential
192	Name Withheld
193	Confidential
194	Confidential
195	Confidential
196	Ms Marion Cincotta
197	Confidential
198	Name Withheld
199	Confidential
200	Confidential

201	Confidential
202	Confidential
203	Confidential
204	Gratis Recruitment
205	Federation of Ethnic Communities' Councils of Australia
206	Australian Unity
207	Associate Professor Denise Jepsen
208	Allied Health Professions Australia
209	HammondCare
210	Australian Medical Association
211	Catholic Health Australia
212	Illawarra Forum (plus an attachment)
213	Brightwater Care Group
214	GLBTI Rights in Ageing Inc
215	Queensland Nurses' Union
216	Name Withheld
217	Australian Association of Gerontology
218	Name Withheld
219	Baptist Care Australia
220	Aged Care Guild (plus a supplementary submission)
221	Australian Bureau of Statistics (plus an attachment)
222	Leading Age Services Australia
223	IRT Group

224	Name Withheld
225	Australian Nursing and Midwifery Federation (plus two attachments)
226	Better Caring
227	Queensland Government
228	Confidential
229	Aged and Community Services Australia
230	Name Withheld
231	Name Withheld
232	Australian Society of Physician Assistants
233	Name Withheld
234	Name Withheld
235	Mr Denis Jones
236	Australian Association of Social Workers
237	Healthy Ageing Research Group, La Trobe University
238	Services for Australian Rural and Remote Allied Health
239	Confidential
240	Benevolent Society
241	Local Government Association of Northern Territory
242	Confidential
243	Australian Human Rights Commission
244	Health Services Union
245	Ms Jan Barham MLC
246	Business Council of Co-operatives and Mutuals

247	United Voice
248	Health Workers Union
249	Dr Maree Bernoth
250	Confidential
251	Australian College of Rural and Remote Medicine
252	Name Withheld (plus an attachment)
253	Attendant Care Industry Association
254	Australian Council of Trade Unions
255	Australian Services Union
256	UnitingCare Australia (plus a supplementary submission)
257	Name Withheld
258	Ms Mirrigan Dennis
259	Name Withheld
260	Name Withheld
261	Name Withheld
262	Name Withheld
263	Ms Mary Ebbott
264	Mr David Fraser
265	Ms Stephanie Warren
266	Name Withheld
267	Name Withheld (plus two attachments)
268	Municipal Association of Victoria
269	Carers Australia

270	Anglicare Australia (plus a supplementary submission)
271	Name Withheld
272	Volunteering Victoria
273	Name Withheld
274	Name Withheld
275	Aged and Community Services Tasmania
276	Speech Pathology Australia
277	National Disability Services
278	National Seniors Australia
279	Ms Jennifer Abbey
280	Name Withheld
281	Royal Australian College of General Practitioners (plus an attachment)
282	Occupational Therapy Australia
283	COTA Australia
284	Law Society of New South Wales
285	Australian College of Nursing
286	Name Withheld
287	Ms Kim McKenzie
288	Name Withheld
289	Ms Susan Henderson
290	Professor Sara Charlesworth
291	Victorian Healthcare Association
292	Confidential

293	Department of Health
294	People Living With HIV Community Forum WA
295	Combined Pensioners and Superannuants Association of NSW Inc Response from IRT Response from Australian Aged Care Quality Agency
296	National Rural Health Alliance
297	Confidential
298	Confidential
299	Confidential
300	Confidential
301	Dr Robyn Thompson
302	Aged Care Crisis Inc (plus two supplementary submissions and three attachments)
303	Hall and Prior Aged Care Organisation
304	Confidential
305	HANMAC Pty Ltd
306	Ms Jennifer Davis
307	Eldercare
308	National LGBTI Health Alliance
309	Mr Paul Baxter

Additional Information

- 1 New Roles in Community Services and Health Scoping Project, Community Services and Health Industry Skills Council, from Australian Association of Social Workers, received 28 April 2016
- 2 Valuing Lives, Living Well, The distinctive role of faith-based organisations in aged care in New Zealand, from Anglicare Australia, received 4 November 2016
- 3 Information following on from public hearings in late 2016, from Department of Health, received 3 March 2017
- 4 Information, from Warrigal, received 25 March 2017
- 5 Lungurra Ngoora Community Care Service Evaluation Report August 2010, from WA Centre for Health and Ageing, University of Western Australia, received 19 June 2017
- 6 Lungurra Ngoora - a pilot model of care for aged and disabled in a remote Aboriginal community – can it work?, from WA Centre for Health and Ageing, University of Western Australia, received 19 June 2017
- 7 'Gotta be sit down and worked out together': views of Aboriginal caregivers and service providers on ways to improve dementia care for Aboriginal Australians, from WA Centre for Health and Ageing, University of Western Australia, received 19 June 2017

Answers to Questions on Notice

- 1 Answers to Questions taken on Notice during 28 April public hearing, received from Australian Psychological Society, 11 May 2016
- 2 Answers to Questions taken on Notice during 28 April public hearing, received from Healthy Ageing Research Group, La Trobe University, 16 May 2016
- 3 Answers to Questions taken on Notice during 28 April public hearing, received from Australian Association of Gerontology, 19 May 2016
- 4 Answers to Questions taken on Notice during 28 April public hearing, received from Royal Australian College of General Practitioners, 23 May 2016
- 5 Answers to Questions taken on Notice during 28 April public hearing, received from Centre for Cultural Diversity in Ageing, 13 October 2016
- 6 Answers to Questions taken on Notice during 28 April public hearing, received from Speech Pathology Australia, 24 October 2016
- 7 Answers to Questions taken on Notice during 28 April public hearing, received from Australian Association of Social Workers, 3 November 2016

