COTA NATIONAL SENIORS
WORKING IN PARTNERSHIP

Submission to

Productivity Commission

The Health Workforce

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prepared by
National Policy Office
COTA National Seniors Partnership
ACN 008 483 574
E-mail: NPO@nationalseniors.com.au Web: www.cota.org.au

TABLE OF CONTENT

1. Introduction

COTA National Seniors Partnership (CNSP) is the largest seniors organisation in Australia with over 280,000 individual members and over 800 affiliated organisations. It offers members a vast range of services and benefits and is an influential vehicle for contributing to policy debates affecting seniors in Australia.

CNSP develops policy based on membership input, including through branches and member organization forums and has a pre-eminent role in representing, advocating for, and serving, senior Australians.

CNSP appreciates this opportunity to express our concerns related to the Australian health workforce and our recommendations to address these issues.

The Australian health workforce is facing a critical time in the next few years. The Federal Government has done much groundwork in terms of research and collection of statistical data. Based on the outcomes of this work, it has developed strategic goals to ensure that provision of health and aged care services will meet future demand. (*National Strategy for an Ageing Australia – An Older Australia, Challenges and Opportunities for all* and *National Aged Care Workforce Strategy* are referred.)

CNSP welcomes and acknowledges the Federal Government efforts made so far which have been evidenced through many programs and federal budgets. It is crucial that these efforts and investments are focused on long term strategic outcomes and avoid any 'bandaid approach' as a quick fix to emerging problems.

CNSP would like to recommend that the Productivity Commission consider the following issues:

- develop a mechanism that will bring all current research outcomes together and effectively utilise the research results to structure a more systematic and long term health system reform that will ensure Australia's health system will provide services expected by the whole community,
- identify gaps between the current capacity of the health system and its future demand. The system needs to be reviewed as a whole including the needs of each component, in the short and long term, and how these connect,
- develop short, medium and long term strategic plans to reduce and close the gaps, with effective mechanisms to monitor progress of implementations of these plans, and
- identify areas where increased funding is needed for immediate support and which are consistent with medium and long term plans.

More issues are discussed in the following sections of this submission.

2. Demographic Overview

This section will provide an overview of Australia's demographic environment in the next decade, and in a broad sense, till 2050. It will include available statistic information (various projections), including projected demand on health and aged care services, potential pressure on health expenditures, and challenges originated from the ageing population. The focus will be more on medium term demand and the needs for the health system and its workforce as well as the capacity and readiness of the system in terms of satisfying these needs.

Australian population ageing will continue in the next few decades, as the inevitable result of a low fertility rate over a long period of time and expanding life expectancy.

The Australian Bureau of Statistics (ABS) estimated that the median age of the population will increase from 35 years in 2001 to 41 years in 2021 and to around 48 years in 2051. By 2051, there will be about 27 per cent of the population aged 65 years or older, compared with the current 13 per cent. The highest annual rate of growth for this age group will occur in 2012, when the "baby boomer" generation commences to reach retirement age.

The number of people aged over 65 will increase from 2.4 million now to 4.2 million in the next 20 years. The projections roughly double the present proportion of seniors and indicates a senior population of about 7 million by 2044-45. The population aged 85 years and over is estimated to increase to 1.6 million in 2051.[1]

In 2006, 1,327,100 Australians will have certain levels of disability and will be in need of care services, according to the Community Care Coalition report (2004).

The demographic change and increases in identified disabilities will increase the demand for health services and thus will require appropriate policy settings.

In addition to challenges that have emerged for future policy and planning in areas such as superannuation, income support and provision of health and aged care services, the ageing population and ageing workforce will create a severe labour force shortage, which will be a significant challenge that all industries and sectors will face. According to ABS projections, Australia will experience a sluggish labour supply in the next 6 years to 2011. It was projected that in 2011 annual labour growth rate will reach its peak. It will be equal to the growth rate of the entire 21 years from 2023 to 2044. Meanwhile the number of hours worked per capita will decline by 10% from 2011 all the way to 2045.

