CHAPTER 2

WORKFORCE SHORTAGES AND TRAINING

Introduction

2.1 Issues surrounding workforce shortages and training in nursing, including the aged care sector, have been debated and reviewed for some time: there have been 34 reviews of nursing in seven years.[1] Indeed, in June 2002 this Committee tabled its report on its inquiry into nursing.[2] In the report the Committee noted the acute shortage of nurses in the aged care sector. The Committee pointed to evidence which indicated that delivery of quality care was under threat from the retreat of qualified nurses, both registered nurses and enrolled nurses, from the aged care sector. The Committee made a range of recommendations directed to improving recruitment and retention of nurses in the aged care sector including changes to workplace practices and at improving the image and training of nurses in the aged care sector.[3]

2.2 Evidence received during this inquiry suggests that there has been little improvement to the situation since 2002 with concerns being raised not only about the shortage of aged care nurses but also general practitioners with older persons' health expertise, geriatricians, psycho-geriatricians and allied health professionals.[4] The challenge for the future is to ensure a skilled and committed workforce, able to meet the growing demand for services for ageing Australians.

The aged care workforce

2.3 The following provides an overview of trends in the aged care workforce from the *Review of Pricing Arrangements in Residential Aged Care Final Report* (Hogan Review)[5]:

- in June 2000, approximately 131 230 people, or 1.3 per cent of the Australian workforce were employed in the aged care industry;
- an estimated 32 628 people volunteered in aged care;
- between 1995-96 and 1999-2000, the number of employees in residential aged care declined while the number of people being cared for increased;

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1 *Submission* 73, p.1 (Benetas).

2 Senate Community Affairs References Committee, *The Patient Profession: Time for Action: Report on the Inquiry into Nursing*, Canberra, June 2002.

3 *The Patient Profession*, pp.158-59.

4 See for example, *Submission* 202, p.8 (NSW Health).

5 Hogan WP, *Review of Pricing Arrangements in Residential Aged Care, Final Report*, Canberra, 2004.

- in accommodation for the aged (low care), the number of employees increased by 33 per cent; and
- between 1996 and 2001 the share of direct care provided by registered and enrolled nurses declined in both nursing homes and accommodation for the aged while the use of personal carers increased significantly.

2.4 The decline in employees in residential care was attributed to the decline in the use of staff not involved in the direct provision of care as a result of consolidation within the sector which enabled greater economies of scale; a greater reliance on outsourcing of some activities; and, greater use of multiskilling. The increase in the use of personal carers reflected both the growing shortage of nursing staff and the development of more efficient workforce structures.[6]

2.5 Australian Institute of Health and Welfare data on nursing shows that:

- in 2001 there were 19 109 registered nurses and 13 109 enrolled nurses employed in geriatrics/gerontology which represented 12 per cent of all registered nurses and 31.2 per cent of all enrolled nurses;
- between 1997 and 2001, the number of nurses working in geriatrics/gerontology declined 8.7 per cent;
- nursing homes and aged care accommodation accounted for 14.6 per cent of all nurses – the second largest proportion;
- the number of nurses working in nursing homes and aged care accommodation declined by 28.0 per cent between 1995 and 2001; and
- nurses working in nursing homes and aged care accommodation tended to be older than nurses in other work settings and they worked shorter hours.[7]

2.6 The National Institute of Labour Studies (NILS) report, *The Care of Older Australians: A Picture of Residential Aged Care Workforce*, stated that 'the existing level of knowledge about workers in aged care is remarkably limited' and no single data source provides an accurate and detailed appraisal of direct care employment in residential aged care, especially to inform complex workforce planning. The Report stated that, in 2003, there were 116 000 direct care employees of whom 25 000 were Registered Nurses, 15 000 were Enrolled Nurses, 67 000 were Personal Carers and 9 000 were Allied Health workers. NILS stated that 'there are few signs that this is a labour market in crisis, or even under serious stress' but went on to noted that there were some indications of stress. These included that nurse are substantially older than the typical female worker, the relatively high number of vacancies for Registered Nurses and the high levels of turnover of direct care staff.[8]

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6 Hogan Review pp.219-221.

7 AIHW, *Nursing Labour Force 2002*, AIHW, pp.3, 13-15, 20-21.

8 Richardson S & Martin B, *The Care of Older Australians: A Picture of the Residential Aged Care Workforce*, National Institute of Labour Studies, 2004, pp.1-5.

Issues facing the aged care workforce

> There are a range of significant workforce issues in the aged care sector. Serious staff shortages, especially of qualified nurses and allied health professionals, are widespread. We experience continuous difficulty in recruiting qualified staff because of shortages and the necessity to compete with the acute sector that has a capacity to remunerate at much higher levels. Too much paperwork leads to staff burnout as dedicated staff struggle to maintain levels of care while dealing with burdensome documentation requirements. There is no real measure of the actual staff requirements for residential care.[9]

Nursing staff

2.7 The general shortage of nurses is impacting on the aged care sector. The Hogan Review stated that the shortage of nurses was greater in the residential aged care sector than in other areas of the health system.[10] Even though there is a general shortage, some areas are more acute with the Queensland Government pointing to shortages of psychogeriatric nurses and aged care nurses in rural and remote communities, including Indigenous communities. In the future staff shortages will be exacerbated as the present residential aged care workforce is ageing and there are high levels of casualisation in the sector.[11]

2.8 Witnesses stated that the barriers to recruitment, retention and re-entry of nurses to the aged care nursing were well known and include:

- lack of wage parity;
- inadequate staffing levels;
- inappropriate skills mix;
- workload pressure;
- increased stress levels; and
- an inability to deliver quality care.[12]

2.9 The lack of wage parity was seen as a major barrier. Witnesses indicated that there were still significant differences in wages between aged care nurses and those working in other sectors.[13] The Queensland Nurses Union (QNU) pointed to differences in maximum and minimum wages in Queensland in 2004 ranging $68.06 per week (13.3 per cent) for an assistant in nursing to $93.98 per week (15.7 per cent) for Enrolled Nurses and from $165.35 to over $300 for Registered

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9 *Committee Hansard* 11.2.05, p.2 (UnitingCare).

10 Hogan Review, p.221.

11 *Submission* 193, p.5 (Queensland Government).

12 *Submission* 179, p.2 (NSW Nurses Association).

13 *Submission* 73, p.1 (Benetas).

Nurses levels 1 to 5.[14] The ANF commented that the wage disparity has been progressively widening as nurses in the private and public acute sectors have secured superior outcomes through enterprise bargaining. As at April 2004 the wage disparity stood at 21.6 per cent.[15] As a consequence, the aged care sector is struggling to be competitive both in relation to wages and career opportunities for staff.

2.10 Evidence pointed to changes in staffing levels impacting adversely on the aged care workforce. The QNU stated the lack of accountability in the private sector has led to the erosion of staffing levels, with many employers continuing to cut nursing hours. The QNU commented that it was assisting members in facilities where this is occurring. Members in those facilities reported that their workloads were already unsustainable even prior to any cuts being implemented. Unpaid overtime was worked to complete duties.[16] Witnesses also noted that the changes to staffing levels are being made when the dependency levels in residential aged care facilities has risen, with the number of residents receiving high level care increasing from 58 per cent in 1993 to 63.6 per cent in 2002.[17]

2.11 The shortage of nurses and other workers also raised occupational health and safety concerns. Many submissions pointed to the high incidence of injuries in the aged care sector. The QNU stated that nursing homes alone account for 10.3 per cent of injures in the Health and Community Services Sector, with increased workloads correlating to increased injury rates.[18] Nurses often work through breaks and find it difficult to comply with manual lifting policies that, for example, require two staff to perform resident transfers. Excessive workloads lead to shortcuts being taken. This adds to the stress of staff who cannot deliver quality care to residents.

