



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Future of Australia's aged-care sector workforce

THURSDAY, 28 APRIL 2016

MELBOURNE

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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Thursday, 28 April 2016

Members in attendance: Senators Moore, Polley, Siewert.

Terms of Reference for the Inquiry:

To inquire into and report on:

The future of Australia's aged care sector workforce, with particular reference to:

- a. the current composition of the aged care workforce;
- b. future aged care workforce requirements, including the impacts of sector growth, changes in how care is delivered, and increasing competition for workers;
- c. the interaction of aged care workforce needs with employment by the broader community services sector, including workforce needs in disability, health and other areas, and increased employment as the National Disability Insurance Scheme rolls out;
- d. challenges in attracting and retaining aged care workers;
- e. factors impacting aged care workers, including remuneration, working environment, staffing ratios, education and training, skills development and career paths;
- f. the role and regulation of registered training organisations, including work placements, and the quality and consistency of qualifications awarded;
- g. government policies at the state, territory and Commonwealth level which have a significant impact on the aged care workforce;
- h. relevant parallels or strategies in an international context;
- i. the role of government in providing a coordinated strategic approach for the sector;
- j. challenges of creating a culturally competent and inclusive aged care workforce to cater for the different care needs of Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups and lesbian, gay, bisexual, transgender and intersex people;
- k. the particular aged care workforce challenges in regional towns and remote communities;
- l. impact of the Government's cuts to the Aged Care Workforce Fund; and
- m. any other related matters.

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Committee met at 08:31

CHAIR (Senator Siewert): I declare open this public hearing and welcome everybody here today. We would like to acknowledge the traditional owners of the land on which we meet today and pay our respects to elders past and present. This is the first public hearing of the committee's inquiry into the future of Australia's aged-care sector workforce. I thank everybody who has made a submission to the inquiry. This is a public hearing and a *Hansard* transcript of the proceedings is being made and audio of this public hearing is also being broadcast via the internet.

Before the committee starts taking evidence I remind all present here today that, in giving evidence to the committee, witnesses are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to the committee. Such action may be treated by the Senate as contempt. It is also contempt to give false or misleading evidence.

The committee prefers all evidence to be given in public but, under the Senate's resolutions, witnesses have the right to request to be heard in private session. It is important if witnesses want to do that that they let us know in advance. If you are a witness today and you intend to request to give evidence in private, please speak to one of our secretariat staff. Finally, please check your mobile phone is off or rendered silent, or the chocolate penalty that this committee applies will be applied.

There is a slight change to the way we are doing our first session. In fact, instead of doing it jointly, we are doing two half-hour slots this morning between 8.30 am and 9.30 am. I am hoping that is okay with everybody. I now welcome representatives from the Health Workers Union. I want to check before we start that you have been given information on parliamentary privilege and the protection of witnesses and evidence.

Mr Eden: Yes, we certainly have.

Mr Bekhazi: Yes.

CHAIR: Welcome as our first witnesses to this inquiry. We have your submission. It is No. 248. You can see by that number that we have had a lot of interest in this inquiry. I invite you to make an opening statement and then we will ask you some questions.

Mr Eden: I was a nurse in the aged-care sector from 1988 to 1998. From there I went and worked for the Health Services Union Victoria No. 1 Branch for a period of five years. Over that period of time I did a lot of work throughout aged care and I was involved in developing the nurse-patient ratio in the public sector in Victoria. After that was completed I returned to the coalface, where I picked up my old position as a nurse in the aged-care sector, where I had seen a decline in the overall care even though we had a nurse-patient ratio in place. I worked for aged-care facilities in the public sector from 2005 to 2008, when I then turned my attention to the private sector acute areas. I have been working for the Health Workers Union since my election, firstly as the president and then as the assistant secretary, since 2012. That is a little of my background.

Mr Bekhazi: Prior to working at the Health Workers Union as a research and project officer—I have been there for about three years—I was working as a clinical psychologist, mainly in the public hospital sector, and specifically in mental health and disability, but also within the aged-care sector. Sometimes, when I was doing the CAT team or the psych triage shift, we would get a number of call-outs to assess older Australians with certain conditions. I have had lots of experience in working with people of all ages.

I am particularly interested in the aged-care sector because I think it is one of the biggest-growing sectors. The workforce needs to pretty much triple within the next several decades. Our union has two dedicated aged-care organisers. We have actually placed a large number of resources at the Health Workers Union to make sure that the aged-care sector is adequately represented.

CHAIR: Senator Polley, I presume you want to kick off?

Senator POLLEY: Thank you both for appearing before us today and for your submission. In your submission you outlined the importance of the government actually working with the unions and the sector in relation to resolving the aged-care workforce shortage that we are obviously facing, and I assume that there are issues around conditions. Can you outline what your resolution to this would be, and whether or not you have been supportive of the Living Longer. Living Better framework—whether part of the issue is not actually the framework, but the inability of the government to actually implement these changes?