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[1] Various Australian Bureau of Statistics (ABS) statistics and *Australian Social Trends 2004*, available at ABS web site and http://www.immi.gov.au/facts/15population.htm

The severity of the labour shortage, however, can be alleviated by increasing labour force participation, particularly that of older people[2]. In the past twenty to thirty years there has been an increase in overall labour force participation, particularly for women. For certain age groups, however, workforce participation is still comparatively low. Many people discontinue employment well before their eligible pension age. Only 26% of the population at the age of 64 years remained in the labour force in Australia. This represented a reduction of 50% compared with the participation rate at the age of 50 years[3]. The positive side of this is that there are substantial potentials to raise the workforce participation rates of both men and women at this age.

To achieve a high participation rate depends on many factors including government policies, financial incentives, job status, skills development and training opportunities and flexibility in workplace practices that encourages people to remain in the workplace.

3. Health Workforce – Domestic and Global Picture

This section will focus on issues that industries and workforces will face while the effect of the ageing population deepens. In general, all industries will experience labour shortages and associated difficulties, as much as the health and aged care sector. Competition for skilled human resources between industries and sectors is foreseeable. It will highlight the critical fact that a well-balanced national workforce strategy is needed to prepare Australian industries and sectors, including the health workforce, to face emerging challenges.

With reference to *The National Aged Care Workforce Strategy* (Department of Health and Ageing) and other government policy documents, issues for the Australian health and aged care workforce will be analysed, with consideration of the global environment, including recruitment from overseas and other relevant issues.

Australia's health workforce[4] can be summarised as having a high percentage of female employees (including its proportion in GPs), an average age of employees of over 43 years, a higher percentage of part time employees, wage disparity, geographic mal-distribution and a shortage of skilled workers.

It will be increasingly difficult to find the number and quality of staff required by the health and care industry, particularly in rural and remote areas, to provide high quality services for the growing number of service users.

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[2] OECD (2005) *Ageing and Employment Policies – Australia* , OECD publication
[3] OECD (2005) *Ageing and Employment Policies – Australia* , OECD publication
[4] Health workforce here refers to the broad workforce in both health and aged care sectors and includes all that directly provide their services to these sectors, either as employees or contractors.

There are insufficient statistics to provide a comprehensive picture of what the gaps are, and will be, between the demand for, and supply of, health workers as a whole, which is crucial for workforce planning and policy development. Few studies on the health workforce focus on an analysis of demand and supply with projections of demand for residential aged care and community care. Estimations of demand for the health workforce (in particular qualified carers), based on the population projections, are limited to a few studies.

In addition to the current statistical data on the number of medical practitioners and nursing staff or health workers and their ratios against population, it is also necessary to collect information on current labourforce hours needed for older people in the aged care sector including residential aged care, community care services and all other care services. Labour hours or days required in the current health sector and their equivalent demand based on the projected Australian senior population as well as the health and aged care sector's labour intakes in the next 10 to 50 years are also required. This data will assist in the provision of a more accurate picture of the required increase in workforce supply to meet demand and thus assist governments and relevant organisations to develop sound and achievable strategies.

Turnover of the workforce in the aged care sector has also attracted attention. Richardson (2004) noted that around one in four personal carers and one in five nurses have to be replaced each year. The major cause of this is the wage disparity between the acute health sector and aged care sector and the working environment. There are significant challenges in maintaining attractiveness of pay and improving working conditions in the aged care sector.

Work content and responsibilities for GPs and nurses have narrowed steadily over the years. This issue has not been well considered by the sector[5]. Arguments vary depending on points of view, however, the shortage of health workers has been confirmed across sectors by the absence of unemployment in the health sector.

Demographic and life-style changes are pressing the healthcare system for corresponding changes. The concept of health and care goes beyond medical treatments of diseases and/or care services. The healthcare system ought to provide services that will maintain public health such as various levels of preventive services that often include, for instance, public health education. Public health education is built on extensive knowledge and skills and applications of new technologies. Health promotion, disease prevention and health life style coaching require sufficient qualified human resources.

