

Submission to the Senate Inquiry into the Future of our Aged Care Workforce

February 2016

Introduction

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

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

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

Major issues

This submission identifies four sets of issues that extend across several of the individual Terms of Reference and that need to be addressed to increase the capacity of the aged care sector to meet future needs. They are:

1. There is a need for a shift in focus from attributes of both existing and potential workers that affect their workforce participation to a focus on structural factors that govern work conditions and remuneration, and on management practices associated with variations in pay and conditions between individual workplaces. A particular source of instability in the workforce is the considerable level of structural change occurring in the sector with mergers of providers and take-overs of services. Financial instability and compliance issues often associated with these kinds of restructures can have significant impacts on workers.
2. The need for greater consistency across the aged care sector and related sectors in levels of qualification and recognition of qualifications, in wages and in other working conditions. Competition can lead to better outcomes for workers, but this should not come at the costs that a high level of 'churn' imposes on clients, employers and employees. While aiming for overall consistency, differences in the work settings of residential and other centre-based services compared to community care have to be recognised, particularly in relation to

possibilities for team work and supervision in residential care that are less available in community care delivered in clients' homes.

3. It appears that these differences are growing with the expansion of community care, and especially Consumer Directed Care, and that there is a growing risk of workers conditions being compromised, to the detriment of their clients.
4. Specific and concerted action is needed to recognise and address the different segments of the aged care workforce and two broadly different sets of problems:
 - The sector is not in an overall state of 'crisis' but there are a number of chronic workforce problems that occur unevenly across the sector and that have not been resolved despite numerous but fragmented initiatives, and there are newly emerging areas of concern.
 - There is considerable variation in the experience of workers and providers; while some have few difficulties, others face a range of problems. Situations that diverge markedly from the norms need to be seen as such and not generalised to the sector as a whole, and addressed selectively.

Background to this submission

The context much of this submission is set by reference to two main sources as well as the direct experience of NFAW members in different aspects of aged care policy and administration:

- The reports on the Aged Care Workforce compiled by the National Institute of Labor Studies at Flinders University (NILS) for the Commonwealth in 2007 and 2012, and NFAW is aware that NILS has been commissioned to undertake a further survey in 2016.
- The Stocktake of Commonwealth Funded Aged Care Workforce Activities, prepared for the Department of Social Services and released in August 2015.

The submission also draws on a number of studies based on further analysis of NILS data. Electronic copies of these papers can be made available to the Inquiry Secretariat.

- A. Howe (2009) Migrant care workers or migrants working in long term care? A review of Australian experience. *Journal of Aging and Social Policy*. 21: 374-392.
- A. Howe, D. King, J.M. Ellis, Y.D. Wells, Z. Wei & K. Teshuva. (2012). Stabilising the aged care workforce: an analysis of worker retention and intention. *Australian Health Review*, 36: 83-91.
- D. King, Z. Wei and A. Howe. (2013). Worker satisfaction and intention to leave among direct care workers in community and residential aged care in Australia. *Journal of Aging and Social Policy*, 25:301–319.
- A. Howe with P. Cotter (2014). Ageing in Australia's Indigenous and culturally diverse communities. Ch. 26 in G. Caplan (Ed). *Geriatric Medicine: An Introduction*. IP Communications, Sydney. 2014. Pp.384-410.

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Recommendations

The 22 recommendations made through this submission under each Term of Reference are:

A. The current composition of the aged care workforce

- [1] that evidence be sought from the Aged Care Quality Agency on the extent of changes in staffing in line with increases in resident dependency and the removal of the high care/low care distinction, that the report on the NILS 2016 survey make detailed analysis of the trends in level of all categories of staff relative to residents' care needs.
- [2] that the Inquiry give attention to the impact on the aged care workforce of shortages of professional and other staff in the service systems that support the delivery of residential and community aged care.