Mr Eden: We have certainly witnessed a lot of changes to aged care in recent times, with more people choosing to remain at home with community supports around them. That is an absolutely fantastic outcome for those individuals. There are a lot of facilities that are still operating as high care and low care—as separate facilities—so they are not operating as aging in place.

What we are now seeing in hostels are people who, traditionally, we would have seen in nursing homes. The types of clients that we are getting into nursing homes are really at end-stage life. We question whether or not they should be treated more like large palliative care units, because these individuals have usually passed on within six months. We are concerned about the lack of supports around those individuals and their families during that process. If you are a young person with six months to live and you are in a palliative care unit, you would have lots of psychological supports around you. If you are in an aged-care facility, those supports are just not there. Usually, the staff are predominantly personal care workers with fairly minimum levels of training, mainly because of the fact that if they had high levels of training they would cost more to employ. So you have a de-skilled workforce in aged care, and they are under a lot of work pressures as well.

Mr Bekhazi: If I can just add to some of what David was talking about? David talks about the de-skilling of our workforce, especially in the health sector. At the moment in the aged-care sector, you can work as a care worker and get your certificate 3 or 4, either in Home and Community Care or Aged Care, and work in residential facilities. There are no diplomas and there are no advanced diplomas, so if you want to specialise you have to do some postgraduate training in aged care, such as a Graduate Diploma in Palliative Care, a graduate certificate or even a masters degree. A lot of our carers are not going to do that. We think that the government's attempt to deal with the aged-care workforce challenge through the 'Living Longer' framework that they have outlined is on track, and we think that it is part of the solution.

However, we feel that it needs to be linked to industrial instruments, such as enterprise agreements, and that those instruments must contain improved pay and work conditions for the workers. We think one aspect of that would be a portable long service leave scheme, so that workers can move within the aged care sector and not lose their long service leave entitlements. We also think the government needs to work closely with the unions, so that we can get these enterprise agreements up. What our union has been doing for the last three years is working on these aged care enterprise agreements. Over the last year and a half or two years, David himself has negotiated dozens of enterprise agreements with aged care providers. That is why the aged care sector is actually ahead of the disability sector at the moment when it comes to pay rates and work conditions. We are quite happy about that fact, but there is a lot of room to go. If we are to meet the future workforce challenges, which are to get, basically, a doubling of the aged care workforce, then we need to work on those conditions.

Senator POLLEY: How many times have you met with the minister—either the current minister or one of the previous three or four ministers—in the last three years? How many meetings and consultations have you had with the government via the minister?

Mr Bekhazi: I have met with Martin Foley, the minister for ageing and disability, on numerous occasions.

Senator POLLEY: I am talking about the federal ministers.

Mr Bekhazi: Federal ministers—no. We have not had access to them.

Senator POLLEY: Not yet.

Mr Bekhazi: No. But we have tried to work on a state level with Martin Foley, the minister for ageing and disability. In fact, I have a meeting with him at midday today in Exhibition Street.

Senator POLLEY: Can you go back to the issue around qualifications. Obviously, part of my concern going forward is that there does not appear to be a career path. Are you saying that Certificate III and IV are not enough in terms of qualifications? What would be the average qualification across your membership?

Mr Bekhazi: As part of our enterprise agreement campaign, David went on a roadshow with our secretary. One of the biggest things that he was hearing from the members was about career progression and development. I think he might say a bit more about that before I talk about it.

Mr Eden: Predominantly, our members have a certificate III in aged care. If they have a certificate IV, and there are a choice of potential employees by the employer, the employer is more likely to go to the cheaper option. It is cheaper to employ someone with a certificate III than a certificate IV. They are on a higher rate of pay if they have a certificate IV. That is a backward view on things. Those with certificate IV obviously have higher skill levels, but unfortunately, especially in the private for-profit area, it is all profit driven. They are perfectly happy to employ someone with a certificate III and get less out of them than someone with a certificate IV or above.

Senator POLLEY: Can you give me an outline in terms of rosters. I visited some facilities where they have been able to make some changes through the rostering system to assist their employees in being able to have adequate balance between family and work life. Can you give me your views on whether or not that is an appropriate tool to assist in this area.

Mr Eden: We certainly have to do more about attracting younger employees into aged care. There is a small aged care facility just out of Ballarat in Victoria that has a number of aged care workers. The average age of the aged care worker in there is 72. That is the worker. The average age of the worker is 72. You do not see a lot of younger employees working in aged care.

Senator POLLEY: It is 72?

Mr Eden: That is the average age of the employee in that facility. I think it is about 50 overall.

CHAIR: A bit higher, I think.

Mr Eden: We have to do more about attracting younger people. I think one of the ways to do that is, certainly, to improve the conditions but also to provide a clearer pathway to enable them to advance their careers and, preferably, to remain in the aged care sector. When it comes to rostering, we find there is some flexibility with employers. Generally, in Victoria they do try to roster around people's home-life balances, but the rosters are really skeleton rosters. They are operating on very, very low levels of staff.