2.12 Dr K Price of the Centre for Research into Sustainable Health Care also noted that employers are reticent to employ older workers because of their age. Research had indicated that aged care employers considered that older workers were at risk of injury and were using occupational health and safety laws not to employ older workers.[19]

2.13 Inadequate skills mix was another continuing and major concern. It was noted that there had been substantial substitution of personal carers for nurses in recent years. The ANF (Victoria) commented that in Victoria the skills mix of Registered Nurses (RNs) to residents had fallen from an average of 1 RN to 30 residents across all shifts in 1997 to 1 RN to 60 residents during the day, out to 1 RN to 90 or 120 at the evening and night shift. Some high care facilities only employ a registered nurse

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14 *Submission* 186, p.5 (QNU); see also *Submission* 95, p.7 (QNC).

15 *Submission* 201, p.7 (ANF)

16 *Submission* 186, p.7 (QNU).

17 *Submission* 201, p.6 (ANF).

18 *Submission* 186, p.8 (QNU).

19 *Committee Hansard* 22.2.05, p.20 (Centre for Research into Sustainable Health Care).

for two two-hour shifts per day – to administer medications. The ANF (Victoria) noted that these facilities still meet accreditation standards.[20]

2.14 Dr Price also commented:

> …we limit the number of RNs, we limit the number of ENs and we put in care workers with only a certificate 3 at the most – and we expect to get a workforce. Why should an RN go into a workforce where he or she knows that they are going to be the only one on for 60 residents? Why should somebody? We have to stop it at some point. There should be many more. There is a one to five ratio in acute care: why isn't there that ratio in aged residential care?[21]

2.15 While not opposing the use of personal carers, the ANF commented that it was opposed to the replacement of registered and enrolled nurses with unlicensed workers 'where the work requires the skills and knowledge of either an enrolled or registered nurse'. Unlicensed nursing and personal carers generally are competent but they are not able to always recognise serious problems including changes in the health status of residents and they require supervision and support from registered nurses.[22]

2.16 As a result of these changes, registered nurses in aged care workplaces are facing increases in spans of responsibility and associated difficulties in adequately supervising other staff, including staff with lower qualifications. The QNU stated that 'these factors are significant influences on why registered nurses are leaving and are not being attracted to work in aged care services'.[23] Skills mix is discussed further in Chapter 3.

2.17 The level of paperwork remains an issue for nurses.[24] ANHECA commented that one of the major reasons given for registered nurses leaving the residential care sector or declining to enter the sector is the sheer volume of paperwork required of registered nurses working in residential care.[25] Witnesses commented that excessive paperwork is required to validate appropriate resident classification for the Resident Classification Scale (RCS) funding scheme, accreditation processes and the complaints resolution scheme. Nurses were spending valuable time 'form filling' rather than providing hands-on nursing care. The issue of excessive documentation is addressed in the Chapter 3.

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20 *Submission* 66, p.1 (ANF Victoria).

21 *Committee Hansard* 22.2.05, p.23 (Centre for Research into Sustainable Health Care).

22 *Submission* 201, p.17 (ANF); see also *Submission* 127, p.3 (AMNC).

23 *Submission* 186, p.9 (QNU).

24 *Submissions* 71, p.4 (RCNA); 95, p.8 (QNC).

25 *Submission* 74, p.3 (ANHECA).

Personal carers

2.18 The Health Services Union (HSU) and the Liquor Hospitality and Miscellaneous Union (LHMU) drew the Committee's attention to significant issues for personal carers in the aged care sector. Personal carers received relatively low wages. The HSU (NSW) stated that a carer with a Certificate III in Aged Care earns $13.53 per hour. The hourly rate is less than that of checkout operators in supermarkets but requires TAFE certificate qualifications in aged care. Carers are required to provide a range of personal care services, with minimal supervision as well as simple health needs such as wound dressing, attend to blood pressure, and temperature and pulse checks. As a result, it is extremely difficult to attract and retain younger staff.[26]

2.19 The Brotherhood of St Laurence also noted that personal carers in the community work in relative isolation which makes it difficult to attract and retain workers. Of particular concern was the lack regular support and supervision for many workers. Many organisations provide only limited support to workers to undertake training – in some cases all training costs, including time, are borne by the worker.[27]

2.20 Staffing shortages also impact on personal carers and the level of care they can provide to residents. The HSU stated that its members reported that because of understaffing they only have time to provide 'basic care' to residents and regret that the feeding and showering of residents is too often 'like a production line'. In some instances, basic hygiene suffers with residents going without showers, teeth not being brushed and hair not combed or washed.[28] The LHMU indicated that at one facility it was reported that three care workers had 60 minutes to get 49 residents out of bed, showered, dressed and into the dining room for breakfast.[29]

2.21 Of serious concern to members of the HSU was understaffing at night. It was stated that it is not uncommon for one carer to be rostered on alone overnight in a hostel looking after up to 50 residents. If an emergency occurs there is no backup. For example, if a resident falls the carer is often physically unable to assist the resident off the floor and back into bed. In such cases, carers will either call an ambulance to assist or make the person comfortable on the floor until morning when more staff arrives.[30]

2.22 Because of staff shortages, the HSU stated that carers are often required to work double shifts. Unpaid overtime is also worked by carers to fulfil their own sense of obligation to frail residents.[31] This contributes to stress and fatigue The HSU also

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26 *Submission* 59, p.4 (HSU NSW); see also *Submission* 122, p.5 (HSU).

27 *Submission* 52, p.2 (BSL).

28 *Submission* 122, p.4 (HSU).

29 *Submission* 124, p.6 (LHMU).

30 *Submission* 59, pp.8-10 (HSU NSW).

31 *Submission* 124, p.7 (LHMU).

voiced concern that staff shortages contributed to safety problems for staff, citing cases of assaults by intruders at aged care facilities.[32]

Community care

> One of the things that we are now seeing is a reluctance of people to take up work in the community sector. I get a sense from within my own membership that the community care work force is in – I hate using the word 'crisis' – peril of leaving a good number of people in their homes without ongoing support if we as a nation do not do something to enhance the benefits that community care workers get to make it an attractive field of endeavour for workers to work in. That is the community care aspect.[33]

2.23 In the community care sector there is increased demand for workers as the sector is experiencing significant growth. The Queensland Government stated that the three drivers in the size and occupational distribution of the workforce were seen as: the rate of funding growth in community aged care programs and related areas; increased reliance on the paid care workforce as opposed to the volunteer workforce; and the preference of many older people who have significant impairments to stay at home.[34]

2.24 All States and Territories are experiencing rapid growth of community care programs in both ageing and disability. In Queensland, for example, HACC has had an average growth of around 10 per cent per annum over the past five years. At the same time Community Aged Care Packages have grown at a rapid rate and a number of other programs have either been initiated or expanded, most notably Veterans Home Care and the Extended Aged Care at Home (EACH) program. As a result, demand for a skilled workforce has increased.[35]

2.25 The expansion of disability programs which employ people with similar skills for similar tasks such as personal care (eg help with toileting, showering and dressing) means that there is a competitive market for trained staff. NSW Health commented that there are staff shortages for community care services for older people, particularly for nurses and therapists. The impact is that older people may not receive appropriate community care services.[36]

2.26 Workers in the community care workforce are often part time or casual workers or contractors. It was reported that there is a high turnover of workers which poses difficulties for staff replacement, especially in rural areas. Reasons given for the high turnover include low pay, lack of career path, having to work in relative

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32 *Submission* 122, p.8 (HSU).