B. Future aged care workforce requirements

- [3] that the employment of casual staff be further investigated through further analysis of the NILS 2012 data and in the 2016 survey, to determine variations in patterns of casual employment, investigate how far exceptionally high levels of casual employment reflect management practice rather than workforce shortages, and consider strategies to address these aberrant situations.
- [4] that the role of self-employed workers in the delivery of community care be closely monitored, especially in care packages operating on Consumer Directed Care models.
- [5] that the Outcome Standards be reviewed with attention to recognition of the part that new technologies have to play in provision of high quality care; that measures be taken to promote the adoption of best practice information technology and assistive devices, particularly those which reduce injury; and that recurrent and capital expenditure on care technologies be monitored by the Aged Care Funding Authority.

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

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

D. Challenges in attracting and retaining aged care workers

- [7] that the Government work with employer and employee bodies to identify a range of strategies to enhance retention of new workers and promote continued workforce participation on the part of workers aged over 50, especially as the age at which women can access the Age Pension rises to 67, and that expansion of these initiatives be balanced by a review of strategies focused on recruitment.
- [8] that priority be given to developing career pathways for workers who have obtained qualifications at Certificate 4 level and that the wide range of these qualifications be reviewed to identify those which could be consolidated into a career path towards a further qualification in the formal tertiary education system.

E. Factors impacting aged care workers

- [9] that the Inquiry ask the Fair Work Commission to provide a report on the industrial relations arrangements that cover the aged care workforce, with special reference to trends in the application of Modern Awards in the sector, and identifying anomalies within the sector and between the aged care, disability and health sectors.
- [10] that steps be taken to increase the proportion of permanent part-time workers as a means to stabilising the workforce, with particular attention to management practices that shape conditions of employment offered to workers.
- [11] that the Commonwealth support the development of staffing models that take account of staff mix and resident dependency and promote take up of these models as best practice for optimal staffing.

F. Role and regulation of registered training organisations

- [12] that the terminology of Certified Personal Care Worker and Certified Community Care Worker be adopted to designate workers with recognised training at least at Certificate 3 level in order to correct community perceptions that a large part of the aged care workforce is unskilled, to encourage providers to employ a trained workforce, and to give recognition to the workers themselves for their attainments.
- [13] that steps be taken to standardise and regulate the aged care education and training workforce and the qualifications obtained from courses they deliver.

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

- [14] that awards and conditions for the aged care workforce be harmonised nationally to provide consistency across the sector and with related sectors, and to facilitate movement of workers between jurisdictions.

H. Relevant parallels or strategies in an international context

- [15] that the Carer Allowance be reported as part of the Aged Care Program in Budget Papers and related reports, and that the mechanisms be put in place to monitor use of Carer Allowance to cover charges for formal services, including those provided under Consumer Directed Care.
- [16] that the term ‘migrant workers’ not be used in discussion of the aged care workforce as in suggesting a group of temporary workers, it is a misnomer for overseas-born workers who join the aged care workforce after shorter or longer periods of residence in Australia, the majority of whom are or soon become permanent residents and Australian citizens.

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

- [17] that the role of the Aged Care Workforce Advisory Committee be reviewed and that it be charged with identifying a small number of priorities for strategic action against the background of on-going, broad based workforce development activities.
- [18] that NILS be commissioned to carry out further analyses of the 2012 survey and a comprehensive plan of analysis be developed for the 2016 surveys to provide answers to questions raised in this Inquiry and to report fully in line with the review of the aged care reforms scheduled for 2017.

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

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

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

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

[21] that the extent to which the impacts of geographic isolation on the aged care workforce can be moderated by organisational integration and outreach be taken into account in the development of service delivery models in rural and remote areas that strengthen and support workers in those areas, and that this strategy consider ways of bringing all services in these areas into such support networks.

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

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

Authorisation and endorsement

This submission has been authorised by the NFAW Board and is also endorsed by
Women in Adult and Vocational Education (WAVE)
Economic Security for Women (eS4W)
Equality Rights Alliance, as per the attachment.