Demand for elective surgery to improve quality of life is yet another factor that is putting more pressure on the current health workforce. Effective and balanced

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[5] John Paterson (2002) *Australian Health Care Agreements 2003-2008: a new dawn?* Medical Journal of Australia .2002 177 (6): 313-315

use of the scarce health workforce is thus becoming more and more important, which in turn necessitate appropriate workforce planning.

These changes require extending the scope of the health workforce, which will put more pressure on the current level of staffing and skills mix. In addition to the required skills to meet demand from people requiring, or in receipt of, traditional health and care services, extra skills will be needed for special needs groups such as dementia sufferers and those needing palliative care. It will be necessary to enhance the skills base of those in the health workforce who deal with Aboriginal health and with people from culturally and linguistically diverse background.

Health workforce should thus include all people directly employed in or providing services to health and care facilities, health education and training as well as those working to improve general public health status.

Health and community care services in Australia are currently the third largest employer for women, and the fifth for men. This sector will have to compete with other industries for human resources. Within the sectors, states and territories will also compete with each other for skilled and qualified workers.

The flexibility of work environments needs to be improved to suit employees' situations, including family responsibilities, childcare, spousal career needs and elder care responsibilities. This may require matching the community's needs with working patterns for health professionals that are closer to reasonable working patterns in the general community. Structural impediments such as lack of part-time or job-sharing posts and inadequate mentorship of trainees need to be addressed to attract new entries.

Government and employers in the health industry need to develop effective strategies to promote career opportunities for young people through education and training, career development paths and improved job satisfaction and sense of achievement.

Improvement of the above-presented situation requires a well-balanced national strategy that will work around a continuum across all sectors, the interface between all services and cross-jurisdictional collaboration on workforce planning, training and education. Regulations that govern the health and aged care workforce need to be consistent between jurisdictions and take account of the future shifts in health service structure and delivery (more at home care with the aid of technology, possibly more step down hospitals to minimize stays in tertiary hospitals, etc).

Across countries in the Organisation for Economic Cooperation and Development (OECD), the scenario does not differ, particularly in the USA and UK. It was reported that the causes lie in common and fundamental characteristics of system structure and labour force shortage in general and thus in the health workforce.

Internationally health professionals form the biggest group of skilled migrants[6]. Although Australia may gain a number of health professionals from overseas, there is a concern in terms of whether one should question the ethics of drawing health professionals from where they are more needed. Other issues that have caused concerns include the differential in knowledge – particularly pharmacology and possibly technology when coming from third world countries.

Canadian Health Services Research Foundation conducted a study of the health systems of five countries *ie* Australia, France, Germany, Sweden and the United Kingdom. This study found that in most systems, workforce planning was driven by health expenditure and often ignored variations in practice and the possibility of changing productivity, skills mix and substitution. Weaknesses identified in this study include fragmentation of planning process, ignoring interrelationships between health professions, absence of integrated workforce planning and inefficient and/or inequitable distribution between geographical regions and clinical specialties[7].

Reform in funding mechanisms is crucial. Dwyer (2004) focused very much on the necessity for a structural shake-up that will bridge the federal-state divide and shape a health and aged care system that will be consumer-oriented. It pointed out that the recent improvement of health services in the UK and New Zealand were achieved because they put all their health funds in the same single 'pot'[8].

4. Mature Age Workers

This cohort of human resources is under-utilised. This section will focus on policy implications and what can be done to maximise the use of the available resource, such as innovative strategies to motivate mature age workers to stay in the workforce longer, redesign of work responsibilities and roles so as to avoid early exit/retirement, workforce structure changes to improve retention, flexibility, efficiency and thus capacity and effectiveness as a whole.

The improvement of the participation rate of mature age workers involves future policy that will provide incentives and opportunities to them to pursue further education and training which has a clear positive linkage with the competencies required to participate[9] [10].