33 *Committee Hansard* 22.2.05, p.1 (ACS SA & NT).

34 *Submission* 193, p.5 (Queensland Government).

35 *Submission* 193, p.5 (Queensland Government).

36 *Submission* 202, p.10 (NSW Health).

isolation, occupational health and safety challenges associated with working in the client's own home and the age profile of the community care workforce.[37]

2.27 It was also stated that there is evidence that many organisations which relied on volunteers to provide services such as day respite programs, meals on wheels, social support and transport are finding it difficult attract volunteers. Organisations are also finding that they must employ more staff as there is increased demand to provide more services, to improve quality and to deliver on compliance obligations such as meeting standards, entering client information on data bases and preparing reports to funding agencies.

2.28 As more people are now opting to stay at home for longer as they age, greater numbers of extremely frail older people who have significant dependencies and complex service requirements are living in the community. To ensure that older people can live at home safely, requires a more highly skilled workforce.

2.29 The Queensland Government noted that 'there is a paucity of information about the community care workforce'. There is no comprehensive data source available for the community aged care workforce in Queensland that would enable Queensland Health to identify shortages of skilled staff, turnover rates, or occupational categories/geographic areas where shortages are particularly severe. The Government suggested that this would appear to be a national issue where the Commonwealth Government could take an important leadership role as it is the primary funder of community aged care programs.[38]

Medical practitioners and allied health professionals

2.30 The Australian Medical Association (AMA) indicated that there had been a decline in the number of general practitioners visiting residential aged care facilities. The AMA stated that there were a number of barriers to health professionals visiting residential aged care facilities including the absence of appropriate Medicare Benefits Schedule items for geriatricians, the large amount of paperwork expected of GPs and staff of the facilities and the lack of integration of medical services in the aged care system.[39]

2.31 The Victorian Government also commented on the role of GPs and noted that, although the GP workforce does not strictly form part of the aged care workforce, GP workforce shortages have contributed to the decline in Medicare Benefit Schedule funded services provided to people in residential care. The Government welcomed the Commonwealth's plan to enhance GP services for older people by introducing a new Medicare rebate for GPs to visit aged care facilities to provide a comprehensive

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37 *Submission* 125, p.2 (ACS SA & NT).

38 *Submission* 193, p.6 (Queensland Government).

39 *Committee Hansard* 11.2.05, p.21 (AMA); see also *Committee Hansard* 22.2.05, p.14 (Resthaven); p.54 (Adelaide North East Division of General Practice).

assessment of residents' health and funding to Divisions of General Practice to establish panels of GPs for residential aged care facilities in their area.[40]

2.32 In relation to specialist care, the AMA stated that consultant physicians in geriatric medicine were best placed to provide specialist aged care advice and education across the whole continuum of care. However, 'government health programs such as the existing Medical Benefits Schedule (MBS) structure and the MedicarePlus initiatives economically marginalise the geriatric medical workforce and restrict the provision of private hospital, community and religious specialist aged care'.[41]

2.33 The Australian Society of Geriatric Medicine also commented on the lack of geriatricians and other specialists working in aged care facilities.[42] Most consultant physicians in geriatric medicine working in Australia work in the public hospital system. The AMA commented that this means that 'despite the clear health needs and the increasing numbers of older people in our community, those other than in public hospitals have limited access to the type of specialist aged care expertise that geriatricians and consultant physicians specialising in aged care can provide'. Ways to train and attract more consultant physicians to geriatric medicine, to make the most of their time and to involve the GP and other health professionals in more integrated team approaches are needed. The AMA concluded that a key to this development is the MBS items, which encourage GPs to work in aged care settings and for geriatricians to provide core geriatric medical services.[43]

2.34 NSW Health indicated that with the exception of paediatrics, NSW has existing or emerging shortages in 24 key medical workforce groups. Geriatric medicine is one of the specialties in shortage. To address all of these shortages, 'every State and Territory Government needs to negotiate training plans and numbers for medical specialty trainees based on workforce requirements' with the medical colleges. The NSW Government has already begun this process through their negotiation with the Royal Australian College of Physicians on basic physician training. NSW Health commented that this new system is based on a number of principles that ensure trainees are equitably distributed across the State at the same time as improving their training experience.[44]

2.35 Another area of concern was the lack of specialist and generalist nutritionists and dietitians. Metropolitan Domiciliary Care noted that 'good nutrition is particularly important for older people to maintain an independent lifestyle for as long as possible and to minimise morbidity and premature death'.[45] It also stated:

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40 *Submission* 180, p.3 (Victorian Government).

41 *Committee Hansard* 11.2.05, p.22 (AMA).

42 *Committee Hansard* 19.8.04, p.35 (ASGM).

43 *Committee Hansard* 11.2.05, p.22 (AMA)

44 *Submission* 202, p.9 (NSW Health).

45 *Committee Hansard* 22.2.05, p.40 (Metropolitan Domiciliary Care).

> A network of specialist and generalist nutrition workers is needed in the public health system to initiate support and help sustain healthy ageing initiatives which are centred on nutrition. We are finding that the initiatives the organisations want to take are not able to be supported because the specialist nutrition workforce or generalist workers who have some experience in that area are just not there…There is an insufficient nutrition workforce that is adequately skilled and actively engaged in the aged care setting.[46]

Commonwealth Government Programs and Initiatives

2.36 The Commonwealth has recognised the need to address the shortage of nurses, including aged care nurses. The Department of Health and Ageing (DoHA) provided these recent initiatives directed at aged care workforce issues:

- The Aged Care Workforce Committee: established in 1996 with representatives of peak organisations, aged care employees, approved providers, higher education and vocational education providers, professional groups and consumers. The Committee has assisted in identifying workforce issues and is developing a framework to respond to current and future issues.
- The National Aged Care Workforce Census and Survey: the Commonwealth, in partnership with the Aged Care Workforce Committee, has commissioned a national census and survey of the residential aged care workforce. The results of the study, which was undertaken by the National Institute of Labour Studies at Flinders University, are contained in the report *The Care of Older Australians: A Picture of the Residential Aged Care Workforce*. Major findings include that the workforce is well qualified, the overall vacancy rate and the vacancy rate for each major occupation was not high, but there was some difficulty in recruiting nurses and the overall shortage of registered nurses is affecting the aged care workforce.
- *The Recruitment and Retention of Nurses in Residential Aged Care*, published in 2002, was commissioned by the Commonwealth from La Trobe University. It identified several solutions to improve the recruitment and retention of nurses in the aged care sector. The Commonwealth response included a number of workforce initiatives.
- Nurse Practitioners in Aged Care: the Commonwealth, with the Aged Care Workforce Committee, is investigating opportunities to support trials for nurse practitioners within the aged care sector in recognition of the importance of professional development and career paths for registered nurses in aged care. ACT Health will conduct a trial over a 12-month period and cover residential, community and acute care settings.
- Nurse Re-entry Programs: the Commonwealth is funding several aged care specific nurse re-entry program pilots. The aim of the programs is to prepare

46 *Committee Hansard* 22.2.05, p.41 (Metropolitan Domiciliary Care).

former nurses for employment in the aged care sector, by offering them aged care nursing courses to encourage them to return to practice in rural and regional aged care services.