Marie Coleman AO PSM

Chair, Social Policy Committee,

National Foundation for Australian Women

Inquiries about this submission should be directed to Marie Coleman at mcmariecoleman@gmail.com

A. The current composition of the aged care workforce

A.1 Ageing of the workforce

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

The NILS data also shows that newly hired staff are younger. In residential care, 24% were aged 35-44, and close to 20% aged 25-34 and almost another 20% under 25. The age distribution of new hires was similar in community care, with 28% aged 35-44 and close to 15% between 25-34, but only some 10% aged 16-24. The differences between the cross sectional view of all workers and new hires point to the importance of understanding the flow of workers into the aged care workforce and subsequent turnover. Some of the differences in the profile of new hires in the residential and community care fields can be attributed to the more rapid growth of residential care in the years up to 2012 compared to limited growth of community care, and the attraction of professional staff under age 30 into residential care compared to more limited growth of these opportunities in community care.

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

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

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

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

NFAW recommends [1] that evidence be sought from the Aged Care Quality Agency on the extent of changes in staffing in line with increases in resident dependency and the removal of the high care/low care distinction, that the report on the NILS 2016 survey make detailed analysis of the trends in level of all categories of staff relative to residents' care needs.

A.3 Supporting services workers

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

1. **Assessment, rehabilitation, restorative care and palliative care services** that support residential and community care services employ a wide range of professional staff in geriatric medicine, allied health, podiatry, dentistry, psychology, social work and related disciplines. Shortages of these staff have adverse effects on clients and staff in residential and community care services as they compromise the support that can be provided to staff and clients and impose additional tasks on staff that may be beyond their scope of practice. Availability of expert consultancy staff in all these areas needs to be addressed if the aged care workforce is to function optimally. Overcoming the shortage of placements for training is a starting point for addressing these concerns and increasing the availability of professional support staff for aged care in the longer term.
2. **Managerial and administrative staff** who are not employed in direct care account for about one third of the total aged care workforce. The non-direct care workforce include domestic workers on one hand and administrative and management staff on the other. Performance of management has repeatedly been found to be a major determinant of satisfaction staff and turnover. There is no unified system of training or recognised management qualification in the aged care sector akin to those elsewhere in the health sector. Management training for entry to aged care and for promotion of existing staff is needed to address this gap.
3. **Domestic workers in residential and community care work are not equally recognised as part of the aged care workforce.** This issue is taken up below under C.3.

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

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

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

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

B.1 Growth and general labour market conditions

The aged care workforce is growing at a faster rate than the workforce in general and this ‘excess’ growth itself contribute to shortages. The aged care workforce is also highly sensitive to general labour market conditions as many workers have skills that are readily transferrable to other service sectors, including sectors outside health and community services. Some of the changes in workforce shortages reported in the NILS 2007 survey, around the peak of the mining boom, and then in the 2012

survey, after the GFC, show these effects. These labour market effects need to be well understood so that factors affecting the aged care workforce are not misattributed to the sector when they arise from more general labour market conditions.

The expectation of a period of moderate labour demand in the economy overall may reduce some of the pressures on the aged care workforce, but demand will continue at a stronger rate than in many other sectors, with the notable exception of health care, a major competitor for similar kinds of workers. Rather than relaxing the need for a strong development strategy, the next 5 to 10 years should be seen as providing a window of opportunity to consolidate and strengthen aged care as a preferred field of employment.

B.2 Casualisation

Casualisation of the workforce is a growing concern although it is difficult to discern trends from published data. The NELS 2012 report showed that just under 20% of the residential aged care workforce and almost 30% of the community care workforce were employed on a casual or contract basis. These levels had remained stable over the period from the 2007 NELS survey, and there had been some increase in permanent part-time employment in some workforce groups and this was the overwhelmingly preferred basis of employment.