- 8 Answers to Questions taken on Notice during 27 September public hearing, received from Baptistcare, 27 October 2016
- 9 Answers to Questions taken on Notice during 27 September public hearing, received from St Ives Home Care, 9 November 2016
- 10 Answers to Questions taken on Notice during 27 September public hearing, received from Aged and Community Services WA, 30 November 2016
- 11 Answers to Questions taken on Notice during 28 September public hearing, received from Bethanie Group, 26 October 2016
- 12 Answers to Questions taken on Notice during 25 October public hearing, received from Occupational Therapy Australia, 25 November 2016
- 13 Answers to Questions taken on Notice during 26 October public hearing, received from MacDonnell Regional Council, 25 November 2016
- 14 Answers to Questions taken on Notice during 31 October public hearing, received from Wicking Dementia Research and Education Centre, University of Tasmania, 25 November 2016
- 15 Answers to Questions taken on Notice during 31 October public hearing, received from National Rural Health Alliance, 19 December 2016
- 16 Answers to Questions taken on Notice during 3 November public hearing, received from Services for Australian Rural and Remote Allied Health, 5 November 2016
- 17 Answers to Questions taken on Notice during 3 November public hearing, received from Australian Institute of Health and Welfare, 16 November 2016
- 18 Answers to Questions taken on Notice during 3 November public hearing, received from Alzheimer's Australia, 21 November 2016
- 19 Answers to Questions taken on Notice during 3 November public hearing, received from Department of Health, 29 November 2016
- 20 Answers to Questions taken on Notice during 3 November public hearing, received from Aged and Community Services Australia, 1 December 2016
- 21 Answers to Questions taken on Notice during 3 November public hearing, received from Department of Education and Training, 2 December 2016
- 22 Answers to Questions taken on Notice during 3 November public hearing, received from Palliative Care Australia and Palliative Care Nurses Australia, 2 December 2016
- 23 Answers to Questions taken on Notice during 3 November public hearing, received from Australian Bureau of Statistics, 5 December 2016
- 24 Answers to Questions taken on Notice during 3 November public hearing, received from Department of Immigration and Border Protection, 6 December 2016
- 25 Answers to Questions taken on Notice during 13 June public hearing, received from Department of Health, 19 June 2017

Correspondence

- 1 Letter clarifying evidence given at the 3 November 2016 public hearing, received from Australian Bureau of Statistics, 5 December 2016

Tabled Documents

- 1 Diagram, tabled by Healthy Ageing Research Group, La Trobe University, at Melbourne public hearing 28 April 2016
- 2 Opening statement, tabled by Australian Skills Quality Authority, at Melbourne public hearing 28 April 2016
- 3 Training for aged and community care in Australia report, tabled by Australian Skills Quality Authority, at Melbourne public hearing 28 April 2016
- 4 Australian Unity Independent and Assisted Living 2015 workforce by proportion and expected labour market employment growth table, tabled by Australian Unity, at Melbourne public hearing 28 April 2016
- 5 The Training Program Streaming and process of learning table, tabled by Australian Unity, at Melbourne public hearing 28 April 2016
- 6 Culture, Communication and Relationships brochure, tabled by Brightwater Care Group, at Perth public hearing 27 September 2016
- 7 Submission, tabled by Australian Regional and Remote Community Services, at Darwin public hearing 25 October 2016
- 8 Solutions from the frontline, practical approaches to reduce the risk of abuse in aged and disability services, tabled by NSW Nurses and Midwives Association, at Canberra public hearing 3 November 2016
- 9 Who will keep me safe, Elder Abuse in Residential Aged Care, tabled by NSW Nurses and Midwives Association, at Canberra public hearing 3 November 2016
- 10 Nurses are Essential in Health and Aged Care Reform, A White Paper by ACN 2016, tabled by Australian College of Nursing, at Canberra public hearing 3 November 2016
- 11 Nurse Leadership, A White Paper by ACN 2015, tabled by Australian College of Nursing, at Canberra public hearing 3 November 2016
- 12 Updated information for the Commonwealth's submission (no. 293), tabled by Department of Health, at Canberra public hearing 3 November 2016
- 13 Snap shot of LBHA Care Staff statistics, tabled by Lower Burdekin Home for the Aged Society, at Townsville public hearing 23 February 2017
- 14 My health, Queensland's future: Advancing health 2026, tabled by Queensland Health, at Townsville public hearing 23 February 2017

APPENDIX 2

Public hearings

Thursday, 28 April 2016

Hotel Grand Chancellor, Melbourne

Witnesses

Health Services Union

JACOBSON, Mr Tim, National Assistant Secretary

SVENDSEN, Ms Leigh, Senior National Industrial Officer

Health Workers Union

EDEN, Mr David, Assistant Secretary

BEKHAZI, Mr Kamal, Research and Project Officer

Healthy Ageing Research Group, La Trobe University

WELLS, Professor Yvonne, Coordinator

EDVARDSSON, Professor David, Director, Austin Health and Northern Health
Clinical School of Nursing

OAKMAN, Dr Jodi, Head, Department of Public Health; and Program Coordinator of
Ergonomics, Safety and Health, Centre for Ergonomics and Human Factors, School of
Psychology and Public Health

