10 November 2005

Robert Fitzgerald
Commissioner
Health Workforce Study
PO Box 80
Belconnen ACT 2616

Dear Robert

Australia's Health Workforce

Thank you for the opportunity of providing a submission to your very important work on the health workforce.

I look forward to participating in the roundtable discussions in the near future and to reading your final report.

Yours sincerely

Greg Mundy
Chief Executive Officer

Aged & Community Services Australia
Level 1, 36 Albert Road, South Melbourne, VIC 3205
PH: (03) 9568 3347 FAX: (03) 9686 3453
Email: info@agedcare.org.au www.agedcare.org.au

SUBMISSION ON THE PRODUCTIVITY COMMISSION'S POSITION PAPER - AUSTRALIA'S HEALTH WORKFORCE

ACSA is the leading national peak body for aged and community care providers and represents over 1,200 church, charitable and community-based organisations providing housing and supported accommodation, residential and community care services to around half a million older people, younger people with a disability and their carers.

Level 1, 36 Albert Road, South Melbourne, Victoria 3205

Telephone: (03) 9686 3460 Fax: (03) 9686 3453

Website:[*www.agedcare.org.au*](http://www.agedcare.org.au)

Aged and Community Services Australia (ACSA) welcomes the Commission's Position Paper on Australia's Health Workforce. We have reviewed your draft proposals and believe that generally the reforms will assist in the development of sustainable and responsive workforce arrangements into the future.

Introduction

Before offering more specific feedback on the proposals I wish to reiterate an important contextual point we made in our earlier submission. At that time ACSA urged the Commission to actively consider the special characteristics and requirements of aged care services and not to subsume them completely within the more general consideration of the issues as they relate to health care. We agree with your assertion that the system wide institutional, procedural and funding changes proposed will help to underpin better outcomes generally for all within the broader sector. The aged care industry shares many characteristics with the broader health sector and will share in any benefits. However it also has some differentiating factors that require more industry specific emphasis and attention. To designate the aged care industry as a special needs area implies a residual status which does not adequately reflect the size, structure, complexities and interrelationships within our industry. Draft Proposal 11.1 stating that *the Australian Health Ministers' Council should ensure that all broad institutional health workforce frameworks make explicit provision to consider the particular requirements of groups with special needs* does not inspire confidence that the urgent needs of the aged care workforce will be appropriately and expeditiously addressed.

The Aged Care Workforce

Unfortunately there is a dearth of data on the aged care workforce, particularly within community care programs. However the data that does exist paints the following picture of our industry:

- Based on data from 2000, the residential aged care sector alone is the ninth largest employing industry in Australia: employing 131,230 people or 1.3% of the workforce.[1]
- In 2003 there were 116,000 direct care employees in residential aged care made up of 25,000 registered nurses, 15,000 enrolled nurses, 67,000 Personal Carers and 9,000 Allied Health Workers.[2]
- The Commission's report cites the following numbers of health care workers operating in the health industry in 2001 - registered nurses 174,000, Enrolled nurses 19,000 and personal carers/nursing assistants 51,000.[3] On this basis residential aged care employs over 14% of registered nurses, over 78% of enrolled nurses and the vast majority of personal carers.[4]
- These figures demonstrate that residential aged care alone is a substantial health care employer. No data is available for community care but an educated guess would put the total residential and community care workforce at more than 2% of the total Australian workforce.
- The NILS study found that the residential care workforce is highly educated with 88% of the workforce having a post school qualification. The comparable figure in community care is unlikely to be as high.[5]

[1] ABS data cited in Hogan WP - *Review of Pricing Arrangements in Residential Aged Care Services*, p 219
[2] National Institute of Labour Studies Report - *The Care of Older Australians - A Picture of the Residential Aged Care Workforce*, 2004 p1. The NILS data provides a more refined and accurate analysis than ABS data.
[3] Productivity Commission Position Paper - *Australia's Health Workforce* 2005 pxxi
[4] These percentages were calculated using the NILS 2003 data and the 2001 data contained in the Productivity Commission Position Paper.
[5] NILS - op cit p2

- Two thirds of the residential workforce is part time and this figure is likely to be higher within the community sector.
- Over half of the patients in the acute sector are over 65. This means that staff in the acute sector will also need to understand the process of ageing, managing chronic conditions and dementia.

Industry Needs

ACSA believes that the profile of aged care needs to be raised within the Commission's final report. The report should demonstrate how the general proposals will meet the shared and distinct needs of the aged and community care sector. These needs include:

Increased number of trained care workers
Our industry needs more trained workers in all aspects of our delivery. Nurses, GPs, personal carers and allied health professionals are all in demand to varying degrees. The shortages are well documented and are felt more acutely in rural areas. The Department of Health and Ageing (DoHA) has responded to this urgent need by developing a *National Aged Care Workforce Strategy* (Workforce Strategy) for residential care. This is a useful beginning but it does not cover allied health positions in residential care or any of the community care workforce.

Role redesign
With the expected growth in aged care services in response to the ageing of Australia, the gap between workforce supply and demand is projected to increase. Evolving models of best practice will rely on the availability, skill and growth of an effective aged care team and flexibility is imperative to allow solutions to be tailored to the local circumstances and the available workforce within agreed parameters. We need the capacity to redesign roles and delegate tasks to accommodate different models of care. For example, nursing is still operating on an essentially craft model where the knowledge rests with the individual. There are opportunities to explore techniques such as care pathways where the systems and technology, rather than just individually held knowledge, support effective and safe practice.