Two considerations abate concerns about casual employment. Casual employment has advantages both for some staff wanting flexibility, and for employers needing to fill gaps. And to the extent that casual staff worked fewer hours than permanent full or part-time workers, their contribution to the sector may be less overall. Even where employers seek to minimise casual employment for reasons of administration and quality of care, they may not be able to do so if there is strong competition for workers to fill shifts at peak demand times. Some workers also prefer to continue casual employment even though offered permanent part time positions.

At the same time, there are grounds for concern about the wide variations in the level of casual employment, when high proportions of staff employed on a casual basis engender high levels of instability for workers and for clients. There is a need for further investigation of patterns of casual employment and especially factors associated with high levels of casual employment in particular services. It appears that casual employment may be associated with the use of labour hire companies to supply workers rather than direct employment by aged care providers.

NELS presents a detailed and complex picture of the use of casual employment and non-PAYG staff, mainly from agencies. There are differences between residential and community care, between categories of workers and between jurisdictions. The growth of such non-PAYG employment carries the potential to affect contractual relationships not only between the worker and the aged care provider but also between the worker and provider and the client. Changes of this kind are one of the risks associated with Consumer Directed Care to the extent that it involves more brokerage of staff rather than direct employment by providers.

NFAW recommends [3] that the employment of casual staff be further investigated through further analysis of the NELS 2012 data and in the 2016 survey, to determine variations in patterns of casual employment, investigate how far exceptionally high levels of casual employment reflect management practice rather than workforce shortages, and consider strategies to address these aberrant situations.

Beyond concerns about the terms and conditions of casual workers who are covered by award conditions, the prospect of the growth of self-employed care workers in conjunction with Consumer Directed Care and similar models raises even greater concerns about risks to workers and clients. Among the direct risks are working excessive hours to earn an adequate income and increased injury to workers and clients. Indirect risks include an erosion of conditions with no accident and injury

insurance, no holiday pay and no sick leave, and shifting costs such as transport to the worker. There is a risk of unscrupulous workers charging clients for services that are not delivered, of low quality or that are of no benefit to the client. These paid services also undermine the recognition of the role of volunteers who provide companionship and other support in both residential and community services. Volunteer coordination funded through the Community Visitor Scheme and the Commonwealth Home Support Program encourage providers to engage with volunteers and provide them with training and the necessary checks, liaison with families and with other service providers wishing to take on volunteers.

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

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

B.4 Technology and assistive devices

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

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

NFAW recommends [5] that the Outcome Standards be reviewed with attention to recognition of the part that new technologies have to play in provision of high quality care; that measures be taken to promote the adoption of best practice information technology and assistive devices, particularly those which reduce injury; and that recurrent and capital expenditure on care technologies be monitored by the Aged Care Funding Authority.

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

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

C.1 Nursing staff

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

C.2 Personal and home care staff

Interaction between non-nursing staff appears most likely between disability services and community aged care, but even here segmentation of the workforces may limit mobility. This segmentation may be because of distinctive skill sets required in each sector, with different training pathways in TAFE and on the job training, and the focus of employers on one area of service delivery. The report of the survey of 116 RTOs conducted as part of the Stocktake of Commonwealth funded aged care initiatives notes that while it was recognised that aged care and disability workers require a common set of core skills, close to 60% of RTOs considered that the differences in other areas meant that training should remain specialised for each area rather than being fully combined into one qualification. The need is for consistency in training in different areas, not uniformity.

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

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

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

Workers providing domestic support in home care, mainly in cleaning and related tasks, are recognised as part of the community care workforce and a high proportion have Certificate 3 training. This is not the case in residential care, yet similar workers provide support services such as cleaning

and meals preparation. These support staff are essential to ensuring that personal care and nursing staff are engaged in delivering care and not deflected to performing other tasks.