If I were on the accreditation committee going around and checking out these places, I would look at the rosters over the preceding 12 months within the organisation that I was in. When the accreditors are in it is typically not unannounced—they are aware that the accreditors are coming, so the employers run around like headless chooks in the couple of months leading up to the accreditation process. They load heaps and heaps of staff on and they actually bring the place up to scratch.

But accreditation is something that you should not be aiming for; you should be maintaining it. They are aiming to meet accreditation, and once the accreditation process takes place the staffing levels just drop back down to normal. I think the accreditors certainly should be taking notice of what the rostering systems are like over the preceding 12 months and ask them serious questions around why they have so many staff on leading up to and during the accreditation process. That is probably a better reflection of where the staffing levels ought to be all the time.

Senator POLLEY: What are the biggest barriers to recruiting people into the aged care sector and also to retaining them?

Mr Eden: Workload.

Mr Bekhazi: Workload, and that is linked to worker-to-inpatient ratios as well. Sometimes we are looking at 30 to 1, and that is just too difficult to manage. A lot of our members are telling us that. There is a particular type of person that is attracted to aged-care work and disability work. I mention disability because we need to be mindful that we are competing for the same workforce, so we need to do things better than the disability sector if we are to attract those workers. The workers are generally caring, supportive people that are in the industry because they care; they are not there to make money. I guess if we could reduce the worker-to-patient ratio—if we could get some mandated ratios and say, 'Listen, we understand that we can't overwork you, because you're going to leave within 12 months,' which I think is the average burnout rate, it would help.

And if we can give them professional development opportunities, if we can allow them to have better supervision, if we can bring in a multidisciplinary team within these aged-care facilities, it would help. What has been happening is that you have the carers who have been taking on the enrolled nurses' jobs, then you have the enrolled nurses who have been taking on the registered nurses' jobs. What we have is registered nurses leaving the sector in droves and going to the acute sector, where they can earn over 30 per cent more than they are earning in the aged-care sector.

Senator POLLEY: Do you have any figures in relation to the number of registered nurses that have moved out of the sector?

Mr Bekhazi: There are figures. Over the last, let's say, five to 10 years, I think it is about 20 per cent that has been reduced to about 15 per cent, or 13 per cent. It is a similar figure for enrolled nurses, so what you have now is that 68 per cent of the aged-care workforce are actually care workers, rather than attracting a multidisciplinary team—and that includes allied health professionals such as psychologists, social workers, OTs, speech therapists—which is what we need, and rather than have medical practitioners and specialists in aged care regularly visiting these facilities, or even having a consulting room to use when they do visit these facilities. A lot

of these facilities do not even have a consulting room for visiting specialists, so we need a multidisciplinary approach.

That is what we are seeing in the countries that are doing well with their aged-care sector—for instance, in the Netherlands. By introducing this multidisciplinary system in the Netherlands by capping the patient to worker ratios and making sure there are psychologists in there working with people who are feeling depressed, not only have they improved the quality of care and increased the retention of staff, but they have actually reduced the percentage of inpatients with mental health issues. Here in Australia more than 50 per cent of the people in our aged-care facilities suffer from dementia, then about 80 per cent of them have a comorbid condition such as depression or anxiety or what have you. One way that the Netherlands has been able to reduce the number of psychological disorders within the aged care facilities is by bringing in these multidisciplinary teams. I think that is what the key is.

Senator POLLEY: Do you have any knowledge of whether or not 457 visas are widespread through the sector in Victoria?

Mr Eden: There seem to be some employers more than others that are attracting 457 visa holders. For example, Opal made a lot of positions redundant, especially throughout the Gippsland region, only to then advertise those positions and advertise that people with 457 visas may apply. There are other organisations which, because of the very poor treatment of the staff, cannot attract local employees any more because they have such a bad reputation. They are also advertising for 457 visa people to work for them.

I also think part of the problem is the bullying within the aged care sector. There is a lot of focus on the funding, and many employers are now employing people purely to do ACFI funding. They do not do any direct care themselves. They are just there to generate income for the employers. ACFI documentation is a creative writing exercise at best, and fraudulent at worst. If staff do not comply and do not exaggerate the fraudulent claims, they are bullied and harassed by the organisation. That is why I personally left aged care a number of years ago. I was working at an aged care facility, the Geoffrey Cutter Centre at Ballarat Health Services, where a person was admitted after having a bilateral amputation and was suffering from postoperative delirium. The ACFI documentation was done whilst he was suffering from the postoperative delirium. He had his house sold out from underneath him while he was in there. When his delirium finally cleared, the organisation wanted me to continue to write fraudulent claims against this individual. With the proper equipment supplied by the occupational therapist he was completely independent, but they wanted him to come in at the highest category. I refused to do that. I managed to get that gentleman assessed and he was discharged—not back to his home, obviously, because it had been sold out from underneath him but back into the community—and lives, to this day, independently. But I was bullied and harassed out of that organisation as a result of standing up to the system and ensuring that that place was not going to continue to be his prison. He had a life to lead and that was not in a nursing home.

