Chapter 5

The dementia care workforce

5.1 The terms of reference for this inquiry directed the committee to consider the care and management of Australians living with dementia. Much of that care and management is provided by the staff in residential aged care facilities (RACFs). The impact of appropriate staff training on the care of people with dementia was regularly noted in evidence received by the committee as a key determinant in the quality of care received by people with dementia. People working in aged care were almost universally lauded for their work in a sector that is widely recognised to be personally very challenging, while not generally financially rewarding. Many working in aged care advised that they had chosen the field because they enjoyed working with older people.[1]

5.2 Although providing dementia appropriate environments is important, unless staff have the appropriate training, 'they have little ability to understand and manage behaviour disturbances' associated with dementia and Behavioural and Psychological Symptoms of Dementia (BPSD).[2] The commitment to staff training—from the executive through to the entry levels—is a notable commonality between the leading dementia service providers. This chapter highlights the importance of appropriately skilled staff and discusses issues around staff training.

5.3 The care of people with dementia and BPSD requires a number of professions including geriatricians, social workers, occupational therapists, nurses, aged care attendants, psychologists and physiotherapists, among others.[3] In addition to formal qualifications, the committee heard the importance of people working with people with dementia being empathetic to their needs: 'you really need people who have personal attributes such that they can engage with people with dementia. They need understanding and some empathy'.[4]

Human resources in dementia care

5.4 The committee heard that there were increasing pressures on a workforce that is concurrently dealing with more complex clients while at the same time managing with a less skilled workforce.[5] The Productivity Commission report

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1 NSW Nurses and Midwives' Association, *Submission 55*, p. 2.

2 Mercy Health, *Submission 29*, p. 3.

3 Professor McInerney, Professor of Aged Care, Mercy Health and the Australian Catholic University, *Committee Hansard*, 14 February 2014, p. 26; Mr Li, Senior Policy Adviser, Australian Psychological Society, *Committee Hansard*, 16 December 2013, p. 20.

4 Ms Morka, General Manager, Retirement, Ageing and Financial Inclusion, Brotherhood of St Laurence, *Committee Hansard*, 16 December 2013, p. 10.

5 NSW Nurses and Midwives' Association, *Submission 55*, p. 2.

Caring for Older Australians detailed a troubling trend of movement toward a lower skilled workforce, while expanding the responsibility of that workforce:

> There is a trend towards employing less skilled (and lower cost) staff in residential settings in the delivery of direct care services. Despite an increase in the workforce overall, the number of full-time equivalent registered and enrolled nurses working in [residential aged care facilities] fell from 27,210 to 23,103 between 2003 and 2007. This represents a decrease from 35.8 per cent to 29.3 per cent of all full-time equivalent direct care employees in only four years, with most of the reduction occurring at the registered nurse level.
>
> While the substitution towards less skilled workers may be partly driven by financial constraints and difficulties in attracting and retaining nurses, the scopes of practice for some personal carers have also been widened (for example, undertaking medication management).[6]

5.5 Evidence presented to the committee argued that this trend is also in evidence in community care where workers are often untrained in important skills such as hygiene and nutrition, as well as unprepared for the emotional aspects of care giving.[7] Highly trained workers are especially important in community care as care workers only have short periods of time with each patient.[8] Care workers entering peoples' homes also need to be adequately resourced to provide the sub-acute care needed by people with dementia.[9]

5.6 The committee heard that the difficulty of attracting skilled workers to the sector was seriously lowering the barriers to entry to dementia and aged care:

> Staffing is an ongoing issue in the aged care industry. Staff work across a number of organisations. People apply and are appointed without qualifications and with minimal experience or expertise…We are short-staffed. If they have a police check and can speak English, they can be given a job and start that day.[10]

5.7 There are currently no legislated staffing ratios in residential aged care. The committee heard that the level of staffing is a reflection of the level of resourcing of aged care, and that providers would choose to have more staff on shift:

> Choices often have to be made by administrators about staffing levels, and some family members are still shocked to discover that residential aged care is not like an intensive care unit. I think every administrator of

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6 *Caring for Older Australians*, Canberra, 2011, p. 351.

7 *In-camera evidence*.