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

The 2016 NILS survey should give more attention to these categories of workers and especially to the extent to which their skills and conditions of employment are consistent with their roles in supporting provision of high quality care. Maintaining the conditions of these generally low paid workers across community and residential care is essential to provide a strong base for both the residential and community care sectors and ensure that conditions of direct care workers and support staff are not eroded.

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

D. Challenges in attracting and retaining aged care workers

D.1 Relative shortages and underemployment of available workers

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

D.2 Drivers of turnover

Turnover in the aged care sector is the same as in the Australian female workforce as a whole and so is not unduly high. Dual drivers of turnover have been identified and show that factors associated with intention to stay are not simply the 'other side of the coin' to factors associated with intention to leave. Four aspects of turnover warrant note:

- Notwithstanding reports of difficulties in recruiting workers, the aged care workforce has grown considerably.
- Further analysis of the NILS 2007 Survey found that the great majority of workers, 65%, had been in their job for more than a year and expected to be there in a year's time, and only 12% of established workers intended to leave, mainly due to retirement and other personal factors.
- The great majority of the 18% who were new recruits who had been in their job for less than a year expected to be in the same job in a year's time and far outnumbered the 5% of all workers who were new recruits who did not intend to stay.

- There is an element of ‘churn’ in turnover, that is, workers leaving one job for another job in the aged care sector. Not all turnover thus means losses to the aged care workforce.

These findings point to a need to give more attention to retention of workers than just recruitment and to recognise that different strategies will be needed to retain new entrants to the field vis-à-vis prolonging participation of those who have been in the sector for some time. As well as training, the former are likely to include meeting workers’ preferred hours of work and flexible arrangements for achieving a positive work-life balance for younger workers with dependents. The later are likely to include flexible arrangement for transition to retirement and reducing physical demands on older workers. While better screening and assessment might reduce entry of workers who have very short stays in the sector, this is a small group and may be hard to reduce further. Focusing on retention of those who intend to stay is likely to yield better results.

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

D.3 Career pathways

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

BOX 1: Pathways into and progression in the aged care workforce						
	Nurses		PCAs		CCWs	
Paid work prior to aged care	No paid work	<10%	No paid work	<15%	No paid work	~10%
	Acute Care	~50%	Health/Care	~20%	Health/Care	20%
	Other health/care	~20%				
	Other	~20%	Other	~65%	Other	70%
Qualifications held*	None post school	<5%	None post school	15%	None post school	~15%
	Nursing non-degree only	15%	Certificate 3	~75%	Certificate 3	~70%
	Degree	~80%	Certificate 4	20%	Certificate 4	20%
			Other aged care	15%	Other aged care	25%
Progression	Not studying	87%	Not studying	75%	Not studying	80%
	Studying	13%	Studying	25%	Studying	20%
			Aged Care	~6%	Aged Care	7%
			Health(Nursing)	15%	Health(Nursing)	3%
			Other	~4%	Other	10%

* Figures refer only to health and aged qualifications.

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

Notable features of three pathways of entry and progression in the aged care workforce are:

- Although relatively few had no previous paid work experience, offering opportunities for training and placement may be particularly effective in attracting women with no paid workforce experience into the aged care workforce. Most workers had prior paid work experience outside aged care, suggesting that efforts to attract workers seeking a job change or to re-enter the workforce may have more success than attempts to make aged care an entry level job, especially for younger workers.
- One current and quite distinctive pathway is identified for PCA and CCWs who are studying health courses. These are most likely student nurses, and include international students for whom work experience assists in obtaining Permanent Residence. While adding to the nursing workforce and other categories of health care workers, these students may not necessarily remain in aged care.
- A potential pathway can be identified among PCAs and CCWs who are undertaking Certificate 4 or other training. The majority of these workers reported that they were studying to improve skills for their current job or similar reasons and only a small proportion were interested in promotion. Most of these workers are likely to remain in their present roles in the aged care workforce and scope for developing career pathways to nursing or management positions remains untested.
- Realising this potential will require a variety of strategies as only small numbers of workers may be interested in or able to pursue career pathways at different life stages and with other commitments. Over time however, a steady flow through these pathways would build on experience and could lead to significant cumulative outcomes.
- Consolidating the current proliferation of qualifications and training is a prerequisite to developing career pathways for those already working in aged care and enhancing retention in the sector. Rather than relying on individual providers to take these steps, action needs to be taken with the tertiary education sector to develop nationally standardised formal qualifications.