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[6] World Health Organisation (2005) *Strengthening capacity - policy and practice,* http://www.eldis.org/healthsystems/dossiers/hr/policy/index.htm
[7] Canadian Health Services Research Foundation (2003) *Planning human resources in health care: towards an economic approach an international comparative review*.
[8] John Dwyer (2004) Moving from a Provider- to a Patient-Focused Health Care System: The Health Reform Imperative.
[9] National Centre for Vocational Education Research (NCVER) *The mature-aged and skill development activities: A systematic review of research,* http://www.ncver.edu.au/research/commercial/op320b_e.htm
[10] OECD (2005) *Ageing and Employment Policies – Australia,* OECD Publication

The strength of policy lies in its ability to encourage organisations and industry to collaborate to ensure an attitude and culture change. The factors that affect whether mature age workers undertake skill development activities and achieve competency to remain or re-enter their intended sector of labour force have been identified as:

- attitude and behaviours of employers and employees towards older people working and learning new skills[11],
- individual's circumstances such as financial situation, family responsibilities, availability of learning opportunities and access to them and learning attitude and skills[12], and
- whether government policies provide incentives to encourage mature age workers to remain in the workforce longer or re-enter the workforce, such as policies on access to the age pension and superannuation and income tax[13].

The health and community services sector is the 2nd highest expending industry in Australia (after the property and business management industry) and employs more mature workers than other industries. This indicates opportunities for mature age workers as well as challenges in terms of an adjustment of their skills and readiness to alter career paths, which in turn requires access to appropriate education, training and lifelong learning facilities[14].

It is important that the program design of education and training for mature age workers take account of diversity in approaches, learning and teaching methods, appropriate use of technology and linkages of components of programs[15].

To achieve better participation from this cohort, it is necessary that government policies provide incentives for mature age workers to remain longer in and/or re-enter into the health workforce, through tax incentives, competitive salary packages, flexible working arrangements, favourable working environment, improved employer attitude, and sufficient provision of education and training that is provided in a way that is suitable to mature age people – generally not traditional classroom style with pass/fail exams.

5. The Unpaid Health Workforce

The role that unpaid carers have played in the current health and aged care sector needs to be stressed to gain more recognition of the economic value it has created and many other advantages, particularly when advocating 'ageing in

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[11] CNSP (2005) *Response to the Productivity Commission Draft Report 'Economic Implications of an Ageing Australia' 2004.*
[12] NCVER *The mature-aged and skill development activities: A systematic review of research*
[13] CNSP (2005) *Response to the Productivity Commission Draft Report 'Economic Implications of an Ageing Australia' 2004.*
[14] OECD (2005) *Ageing and Employment Policies – Australia*
[15] CNSP (2004) *Response to Department of Treasury Australia's Demographic Challenges*

place'. Favorable government policy will improve utilisation of this group of carers which will most likely reduce the pressure on the health and aged care workforce.

There are 2.5 million Australians who provide care for family members or friends with a disability, mental illness, chronic condition or who are frail aged. Almost 20% of them are primary carers who provide the main source of unpaid informal support. Most of the primary carers indicated that they provide care because alternative care is unavailable or too costly and they have no other choices[16].

The Home and Community Care (HACC) program, one of the major care service programs, provides care at home with the combined Commonwealth and State/Territory governments funding cost of $1 billion in 2003. This program helps to maintain people at home but the average amount of assistance received at home by HACC clients (198,746) was only 38 minutes per week[17]. The remainder of care time is generally provided by an unpaid carer.

Without these unpaid carers, many people would have to leave home and thus impose great pressure on the health and aged care system and in turn government expenditure. The economic and social value of unpaid carers is therefore apparent yet not fully recognised and appreciated by either the broad community or governments.

Population mobility and geographic family separation, early retirement with family absences, increased demographic of fewer children per family, and the fact that there will be more single aged persons (no spousal carer) – will collectively mean that the availability of unpaid or poorly subsidised carers is going to drop dramatically over the next two decades.