8 Mr Oldham, Private Capacity, *Committee Hansard*, 10 July 2013, p. 7.

9 Mr Brooks, Chief Executive Officer, Presbyterian Care Tasmania, *Committee Hansard*, 10 July 2013, pp 26–27.

10 Ms Morley, Chief Executive Officer, Rural Northwest Health, *Committee Hansard*, 17 December 2013, p. 2.

> aged-care facilities would like to increase staffing levels, but organisations need to break even unless they have other sources of income.[11]

5.8 It was suggested to the committee that one worker for eight residents is a functional ratio when working with people with dementia.[12] It was also reported to the committee that at times when the needs of patients with BPSD are at their highest, during the nights, staffing levels in residential facilities are at their lowest.[13]

Current staffing situation exacerbates BPSD

5.9 It was reported to the committee that people caring for clients with dementia without the appropriate skills and training may exacerbate BPSD.[14] The committee also heard that low staff levels result in a greater use of restraints (see chapter 6 of this report).[15]

5.10 From the point of view of the residents in aged care facilities, the people that work in aged care are guests in their home. The committee heard concerns that workers do not have the time to work with residents as if they were assisting someone in their home, but instead endeavoured to move through their list of tasks as fast as possible. One care worker explained:

> I do not believe that there is enough time spent with people with this cognitive problem. They have this illness through no fault of their own, and they are just treated like a herd of sheep…We as carers were expected to get nine or ten people up in just over an hour – wake them up, shower them, dress them and do a full bed change if need be, and have them sitting out at breakfast. That is just not right. It is those people's homes. They should not be rushed.[16]

5.11 Simple considerations are often overlooked due to a lack of understanding and the speed at which some staff members are either required to—or feel they are required to—work.[17] Examples include male carers showering female residents and residents being changed in rooms with open curtains.[18] One submitter who had a parent with dementia in residential care observed that:

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11 Mr Hunt, Private Capacity, *Committee Hansard,* 10 July 2013, p. 33.

12 Ms Morley, Chief Executive Officer, Rural Northwest Health, *Committee Hansard*, 17 December 2013, p. 11.

13 NSW Nurses and Midwives' Association, *Submission 55*, p. 2.

14 Ms Morley, Chief Executive Officer, Rural Northwest Health, *Committee Hansard*, 17 December 2013, p. 2.

15 BlueCare, *Submission 32*, p. 8.

16 Ms Mathers, Dementia Care Tasmania, *Committee Hansard*, 10 July 2013, p. 1.

17 Mrs Di Mezza, Advocacy Coordinator, Australian Capital Territory Disability, Aged and Carer Advocacy Service, *Committee Hansard*, 17 July 2013, p. 4.

18 Mr Oldham, Private Capacity, *Committee Hansard*, 10 July 2013, p. 3; Dr Macpherson, *Submission 62*, p. 4.

> In circumstances of chronic under-staffing, apparent lack of training in the emotional and social needs of dementia [patients], and lack of funds, care tasks centre overwhelmingly on the physical needs of patients: showering, toileting and feeding.[19]

5.12 The Australian Medical Association (AMA) was unequivocal in reporting that poorly trained staff exacerbate BPSD:

> **Senator THORP**: Is it fair to say that, if you have a carer who does not have that level of education and understanding, their reaction to a patient can exacerbate and accelerate that patient's behaviours?
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> **Dr Kidd**: Yes, absolutely, and that is one of the bad outcomes I was starting to refer to. That is why I think it is quite critical that in this area there is adequate resourcing and funding so that staff can have appropriate and adequate training and also that the industry can afford staff that have sufficient literacy, sophistication, qualifications, I guess, to be able to provide what can be very challenging services at a level that requires quite a bit of knowledge and at times quite a bit of emotional sophistication or emotional intelligence.[20]

5.13 Due to staffing shortages many service providers use agency staff to fill short-term gaps in their workforces. It was reported that this practice can exacerbate residents' BPSD as the staff do not know the residents' personalities, likes, dislikes and behavioural triggers.[21]

5.14 A lack of experienced staff has also meant that new staff are quickly moved into leadership positions that they do not have the experience to adequately manage:

> The problem is that a registered nurse comes out and we put them in charge of a ward in aged care. It is really hard to get into a graduate program at the moment, so they work in aged care because it is easy to work in. They have no experience and their training does not give them any real in-depth expertise in dementia. So the first thing they are going to do is either cause the resident to behave in an inappropriate manner, because of the way they have responded to the person with dementia, or ask the doctor to put them on drugs. So we have doped people who are more at risk of fall, who do not eat, who lose weight and who are unhappy, and it is because the nurse does not have the expertise to know that there are other ways.[22]

5.15 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) recommended:

> All residential aged care facilities have access to a clinician with expertise in BPSD and mental health who is employed by the facility and is

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19 Dr Macpherson, *Submission 62*, p. 4.