NFAW recommends [8] that priority be given to developing career pathways for workers who have obtained qualifications at Certificate 4 level and that the wide range of these qualifications be reviewed to identify those which could be consolidated into a career path towards a further qualification in the formal tertiary education system.

E. Factors impacting aged care workers

E.1 Industrial relations, awards and enterprise agreements

There is a history of undervaluation of work in the aged care sector, due partly to funding models and to structural issues affecting unionisation of employees and their access to enterprise agreements. The equal remuneration provisions of the 2009 *Fair Work Act* effectively addressed key limitations of the previous legislation, enabling both these issues and their impacts to be aired before the Fair Work Commission. The 2009 Act removed the requirement to demonstrate discrimination as a threshold to bringing an equal remuneration claim, and accepting instead a requirement to establish an undervaluation linked to, or attributable to, gender. In its first decision under the revised legislation, the Commission confirmed that there was no requirement for applications to reference an explicit male comparator group. It also recognised that there may be impediments to bargaining and implementation of Equal Remuneration Orders; for example, phasing in required wage increases over a number of years can give rise to considerable uncertainty. The ERO resulting from this case was not extended to the aged care workforce and the Aged Care Workforce Fund proposed in the Living Long Living Better package in 2012 sought to address this gap. The dismantling of the Fund is taken up in section I below.

Aged care workers are covered by a mix of Modern Awards introduced from 2010, federally and state registered Collective Agreements, and other Agreements, including contracts. All awards and agreements required adherence to the National Employment Standards that set out minimum conditions and pay rates and prohibit discrimination on several grounds including gender. Potential for different treatment of segments of the workforce nonetheless arises from this varying coverage and the capacity of unions to pursue claims. For example, PCAs in aged care are covered by the Aged Care Award 2010 and Community Care Workers are covered by the Social and Community Services Award 2010. Union representation is also divided between the Health Services Union and United Voice, covering SACS workers. There is a need for a clearer view of the industrial relations applying to the aged care workforce and to streamline anomalies where they are identified.

NFAW recommends [9] that the Inquiry ask the Fair Work Commission to provide a report on the industrial relations arrangements that cover the aged care workforce, with special reference to trends in the application of Modern Awards in the sector, and identifying anomalies within the sector and between the aged care, disability and health sectors.

E.2 Pay, conditions and preferred work arrangements

Total pay remains the single area of marked dissatisfaction in the aged care workforce and interactions of structural and management factors are identified as contributing to this outcome. Pay rates and hours worked are inextricably linked and both contribute to total pay and as a substantial proportion of workers have reported wanting to work more hours, attention is required to unresponsive management practices that fail to make optimal use of the available workforce. Permanent part-time work is the most common and highly preferred basis of employment. Working preferred total number of hours and preferred, stable rosters, are major factors in worker retention and satisfaction, in part because they enable workers to have a positive work-life balance.

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

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

NFAW recommends [10] that steps be taken to increase the proportion of permanent part-time workers as a means to stabilising the workforce, with particular attention to management practices that shape conditions of employment offered to workers.

E.3 Staffing ratios

The underlying principle of the Aged Care Standards is that the skills of workers and staffing levels should be appropriate to the clients care needs and the complexity of care being delivered. Simple

staffing ratios are now widely regarded as blunt tools for capturing the interaction of these factors and ensuring effective provision and use of staff. Two steps can be taken to develop more effective tools.