CHARLESWORTH, Professor Sara,

School of Management, Centre for People, Organisations and Work, RMIT University

Australian Centre for Evidence Based Aged Care, La Trobe University

FETHERSTONHAUGH, Dr Deirdre Marie Anne, Director

BAUER, Dr Michael, Senior Research Fellow

RAYNER, Dr Jo-Anne, Senior Research Fellow

WINBOLT, Dr Helen (Margaret), Senior Research Fellow

WHILE, Mrs Christine, Research Fellow

Royal Australian College of General Practitioners

WENCK, Dr Beres, Chair, Expert Committee, General Practice Advocacy and
Funding

Australian Association of Gerontology

STIRLING, Dr Christine Mary, Vice President, Board

Allied Health Professions Australia

OKE, Ms Lin, Executive Officer
CORDOBA, Mr Sebastian, Representative
LEWIS, Ms Amy, Representative

Australian Psychological Society

STOKES, Mr David Lewis, Acting Head, APS Institute
ROUFEIL, Dr Louise, Executive Manager (Professional Practice)

Audiology Australia

COLES, Dr Tony, Chief Executive Officer
DEWBERRY, Ms Margaret, Member

Speech Pathology Australia

CARTWRIGHT, Dr Jade, National Adviser Aged Care
BENNETT, Dr Michelle, National Aged Care Working Group Member

Vision 2020 Australia

FITZSIMMONS, Ms Haylea, Policy and Advocacy Coordinator
ARMSTRONG, Ms Jaci, Principal Policy Adviser, Guide Dogs Australia
CHAPLIN, Mr Rikki Bernard, Advocacy and Policy Officer, Blind Citizens Australia

Ethnic Communities' Council of Victoria

LAU, Mrs Marion, Deputy Chairperson
SEMPLE, Ms Jenny, Chief Executive Officer, Southern Migrant and Refugee Centre
TSIGARAS, Mr Elias, Deputy Director, New Hope Foundation

DutchCare

MICHAEL, Ms Penni, Manager Business Development

Jewish Care Victoria

COOKSON, Ms Julia, General Manager People and Culture
ROB, Ms Daniyela, Implementation Manager, Person Centred Approaches

Centre for Cultural Diversity in Ageing

PETROV, Ms Ljubica, Manager

Australian Skills Quality Authority

ROBINSON, Mr Christopher, Chief Commissioner and Chief Executive Officer
GRIFFITHS, Ms Bronwen, Manager, Strategic Reviews

Australian Unity

McMILLAN, Mr Derek, Chief Executive Officer, Independent and Assisted Living
HOUSTON, Ms Annette, Manager, Indigenous Development

Tuesday, 27 September 2016

International on the Water Hotel, Perth

Witnesses

Aged and Community Services Australia, Western Australia

LOVELLE, Mr Trevor, Chief Executive Officer

Juniper

HARDING, Mr Vaughan, Chief Executive

ANTONUCCI, Mrs Margaret, Manager, Training and Development

Curtin University

GRIBBLE, Mr Nigel Charles, Lecturer and Researcher

St Ives Home Care

DE RONCHI, Ms Liza Michelle, Chief Operating Officer

BRIERTY, Ms Emma, General Manager Western Australia

PRETORIUS, Miss Samantha, Human Resources Manager

BaptistCare

TOMKINSON, Mrs Rebecca, Chief Operating Officer

VIVIAN, Mrs Amanda, Chief Support Services

People Living with HIV Community Forum WA

BUCKLEY, Mr Neil, Community Aged Care Spokesperson

HASTINGS, Dr Robert, Aged Care Committee Spokesperson

MONTAUT, Ms Katrina, Private capacity

Brightwater Care Group Limited

LAWRENCE, Ms Jennifer, Chief Executive Officer

LITURI, Ms Danyelle, Acting General Manager, People Services

United Voice

GONZALEZ, Ms Catalina, Organising Director, Executive

MITCHELL, Ms Jodie, Organiser

CLARKE, Ms Philippa, Research Officer

CLARKE, Ms Jude, Delegate

OGANYO, Brenda, Delegate

Wednesday, 28 September 2016

Hotel Lord Forrest, Bunbury

Witnesses

The Bethanie Group Inc

CHRISTIE, Ms Joanne, Chief, People and Culture

BEER, Ms Sharon, Facility Manager, Bethanie Fields ACF

Bess Home and Community Care Inc

COOPER, Ms Julie, Executive Officer

KESKKULA, Ms Cara, Manager

WA Primary Health Alliance

LAURENTSCH, Ms Krystal, Aged Care Representative, Regional Clinical
Commissioning Committee

Opal Aged Care

JOSEPH, Mr Damon, Regional Manager WA

POPE, Ms Rebecca, HR Business Partner

Hall and Prior Health and Aged Care Group

PRIOR, Mr Graeme, Chief Executive Officer

GRIEVE, Mrs Jennifer, General Manager Health and Care Services WA

JACKSON, Mrs Linda, Manager of People and Risk

Wattle Hill Lodge Inc

GORDON, Mrs Hazel, Facility Manager

Tuesday, 25 October 2016

Parliament House, Darwin

Witnesses

Occupational Therapy Australia

O'REILY, Ms Nicole, Board Director

GELLE, Ms Roxanne, Industry Adviser

Australian Regional and Remote Community Services

STEPHENSON, Mr Paul, General Manager

ESPUIS, Ms Melanie, Senior Human Resources Adviser

Pearl Supported Care

TREACY, Mrs Sylvia Aletta, Residential Service Manager

The Local Government Association of the Northern Territory

TAPSELL, Mr Tony, Chief Executive Officer

Wednesday, 26 October 2016

Convention Centre, Alice Springs

Witnesses**MacDonnell Regional Council**

MARKS, Mr Rohan, Director, Community Services

Ngaanyatjarra Health Service

BOWMAN, Mr Geoff, Healthy Aging and Disability Program Manager

Central Desert Regional Council

SNELL, Ms Katie, Manager, Aged and Disability Services

Monday, 31 October 2016

Hotel Grand Chancellor, Launceston

Witnesses**Aged and Community Services Tasmania**

MATHEWSON, Mr Darren, Chief Executive Officer

VEITCH, Mrs Lee, Manager, Workforce and Innovation

Volunteering Tasmania

COVENTRY, Mr Donald Hugh, Deputy Chair

Australian Nursing and Midwifery Federation

THOMAS, Ms Lee, Federal Secretary

ELLIS, Ms Neroli, State Secretary, Tasmanian Branch

HURLEY, Ms Jennifer Margaret, Manager, Professional Programs, SA Branch

PRICE, Dr Kay, Associate Professor, School of Nursing and Midwifery, University of South Australia