20 Dr Kidd, Chair, Australian Medical Association Committee for Health and Ageing, *Committee Hansard*, 14 February 2014, p. 3.

21 Ms Dickens, *Submission 2*, p. 1.

22 Ms Morley, Chief Executive Officer, Rural Northwest Health, *Committee Hansard*, 17 December 2013, p. 12.

> responsible for core tasks required if a facility is to meet the needs of people with BPSD.[23]

5.16 Wintringham similarly suggested that aged care facilities have ready access to BPSD management techniques.[24]

Staff training

5.17 Despite the clear importance of those working with people with dementia having the appropriate skills to manage that condition, the committee heard that many workers do not have the necessary skills. Unfortunately, the committee heard that many people are not made aware of, or taught, appropriate management techniques. As the Co-Chair of the Minister's Dementia Advisory Council lamented:

> We are dealing with a system that systematically fails to train, educate, monitor and incentivise people who have responsibility for supporting people with dementia to do so in a way that allows them dignity and a quality of life.[25]

5.18 Professor Draper similarly explained:

> [Overall] I think there is a general lack of training there in the system and so many of the staff who work in residential facilities but also in community care settings are not that well trained. They are people who have had very limited general training and it is a challenge for the whole system to actually increase the level of training that people are receiving and have received.[26]

5.19 There were regular calls throughout this inquiry to improve the level of training for staff working with people with dementia.[27] Rural Northwest Health recommended that all staff interacting with people with dementia—from registered nurses through to administration staff—should be required to undertake 'an accredited module in dementia of at least two days in length'.[28]

5.20 Service providers are already required to provide their workers basic training in a number of areas such as manual handling, emergency situations and infection control. In this environment, dementia training falls down the list of priorities. There is a need to convince providers that dementia training is both important and

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23 *Submission 49*, p. 8.

24 Mr Lipmann, Chief Executive Officer, Wintringham Specialist Aged Care, *Committee Hansard*, 16 December 2013, p. 6.

25 Ms Pieters–Hawke, Co-Chair, Minister's Dementia Advisory Council, *Committee Hansard*, 17 July 2013, p. 27.

26 Professor Draper, private capacity, *Committee Hansard*, 17 July 2013, p. 51.

27 Mr Oldham, Private Capacity, *Committee Hansard*, 10 July 2013, p. 3; Mr Osbourne, private capacity, *Committee Hansard*, 17 December 2013, p. 23.

28 Ms Morley, Chief Executive Officer, Rural Northwest Health, *Committee Hansard*, 17 December 2013, pp 2–3.

beneficial.[29] Providers also face the challenge of high staff turnover which results in a situation where 'you can train all of your people today but in six months' time you would have to go back and do it [again]'.[30]

5.21 The New South Wales Nurses and Midwives' Association (NSWNMA) noted that even registered nurses—who shoulder much of the responsibility for care decisions in residential facilities—rarely have sufficient training in mental health:

> Many registered and enrolled nurses working in aged care do not have mental health as part of their general training, and care staff seldom have specific training or experience in mental health matters.[31]

5.22 Rural Northwest Health voiced similar concerns:

> If you look at any allied health professional and nursing qualification—enrolled nurses and registered nurses, which are the majority of people who work in residential aged care—if you look at their training, the time they spend on learning about dementia is about three hours. There is not a significant module on dementia. They come out and they do not know how to care for people living with dementia. They have a registered nurse or an enrolled nurse qualification but it is not a priority.[32]

5.23 It appears that many healthcare professionals are graduating, and being employed, without the necessary skills to adequately manage dementia. However, the evidence provided to this committee indicates that the necessary skills can be developed in the dementia care workforce.

5.24 The skills and techniques to manage dementia and BPSD are learnable provided the training is made available.[33] As explained by the Minister's Dementia Advisory Council:

> As the experts and people who work closely and with compassion in such a situation understand, the behaviour of a person with dementia will make perfect sense correlated to their experience of the world. We can support them based on that. This is not to say that some of the behaviours that happen are not challenging to the people around them, but it is our job if we are working in care to learn the ways that do exist to support that person without demeaning them or attributing a demeaning set of motives, intent or incapacity to them.[34]

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29 Ms Calvert, Manager, Dementia Tas, *Committee Hansard*, 10 July 2013, p. 13.

30 Mr Reed, Assistant Director of Nursing – Mental Health Services, Department of Health and Human Services, *Committee Hansard*, 10 July 2013, p. 22.