1. Data from the NILS 2012 survey need to be analysed to establish existing ratios of different categories of staff to residents in residential aged care homes to identify normative ratios, the extent of variation above and below these norms and factors associated with these variations. These findings can then be compared to results of the NILS 2016 survey when they are to hand to detect changes in ratios and the balance between categories of staff.
2. More complex staffing models that take account of staffing mix and client dependency are now being developed and applied on a limited scale in the sector. The Aged Care Funding Instrument provides nurse managers with information on funding available for the mix of residents in a home, and in conjunction with this knowledge, staffing models can enable development of rosters that ensure all staff are allocated to the times and tasks that optimise delivery of care in accord with resident care plans and available funding. Further work on these models should provide a basis for developing best practice in staffing that takes account of the roles of different staff and responsibilities within their scope of practice. By identifying the staff mix that is most appropriate to meeting client needs, use of these approaches can also promote effective team work and leadership.

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

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

F.1 Access to affordable training

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

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

F.2 Proliferation of training providers

The proliferation of training providers and relaxation of regulation has resulted in very varied outcomes for both workers and providers. Workers lack standard qualifications across the sector and

providers have no real way of understanding what qualifications obtained from diverse providers, including on-the-job and provider training, mean in terms of workers' competencies.

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

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

F.2 Recognition of Certified workers

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

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

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

F.3 The aged care education and training workforce

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

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

1. Ensuring that funding for education and training goes only to education and training providers who deliver recognised qualifications, and

2. Recognising only authorised or approved training in monitoring the relevant Standards Outcomes in all aged care services.

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

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

As aged care is now almost entirely a Commonwealth responsibility, it should be expected that the workforce would be covered by national awards and conditions.

State awards and regulations apply only to the workforce in services operated by State Government, and these are only a very small part of all provision. The most notable case is the use of staffing ratios in Victorian State Government aged care homes; levels of nursing staff are reportedly higher in these homes but the effect on care outcomes has not been demonstrated. NSW has investigated the application of ratios but no move has been made to adopt them. Issues relating to staff ratios have been discussed and a recommendation made in section E.2 above.

NFAW recommends [14] that awards and conditions for the aged care workforce be harmonised nationally to provide consistency across the sector and with related sectors, and to facilitate movement of workers between jurisdictions.

H. Relevant parallels or strategies in an international context

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

H.1 International standing of the Australian aged care system

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

- it is a coherent national system,
- it spans residential and community care, and in community care especially avoids the division between 'health care' and 'social care',
- it provides equity of access taking account of assessed client care needs and consistent means testing
- there is a high degree of national coverage of services, and
- it is cost effective, in line with the Australian health care system.

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

H.2 Exceptional or typical models?

Many of the actual or proposed importations of overseas experience come from small scale, innovative projects. It is often difficult to know if these innovations have been taken up more widely in the other

country, and if so, whether the same conditions for such spread apply in Australia. In particular, transfer of models from Scandinavian countries needs to take account of the much higher taxation rates that apply in those countries and the very different social insurance schemes that cover social services.

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

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

An important aspect of aged care in Australia that has been overlooked in the promotion of CDC as giving clients control over care budgets is the role of the Carer Allowance in providing a cash component in the system for many years. Take-up of CA is high among the eligible population and compares to the ABS data on the target population of the HACC Program who have a carer. Even more importantly, total expenditure on CA was close to that on HACC at the time the HACC program was transferred to the Commonwealth Home Support Program and the NDIS. The Australian Institute of Family Studies has reported that CA is widely used to supplement family income and is applied to extra general household expenditures associated with a family member’s care needs and not used for covering charges for formal services. Women are the majority of recipients of CA and there is a risk that CDC will see this general purpose of CA diverted to user charges.

NFAW recommends [15] that the Carer Allowance be reported as part of the Aged Care Program in Budget Papers and related reports, and that the mechanisms be put in place to monitor use of Carer Allowance to cover charges for formal services, including those provided under Consumer Directed Care.