WILLIS, Prof. Eileen Mary, Deputy Executive Dean, Faculty of Medicine, Nursing and Health Sciences, Flinders University

MURRAY, Ms Lani Gai, Registered Nurse

PECK, Mrs Sonya Maree, Registered Nurse

Health Services Union Tasmania Branch

MOORE, Mr Robert Eric, Assistant State Secretary

Australian Services Union

McFARLAND, Mr Angus, Assistant Secretary, New South Wales and ACT (Services) Branch

PRIMROSE, Ms Jan, Organiser, New South Wales and ACT (Services) Branch

BOZINOVSKI, Mr Robert, Research and Policy Officer, Victorian and Tasmanian Authorities and Services Branch

Carers Australia

ELDERTON, Ms Sue, National Policy Manager

Wicking Dementia Research and Education Centre, University of Tasmania

ROBINSON, Professor Andrew, Co-Director

VICKERS, Professor James, Co-Director

Dementia Training Study Centres

WINBOLT, Dr Helen Margaret, Former Director, Victoria and Tasmania, and Chair, National Leadership Group

Palliative Care Tasmania

JOHNSTONE, Ms Colleen, General Manager

KING, Ms Sharon, Program Manager, Northern Tasmania

Hobart District Nursing Service

MACGOWAN, Mrs Kim, Chief Executive

ONSLOW, Miss Fiona, Director of State-wide Operations

Primary Health Tasmania

EDMONDSON, Mr Phil, Chief Executive Officer

National Rural Health Alliance

BUTT, Mr David, Chief Executive Officer

Thursday, 3 November 2016

Parliament House, Canberra

Witnesses**Aged and Community Services Australia**

SPARROW, Ms Patricia, Chief Executive Officer

WITHAM, Ms Heather, Manager, Government Relations

Leading Age Services Australia

ROONEY, Mr Sean, Chief Executive Officer

RICHARDS, Ms Kay, National Policy Manager

PATTON, Ms Emma, Manager, Employment Relations

Aged Care Guild

O'REILLY, Mr Cameron, Chief Executive Officer

Australian Medical Association

KIDD, Dr Richard, Member

KOTZ, Ms Jodette, Senior Policy Adviser

Services for Australian Rural and Remote Allied Health

WELLINGTON, Mr Rodney, Chief Executive Officer

FARTHING, Ms Annie, Member

HammondCare

RAGUZ, Ms Angela, General Manager Residential Care

Catholic Health Australia

MAHER, Mr David, Managing Director, Catholic Healthcare

MERSIADES, Mr Nick, Aged Care Director

Anglicare Australia

MANDERSON, Mr Roland, Deputy Director
COOKE, Mrs Sue, Director, Service Delivery, Anglicare Southern Queensland
ROBERTSON, Mrs Jacinta, Positive Ageing Specialist, Anglicare SA
JAMIESON, Mr Andrew, Learning and Organisational Development Manager, Benetas

Alzheimer's Australia

SAMUEL, Professor Graeme, President
CAMPBELL, Mrs Jessica, Senior Executive Manager Policy, Programs and Research

Palliative Care Australia

CALLAGHAN, Ms Liz, Chief Executive Office

Palliative Care Nurses Australia

McINTYRE, Ms Lara, Member
PARKER, Ms Deborah, Member

COTA Australia

YATES, Mr Ian, Chief Executive

National Seniors Australia

LAWLESS, Ms Suzanne, Policy Manager
RADFORD, Dr Brendon, Senior Policy Adviser

Combined Pensioners and Superannuants Association

BLAIKIE, Ms Ellis, Senior Policy Adviser

Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

GIBBS, Ms Colleen, Senior Policy and Research Officer

Indigenous Allied Health Australia

MURRAY, Ms Donna, Chief Executive Officer

Australian College of Nursing

WARD, Adjunct Professor Kylie, Chief Executive Officer
GUNN, Mrs Michelle, Executive Director, Professional and Leadership

New South Wales Nurses and Midwives' Association

HOLMES, Mr Brett, General Secretary
MACUKEWICZ, Ms Helen, Professional Officer

Australian Bureau of Statistics

JONES, Ms Jacqui, Program Manager, Labour and Income Branch

Australian Institute of Health and Welfare

WEBSTER, Dr Adrian, Head, Expenditure and Workforce Unit
COOPER-STANBURY, Mr Mark, Acting Head, Community Services and
Communication Group

Department of Health

McCARTHY, Dr Margot, Deputy Secretary
BALMANNO, Ms Rachel, First Assistant Secretary
HALLINAN, Mr David, First Assistant Secretary

Australian Aged Care Quality Agency

RYAN, Mr Nick, Chief Executive Officer

Department of Employment

NEVILLE, Mr Ivan, Branch Manager

Department of Education and Training

PATTIE, Mr David, Acting Group Manager, Industry Skills and Quality
KINDER, Mr Tim, Acting Branch Manager, Workforce and Apprenticeships Policy
Branch