31 *Submission 55*, p. 9.

32 Ms Morley, Chief Executive Officer, Rural Northwest Health, *Committee Hansard*, 17 December 2013, p. 12.

33 Mr Lipmann, Chief Executive Officer, Wintringham Specialist Aged Care, *Committee Hansard*, 16 December 2013, p. 5.

34 Ms Pieters–Hawke, Co-Chair, Minister's Dementia Advisory Council, *Committee Hansard*, 17 July 2013, p. 27.

5.25 High level training in dementia and BPSD also allows for more services to be provided to people in the community, helping them remain there for longer.[35]

5.26 One of the factors that the facilities most successful in managing dementia had in common was the extensive training given to staff regarding dementia.[36] As noted by the Psychogeriatric Care Expert Reference Group:

> Well trained and experienced staff have the capacity to recognise early signs of behavioural disturbances and prevent their escalation, while conversely, the actions of inexperienced staff can readily escalate behaviours.[37]

5.27 As well as providing appropriate training to those providing direct services to residents, it was argued that training should be provided at the decision-making level:

> One of the things that has been a strong push from the Commonwealth over the last decade is providing training at the frontline care worker level. There have been a lot of systemic programs that aim to increase the knowledge, expertise and qualifications that people at that level are receiving. The gap is that we have not done the same thing for our registered nurse population and we have not done the same thing for our GP population. Those education programs have been more ad hoc. We need to address that if we are going to raise the bar. We want clinical care to be driven at the registered nurse and primary care level, yet we are feeding a lot of the care approaches to the direct frontline care staff, and we do not have the expertise in the people who are leading those services. If you do not address that, there are going to be leaky buckets down at the bottom.[38]

5.28 Targeting training at senior levels would also seem to address one of the problems reported to the committee whereby staff who had received training in dementia care were overruled by more senior but less qualified colleagues.[39] The Minister's Dementia Advisory Council similarly emphasised the importance of ensuring those in leadership positions support the work of those trained in appropriate dementia care.[40]

5.29 It was suggested that there is strong demand for dementia specific training within the aged care sector as staff and facilities recognise that they do not presently have the tools to manage dementia, but often people do not know where to go for

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35 Ms Small, General Manager of Operations, Wintringham Specialist Aged Care, *Committee Hansard*, 16 December 2013, p. 7.

36 Ms Dickins, *Submission 2*, p. [1]; Benetas, *Submission 21*, p. [3].

37 Professor Draper, *Submission 17 – Attachment 1*, p. [6].

38 Ms Raguz, General Manager – Residential Care, HammondCare, *Committee Hansard*, 17 July 2013, p. 15.

39 Mr Cunningham, Director – The Dementia Centre, HammondCare, *Committee Hansard*, 17 July 2013, p. 15.

40 Ms Pieters–Hawke, Co-Chair, Minister's Dementia Advisory Council, *Committee Hansard*, 17 July 2013, p. 36.

assistance. As well as recognising a need for further learning, those working with people with dementia are eager to utilise what they have learned:

> Their desire for staff education and seminars and group meetings and so forth has been much greater than we expected. It is a question that they have a sense of need, they have no way of knowing how to satisfy that need but once you give them that they certainly move towards it with considerable enthusiasm.[41]

5.30 The committee heard of a number of initiatives that have been undertaken, such as working with universities, to improve training for staff working with people with dementia.[42] Medical professionals also reported taking time to run dementia awareness and training courses, some of which are undertaken on a pro bono basis.[43]

5.31 HammondCare emphasised that Australia has a good variety of programs to improve dementia care, such as Dementia Care Essentials.[44] Dementia Care Essentials is a Commonwealth-funded initiative providing dementia training to aged care workers throughout Australia. It was reported that approximately 35,000 aged care workers had received accredited dementia training by June 2013 under the program.[45]

5.32 The Department highlighted that $10 million has been provided over the previous three years to the Dementia Training Study Centre to 'up skill the workforce in terms of dementia care'.[46] The Commonwealth also funded the Encouraging Better Practice in Aged Care program which included 'a range of projects increasing the skills of workers caring for people with dementia'.[47] Alzheimer's Australia provides training and education services[48], and innovative approaches such as *Spark of Life* courses are provided by Dementia Care Australia.[49] The Wicking Dementia Research and Education Centre was highlighted as an excellent provider of training:

> On quite a positive note and on the role of the Wicking centre, they are doing some really amazing stuff with not huge amounts of dosh to assess the needs of people providing care in aged-care settings, recognising things

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41 Mr Stokes, Principal Advisory, Australian Psychological Society, *Committee Hansard*, 16 December 2013, p. 19.