H.3 Migrant workers

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

It is important to distinguish these ‘migrant workers’ from ‘migrants who happen to be working in aged care’ in Australia. Migrants working in aged care in Australia have been recruited from the population at large, and in many regards are little different to overseas born workers in other sectors of the economy, or to their Australian-born counterparts in the aged care workforce. Most have been here for many years and are citizens. A number of aspects of Australia’s immigration arrangements mean that there is not a segment of low paid, temporary and largely female workers in the aged care workforce. There is little evidence of aged care being a point of entry to employment for recently arrived migrants. The practices of job network agencies in some areas of high unemployment of attempting to place new arrivals in jobs in nearby residential aged care homes is an exception.

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

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

NFAW recommends [16] that the term ‘migrant workers’ not be used in discussion of the aged care workforce as in suggesting a group of temporary workers, it is a misnomer for overseas-born workers who join the aged care workforce after shorter or longer periods of residence in Australia, the majority of whom are or soon become permanent residents and Australian citizens.

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

I.1 Commonwealth leading role

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

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

I.2 Reinvigorate a coherent workforce strategy

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

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

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

NFAW recommends [17] that the role of the Aged Care Workforce Advisory Committee be reviewed and that it be charged with identifying a small number of priorities for strategic action against the background of on-going, broad based workforce development activities.

I.3 Comprehensive analysis of robust data

Many more questions could be answered by further analysis of data already available from the NILS surveys. The Commonwealth could have made far more use of this high quality data to inform policy and program development and to give a full and detailed account of the aged care workforce. The want of this picture means that debate about many aspects of the aged care workforce is poorly informed and relies on anecdote and partial information. Overgeneralisation means that exceptional situations are not sufficiently distinguished from typical situations and trends over time are not established.

NFAW recommends [18] that NILS be commissioned to carry out further analyses of the 2012 survey and a comprehensive plan of analysis be developed for the 2016 surveys to provide answers to questions raised in this Inquiry and to report fully in line with the review of the aged care reforms scheduled for 2017.

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

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

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

- Recognition that the majority of clients of diverse backgrounds receive care through mainstream services;
- The majority of workers from diverse backgrounds provide care to clients who were born in Australia and for whom English is their only language;

- Changes in the cultural backgrounds of the cohorts now reaching advanced old age and of workers means that while matching clients and workers remains a central strategy, it only applies to a part of the total client population and workers; and
- That workers from different backgrounds work alongside others whose only language is English and that there is a need for good communication both ways between workers as well as with clients.

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

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

There is growing recognition of diversity in gender and cultural norms across the community as well as between generations, and workers need to be equipped to recognise and respect the differences that are likely to be found among the clients they care for. In cases where norms may be transgressed, such as a very old woman rejecting provision of personal care by a young male worker, client preferences should take precedence.

NFAW recommends [19] that training for all aged care workers give attention to the 3 R's of recognition of, respect for and responsiveness to differences in cultural norms across the community, including gender norms, and that client preferences take precedent in cases of potential transgression of norms.

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

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

NFAW recommends [20] that action be taken to develop the primary health care workforce alongside the aged care workforce to deliver a better balance of primary health care programs to tackle chronic illness as well as to provide aged care services in Indigenous communities and that the definition of the Indigenous target population for aged care be reviewed to ensure that is an accurate and appropriate basis for planning this range of services.

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

K.1 Roles and responsibilities of major providers

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

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

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

NFAW recommends [21] that the extent to which the impacts of geographic isolation on the aged care workforce can be moderated by organisational integration and outreach be taken into account in the development of service delivery models in rural and remote areas that strengthen and support workers in those areas, and that this strategy consider ways of bringing all services in these areas into such support networks.

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

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

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

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

NFAW recommends [22] that funding of all workforce development activities give attention to funding and that a clear distinction be made between time-limited initiatives intended to achieve particular changes in the short term and initiatives that have to be continued over the longer term to sustain growth of the workforce and quality improvements.