With increased pressure and need for unpaid carers due to the rapid growth in the number of people needing care and the fact that the health and aged care system is not meeting existing demand, it is obvious that appropriate and encouraging government policy needs to be in place to provide assistance and incentives to unpaid carers so as to maximise the resource that this group are currently injecting into the economy and community. Similar mechanisms to Carer Allowance and Carer Payment for unpaid carers will improve the equity of accessibility to financial assistance.

Unpaid carers will need to use technological aids to assist in future, which will involve outlays and training. Governments need to consider the allocation of sufficient funding to accommodate this need.

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[16] Community Care Coalition (2004) *Key Messages*
[17] Community Care Coalition (2004) *Key Messages*

6. New Technologies

In addition to cost (for purchase, use, maintenance of facilities and training for new and existing health care workers) associated with new technologies, accessibility (including in rural and remote areas) and consumer expectations are issues that have generated many debates. The use of new technologies in the health industry is an economic as well as a moral issue. Technologies bring advantages and disadvantages into people's lives. Implications will be analysed and issues will be identified for further discussion or policy consideration.

Unprecedented medical technology development has provided unlimited possibilities and potentials. The advantages of effective uses of new technologies in health and aged care services are evident.

The new technologies used in communication, telemedicine, monitoring and security, assistance in mobility and daily activities have improved the efficiency of the health and care services and reduced pressure on the workforce. They help many older people remain self-reliant for longer. New medicines for previously untreatable conditions and preventative purposes have improved Australians' health in general and extended life expectancy.

These technologies, such as integration of video conferencing and the clinician's systems which make it possible to incorporate the virtual health record, high resolution diagnostic workstation, real-time interactive high speed transmission of voice, data, charts, medical images and specialised medical diagnosis software, make telelconsultancy and continuing provision of education and training possible.

At the same time, the increased use of medical innovations has been the primary driver of rapidly increasing health and care expenditure. These technologies may be far out of reach for many, particularly those in rural and remote areas. The cost associated with their applications even when they are available could also restrict the accessibility to people with limited financial capability.

This use of these innovations has generated a broad range of issues and debates covering regulation and legislation, equity in terms of accessibility and availability, morality and consumer expectations.

7. Education and Training

There appears to be much research on health education and training and the findings are well documented. Issues focused in many studies include places in universities for medical professionals including nurses, curriculum development and availability of training programs. This section reinforces the majority of research findings with an emphasis on education through VET, on-job training programs and opportunities for mature age workers.

Through the package *Investing in Australia's Aged Care: More Places, Better Care,* the Government has allocated funding to increase nursing places in universities and other education and training facilities. There will be 1,203 aged care nursing places to universities by 2008, commencing with 440 from next year[18]. The question is - will this be sufficient to meet the demand for nurses in aged care?

CNSP believe that there are not enough graduates going through the system to make up the acknowledged shortfall in health professionals. Until the whole education and training issue is effectively addressed, the numbers of health professionals will remain small in certain professions and salaries will be commensurately very high.

The Federal Government has managed to provide special HECS arrangements for teaching and nursing students. It will be necessary to do the same for medical, dental and allied health professionals.

In line with the health workforce strategy, workforce structure and future demand, education and training should focus on emerging needs for skills and the skills mix required in the health and aged care workforce. It should enable capability and flexibility for skill transfers between sectors. Purpose and levels of training need to be well defined and maximise both personal and organisational investment in training.

Increased scientific knowledge and new technologies and treatment methods have increased the complexity of the skill mix and qualifications required by carers. Development and training for new practical skills has become a critical necessity.

Understanding the concept of roles played by different levels of health workers can be an issue, particularly when the boundary of roles or responsibility is unclear under certain circumstances. It is thus necessary to develop flexibility in terms of roles and responsibilities that is need-based so as to have services delivered in time with quality. However the flexibility should be within legal and regulatory frameworks without compromising accountability.