- Rewarding Best Practice: Good practice in recruitment and retention of skilled staff has been encouraged and rewarded through the Minister's Awards for Excellence in the Aged Care Industry and the Better Health and Safety Awards.

2.37 DoHA also provided information on initiatives in training, both general nurse training and specific aged care nursing training. The Commonwealth has funded the Aged Care Undergraduate Nursing Principles Project, which was conducted by the School of Nursing at the Queensland University of Technology. The resulting *Aged Care Core Component in Undergraduate Nursing Principles Paper* outlines a number of matters including the core values underpinning the learning and teaching of aged care; desirable learning outcomes; and principles for the learning and teaching of aged care.

2.38 In July 2004, the Commonwealth announced new university undergraduate nursing places. In the 2002-03 Budget, the Commonwealth provided $26.3 million over four years to support and encourage more people to enter and re-enter aged care nursing, particularly in rural and regional areas. Approximately $7 million of this funding was for the More Aged Care Nurses Scholarship Scheme. Under this initiative up to 1,000 aged care nursing scholarships, valued at up to $10 000 a year, are being provided. More than 900 have already been awarded for undergraduate study, continuing professional development, honours courses and re-entry programs. The Commonwealth also provided funding to ensure that care staff employed in smaller and less viable aged care homes were provided with appropriate training opportunities.

2.39 In the 2002-03 Budget, the Commonwealth increased residential aged care subsidies by $211 million over four years. DoHA stated that an important aim of this funding was to assist employers of aged care workers with the recruitment and retention of quality staff by offering increases in wages and improved working conditions.[47]

2004-05 Budget initiatives

2.40 In the 2004-05 Budget a further $101.4 million was allocated over four years to assist the aged care sector workforce. Initiatives included in this package, *Better Skills for Better Care*, were aimed at:

- assisting up to 15 750 aged care workers to access recognised education and training opportunities such as Certificate III or IV in aged care, or enrolled nurse qualifications;

47 *Submission* 191, pp.19-25 (DoHA).

- assisting up to 5,250 enrolled nurses to access recognised and approved medication administration education and training programs;
- assisting up to 8,000 aged care workers to access the Workplace English Language and Literacy program (WELL); and
- allowing more than 1,700 students to commence nursing studies over the next four years.

The funding for vocational education and training and medication management training places will be provided to eligible aged care providers to purchase the training directly.[48]

2.41 In the 2004-05 Budget and in response to the Hogan Review, the Commonwealth provided additional funding of $877.8 million over four years for a conditional adjustment payment. This funding was aimed at assisting aged care providers to continue to provide high quality care for older people, including assisting in paying more competitive wages to nurses and other staff. In order to qualify for the payment, aged care providers will be required to encourage staff to undertake training, publish audited financial statements and participate in periodic workforce surveys.

2.42 The Department noted that with the ageing population, there will be increasing demand for aged care nurses across all health sectors, including in hospital and community settings.[49] The Department stated that the Commonwealth had recognised the workforce issues in aged care and has implemented a strategic approach in meeting the challenges. It has 'demonstrated its commitment to the aged care workforce through significant budget investments in training and education for aged care workers, policy and research initiatives and trailing innovative programs in partnership with the aged care sector'. In addition:

> The role of government is not confined to the federal sphere: state and territory governments, and local governments, all have critical roles, in policy and service delivery. A nationally consistent scope of practice for enrolled nurses, for example, depends on state and territory legislation.
>
> Our whole community also has an important role to play, particularly in valuing older people and the people who care for them: the image of aged care continues to represent a major obstacle to recruitment and retention in the aged care workforce.[50]

National Aged Care Workforce Strategy

2.43 In April 2005, the National Aged Care Workforce Strategy was released. The Strategy was developed by the Aged Care Workforce Committee following consultation with the aged care sector. The Strategy identifies the workforce profile of

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48 *Budget Measures 2004-05*, Budget Paper No.2, p.186.

49 *Submission* 191, p.19 (DoHA).

50 *Submission* 191, p.26 (DoHA).

the residential aged care sector and its needs until 2010. The Minister for Ageing, the Hon Julie Bishop, stated that:

> In coming years, we will not only have more older Australians, but more people who are frail, as well as new patterns of disease and disability. We will need a skilled, professional and flexible workforce to provide more services, better quality services and more service choices to the growing number of older people.[51]

2.44 The Strategy aims to provide a people management and development framework for a sustainable and viable aged care sector. The Strategy is made up of seven objectives and 17 strategies. The objectives include workforce profile, education, training and development, a responsive workforce and status and image.[52]

2.45 It was noted that the Strategy focuses on the residential aged care workforce and that further work will be needed to broaden the strategic response to cover the full aged care workforce in all settings. The Productivity Commission is to undertake a study of the economic and fiscal implications of the future ageing of Australia's population on the labour supply and to examine the issues impacting on the health workforce. The Commission's findings will influence the implementation of the Strategy.[53]

State Government initiatives

2.46 In addition to Commonwealth Government initiatives to address workforce issues in the aged care sector, State and Territory Governments have instituted programs to strengthen the aged care workforce. For example, in Victoria the HACC Workforce Development Strategy Project aims to improve the recruitment, retention and training of community case workers, increase the diversity of the HACC workforce and enhance professional development opportunities for staff. Aged care training has been enhanced through the Office of Tertiary and Training Education and the New Apprentice Trainee Completion Bonus scheme. In addition, a pilot project to increase the number of geriatric medicine trainees has been launched.[54]

2.47 Queensland Health has also instituted a program to improve recruitment of nurses to aged care work. This includes an initiative which funds and supports placements for new graduates across the aged care continuum (acute, community, residential aged care); the Transition to Practice training program; and trialing the Nurse Practitioner in Aged Care settings. Queensland Health is also developing a HACC Workforce Skills Development Strategy to develop a framework for the skills

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51 The Hon Julie Bishop, Minister for Ageing, 'Planning the future of the aged care workforce', *Media Release*, 21.4.05.

52 Aged Care Workforce Committee, *National Aged Care Workforce Strategy*, Canberra, March 2005, pp.v-vii, 3.

53 *National Aged Care Workforce Strategy*, pp.v-vi.

54 *Submission* 180, p.4 (Victorian Government).

development of the HACC workforce in Queensland. This will help develop an appropriate minimum level of skill in areas identified as essential to the provision of quality services. The Strategy will be implemented over a three year period between July 2005 and June 2008.[55]

Impact of Commonwealth Government initiatives and programs

> The federal budget of 2004 was a defining moment for the aged care sector. However, much more must be done and further guarantees need to be given that people accessing aged care services will not be disadvantaged by changes and reforms to aged care.[56]
>
> Geriaction therefore believes that the 2004-5 Budget initiatives will have virtually no impact on age care workforce shortages. While the training initiatives are welcomed this organisation believes they will have limited impact on the current workforce situation. These appear to be little more than bandaid measures that fail to address the need for a comprehensive workforce planning strategy. Only with workforce planning will the sector be able to develop recruitment, retention, and training strategies that will deliver quality outcomes over the long-term.[57]

2.48 Many witnesses welcomed the Commonwealth's initiatives in the aged care sector. However, it was generally considered that some of the initiatives would not achieve their objectives and some areas require further work.[58]

Nurse education and training

Undergraduate education

2.49 The Commonwealth has, over a number of years, provided additional funding for undergraduate nursing places. In the 2004-05 Budget, funding was allocated over four years to enable 1 700 additional students to commence undergraduate nursing with a focus on aged care. In addition, the Aged Care Nursing Scholarship and Support Scheme provides funding for undergraduate study, continuing professional development, honours courses and re-entry programs.