42 Ms Morka, General Manager, Retirement, Ageing and Financial Inclusion, Brotherhood of St Laurence, *Committee Hansard*, 16 December 2013, p. 10.

43 Dr Kidd, Chair, Australian Medical Association Committee for Health and Ageing, *Committee Hansard*, 14 February 2014, p. 3.

44 Mr Cunningham, Director – The Dementia Centre, HammondCare, *Committee Hansard*, 17 July 2013, p. 15.

45 Department, *Submission 56*, p. 21.

46 Ms Smith, First Assistant Secretary, Ageing and Aged Care Division, Department, *Committee Hansard*, 17 July 2013, p. 47.

47 Ms Smith, First Assistant Secretary, Ageing and Aged Care Division, Department, *Committee Hansard*, 17 July 2013, p. 47.

48 BlueCare, *Submission 32*, p. 10.

49 Dementia Care Australia, *Submission 54*, p. 7.

> like transient working populations…and they are starting to actually deliver some really cost-effective education packages specifically around dementia care.[50]

5.33 Services for Australian Rural and Remote Allied Health (SARRAH) suggested the provision of 'dementia training modules similar to those available in the vocational sector such as Aged Care Certificate III and IV training for care workers'.[51] The committee notes that there are dementia-specific Australian Quality Framework certified courses available at this level in some states.[52]

Quality of training

5.34 Although there are good education resources available to inform the workforce about dementia, it was put to the committee that some of the training for dementia currently on offer was of an unacceptably poor standard:

> Significant issues exist in the quality of the training provided throughout training organisations. It is not consistent; it is not always of a high standard; and, in some cases, it is substandard.[53]

5.35 One person who worked in dementia care with a specialised qualification in dementia awareness indicated that some formal qualifications in dementia care do a poor job of preparing workers for actually providing dementia specific care.[54]

5.36 The committee heard that in some cases education providers had actively tried to reduce the number of hours required to become qualified to work in aged care.[55] For training to be effective, and for prospective employers to value qualifications, the standards need to be sufficiently high to ensure that a person qualified in dementia care is capable of completing the work they are employed to do.

5.37 Although dementia training resources are available, those working in the field must be able to access those resources.

5.38 One of the barriers to providing better staff training was facilities not having enough staff or financial resources to simultaneously pay for staff members to attend training, pay their salary, and the salary of a replacement worker during the training

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50 Dr Morrissey, Old Age Psychiatrist, Department of Health and Human Services – Tasmania, *Committee Hansard*, 10 July 2013, p. 24.

51 *Submission 19*, p. 5.

52 For example, Alzheimer's Australia Western Australia offers a Certificate IV in Dementia Practice.

53 Ms Morley, Chief Executive Officer, Rural Northwest Health, *Committee Hansard*, 17 December 2013, p. 2.

54 Mr Oldham, private capacity, *Committee Hansard*, 10 July 2013, p. 3.

55 Ms Walters, Innovation and Continuous Improvement Manager, Rural Northwest Health, *Committee Hansard*, 17 December 2013, p. 12.

course.[56] BlueCare and Dementia Care Australia—among others—recommended that additional funding be available to backfill staff to engage in training.[57]

5.39 SARRAH argued that it was necessary to fund education in rural and remote settings for health professionals and ancillary staff working with people with dementia, noting that regional providers have additional costs in accessing training due to the travel distances involved.[58]

5.40 Funding for up skilling the aged care workforce appears to be effective, albeit sporadic. Yarriambiack Lodge was able to provide training for all their staff due to Health Workforce Australia funding.[59] BlueCare reported being able to develop and offer workshops—'resulting in increased knowledge and expertise in why behaviours occur and how to develop strategies to prevent them'—after winning a grant from the Dementia Training and Studies Centre in Queensland.[60]

Committee view

5.41 The current aged-care workforce does not appear to have the skills and training to adequately support Australians living with dementia and BPSD. There is a need to significantly improve the skills in this sector as a matter of priority. Staff without the necessary skills to provide dementia care can actively exacerbate BPSD creating additional stress for workers, patients and families. Conversely, staff with the appropriate training can facilitate the care and management of people with BPSD who may otherwise have been transferred around the health and aged care system.