Thursday, 23 February 2017

Tony Ireland Stadium, Townsville

Witnesses

MIDSON, Mr Stephen John, Private capacity

Lower Burdekin Home for the Aged

COLLINS, Mr James (Jim), General Manager

Queensland Health

KRAAK, Mr Graham, Acting Senior Director, Strategic Policy and Legislation
Branch, Strategic Policy and Planning Division

Northern Regional Aboriginal and Torres Strait Islander Corporation

BOBBERT, Mr Darren, Chair
FISCHER, Miss Krys, Care Coordinator

Palm Island Aboriginal Shire Council

FRECKLETON, Mrs Lyn, Director of Community Services

Australian Society of Physician Assistants

FORDE, Mr Allan, Executive Committee Member and Advisor

BENEKE, Mrs Judith, Physician Assistant

Blue Care, UnitingCare Queensland

BRIDGES, Ms Tamra, General Manager

WEBBY, Mrs Glenys, Director, Service Reform

Warrina Innisfail

ROBERTS, Mr Peter Bruce, Chief Executive Officer

James Cook University

BIRKS, Professor Melanie, Head, Nursing, Midwifery and Nutrition

DAVIS, Ms Jennifer, Senior Lecturer, Nursing, Midwifery and Nutrition

LYNWOOD, Mr Shaedon, Student

TAFE Queensland

PYNE, Ms Jo, General Manager, TAFE Queensland North

CHARNLEY, Ms Bev, Manager, Community Services Lifecycle Management Authority

CREMA, Ms Lisa, Project Officer, Rural and Remote Training Project, TAFE Queensland North

DIXON, Mrs Teena, Registered Nurse and Teacher, TAFE Queensland North

HANMAC Pty Ltd

HANNA, Ms Leeanne, Trainer and Manager

BLOOD, Mrs Denielle, Graduate

Monday, 6 March 2017

Adina Apartment Hotel, Wollongong

Witnesses

RDA Illawarra

MURPHY, Ms Debra, Chief Executive Officer

MUSCIO, Mr David, Project Officer

Illawarra Forum Inc

SLOAN, Ms Nicky, Chief Executive Officer

Multicultural Communities Council of Illawarra

LACEY, Mr Christopher, General Manager

Catholic Care Wollongong

MAUNSELL, Mrs Deanna, Manager, Aged and Disability

Scope Home Access

REEVE, Ms Anne, Chief Executive Officer

IRT Group

McGLYNN, Mr Campbell, Head, People and Culture

TAFE NSW

MACKINNON, Ms Belinda, Deputy Regional General Manager

Warrigal

SEWELL, Mr Mark, Chief Executive Officer; and Director, Aged & Community Services NSW & ACT

Quality Aged Care Action Group

ZANGHI, Mrs Margaret, Chair

Yass Valley Aged Care Ltd

MORGAN, Ms Lynette (Lyn), Chief Executive Officer

TEWES, Mr Alex, Board Member

Australian Unity

HOUSTON, Ms Annette, Manager, Indigenous Development

CHATFIELD, Ms Kelly, Manager, Aboriginal Business Development

Illawarra Aboriginal Corporation

CRAIG, Miss Michelle, Chief Executive Officer

Tuesday, 7 March 2017

Hotel Grand Chancellor on Hindley, Adelaide

Witnesses

Corporation of the City of Port Augusta

O'REILLY, Mrs Anne, Director, Community Services

Wami Kata Old Folks Home Inc.

CHAPMAN, Ms Mandy Jane, Manager

Western Desert Nganampa Walytja Palyantjaku Tjutaku Aboriginal Corporation

BROWN, Ms Sarah, Chief Executive Officer

Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (Aboriginal Corporation)

McRAE, Ms Kim, Tjunga Team Manager

Aged and Community Services Australia

CENTOFANTI, Mrs Melissa, Divisional Chief Executive Officer SA and NT

Resthaven Inc.

HEARN, Mr Richard John, Chief Executive Officer

Gratis Recruitment

KAFKAKIS, Miss Stacey, Director

Exercise & Sports Science Australia

HENWOOD, Dr Tim, Member, Exercise Physiology Advisory Group

Matthew Flinders Home Inc.

McKEOWN, Mr Michael, Chief Executive Officer

Aboriginal Health Council of South Australia

DANN, Mr Robert, Workforce Development Officer

Anangu Ngangkari Tjutaku Aboriginal Corporation

PANZIRONI, Dr Francesca, Chief Executive Officer

Volunteering SA&NT Inc.

O'LOUGHLIN, Mrs Evelyn, Chief Executive Officer

CRANaplus

MALONE, Ms Gerardine Marie, Director, Professional Services
HAKENDORF, Ms Marcia, Professional Officer

National Institute of Labour Studies, Flinders University

MAVROMARAS, Prof. Kostas, Director
MOSKOS, Dr Megan, Research Fellow
ISHERWOOD, Dr Linda, Research Fellow

School of Nursing and Midwifery, Flinders University

HARRINGTON, Dr Ann, Associate Professor, Health Care for the Older Person

Friday, 9 June 2017

Mercure Hotel, Broome

Witnesses**Juniper**

SIFORD, Mrs Raelene, Executive Manager Residential
BLAND, Ms Liz, Transition Manager, Kimberley

Kimberley Aged and Community Services

NIXON, Ms Maxine, Team Leader, West Kimberley and Central Kimberley
CARROLL, Ms Sue, Home and Community Care Project Officer

Kimberley Aboriginal Medical Services

McPHEE, Mr Robert, Deputy Chief Executive Officer

Halls Creek People's Church Frail Aged Hostel

WILLIAMS, Ms Patricia, Facility Manager
ANDREW, Ms Edith Loretta, Lecturer, Aged Care and Health, East Kimberley,
North Regional TAFE