2.50 While the increase in the number of nursing places was welcomed, witnesses expressed doubts that the increase would provide a long term solution to the workforce problems facing the aged care sector. Witnesses pointed to the Hogan Review's recommendations for increases in the number of registered nurse places at Australian universities and the 2004-05 Budget response:

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55 *Submission* 193, p.8 (Queensland Government).

56 *Committee Hansard* 11.2.05, p.3 (CHA).

57 *Submission* 88, p.1 (Geriaction).

58 *Submissions* 71, p.3 (RCNA);

Hogan Review Recommendations	Budget Response
Registered nurse places: 2700 over three years	Registered nurse places: 1094 over four years
1000 in 2004-05	400 in 2004-05

The Hogan Review recommended that these additional places should only be made available to universities which offer specialist training for aged care nurses.[59]

2.51 UnitingCare commented:

> What the government provided in the budget in response to that review was approximately half the level of training and places requested in the Hogan review. Whilst I think that it is great that the government is moving towards a better career path, better training, more places for the nursing industry and the enrolled nurses and carers generally, there needs to be more. I think Hogan probably got it fairly right.[60]

2.52 The ANF also stated:

> The Australian Government has increased undergraduate nursing course places in universities but the number allocated falls well short of what the industry needs. Both the National Review of Nursing Education and the Hogan report called for far greater numbers of undergraduate places. The ANF has estimated that 1100 extra places per year for four years is necessary to adequately address the nursing shortage.[61]

2.53 While expressing concern at the shortage of nurses, NSW Health noted that the NSW State Government has limited influence over the number and type of education and training places that are established in the higher education sector. It argued that it is critical that better linkages between the health, education and training sectors are established to ensure that the right number and type of health professionals are available to meet community need. It was noted that the greatest workforce pressures are in rural, regional and outer metropolitan regions and more HECS funded places for nurses, doctors, dentists and allied health staff in these workforce pressure areas are needed, as well as incorporating more targeted rural clinical placements into curricula.[62]

2.54 Witnesses argued that with the general shortage of nurses, the increase in places would not keep pace with the demands of the acute sector let alone those of the

59 Hogan Review, p.xix.

60 *Committee Hansard* 11.2.05, p.7 (UnitingCare).

61 *Submission* 201, p.20 (ANF).

62 *Submission* 202, p.9 (NSW Health).

aged care sector. The poor image of aged care nursing arising from pay disparity, poor working conditions and lack of access to education and training made it a less attractive option for graduates and there was no guarantee that the new graduates would enter the aged care sector. This concern was highlighted by Aged and Community Services SA &NT which commented that in South Australia in 2003, all registered nurse graduates were absorbed into the public health system, private acute system or nursing agencies with no graduates entering aged care as a professional choice.[63] The aged care sector is a less popular area of practice and with competition from other areas witnesses believed that the shortages would continue.[64]

2.55 It was also noted that demand for nursing staff was increasing across the health spectrum. However, in the aged care sector factors such as the increasing frailty of those entering residential aged care, the increasing number of aged care places and the larger numbers of nurses facing retirement because of the age profile of the aged care nursing workforce, means that demand may be higher than other sectors. Providers will need to employ larger numbers and more highly skilled registered nurses if the quality of care is to be maintained.[65] However, the Royal College of Nursing commented that the Budget initiatives focused on lower level nursing education at the expense of specialist gerontological nursing education.[66]

2.56 Clinical placements for undergraduates was another area of concern. NSW Health argued that offering clinical placements in areas of workforce demand such as rural, regional and outer metropolitan areas is critical. The quality of the clinical placement experience impacts upon recruitment, particularly in areas such as aged care. NSW Health stated that the Commonwealth 'needs to acknowledge that clinical placements are significantly under-funded through the education sector and that this under-funding results in greater difficulties with recruitment and retention of the workforce'.[67]

2.57 The Tasmanian Government also focussed on clinical placements for undergraduates and noted that if students do not have a positive experience whilst on placement in an aged care facility, they will be unlikely to seek future employment in the sector. It argued that scholarships to support work in aged care must be provided in conjunction with quality clinical placements. This is particularly the case given that there is no obligation for recipients to fulfil a period of employment in an aged care facility following admittance to the Bachelor of Nursing degree.[68]

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63 *Submission* 125, p.3 (ACS SA & NT).

64 *Committee Hansard* 27.4.05, p.51 (Royal District Nursing Service).

65 *Submission* 150, p.5 (VAHEC).

66 *Submission* 71, p.2 (RCN).

67 *Submission* 202 p.9 (NSW Health).

68 *Submission* 200, p.3 (Tasmanian Government).

Articulation between nursing levels

2.58 The Commonwealth's response to the Hogan Review provides for 4,500 additional vocational training places to be created each year for aged care workers to improve quality of care and to provide better career pathways for aged care workers. These places are aimed at assisting 15 750 aged care workers undertake vocational education training over the next four years. The funding for vocational education and training will be provided to eligible aged care providers to purchase the training directly. DoHA noted that the initiative 'will be largely focused towards certificates III and IV in aged care, with some possibility of training options for people to do diplomas to reach enrolled nurse level'.[69]

2.59 The HSU noted that 80 per cent of the people who directly look after residents in aged care are carers, not nurses.[70] The level of training of carers varies significantly. The HSU stated that providers can and do use staff who have no training in aged care, with some even working alone at night. One carer stated:

> Personal carers come in and I cannot understand how on earth they got their certificate. Their basic English is not very good and nor is their understanding of looking after somebody. When you orientate them, although they have just got their PC 3 certificate they do not even know how to shower a person, how to wash them properly, how to toilet them properly or how to transfer them properly. Yet these people are being put into aged care to look after elderly people. There needs to be some sort of training outside before you enter them into aged care.[71]

2.60 The Aged Care Lobby voiced similar concerns:

> When you look at the personal carers it is easy to see why care is not what it should be. Personal carers can go to do a TAFE course with year 10 qualifications. They have a 16-week course – seven weeks of lectures and nine weeks of practical work – and they have to have a mature St John Ambulance certificate at the end of the course. Is that adequate to provide someone with the skills to look after elderly people…I suggest to you that that is the problem in most aged care facilities: looking at the prerequisites that are needed to look after elderly people.[72]

The HSU commented that the Commonwealth should 'move as quickly as possible to put in place a requirement for all new staff entering the industry to be qualified to an aged care certificate III standard'.[73]

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69 Senate Community Affairs Legislation Committee, *Estimates*, 2.6.04, p.CA135 (DoHA).

70 *Committee Hansard* 26.4.05, p.47 (HSU).

71 *Committee Hansard* 26.4.05, p.54 (HSU).

72 *Committee Hansard* 22.2.05, p.30 (Aged Care Lobby).

73 *Submission* 122, p.17 (HSU); see also *Submissions* 71, p.4 (RCNA); 74, p.6 (ANHECA).