Mr Bekhazi: David did mention that Opal Aged Care does bring people in under the 457 visa and he did mention the Geoffrey Cutter Centre, which is run by at Ballarat Health Services, which has about 60 beds. They—the latter—are also using the 457 and other visa programs to bring workers in. What I have noticed is that, if you look at the ABS statistics for unemployment in that region, Ballarat is sitting at about seven per cent and Bendigo is probably at about nine per cent. More importantly, if you look at youth unemployment, that is sitting at about 15 per cent. If you look at the young men who are unemployed in those country areas, their unemployment rate is even higher, sitting at about 20 to 24 per cent, especially the ones between 18 and 24. If the government and the Ballarat Health Service had worked together to approach some of the secondary schools and some of the year 11 and 12 students and started to talk to them about a career in aged care and about the benefits—not only intrinsic benefits about helping older people but also a career that is rewarding and that allows you to earn decent money and that has career progression—I do not think they would have had to use 457 visas. I do not think they would have had to bring in these people from overseas.

What makes it even worse is that a lot of these overseas workers—they work very hard so they can keep their jobs, and that is why these organisations bring them in—are not really culturally savvy, if you know what I mean. They come from countries that do not really understand our culture. I will give you an example. When I was working in mental health services, I had a really good doctor from India. We were really short of doctors, so we had a lot coming in from India and Sri Lanka and taking up positions in the Northern Area Mental Health Service. One of the patients was sitting in the interview room doing his monthly medical review, and the doctor said, 'Where do you spend your time? Where do you go?' He said, 'I go to Northlands.' The doctor said, 'What is that?' Northlands is a shopping centre in the north. But, because this doctor was not born and raised in Australia and was not aware of the culture and what youth do to pass their time, he did not know what this young man was talking about. He did not know what Northlands was.

The young man was using jargon and terms that we Australians use, but this overseas-trained doctor just did not understand. I guess they are some of the reasons why we should be wary of bringing in people on visas to work in these facilities.

Senator MOORE: I am going to be asking this question to a lot of the witnesses today. It is about the link between aged care and care for disabilities. Your submission mentions it, as do a lot of others. What is your suggestion in terms of what is going to happen with the workforce into the future in relation to these two specific areas of care? Your submission does talk about the different industrial positions in the areas, and your hope that we would be able to merge those. Is there anything you want to add to that?

Mr Eden: I think that many younger people with a disability have lived at home with their parents' support for a long time, but now their parents are also ageing. Perhaps the aged-care packages and the NDIS packages should be looking at some kind of one-stop-shop for everyone within that household in order to continue those family relationships—perhaps where the person with a disability has lived there all their lives but their parents are getting too old to look after them, and they need care themselves. Perhaps there needs to be a better package for those types of situations.

I was in a facility where there were five people of around my age with MS. What was unique is that they all went to the same high school and all lived in the same neighbourhood et cetera and all knew each other. But they were all in an aged-care facility because there was not a younger persons' facility there that was available for them.

Senator MOORE: There was no option?

Mr Eden: I said at the time that it is a shame that we do not have better links with other disability and aged-care providers throughout Australia where they might have an exchange program. Let's say they are living in Ballarat now, but they might want to go on a holiday; so why don't we have better communications for expressions of interest like: 'Does anyone who lives in Tasmania or Perth want to swap with me for a period of six months? Let's swap homes.' They are young—why should they be trapped within these facilities, within those four walls? People with a disability who are living in aged care are also very, very socially isolated. They know that if someone is admitted there they cannot afford to become close to them, because they know that they will pass away within six months of their admission.

CHAIR: At the end of the year before last or the beginning of last year—sorry, I lose track of the years or the reporting dates—this committee did an inquiry into young people in nursing homes and residential aged care, so we have an understanding of what you have just said. We found the evidence that you just presented was very strongly borne out by that inquiry.

Mr Eden: As I said, we do not have many young people working in aged care either, and if you are caring for someone who is younger with a disability in an aged-care facility what tends to happen is that you become their life. You are the person who is going to continue to turn up past six months. You are their best friend—their closest thing to a family member, quite often—and they become very, very attached. But because of the average age of the employee working in these aged-care centres they are more like their parent than their brother or their sister or their cousin or their mate, as well. We need to do more about encouraging young people into the sector.

Mr Bekhazi: Before we move on, can I add that I was working in psychiatric triage—I am sure you are all aware of that term—most recently at St Vincent's Hospital, where I spent about three years. One trend that I noticed was that one-third of the patients are accidents and emergencies, one-third are people with mental health issues and one-third are older Australians who are regularly being brought into the emergency department. A lot of them come in with upper respiratory tract infections or other complications, but a lot of them are in there because there is nowhere for them to go, and it is basically a pit stop until they can find somewhere to put them.