University of Western Australia

SMITH, Dr Kate, Research Fellow
JOSIF, Mrs Cathryn, Senior Project Officer, WA Centre for Health and Ageing
MALAY, Ms Roslyn, Project and Research Officer

Tuesday, 13 June 2017

Parliament House, Canberra

Witnesses

Department of Health

RULE, Ms Catherine, Acting Deputy Secretary

HALLINAN, Mr David, First Assistant Secretary

GRINBERGS, Ms Helen, Acting First Assistant Secretary

LAFFAN, Ms Amy, Assistant Secretary

APPENDIX 3

Summary of committee site visits related to the inquiry

This appendix contains summaries of the committee's visits to:

- IRT College in Wollongong, New South Wales, on 6 March 2017;
- Juniper Guwardi Ngadu Residential Care, Halls Creek Community Care, and Halls Creek People's Church Aged Care Facility in the Kimberley region, Western Australia (WA) on 8 June 2017; and
- Southern Cross Care in Broome, WA, on 9 June 2017.

Site visit to IRT College, Wollongong NSW

Introduction

On 6 March 2017, Senators Siewert, Duniam and Polley travelled to Wollongong NSW and participated in a site visit to IRT College.

[IRT College](#) is a Registered Training Organisation (RTO) operated by IRT Group, which provides accredited and non-accredited aged care, home and community care and other community service courses that have been developed by industry specialists.

IRT College has been operating since 2012, and is based in Wollongong. IRT College also offers online courses to meet flexible learning needs. In the 2015-16 financial year IRT offered 24 full qualification courses, including Certificate III courses in Aged Care, Home and Community Care.¹ A total of 280 students enrolled in full qualification courses in 2015-16.²

In February 2016 IRT College launched a pilot traineeship program to encourage young people to join the aged care sector. Sixteen year 11 students were employed as trainees in the two-year training program, and will gain a nationally recognised qualification and paid employment for a minimum of 700 hours.³

During the site visit, the Senators had the opportunity to:

- Meet and talk to some of the College's trainers and students and gain a more in-depth understanding of the College's training programs and people, as well as the regional challenges.
- See the College's demonstration equipment in action.

1 IRT Group, *Annual Report 2015-16*, p. 25,
<http://www.irt.org.au/images/PDFs/AGM2016/IRTAnnualReport2016.pdf>.

2 IRT Group, *Annual Report 2015-16*, p. 25.

3 IRT Group, *Annual Report 2015-16*, p. 25.

- Road test new technology for use in residential aged care and home care. This included technology currently under deployment, as well as new technologies still under research and evaluation.

Site visit to Juniper Guwardi Ngadu Residential Care

Senators Siewert, Dodson and Reynolds participated in the three site visits held in WA on 8 June 2017.

Introduction

On 8 June 2017 the committee travelled to Juniper Guwardi Ngadu Residential Care (JGNRC) in Fitzroy Crossing, WA to conduct a site visit. The committee was welcomed at the airport, transported to JGNRC and provided with a tour by Ms Elvira Even, Facility Manager at JGNRC. JGNRC provides residential care services, respite care for up to four weeks, and a bus service to provide residents transport to participate in community activities and cultural observances, such as 'sorry business'. JGNRC also provides catering for meals on wheels services under the Home and Community Care program.

Description of the facility

Juniper Guwardi Ngadu Residential Care consists of 10 residents' rooms which can accommodate up to three residents per room, allowing for 23 residents in total. The facility consists of a ring of buildings built around a central courtyard and communal eating and activity areas which includes some undercover and seating areas and a fire pit. The buildings surrounding this area consist of:

- residential rooms where the residents live;
- a common amenities area with a kitchen and laundry;
- an activities centre with art supplies; and
- an administrative area with staff offices.



Figure 1.1 & 1.2 (from left to right): View of the central outdoor area, including fire pit; and view of residents' room.

Facility staff

JGNRC employs 28 staff, including eighteen multi-skilled care staff, a registered nurse/clinical care coordinator (full-time), three enrolled nurses, a cook and kitchen hand staff. JGNRC also has casual employees who it uses to fill gaps in the roster.

Specialists, such as a dietitian and podiatrist, also visit the facility approximately once per month. The vision van visits the local hospital, which residents are transported by JGNRC to access. The local WACHS hospital does not provide allied health services for the residents at JGNRC.

Staff accommodation is limited, with three staff members living on-site in beds in the facility (it was pointed out that these could be used for further respite if there was more appropriate staff accommodation) and a further eight staff living in the workers camp, which is located approximately 2.5 kilometres away from the facility. JGNRC is currently in the process of seeking approval to build staff accommodation that will house up to 12 staff (including couples) on a block adjoining the facility. Such accommodation would free up beds in the facility, providing up to eight additional beds for community respite.

Facility residents

Residents at JGNRC ranged in age from 28 years and above. All residents are from the Fitzroy Valley, but come from five different Aboriginal and Torres Strait Islander language groups.

Art plays an integral part of the residents' daily lives, with six residents being world renowned artists. The local arts centre, Mangkaja Arts, displays work by several of the residents, and provides JGNRC with art supplies so that residents can create their artworks. Residents can also visit the arts centre and complete artwork there, and participate in educational activities, such as showing their artwork to school students who visit the centre.

Two of the residents also participate on the local radio station, and are provided with transport by JGNRC to do that.



Figure 1.3 & 1.4 (from left to right): Senator Siewert speaks to residents and artists about the baskets they are creating, while Senator Reynolds speaks with Leslie who participates on the local radio station; and image of former residents' art on one of the pathways in the facility.