2.61 In relation to helping care workers to upgrade to enrolled nurses, the Queensland Government supported this initiative as it offers a career pathway for unregulated workers into nursing and stated 'the backbone of both the residential and community care workforces is 'unregulated' workers'. Their access to pre and post employment training to Certificate III and beyond was seen as a key issue that needs to be tackled as part of a national strategy.[74]

2.62 Similarly, the ANF welcomed the funding initiative but advocated that the funding be provided to registered training providers to enable them to offer additional enrolled nursing courses. The ANF noted however that obtaining the quality clinical placements essential to the enrolled nursing qualification may present a significant difficulty. The ANF went on to comment that it was concerned with the growing number of personal carers accessing a Certificate IV qualification that does not lead to licensing as an enrolled nurse. It stated that 'the licensing of people providing nursing care is an important process that provides protection and recourse for the public whose lives depend on those who are caring for them'.[75]

2.63 Geriaction stated that care workers often seek access to enrolled nurse training. However places to do so are short and if they do access a place 'they have to leave their current workplace, go to an acute care environment and work rotating rosters, which is not consistent with family and other work issues'. Geriaction concluded that:

> There are some real barriers to access to those courses…I think there is a need to look at the whole notion of teaching centres for aged care where we develop centres of excellence, have training from multidisciplinary people and develop relationships with universities…They engender the culture of learning and research which is critical to keeping people in the discipline and in the specialty itself.[76]

2.64 The Tasmanian Government commented that, while the 2004-05 Budget included measures for aged care education and training, it is understood that education and training for workers in the residential aged care will be paid direct to aged care providers to fund training for enrolled nursing. Funding through normal VET system channels is preferred as it would enable better strategic targeting of training to meet industry needs.[77] The HSU also called for greater accountability mechanisms to be built into payments for providers to ensure an agreed level of workforce training is provided in each aged care facility.[78]

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74 *Submission* 193, p.7 (Queensland Government); see also *Submission* 173, p.2 (ACS Australia).

75 *Submission* 201, p.20 (ANF).

76 *Committee Hansard* 19.8.04, p.43 (Geriaction).

77 *Submission* 200, p.2 (Tasmanian Government).

78 *Submission* 122, p.18 (HSU).

2.65 The Queensland Government commented on pathways for enrolled nurses to continue into registered nursing and other health professions. It stated that 'for this to occur there would need to be incentives for universities to offer articulation pathways which do not require unnecessary duplication of previous training or unreasonably extend the number of years students need to study'.[79]

2.66 During the Committee's 2002 inquiry into nursing, witnesses commented on articulation. The ANF argued that formal articulation and recognition of prior learning arrangements should be developed between Certificate III courses for unlicensed nursing and personal care assistants (however titled) and enrolled nurse courses. It was also stated that a possible pathway could include the opportunity for students to enter as personal care assistants through the TAFE sector. These students would then be offered the opportunity to progress into an EN program and from then to a Licensed Practical Nurse program (based on the US model where these nurses have a specific role which is different from that of the RN), and then onto completion of the program as a RN. The Committee recommended that formal articulation arrangements and recognition of prior learning be developed between Certificate III courses for unregulated healthcare workers and enrolled nurse courses, and between courses for Aboriginal and Torres Strait Islander health workers and enrolled nurse courses.[80]

Enrolled nurse medication management training

2.67 Enrolled nurses are able to administer certain medication but must receive the relevant training. VAHEC stated that this training cost approximately $3,000 per person and precluded some enrolled nurses and providers from accessing training.[81]

2.68 The Commonwealth's initiative aims to assist 5 250 enrolled nurses to access training to allow them to administer medication. This initiative was seen as overcoming a barrier to medication training and as a positive step in improving the skills base of the aged care workforce. The funding would ensure medication management was not relegated to a category of worker with no pharmacology education. Medication management by enrolled nurses would also allow more effective utilisation of registered nurses and allow 'sensible and rational work practices to evolve based upon the capabilities of the various categories of staff'.[82] It was also hoped that this measure will enhance the enrolled nurse role and lead to more enrolled nurses remaining in aged care.[83]

2.69 However, witnesses questioned whether the funding would be adequate. They pointed to the Hogan Review's recommendation that the Commonwealth should

79 *Submission* 193, p.7 (Queensland Government).

80 *The Patient Profession*, pp.80-81.

81 *Submission* 150, p.5 (VAHEC).

82 *Submission* 74, p.6 (ANHECA).

83 *Submission* 71, p.4 (RCNA).

support aged care providers to assist at least 12 000 enrolled nurses to complete medication management training by 2007-08.[84] The Queensland Government stated that:

> The Commonwealth Government's initiatives in promoting an aged care workforce capable of meeting contemporary and future challenges, while important and useful, operate in the absence of a clear strategic context. Thus while initiatives directed to improving the medication management skills of enrolled nurses are 'a positive', it is not known whether the numbers of positions targeted have been based on the best available evidence of projected need.[85]

Wage parity

> We do not believe that the recent budget initiatives go far enough in addressing wage parity issues. We are concerned that if we do not actually address that problem it will ultimately impact – if it has not already – on the actual quality of care being provided to people in residential care.[86]
>
> No amount of education and training support will make up for the lack of funding to provide comparative wages with the acute sector.[87]

2.70 Wage disparity between the aged care sector and other areas of nursing was seen as a major impediment to recruitment and retention in the aged care workforce. As noted above, wage disparity occurs in all jurisdictions. There is disparity between the aged care sector and other health sectors, between government and non-government facilities and at all workforce levels in the aged care sector.

2.71 The Commonwealth's additional funding aimed to help providers increase wages was made in two parts: in the 2002-03 Budget, funding over four years for subsidy increases was provided; and in 2004-05 funding over four years for conditional adjustment payment was provided.

2.72 Witnesses argued that the Commonwealth's additional funding had failed to close the gap between wages in the aged care sector and other health sectors. Two reasons were advanced for the failure of this initiative. First, it was argued that the funding was not being directed towards wages as there was no mechanism for ensuring that this in fact occurred. Secondly, that the additional funding was insufficient to close the gap.

2.73 Without a mechanism to ensure that the funding went to addressing the disparity in wages, nurses feared that the money would not be used as intended but

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84 See for example, *Submission* 150, p.6 (VAHEC).

85 *Submission* 193, p.4 (Queensland Government).

86 *Committee Hansard* 19.8.04, p.34 (Geriaction).

87 *Submission* 89, p.1 (Nurses Board of Western Australia).

'instead end up in the consolidated revenue of aged care facilities'.[88] The NSW Nurses Association stated:

> Without extra conditions on the $877.8 million incentive payment to mandate that service providers use the money to improve wages and conditions, the NSW Nurses Association does not have any expectation that the employment conditions for nurses in aged care will improve. It will not make any difference in this budget, as it made no difference in previous budgets. Until there is quarantined funding for nurses wages, it is unlikely that service providers will pass on any extra funds.[89]

2.74 The HSU also noted that there is a significant wage gap of $60 to $70 a week for carers between the public sector and the aged care sector. The HSU stated that carers in public hospitals do far less than carers in aged care.[90] HSU (NSW) voiced concerns on behalf of its members that the conditional adjustment payment would not be used to improve wages:

> But I am not confident that they will respond in that manner. I am not confident that they see that money as going towards staffing and salaries and I do not believe there is anything in the budgetary measures that actually locks them in and requires them to spend that money on staffing or salaries. That is our concern.[91]

2.75 The ANF considered that the amounts provided in the Budget provision were sufficient to achieve parity but were not being used to do so:

> The amounts that the government allocates are sufficient to achieve parity. Both in the $877.8 million and previously in the $211 million, the amounts were sufficient. It is just that they do not get to wages because there is no mechanism or no requirement that they do so.[92]

The ANF argued that the providers 'were quite deliberately depressing wages because it is a good reason to put pressure on the government to give them more money'.[93] Witnesses recommended that a mechanism be put in place that ensured that the additional funding provided by the Commonwealth was directed at wages.[94]

2.76 As part of the eligibility requirements for the conditional adjustment, providers are required to encourage staff to undertake training, publish audited financial statements and participate in periodic workforce surveys. The ANF indicated

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88 *Submission* 71, p.3 (RCNA).