I mentioned in my report that a lot of these older Australians, especially in the emergency department, felt like they were a burden on our medical system and on our health system. I noticed that when the nurses or other people were trying to give them some sort of care they felt guilty and they kind of said, 'Why don't you go and see him before you see me?'

I just thought I would add that because it is a big problem. We are having about one-third of our beds in emergency departments taken up by older Australians who really should be in facilities that are better than an emergency department.

Mr Eden: There should be more respite beds. We do see it a lot in the acute sector. When it is the end of the school term and there are school holidays on, there is a 'dump the nanna' thing. People want to go away on holidays and there are no respite beds. What happens? They bring them into the emergency department and they are the hospital's responsibility while they go off and have holidays with their children. They are their parents'

carers, but they deserve a break, too. There is a genuine lack of respite beds out there, and they have no other option but to do that.

CHAIR: We have run out of time, sorry.

Mr Eden: Sorry. We could talk about that all day.

CHAIR: Thank you very much for your evidence today, and for your submission. It was very comprehensive.

JACOBSON, Mr Tim, National Assistant Secretary, Health Services Union

SVENDSEN, Ms Leigh, Senior National Industrial Officer, Health Services Union

[9:01]

CHAIR: Welcome. We have your submission. Yours was number 244. I would like to invite you to make an opening statement, and then we will pepper you with questions.

Mr Jacobson: I have written some notes, and I will skip through them. In our submission, there is a covering page outlining who we are and who we represent—75,000 members right across Australia. Many thousands of those members are working in aged care.

In preparation for this submission, we undertook a survey of members across two jurisdictions. Tasmania and New South Wales participated in that survey. Throughout our submission, you will note there are many comments made by aged care workers, which we would ask you to specifically focus your attention on, particularly around the number of questions that we asked them.

The aged care workforce, as you have probably already noted in terms of submissions, is a predominantly female workforce. One in four workers are over the age of 55. The work is overwhelmingly part time, precarious and intermittent, and fewer than 20 per cent of workers work more than 38 hours per week—a full-time week. Whilst there is a high level of enterprise bargaining in the sector, wages still sit at or around the minimum wage. Bargaining does not necessarily concentrate on wages, simply because of funding. I am sure you will ask me questions about that. The workload is very high, as our colleagues just outlined. One major issue always for our members is workloads and staffing levels, and 62 per cent of respondents to our survey noted that they were often or consistently understaffed.

One of the big issues for aged care, and I think it goes to a range of the issues around, particularly, attraction and retention, is that there is a lack of real recognition of the value of aged care work. We believe that that generally reflects a bias, particularly around the nature of the work, as was the case until a few years ago around the workforce in the social, community, home care and disability area. Because it is a female dominated workforce, there is a gender bias towards, particularly, funding and wages in the workforce itself. One in four respondents to our survey reported that they were likely to leave the workforce within the next 12 months. When you look at the workforce profile, particularly the ageing workforce profile, that has to be a concern. Not only is it a concern in terms of churn, loss of corporate knowledge and people committed to the workforce, but it is compounded by the fact that we are going to need significantly greater numbers of workers in the aged care system over the coming years.

The current aged care reforms largely focus on home care. The Living Longer Living Better reforms were fantastic. They were a breath of fresh air, from our perspective. Unfortunately, the current federal government has undermined the two significant factors that were funded by the previous federal government around workforce. The workforce compact, over \$1 billion, was ripped out—or 'repurposed'—under the current government, away from addressing wages. More recently, the funding that was set aside for workforce development was ripped from workers' hands as part of budget cuts to the industry. We strongly believe that, in dealing with workforce in the aged care sector, nothing will work until issues associated with wages are addressed more particularly. I will leave it there.

CHAIR: Ms Svendsen, do you want to make some opening comments?

Ms Svendsen: I am going to focus a little more on the intersection between aged care and NDIS—not the intersection at age 65 but the intersection in relation to workforce. As we are all very well aware, it was initially tagged, in about 2011 or 2012, to be nearly a doubling of workforce from about 73,000 EFT to around 120,000 EFT. After a couple of years of trials—and I think the information predominantly comes from the two major trial areas, Barwon in Victoria and Hunter in New South Wales, which actually cover the whole gamut and have done for that longer period of time; we now have other areas that do too, but those two areas have been doing it for longer—it is clear that the NDIS workforce is going to get closer to the 160,000 EFT requirements, which is in excess of double of what it was when we started. That is happening at the same time as we are implementing similar sorts of reforms in aged care—as we all know, in the consumer directed care and the necessity to increase largely the workforce in that area.