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[18] Julie Bishop, *Media Release*, dated 2 July 2004, available at http://www.health.gov.au

The demand driven expansion of roles and responsibilities (also as a result of new technologies) have raised policy challenges to the existing statutory limitations on practices, in particular for health and care workers in rural and remote areas when it is more likely that they are expected to fulfill a bigger variety of tasks[19].

New technologies and other medical developments require lifelong learning opportunities for the health workforce to update their skills and knowledge on new equipment, facilities and so on.

It is important to foster a sense of need for a health cultural change in Australia's broader community. It is necessary to broaden the concept that the health workforce is only to look after the sick, the weak and those in need. The workforce should take up new roles in educating people to maintain lifestyles that will keep them healthy. Gerontology, dietetics and coaching on general health and well-being should be regarded as essential skills that health workers attain through various training and education. This also broadens the definition of what the health workforce should be and what services they provide.

There is very low appeal for young people to work in aged care - as evidenced by the low numbers, particularly males. The cultural change is likely to have positive impact on the current image and low appeal to younger people to come into the health workforce other than in high paying areas.

The Commonwealth Government and State/Territory governments need to work together on qualification recognition and practice recognition, as well as a national framework that recognises skills updates, prior learning and re-entry to workforce.

8. Health Workforce in Rural and Remote areas

This section looks into current issues, policies and what has been done and what needs to be done in terms of the health workforce in rural and remote areas in comparison with that in metropolitan areas.

Australians living in rural and remote areas are worse off in term of access to health and aged care services. The key issues are the limited workforce resources, difficulties in recruiting and retaining qualified staff and updating health and care facilities. It is crucial to develop an effective national approach to address these issues[20].

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[19] The Medical Journal of Australia editorial (1996) *Nurses in Australia: their role today and tomorrow,* http://www.mja.com.au/public/issues/may6/perciv/perciv.html

[20] Regional Australia Summit (2000) *Summit Outcomes* http://www.dotrs.gov.au/regional/summit/outcomes/committee/report/equity.aspx

The Regional Australia Summit (2000) proposed a national rural health reform agenda with strategies to achieve the desirable outcomes. It recommended that existing schemes (through quotas, modified entry and financial assistance) could be strengthened to establish an on-going supply of skilled and qualified workers and incentives to practice in rural areas on completion of their studies and training. Curricula of the education and training programs, including upskilling programs, should address the need for dedicated rural health competencies and streams. Improved working environments can further support the retention of staff.

Strategies should recognise the diversity and complexity of rural general practice, particularly more isolated areas and provide appropriate rewards to improve its attractiveness.

Salary packages could be a powerful tool to attract and retain medical practitioners and health workers. There are however many other facets involved, for instance, working environment, support from communities, life style choices and local facilities and services required for family living including schooling and employment opportunities for family members.

The Federal Government should allocate more funding so as to provide greater education and training opportunities for health professionals in rural and remote areas and greater use of technology. It may be necessary to develop a mechanism that will assist to retain students to work in rural and remote areas after graduation.

Governments need to work together and have a solid commitment with sufficient funding for a national framework to provide adequate health and aged care infrastructure including utilisation of new technologies to improve service outcomes, *ie* access to and equity in service provision.

The Northern Territory has particular problems with access to the required numbers of health professionals. Even Darwin, the only part of the NT that is not considered to be "remote", has trouble getting and keeping enough qualified health professionals. In many of its very remote areas most of the population is Indigenous, and there are special needs (such as the language skills to ensure communication is adequate). When there are insufficient qualified people to live in these remote areas, it is then necessary to focus on getting "flying squads" into bigger centres and servicing the remote areas on a "fly-in fly out" basis, similar to the way remote mining areas are serviced.

9. Roles of All Levels of Governments

There need to be clear responsibilities for each level of government. Governments should work together and develop policies that enable them to

> collaborate and achieve the best possible outcomes. Issues include funding, education and training, curriculum development, qualification transfers and any other demarcations in roles and responsibilities.