The role of all health professionals needs to be examined to determine the nature of the contribution they can most effectively make to the care of the aged. For example, nurse practitioners operating within residential facilities could relieve GPs of some of agreed responsibilities such as prescribing medicines under certain circumstances, personal care workers could administer medications with the assistance of dose administration aids and the roles of personal carers and enrolled nurses differ between states. Nurse practitioner trials are currently underway and the results are encouraging. Structures that promote such innovation are essential.

National standardisation.
Qualifications, training and roles require national standardisation and registration.

Competitive wage rates
The Workforce Strategy noted that there is a paucity of specific research into the structural issues and the personal factors that attract and retain staff in the aged care sector.[6] ACSA agrees that a research agenda is important. However we already know that the aged care sector needs to be able to pay competitive rates to attract staff. While we do not suggest that aged care nurses should receive the same rates as acute care nurses, as their jobs are different, we must be able to compete in the same labour marketplace. Changes to indexation models, subsidies and supplements would assist in this goal.

[6] Department of Health & Ageing - *National Aged Care Workforce Strategy* 2005 - pv

Ageing impacts on health care training
Over half the patients in acute settings are over 65 and your report recognises the compounding impact of ageing. All health care professionals require greater training in geriatric care within their courses and in-service. Hospital staff and GPs need to be able to better manage age related conditions - such as dementia, delirium and chronic illnesses - more effectively.

One of the key differences between aged care work and work in other parts of the care system derives from the fact that the lengths of stay of consumers are much greater within aged care than within acute care which is more episodic. Therefore the interactions between staff and consumers are based more heavily on relationships in the aged care sector while the acute sector's emphasis is on more technical skills. This has implications for recruitment and training that need to be recognised and explored. Generally acute training is managed more effectively. Training for all types of health professionals, including nurses and allied health workers, tends to over-emphasise work in acute settings.

Productivity Commission Proposals

Generally we are supportive of the thrust of the proposals in as much as they work towards developing national streamlined systems and address some of the aged care industry issues. We have a few specific comments that are noted below:

Facilitating workplace innovation
ACSA supports the development of a body to consider job substitution and redesign opportunities on the basis that it considers those relevant to our industry and is not unduly dominated by the acute sector.

At present there is no uniformity between states and territories in their approaches to the administration of medication. There is a strong case for uniformity and the delegation of medication administration to non nursing staff under certain conditions.

More responsive education and training opportunities
As mentioned earlier the aged care workforce is highly trained and many are the product of the VET system which has served our industry well. Once again we support the development of a national education and training council to enhance integration, co-ordination and innovation as long as the needs of our industry are not subsumed and overshadowed.

The proposal to transfer the primary responsibility for allocating funding for university based education and training from DEST to DoHA is not supported. ACSA does not believe that DoHA has the experience or capacity to take on such a role at this stage. Other strategies could be put in place to better enhance co-ordination and utilise existing expertise.

A consolidated national accreditation scheme
ACSA endorses the position outlined by the Commission that the current VET system is able to respond flexibly to the changing needs of the community and employers. Initially the new national scheme should focus on the university sector. However the operation of a dual system has the potential to frustrate the important job redesigns that are critical to aged care. This body will need to work closely with the workforce improvement agency to ensure that appropriate substitutions, delegations and redesigns are expedited.

As a matter of principle, the needs of the consumers and the sector must inform course content and all health care professionals could benefit from learning more about the process of ageing and the holistic care of individuals.

Supporting changes to registration arrangements
ACSA supports the introduction of nationally uniform registration standards that include nursing.

Improving funding-related incentives for workplace change
As stated earlier ACSA believes that job redesign and delegation are essential to our industry to streamline work practices and respond to the realities of workforce shortages. Extending MBS rebates to a wider range of practitioners is worth exploration. However your report appears to favour the delegation model which may establish the GP as the gatekeeper to the MBS. Given the shortage of GPs in rural areas and within residential care, where only 16% of GPs visit nursing homes on more than 50 occasions a year, a mixed model of delegation and independent access would be more appropriate.

Better focused and more streamlined projections of future workforce requirements
Appropriate planning is required for the future workforce. However in the aged care sector the initial task is to establish the baseline data regarding the nature and the current skills of the workforce. It is incomplete for the residential sector and non existent for community care.

More effective approaches to improving outcomes in rural and remote areas.
Developing a comprehensive National Aged Care Workforce Strategy that also incorporates community care, with particular emphasis on recruitment and retention rural and remote areas is essential.

Ensuring that the requirements of groups with special needs are met
ACSA reiterates that aged care has been dealt with as a special needs area rather than as a substantial and growing part of the overall care workforce sharing many of the characteristics of the health workforce but with its own distinct character and requirements. The Commission's final report needs to reflect this.

ACSA supports the Commission's work in this important area. If we do not start to take action now our health and aged care workforce will come under increasing strain in the coming years. The ageing of the population will simultaneously increase the demand for care services, reduce the overall supply of paid workers and reduce the capacity of family members and other carers to look after people. Crises can be averted with adequate planning and appropriate action - we need to ensure that, as a nation, we do this.