We do not talk about it as much, but it is also happening at a time when we have significantly increased the level of workers in child care. While we are talking 'babes to grave' in those comments, the pool of workers in terms of people who will go into similar sorts of caring professions and who will undertake the mandatory qualifications in child care—not in aged care or disability yet—is, essentially, the same pool of workers. That was

somewhat recognised by the aged care employers in their report 18 months ago. ACSA suggested that to solve the workforce dilemma in aged care they would look to child care and disability. I suppose disability will look to aged care and child care, and vice versa. Clearly, we are looking at the same pool of people, and that is a significant dilemma for us.

The government has actually got rid of all of the programs. The skills councils have now been gutted. We no longer have EScan available from them, and there was a lot of workforce data that came out of that in terms of projections, in terms of what we currently have and in terms of skill development and needs. We do not have Health Workforce Australia looking at projections in relation to health workforce issues anymore. Our understanding of what our needs are is very confined to a sector. We now have NDIS making some projections out of what is happening in, particularly, Barwon and Hunter about what they are going to need. Aged care workforce projections are really relying on data that is much older. We do not actually have new data. I have forgotten the name of the survey that is done every four years, and which is about to be redone, but it used to be linked to funding. It is not linked to funding this year. The fact that that survey, in terms of workforce, will not be linked to ongoing funding probably means that the data that will be received from employers will be less accurate than it previously has been. Comparing it to the last set of figures is going to be a significant problem. The issues are very similar, and we recognise that the issues are very similar.

What I want to say in terms of the workforce issues for aged care is the thing that we all know and is very obvious but cannot be overstated: this is actually a workforce crisis in terms of attraction and retention that is going to smack us all in the face in more than just aged care. It is broader than that. The need in this area is a lot of people. I do not think we cannot do that, but we do not actually have the attraction and retention policies or focus that will enable us to get people into these sectors—and get them trained in doing the work so that they do not throw their hands up in horror in the first six to 12 months because they cannot deal with it and then leave en masse only after you get them used to the place that they are in—and to retain those people because they have a living wage.

While we talk about precarious employment, technically probably most of them can manage, somehow, to get hours by cross-referencing between multiple employers. It is not great. It is really not a good idea to have multiple employers and to have lots of little bits of time. They have very precarious incomes. The income levels are low in this sector, and we will need to do something about that. The ability to put together something approximating a full-time job is really difficult, unless you are working—in home care particularly—over very long hours in a day. Over 16 hours you might get eight or nine hours of work, and that might put together enough for you to have a living wage at the end of the week.

Senator POLLEY: Thank you very much. You covered a lot in your opening statements, and it was great to have that on record. You have already alluded to the enormous amount of money that has been cut out of the aged care sector. Recently, at our Senate estimates, I had the minister at the table saying that the government has no leadership role within the issue around workforce. I was wondering if you could put on record your thoughts about where you see the federal government's role in this very important issue. In fact, as Leigh said, there is a crisis that is upon us.

Mr Jacobson: We would see that as a complete abrogation of the government's responsibility. The reality is that, if the government does not do it, who does? The industry is not an industry that is particularly sophisticated in dealing with these things. Historically, our ability to deal with, particularly, workforce issues is difficult, simply because the single driver to addressing issues around workforce, whether it is around wages and conditions, training and development or career structures, is around money. The majority funder is the federal government. The minister has an absolute responsibility for that. It is not a new thing. That has been the way aged care has been forever. Mark Butler, the previous minister, took the bull by the horns and did make some significant announcements in relation to workforce development and wages, and previous Labor and Liberal governments took on that role as well. It is absolutely the federal government's responsibility.

Senator POLLEY: Can I ask, as I did the previous witnesses, how often you have met and what consultations you have had with the federal minister in this area?

Mr Jacobson: I, particularly, have probably had more access to the federal minister on the basis that I am the HSU's representative on the National Aged Care Alliance. The federal minister—the previous federal minister and the current minister—does attend the alliance on a regular basis and has briefed the alliance in terms of the current reforms that are in place, but obviously the current reforms do not deal with workforce.

Senator POLLEY: In terms of the suitability and the training that is available the big issue, as you said, is that we need to attract people—the right people. That pool is still a limited pool at the moment. What needs to happen in terms of training and qualifications to attract people into the industry? Putting aside the wages, because

we know that a zookeeper gets paid more than an aged care worker, do we not also have to change the concept of what working in aged care and ageing areas means to our community?

Ms Svendsen: Yes, I think so. One of the things that we touched upon before was the fact that the skills council has been changed dramatically, and we actually do not know fully what is going to come out of that. Having attended the first of quite a few of the health and community services including the direct care support workers one, which covers the aged care and community services certificates III and IV, I can say that our primary need right now is to get some workforce research done—data research. The current funding provisions for SkillsIQ are that there is no money and there is not any intention to be any money for that kind of research. We are running on the basis of what we think off the top of our heads is needed in the sector, as opposed to any solid information or even the ability to go out and survey current employers and ask, 'What do you need?'