The public funding for the health and care system is separately provided by different levels of government. These separated responsibilities have caused cost-shifting, perverse incentives, service fragmentation, unclear responsibilities and accountabilities and other negative implications on the quality and appropriate level of care including early discharge.

Funding issues appear to be the focal point of many problems that the health and care system have been facing. What is needed is a coordinated approach that will achieve appropriate and efficient allocation of resources across the whole system. While there are no simple solutions to financing problems, it is crucial that those inter-government funding arrangements must be clarified and that the roles and responsibilities are clearly articulated.

It is also essential that a clear delineation of governments' roles and responsibilities for adequate funding of education and training, research and evaluation are not undermined.

The regulatory and legislation environment governing the aged care workforce should be consistent between jurisdictions[21].

10. Advocacy of Representative Consumer Organisations

> Consumer organisations should be provided with opportunities to participate in strategic policy development at all levels.

These organisations have done a significant amount of work in both research and policy development. They have strong consumer representation and understand needs and expectations.

It should be recognised that consumer oriented quality service is the driving force of the reform of the health system.

It is crucial that all governments recognise consumer organisations in the process of policy development and strategic planning and maintain continuous consultations. The role that consumers play, through their representative organisations, in the development of the workforce should be recognised, encouraged and valued.

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[21] Regional Australia Summit (2000) *Summit Outcomes,* available at:
http://www.dotrs.gov.au/regional/summit/outcomes/committee/report/equity.aspx

11. What CNSP have done and Recommendations

CNSP believes that success of the health and aged care sector depends significantly upon the sector's ability to attract and retain appropriately qualified and skilled staff. We are particularly concerned about the apparent deterioration in the ability of the aged care sector to attract and retain staff, which can be linked to improved wages and conditions elsewhere in the health sector[22].

We recommend that the governments:

1. adopt a synchronized national approach to the health workforce planning and provision that will integrate needs of each sector in the healthcare system[23],
2. provide competitive salaries and working conditions in order to attract and retain highly skilled nursing and other care staff in the aged care sector,
3. ensure that the skills and knowledge of the aged care sector are up-to-date by providing appropriate and on-going training for staff. This is particularly important for staff working with complex, chronic conditions (such as dementia) and episodic acute care,
4. take into account the Australian Health Care Agreements Reference Group on Workforce, Training and Education and support the suggested directions and implementations, in particular to locate aged care workforce initiatives within the broader national health workforce framework,[24]
5. provide sufficient funding for staff training, particularly for staff at care facilities for special needs groups such as dementia, indigenous, at remote and rural areas and with cultural and linguistically diverse background,
6. increase funding and support for informal carers,
7. develop effective return to work strategies to attract mature aged workers into health workforce through specialised services under Welfare Reform such as Career Advice, Assistance with Job Search, Information Technology Training, Transition to Retirement programs and Job Network,[25]
8. provide sufficient funding to improve the use of new technologies including care aids at aged care facilities,[26]
9. increase funding specifically to increase the ratio of trained nursing and trained care staff to residents in aged care facilities, and
10. ensure that additional funds are provided to meet the outcomes of the workforce planning and training review to increase the availability of appropriately trained staff for the aged care sector together with incentives for nursing and other staff to work in the sector.

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[22] CNSP (2005) *Submission to Senate Community Affairs Reference Committee Inquiry into Aged Care* – Public Hearing April 2005

[23] Recommendations 1-3 are sourced from CNSP (2005) *Submission to Senate Community Affairs Reference Committee Inquiry into Aged Care* – Public Hearing April 2005

[24] Recommendations 4-6 are sourced from CNSP (2004) *Submission to Senate Community Affairs Reference Committee – Inquiry into Aged Care*

[25] CNSP (2002) *Coming of age: an integrated policy framework for Australia's ageing workforce – submission to Federal Budget 2002-03*

[26] Recommendations 8 – 10 are sourced from CNSP (2005) *National Policy Document 2005*

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