Key challenges for the facility

During the tour, staff members of JGNRC told the committee about the key challenges JGNRC faces in attracting and retaining qualified staff, including:

- lack of appropriate staff accommodation;

- lack of adequate funding to support staff with the costs associated with living in a remote area; and
- geographical issues associated with living and working in a remote area – including difficulty attracting workers who want to stay long-term.

JGNRC staff noted that it is particularly difficult to attract staff during the 'wet season' when temperatures are high and the community is effectively 'cut-off' for a period of time.

Acknowledgments

On behalf of the committee, Senator Siewert explained to the staff and residents at JGNRC the purpose of the committee's visit and thanked them for warmly hosting the committee.

Site visit to Halls Creek Community Care

Introduction

Following the committee's visit to Juniper Guwardi Ngadu Residential Care on 8 June 2017, the committee travelled to Halls Creek Community Care (HCCC) in Halls Creek, WA to conduct a site visit. The committee was welcomed at the airport, transported to HCCC and provided with a briefing by Ms Kaye T Rangitutia, Coordinator, and staff of HCCC.

Services provided by HCCC

HCCC provides a range of services to people living in and from surrounding areas of Halls Creek, including:

- meals on wheels;
- transport;
- assistance with shopping;
- washing/laundry services;
- showering; and
- social support.

In addition to these services, HCCC also hosts activities, including picnics, barbeques and bus trips.

Clients can access up to three days of support at HCCC, and two days home care per week. Clients can also receive meals on wheels packages five days per week.

HCCC's on-site facility consists of:

- an administrative area with a main office and kitchen;
- toilets, shower and laundry amenities;
- an outdoor communal area; and
- storage space for art supplies and games/jigsaw puzzles.

HCCC also has two vehicles, a bus and a car, which it uses to transport clients.

HCCC staff

At the site visit, the committee had the opportunity to meet five of HCCC's key staff members (pictured below). HCCC employs staff from a range of culturally and linguistically diverse backgrounds, including employees from Australia, New Zealand, and Fiji.



Figure 1.5: Photo of Senator Siewert, Senator Dodson, and Senator Reynolds with HCCC staff (from left to right) Ms Penaisia (Patsy) Burton, Mr Peter Jenkins, Ms Kaye T Rangitulia, Ms Leanne Reynolds and Ms Eileen Lightning outside the main office.

HCCC clients

At the time of the visit, HCCC was providing residential support services to approximately 23 people in Halls Creek. Such services included meals on wheels, assistance with transport, shopping and banking and home cleaning services, for example.

HCCC's clients come from four different Aboriginal and Torres Strait Islander language groups and range in age from 18 years up to about 75 years.

Key challenges for HCCC

During the briefing HCCC told the committee about the key challenges it faces in providing quality care to aged care clients in Halls Creek, including:

- lack of coordinated access to allied health professionals, particularly occupational therapists, speech therapists and dentists, and lack of monitoring of clients with chronic health conditions, such as diabetes;
- difficulty attracting appropriately skilled and qualified workers that possess the adequate life experience, and practical and communication skills to do the job; and
- difficulty obtaining timely Aged Care Assessment Team (ACAT) assessments.

During the briefing, HCCC told the committee that timely ACAT assessments are difficult to obtain as an assessor only comes to Halls Creek once per month. This creates difficulties for HCCC in providing quality care, and means some clients go without crucial support (such as walking frames) until an assessment can be done. In some instances assessments are carried out over the phone by the Regional Assessment Service team based in Broome.

HCCC also told the committee that it has recently applied to be a registered provider for the National Disability Insurance Scheme (NDIS), as there is a gap in disability support in Halls Creek, with no registered NDIS providers. If successful, this would enable HCCC to expand some of the services it already provides to some of its clients.

HCCC is in the process of establishing a small team to start to provide aged care services to Yiyili, a remote community that is not currently receiving any services. It became apparent during the discussion that there are a number of remote communities where elderly residents are not receiving aged care services.

Visit to Yarliyil Arts Centre

Following the briefing, Peter, bus driver and support worker at HCCC, drove the committee to Yarliyil Arts Centre so that the committee could view some of the artwork created by some of its Aboriginal and Torres Strait Islander clients in the local community and better understand the important role art centres play for Aboriginal and Torres Strait Islander people in aged care.

HCCC told the committee that the arts centre has a significant role in aged care in maintaining culture and connection to community and country.

At the arts centre the committee learnt about a project that is currently underway to boost the morale and reputation of the Halls Creek Community. The project involves the painting of old car bonnets and rubbish bins which will be placed around Halls Creek, and is aimed at attracting tourists and improving the image of Halls Creek. Staff at the arts centre told the committee that numerous Aboriginal and Torres Strait Islander peoples utilise the facilities and have their artwork displayed at the centre.



Figure 1.6 & 1.7 (from left to right); Senator Dodson speaks to the manager of the Yarliyil Arts Centre about the centre's current community project; and photo of some of the artworks which will be placed around Halls Creek.

Acknowledgments

On behalf of the committee, Senator Siewert thanked the HCCC staff for warmly hosting the committee's visit.

Site visit to Menkawum Ngurra, Halls Creek People's Church Aged Care Facility

Introduction

Following the committee's visit to Halls Creek Community Care on 8 June 2017, the committee travelled to Menkawum Ngurra, Halls Creek People's Church Aged Care Facility (Halls Creek ACF) in Halls Creek, WA to conduct a site visit. The committee was welcomed and provided with a briefing and tour by Ms Patricia Williams, Facility Manager at Halls Creek ACF. Halls Creek ACF was established in 1978 and provides residential care and respite care to aged and people with disability in the Shire of Halls Creek.