89 *Submission* 179, p.3 (NSW Nurses Association).

90 *Committee Hansard* 26.4.05, p.44 (HSU).

91 *Committee Hansard* 19.8.04, p.73 (HSU NSW).

92 *Committee Hansard* 11.2.05, 37 (ANF).

93 *Committee Hansard* 11.2.05, p.45 (ANF).

94 See for example, *Submissions* 186, p.5 (QNU); 201, p. 19 (ANF); *Committee Hansard* 19.8.04, p.63 (HSU NSW).

there were some difficulties with providing audited statements in that some entities are part of a larger entity 'which means it is impossible to differentiate'. The ANF stated that a working group was 'trying to develop a format for what that reporting means and what will actually be reported'. While it was hoped that would enable the allocation of funds to be identified 'at the moment we do not have – and have not had since 1997 – any way of telling how much providers are spending on particular things, and the audited accounts do not give that detail at all'.[95]

2.77 Other witnesses argued that wage disparity would not only continue but would increase as the additional funding was insufficient to close the gap. The Tasmanian Government commented:

> The Commonwealth Budget provided a welcome increase in the subsidies paid for residential aged care, with a supplement of 1.75 per cent being added annually for the next four years. However, this will generally not be sufficient to enable aged care employers to pay wages that are competitive with the public hospital sector. Linking aged care subsidies to an appropriate index of health sector wages would achieve this, or alternatively, increasing the supplementary payment. Until pay parity is achieved it will remain very difficult for the current workforce issues in residential aged care to be effectively addressed.[96]

2.78 CHA stated that its modelling of the conditional adjustment payment would mean that there would still be a shortfall of around $170 a week for a nurse working in an aged care facility as compared to a hospital. CHA commented that 'because the aged care program is so heavily reliant on government subsidy around the care funding, which goes to wages, and because the overall operating budget is so significantly determined by wages, the gap unfortunately is exacerbated'.[97]

2.79 UnitingCare stated that the current indexation system resulted in inaccurate costing of wages in the sector. It gave the example of one of its providers in Queensland which faced wage rises of approximately 6 per cent per year over the last three years, while indexation had been closer to 2.5 per cent.[98]

2.80 UnitingCare also noted that the 2004 Budget allocation of $877.8 million over four years meant that the Commonwealth had agreed to indexation totalling 3.76 per cent (1.75 per cent for the adjustment and 2.01 per cent indexation) in the current financial year. UnitingCare concluded that, while the increase in funding is welcome, 'the figures strongly suggest the scope of the increase is not large enough to keep pace with annual cost increases and:

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95 *Committee Hansard* 11.2.05, p.37 (ANF).

96 *Submission* 200, p.2 (Tasmanian Government).

97 *Committee Hansard* 11.2.05, p.9 (CHA).

98 *Submission* 57, p.5 (UnitingCare).

> The increase will certainly not provide sufficient funding to redress the existing disparity of wages between the aged care and public hospital sectors. The aged care sector is reaching the end of it's capacity to absorb the disparity between funding and expenditure.[99]

2.81 The Aged and Community Services Association of NSW & ACT also agreed that although the increased residential aged care subsidies would 'go some way to alleviating the pressure for providers, it will generally not be sufficient to enable aged care employers to pay wages that are competitive with the public hospital sector'. The Association stated that actual wage costs were rising faster than aged care subsidies. The formula for the annual indexation of subsidies included only the amount of the safety net wage adjustment. Industry pay rates have increased by significantly more than the subsidy rates, driven in large part by wage settlements in the public hospital sector. In addition, the Association argued that setting of a national rate for the subsidy, did not take into account differences in wage rates between jurisdictions. For example, nurse wages in NSW are 12 per cent more than in any other jurisdiction.[100]

Community care

2.82 As noted above, the aged care community workforce has grown rapidly in response to changes in policy direction. Witnesses commented that the Commonwealth's initiatives tend to address residential aged care workforce issues only. The Tasmanian Government commented that the initiatives were inconsistent with the direction of government policy as programs emphasised people remaining in their homes as long as possible and the focus is on training funding in residential care.[101] CHA believed that:

> …there would be greater merit in bringing together the strategic workforce issues affecting all aspects of aged care. This would provide a more comprehensive and coordinated response which would address residential and community care together with geriatric care in the acute sector.[102]

Workforce planning and the National Aged Care Workforce Strategy

2.83 While there was support for the Commonwealth's initiatives, they were seen as only addressing part of the problems facing the aged care sector. The Tasmanian Government stated that while these initiatives are useful in their own right, they tend to focus on the residential aged care workforce and neglect strategic issues confronting the aged care sector as a whole. Community care workforce issues, in

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99 *Submission* 57, p.6 (UnitingCare).

100 *Submission* 170, p.6; *Committee Hansard* 19.4.04, p.23 (ACS Association of NSW & ACT). See also *Committee Hansard* 18.3.05 p.16 (Aged Care Qld).

101 *Submission* 200, p.3 (Tasmanian Government); see also *Submissions* 13, p.2 (Inner West 5 Home and Community Care Forum); 193, p.7 (Queensland Government).

102 *Submission* 166, p.4 (CHA).

particular, merit further attention.[103] Geriaction saw the initiatives as 'bandaid measures', which failed to address the need for a comprehensive workforce planning strategy.

2.84 The need for a long term and national approach to workforce planning was supported by other evidence.[104] For example, the Queensland Government commented that there is a case for the development and implementation of a coherent national workforce plan to deal with immediate and medium term workforce challenges. In doing so, the Queensland Government stated that the Commonwealth and State and Territory Governments will need to work closely in partnership with professional associations and education/training providers in the development of a national approach. The Government noted that the Council of Australian Governments (COAG) recently agreed to the development of a health workforce plan and stated that work on an aged care workforce plan could usefully occur in tandem with this work.[105]

2.85 NSW Health also argued that greater collaboration between all parties involved in the training of our health workforce is critical to ensure it is truly patient focused. It considered that a team-based approach to learning, across and within professions, needs to be fostered in the education sector and reinforced in the workplace. This is particularly important in care of the aged where coordination of professional effort can result in significantly improved health outcomes.[106]

2.86 NCOSS stated that commented, in relation to community care:

> …we all know of the shortages that are emerging in aged and community care services and the desperate need – beyond perhaps some of the shorter-term measures that have been taken in recent times by governments at the Commonwealth and state levels – to have a much longer-term approach to work force development dealing with skill shortages and looking at the growth areas within these industries, broadly speaking.[107]

2.87 In April 2005, the Minister for Ageing launched the *National Aged Care Workforce Strategy*. In doing so the Minister stated that:

> There are strategies to deal with workforce supply, education and training, recruitment and retention issues, the image of aged care, so that we can promote aged care across all age sectors, as a career of choice…[it] will take this sector forward, and add much to the maturity of the aged care

103 *Submission* 200, p.2 (Tasmanian Government).