There has been some feedback to us about the concept of busting up all of those certificates into skill sets. That is, as an employer, I just want my employee to be good at customer relations and maybe the odd skill set or two beyond that, and that will solve the problem. That will lead to a considerably increased turnover, because people will not actually have the skills to undertake that work. We know from historic data that if people in any of the caring sectors do not have the skills to undertake the work they will leave much more quickly, because it is a much harder thing get over those first hurdles without some understanding of what the work entails before you get there and without support in continuing in that process.

The reality around that stuff is, again, that that is guesswork off the top of our heads. We do not actually have the data. From our point of view, and from what we have talked about with our members in relation to minimum qualifications—but staggered; we do not actually believe that everybody needs to have the highest level of qualifications—there is a need for the sector to have minimum mandatory standards. There is a need to have some staggering—some grading, if you like—of what those qualifications or needs are which will meet the sort of work that they are doing. For instance, if I was working with dementia clients, having an additional skill set or unit of competency in relation to dementia would be ideal. You need to be able to access additional things. But there is no funding providing people with encouragement to allow their staff to undertake further career development. Even in those kinds of caring areas where there are additional units of competency available, there are no funds to actually do that, so those people who are quite lowly paid are actually being required to fund the additional training themselves.

Senator POLLEY: There are obviously a couple of cohorts within this ageing group, like the LGBTI and Indigenous. My concern, and I think others here share it, is that there is certainly not enough training for those who are working within the sector to be able to give the sort of care and to have the understanding that they need going forward. Is there any training currently available that you are aware of in this area?

Mr Jacobson: Not in that field, no. In fact, is largely employer driven. If the employer wants to provide it, they provide it; if they do not, it does not happen. I think the point around that particular question is that aged care, certainly over the last 15 to 20 years, has become a far more complex place to work, particularly in residential aged care facilities. Back in the 1980s, residential aged care facilities were nice places that nan or pop went to, where they could have a rest when they could not live at home and could not look after themselves. Now they are high-care acute facilities—

Ms Svendsen: They used to drive themselves in when they were first admitted.

Mr Jacobson: They did. They used to have their own car park. Now, they are high-care acute facilities. We see very significant rates of dementia amongst the general population now, and we have older workers looking after those people. The reality is the level of skill and the level of development that have gone into aged care. I think part of the issue around why we cannot attract workers is that people see that. I know certainly that a number of our members would actively discourage their own children or grandchildren from entering the profession, simply because of the nature of the work. There are high injury rates—back, shoulder and neck injuries—but more often now there are injuries associated with violence and other psychological issues associated with high workload and stress related issues.

Ms Svendsen: The answer to dealing with those issues, be they musculoskeletal difficulties from constant lifting or behavioural issues often associated with dementia—I am sure more people will talk to you about those particular issues—is in fact having the time to deal with them, which actually means having the staffing and the skills to deal with them. It is not about things like restraint and preventing people from assaulting others. It is about having the time to deal with those anxiety levels or dementia, in whatever forms they are taking. We do not currently have enough staff to deal with basic personal care in a way that provides some sort of dignity to people in terms of choice, which is what we are aiming to do. But we actually do not have enough people to do that, let alone to deal with those additional issues.

Senator POLLEY: Yes. We could be here all day. There is one more issue. Things are changing. When you talk about dementia, we have heard recently—it has been on television, so people are hopefully more aware—about how music can help. But, if staff are not trained and do not have the time to do that, certainly not only the staff are at a disadvantage but, just as importantly, the residents also are. Is it time for there to be registration of those people working in the residential aged care facilities, as well as a register of those who are supporting people staying in their home?

Mr Jacobson: Yes, we would agree. In fact, you will note in our submission that we do make a recommendation in terms of a licencing system for aged care workers. We think it should be for care workers in general—a positive registration system, not a negative one. There are various models, but we need one that is positive and portable. The big issue always around these things is: who pays, when you have a workforce that is getting very low pay, when it comes to registration? We had this issue in Tasmania recently with the working with vulnerable people check or the working with vulnerable children check, where workers had to pay significant amounts to continue to work. They are the sorts of issues that will come up. But, yes, we support such a system.

Ms Svendsen: In addition to that we support something that is (a) portable and (b) a bit structured. We believe in the fence at the top of the cliff, not the ambulance at the bottom, which we would argue is what a negative licensing system is. Having a blacklist of people who cannot work in the area is not dealing prospectively with the issues that need to be dealt with. Some form of positive licensing system allows for appropriate professional development where problems are identified and for appropriate interventions where there are health issues for some people in terms of how they are practising. I think those sorts of things are very important.