Description of the facility

Halls Creek ACF consists of a 28 bed facility. At the time of the visit, Halls Creek ACF had 21 permanent residents, the majority of which were high care patients.

The facility consists of:

- residential rooms where residents live;
- an outdoor communal area in the centre of the facility which includes a fire pit;
- a kitchen and dining area; and
- an administrative area with staff offices.

The residential rooms accommodate up to two people, and consist of female or male only rooms.

Facility residents

Residents ranged in age from 40 years up to 104 years, and came from a diverse range of Aboriginal and Torres Strait Islander language groups.

Training initiatives

During the briefing Halls Creek ACF staff told the committee about its partnership with the local TAFE which focuses on training local Aboriginal and Torres Strait Islander peoples in aged care. Loretta Andrew, the local TAFE coordinator, told the committee that 23 students had recently completed their Certificate III in Individual Support through the partnership initiative and would soon be graduating. The course students undertook through the TAFE included training in 13 core areas of competency, including dementia care. Students also completed a total of 120 field hours in order to qualify for graduation.

Key challenges for Halls Creek ACF

During the briefing Halls Creek ACF staff told the committee about the key challenges it faces in attracting and retaining workers, and providing quality care to aged care clients in its facility, including:

- lack of appropriate accommodation for staff;

- lack of resources to provide upgrades to the facility and purchase additional equipment (such as lifting hoists); and
- difficulty attracting and retaining staff due to low rates of remuneration coupled with the additional expenses associated with living in a remote area.

A major concern for aged care staff in Halls Creek appeared to be access to secure accommodation, safety and adequate remuneration to pay for the higher cost of living expenses associated with living in a remote area. To assist with these costs, Ms Williams told the committee that Halls Creek ACF provides staff with subsidised daily lunches and food hampers once per fortnight (with costs deducted from staff wages).



Figure 1.8: Photo of Senator Siewert, Senator Dodson, Senator Reynolds and Secretariat staff, Ms Jeanette Radcliffe and Ms Amelia Hurd with Facility Manager, Ms Patricia Williams, and TAFE Lecturer, Ms Loretta Andrew, seated in a communal area at Halls Creek ACF.

Acknowledgments

On behalf of the committee, Senator Siewert thanked Halls Creek ACF staff for warmly hosting the committee's visit.

Site visit to Southern Cross Care, Germanus Kent House

Introduction

Prior to the committee's public hearing in Broome on 9 June 2017, the committee travelled to Southern Cross Care (SCC) in Broome, WA to conduct a site visit. The committee was welcomed and provided with a briefing and tour by Mr Nick McGregor, Manager at SCC. Senators Siewert, Dodson, Pratt and Reynolds participated in the site visit.

SCC provides residential care and respite care through Germanus Kent House as well as Home and Community Care (HACC) services and packages through Southern Plus and the co-located Bran Nue Dae Centre.

Description of the facilities

Germanus Kent House

Germanus Kent House is a residential aged care facility that provides accommodation and support for up to 55 residents. It also offers short term respite accommodation ranging from one day to a number of weeks.

At the time of the visit that facility had 48 permanent residents and three residents in respite.

Bran Nue Dae

Bran Nue Dae is a co-located facility that provides day centre activities and a breakfast club. SCC transports, showers and administers medication to clients as part of the breakfast club.

The facility also provides 150 packages, including HACC packages, and provides meals on wheels services seven days a week.

The facilities consist of:

- residential rooms where residents live;
- an indoor and outdoor dining area;
- an activities room with art and craft supplies;
- an outdoor courtyard area with a pergola and fire pit;
- a Chapel;
- indoor communal areas;
- a vegetable garden; and
- an administrative area with a reception and staff offices.



Figure 1.9 & 1.10 (from left to right): photo of indoor communal area; and view of outdoor communal area, including fire pit where family members can come and visit residents and participate in ceremonial activities.

Facility staff

SCC employs a total of 6 staff in its facility, and 14 staff in Community. During the briefing Mr McGregor told the committee that the facility has difficulty attracting adequate numbers of staff to cover shifts, especially during the 'wet season'. To boost its workforce during the wet season, SCC relies on a mix of casual staff and migrant workers with varying areas of expertise (such as personal care, and social work).



Figure 1.11 & 1.12 (from left to right): Senators Siewert, Reynolds, Dodson and Pratt, and Ms Jeanette Radcliffe, committee Secretary, speaking to Mr Nick McGregor, Manager; and Senator Siewert, Senator Reynolds and Senator Dodson speaking with staff and residents in the activity room.

Facility residents

The majority of residents are from Aboriginal and Torres Strait Islander backgrounds (variably representing 50 to 70 per cent of residents), and are aged anywhere above 40 years. As well as aged care residents, the facility also accommodates a number of people with disability and persons with an acquired brain injury (ABI). Mr McGregor noted that the facility cares for a larger than usual number of residents with an ABI.

Residents are able to access 52 days leave per year to return to country and participate in cultural observances such as 'sorry business'.

Key challenges for SCC

During the briefing SCC told the committee about the key challenges it faces in attracting and retaining workers, and providing quality care to aged care clients in its facility, including:

- lack of appropriate and affordable accommodation for staff;
- lack of incentives for staff to stay long-term (climate and high cost of living mean staff are more attracted to working in urban areas);
- lack of training and continuing professional development for staff, including
 - lack of training for registered staff to meet specialised areas of care;
 - lack of on-site post-graduate courses; and
 - lack of avenues for enrolled nurses to become registered nurses locally.

Acknowledgments

On behalf of the committee, Senator Siewert thanked SCC staff for warmly hosting the committee's visit.