104 *Submissions* 125, p.2 (Aged & Community Care Services SA & NT);

105 *Submission* 193, p.4 (Queensland Government).

106 *Submission* 202, p.9 (NSW Health).

107 *Committee Hansard* 11.3.05, p.47 (NCOSS).

> sector, and our ability to attract and retain and reward aged care professionals.[108]

2.88 Although the Strategy was launched toward the end of the Committee's inquiry, some witnesses provided comments. Both VAHEC and ACS Australia welcomed the Strategy, but suggested that its scope should be extended to include community care. ACS Australia indicated that it had raised the matter with DoHA and 'that is something that they now support, perhaps for the next iteration of the strategy, which is a welcome development from our point of view'.[109]

2.89 The AMA stated it was disappointed that the Strategy and the National Aged Care Workforce Census did not consider medical practitioners to be part of the aged care workforce. The AMA commented 'general practitioners are the backbone of the health service in this country, yet GP participation in residential aged care facilities has declined'.[110]

2.90 The Australian Physiotherapy Association also commented that the Strategy had not addressed its important place in the aged care sector:

> We struggled to get the very important role of physiotherapy in the aged care sector recognised in the way that it should be…the remit that they had been given by the government or by the department did not allow them to include those comments. During those meetings I had terrific support from the other health professionals who were there as to the importance of physiotherapy in the sector, but we faced this blank refusal to acknowledge that physiotherapists are a core component of the aged care workforce. There seemed to be no logic, and there was no reason or rationale offered; it was simply stated that this was the limit of the study and that was all that would be examined.[111]

2.91 VAHEC raised the issue of funding and the need for cooperation:

> There are also issues, once again, about who will pay for this. It also emphasises the cooperation that will be needed between both levels of government, particularly with regard to the state government addressing some of the barriers we currently experience in recruiting and retaining staff.[112]

2.92 HSU was particularly critical, noting that there was little detail and did not address significant issues:

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108 The Hon J Bishop, Minister for Ageing, *Address to the Australian Nursing Home and Extended Care Association Nursing and Management Congress,* Sydney, 21 April 2005.

109 *Committee Hansard* 26.4.05, p.1 (ACS Australia).

110 *Committee Hansard* 11.2.05, p.21 (AMA).

111 *Committee Hansard* 27.4.05 p.61 (APA).

112 *Committee Hansard* 26.4.05 pp.3-4 (VAHEC).

> Without trying to be too critical, having read through that document I could not understand one thing that it was actually proposing in a concrete sense. It appeared to me to be incredibly general. It did not address any of the issues that we have tried to bring to the Senate's attention today and in our submissions. We ask: how can you ever have some sort of workforce planning document that does not come to terms with the very basic question of how many staff you need to adequately look after people in an aged care facility? That document certainly did not do that at all.[113]

The lack of concrete indication of need was echoed by the Mary Ogilvy Homes which stated 'in this document there does not seem to have been any formal sort of gap analysis'. [114] The HSU concluded that it was 'a lost opportunity' and that:

> We do not even see it as a good step in the first direction, because we do not see that it has set any direction at all in that particular document. We are very critical of the lost opportunity that could have been taken by the committee in that particular document.[115]

Conclusion

2.93 In its conclusion on aged care workforce issues, the Committee can but reiterate what has been said many times before: that the shortage of nurses is real, is increasing and is impacting on the quality of care being delivered in all health sectors but more particularly in the aged care sector. The shortage of nurses will continue and become more severe as the impact of an ageing workforce is felt and if the number of graduates is insufficient to replace those retiring. Shortages of medical practitioners and allied health professionals in the aged care sector are also evident. The shortages in all professions across the sector will increase as demand for a skilled aged care workforce increases as the general population ages.

2.94 The Committee acknowledges that the Commonwealth and the State and Territory Governments have instituted programs and initiatives to address the shortages. However, the evidence continues to indicate that more needs to be done. There is a need for greater coordination of workforce planning and greater coordination between governments and the tertiary sector. In relation to aged care nursing, the Committee considers that the Commonwealth should re-examine the recommendations of the Hogan Review on the number of undergraduate nursing places required with a focus on aged care. However, the Committee is mindful that there is still a need to improve the image of the aged care sector, and more particularly to reach pay parity to encourage new graduates to remain in aged care nursing. Without this, the Government's efforts to increase the aged care workforce will be ineffective.

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113 *Committee Hansard* 26.4.05, p.50 (HSU).

114 *Committee Hansard* 28.4.05 p.28 (Mary Ogilvy Homes Society).

115 *Committee Hansard* 26.4.05, p.50 (HSU).

2.95 The *National Aged Care Workforce Strategy* has been launched in an effort to address the needs of the aged care workforce. While a welcome first step, the Committee is disappointed that after so many years of reports and reviews, the Strategy is limited in scope as it is directed at residential aged care and does not encompass all areas of the aged care workforce. The Committee finds this a particularly disappointing aspect of the Strategy given the Commonwealth's policies aimed at keeping older people in their homes for as long as possible. The Strategy also does not include all professions engaged in the aged care sector. While it is noted in the introduction to the Strategy that work will be needed to broaden the strategic response to cover the full aged care workforce in all settings, the Committee considers that the limited focus of the Strategy is yet another example of where a great deal of work has failed to provide a comprehensive, cohesive and coordinated approach to a significant problem. It is not that residential care is the only area where there are workforce shortages, all areas face difficulties. Strategies to increase the number of skilled workers, be they nurses or other health professions, will take a number of years to impact. In the interim, the significant workforce difficulties in the sector may remain.

2.96 More importantly, the Strategy does not identify who will take a leadership role to ensure that the strategies are progressed and implemented. While there are areas of responsibility without commitment and leadership at the highest levels by all governments, the Committee is concerned that the Strategy will fail to deliver much needed reforms in the aged care sector.

Recommendation 1

2.97 The Commmittee welcomes the Commonwealth's allocation of 400 extra nursing places at universities in the 2004-05 Budget. However, the Committee recommends that the Commonwealth further increase the number of undergraduate nursing places at Australian universities to 1000 as recommended by the Hogan Review.

Recommendation 2

2.98 That the Commonwealth work with aged care providers to ensure that their shared responsibility to assist enrolled nurses to complete medication management training meets the target as recommended by the Hogan Review.

Recommendation 3

2.99 That the Commonwealth implement a strategy which allocates an appropriate number of undergraduate nursing places on the basis that recruitment for those places occurs from the current residential and community care workforce in both rural and urban settings proportionally.

Recommendation 4

2.100 That the Commonwealth investigate the effectiveness of incentives for staff to work in aged care settings in rural and remote areas.

Recommendation 5

2.101 That the Commonwealth, as a matter of priority, expand the National Aged Care Workforce Strategy to encompass the full aged care workforce, including medical and allied health professionals, and all areas of the aged care sector, in particular the community care sector.

Recommendation 6

2.102 That the Department of Health and Ageing and the Department of Education, Science and Training, as part of the National Aged Workforce Strategy, ensure the inclusion of quality aged care curricula in undergraduate nursing.

Recommendation 7

2.103 That the Commonwealth consider implementing mechanisms to ensure that the conditional adjustment payment aimed at restoring wage parity for nurses, personal carers and other staff in the aged care workforce is used to meet this aim.