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]

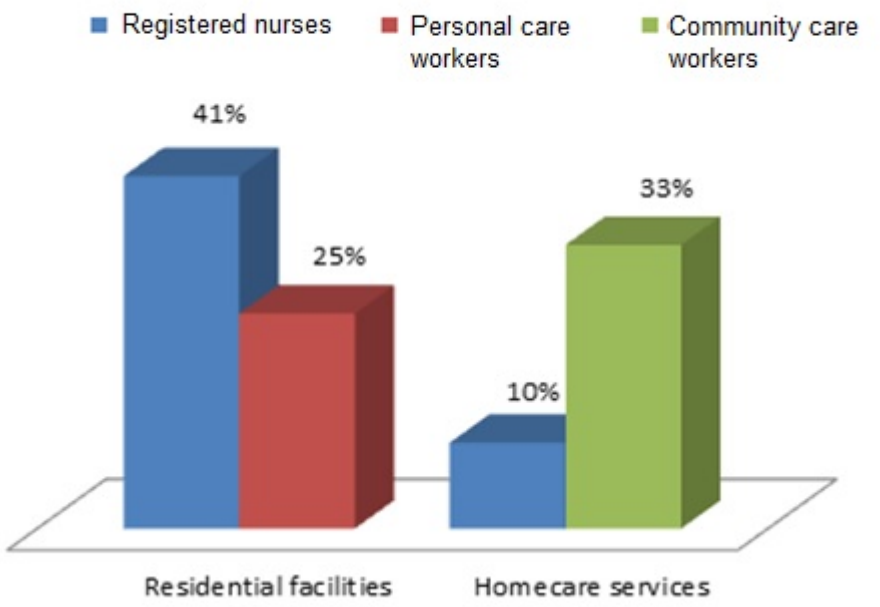
11 Department of Health, *Strengthening Aged Care – developing and aged care workforce strategy*, (accessed 25 May 2017). See also: Productivity Commission, *Caring for Older Australians*, Report No. 53, v.2, 2011, p. 354.

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 homer 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; and[18]

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.

- 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 heath 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' Associaton, *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.