5.42 There are a number of excellent examples from around Australia of providers who have taken the necessary steps to ensure that their workforce is appropriately qualified to provide high levels of care to people with dementia and BPSD. There are also innovative and highly effective training tools available to help train the workforce.

5.43 There may be a role for the Commonwealth to better publicise the training that is available and encourage other providers to raise the skills of their workforce, benefitting from the example of the forerunners in dementia care. The Commonwealth has established the Dementia and Severe Behaviours Supplement in Residential Care which provides RACFs over $6,000 per year, per resident with dementia and BPSD. The purpose of this supplement is to ensure that those residents receive the care that they need. Given the importance of staff training in managing BPSD, it is not

56 BlueCare, *Submission 32*, p. 8; Dementia Care Australia, *Submission 54*, p. 8.

57 Mrs Edwards, Service Development and Improvement Advisor, BlueCare, *Committee Hansard*, 17 July 2013, p. 12; National Rural Health Alliance Inc, *Submission 45*, p. 6.

58 *Submission 19*, p. 3.

59 Ms Morley, Chief Executive Officer, Rural Northwest Health, *Committee Hansard*, 17 December 2013, p. 6.

60 Mrs Edwards, Service Development and Improvement Advisor, BlueCare, *Committee Hansard*, 17 July 2013, p. 12.

unreasonable to expect that some of this additional funding is directed toward providing staff training.

Recommendation 10

5.44 The committee recommends that a phased program of accredited training in dementia and the management of Behavioural and Psychological Symptoms of Dementia (BPSD) be required for all employees of Residential Aged Care Facilities.

Recommendation 11

5.45 The committee recommends that the Commonwealth take a proactive stance in highlighting the importance of staff training in dementia care, and develop linkages between care and education providers.

Retaining skilled workers

5.46 As the percentage of the population with dementia increases, there will be an increasing demand for specialist dementia care. The committee heard that the availability of nurses and other professions with dementia expertise will be the difference between people with dementia remaining in the community or moving into residential care.[61] It was put to the committee that 'the high turnover of care workers with limited training is a core obstacle to successfully managing BPSD'.[62] Once aged care workers have entered the field, received dementia-specific training and begun to gather experience, it is important that those skills are retained.[63]

5.47 The committee heard that it was difficult to retain workers, principally because of low remuneration.[64] Of concern were the wages on offer for the specialist work that is expected:

> Generally our aged-care workers are particularly poorly paid and the work that they do is specialist, especially working with people living with dementia. That is absolutely paramount: giving people the adequate training and also compensating them for that.[65]

5.48 The Productivity Commission similarly noted that the 'current remuneration and working conditions are considered strong disincentives to entering and staying in the sector'.[66] The Royal Australian College of General Practitioners (RACGP)

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61 Brotherhood of St Laurence, *Submission 40*, p. 8.

62 Royal Australian and New Zealand College of Psychiatrists, *Submission 49*, p. 8.

63 Mr Reed, Assistant Director of Nursing – Mental Health Services, Department of Health and Human Services, *Committee Hansard*, 10 July 2013, p. 23.

64 Mrs Di Mezza, Advocacy Coordinator, Australian Capital Territory Disability, Aged and Carer Advocacy Service, *Committee Hansard*, 17 July 2013, p. 10; Services for Australian Rural and Remote Allied Health, *Submission 19*, p. 3.

65 Mrs Edwards, Service Development and Improvement Advisor, BlueCare, *Committee Hansard*, 17 July 2013, p. 15.

66 Productivity Commission, *Caring for Older Australians*, Canberra, 2011, p. 354.

similarly argued that it is necessary to '[improve] the level of resources and remuneration for professional staff involved in dementia care and the status of carers'.[67]

Committee view

5.49 Those working in aged care are some of Australia's lowest paid workers. This low level of remuneration is inconsistent with the responsibilities these workers face and the community's expectation of their experience and expertise. The lack of skills and experience in dementia care can be expected to continue until wages are significantly improved and reflect the time and training required. The committee supports the Productivity Commission's view:

> An increase in the level of remuneration for aged care workers will have a flow-on effect to other factors affecting the workforce. For example, the image and reputation of the sector as an area where caring work is valued would be enhanced by better wages. In addition, the quality and continuity of care may be increased as workers are more content to stay in the sector and turnover is reduced. In turn, this may allow more funding for education and training to be targeted towards up skilling the workforce, rather than basic training for new entrants who are unlikely to stay for long under current conditions.[68]

67 *Submission 52*, p. 7.

68 *Caring for Older Australians*, Canberra, 2011, p. 365.