There is also the issue that Tim referred to in relation to portability in terms of things like vulnerable children's checks or police checks. Currently they are different by state but, primarily, the employer gets the check on you as a person so, if you are working for more than one employer or if you want to shift employers you have to get a new one. If you are paying for that as a worker, then that is a lot of expense. In most cases now it is a requirement to have a police check and a working-with-children check or a working-with-vulnerable-people check, so there might be more than one. That is a significant problem. We think that that sort of pre-employment check system should also apply to the worker so it can go across jobs and may itself also be graded through from being able to do anything at all to having only low-level police checks.

Senator MOORE: I am particularly interested in the comments you made in your opening statement about the links between the caring workforces. That has been an issue that has come up a bit in the submissions, and that links to a lot of the recommendations you have made about training and having accredited training. At the moment, in terms of disability care and aged care, is there any link in terms of support for those workers industrially or in training elements? Do you cover disability care?

Ms Svendsen: Industrially, those workers who work in homes providing people with support are underpinned by the same modern award instrument, but that is also the instrument that covers disability services. The Aged Care Modern Award also applies, but that is for residential aged care, so they are not directly linked. In areas where they are starting to do agreements they are using both modern awards as the underpinning instruments for that enterprise agreement, but the primary reason for enterprise agreements in this sector from our point of view is an attempt to get better conditions for our members. Primarily what we can do in those areas, and this goes across both, is to have better consultation clauses or roster clauses or non-cost clauses, or very low cost clauses.

For example, I do not think they are really thinking about it right now, but some people were putting in small amounts of paid maternity leave but, with a workforce that predominantly was aged over 55, not many people were using it. So it was a fairly low-cost thing to put into an enterprise agreement.

Senator MOORE: I would hope it would be no cost!

Ms Svendsen: That is right—or no cost. The actual impact from a cost perspective was very small, and so small that our enterprise agreements traditionally contain a cover clause that, if the minimum wage goes above those wages in the enterprise agreement clause, then the minimum wage will apply. We put that in as a protection for us because the wages are so close. In terms of industrial instruments, yes and no—they are linked, but only in that sense.

Senator MOORE: I am concerned that I do not think that people across the board are looking at this large pool of workers as a pool of workers—it is still segmented. Even the title of this inquiry is absolute, because we are very concerned about aged care. The whole way that some of the submissions have looked at the NDIS and the impact that is going to have I think is something that we need to come to grips with through government, research and industrial processes.

Ms Svendsen: I would say that employers are starting to actually recognise that, and we are starting to talk to them about it. What disturbs us is that we are not really talking at a government level about that or at a global level. All of the mechanisms that might have actually addressed that, or considered it in a prospective area, are not there anymore; they have all been dumped.

Senator MOORE: Yes, and the skills related to it are not there anymore. I have one more question, and it is something that was in one of the submissions. I was rooting through them to try to find my notes, but I could not. It is about this process that is happening now where, in so many areas, people have the expectation that, if they are on a Centrelink payment, they need to get into work. Some people are actually being encouraged into the care workforce, whether they really want to be there or not.

CHAIR: We have an example of car workers in Adelaide.

Senator MOORE: It is a really big issue, and we just heard people saying that this is going to be the growth area. We used to hear about hospitality; it was going to be the growth area. Now the caring area is going to be the growth area for jobs. Do you have any comments about how we make sure that people are linked because of their skills and their desire to be there, rather than just saying that people who worked in the car industry can translate to carers? And my pet one concerns people who have been voluntary carers, who come up a lot in our submissions. When they cease to be voluntary carers and they are under 65—whacko!—we will turn them into professional carers. From working in the industry, do you have any comments about this expectation that we can just churn out care workers?

Mr Jacobson: Yes, you make the argument, but the point is that we do not see—nor, I am sure, do older Australians—that aged care should be a dumping ground for people who cannot find work. It is not. The reality is that, of those people that are in the aged care work force now, most of them have been there for a long, long time.

Senator MOORE: Yes, that comes out.

Mr Jacobson: They are very committed to the work that they perform. We have got a member who popped up in our survey who is 73 years old. The point was made earlier that we have got aged people caring for people in a particular environment where none of the residents are, in fact, older than them. They are older than any of the residents they have. They are very committed, and committed to the nature of the work. The reality is, and I come back to the point that we made earlier, that what we need to do is put more emphasis on promoting aged care as a workforce.

Senator MOORE: As a profession. It is a profession.

Mr Jacobson: The problem is that, even in disabilities at the moment, if you work in residential disabilities, as fragmented or unstructured as it is, in the award there is at least a small career structure. There really is none in aged care. You are a carer. You are a carer today, and in 25 years time you are going to be a carer. There are not great opportunities for people, once you get into the system, to continue on in the system. We heard before, and it is quite true, that we are seeing fewer and fewer registered and enrolled nurses as well. Even turning to those professions, there are less opportunities.

Ms Svendsen: Looking at the workforce as pool is really important in one sense. But, also, conflating disability and aged care is a no-no. They are not the same, and that actually makes some of the divisions about the consideration of workforce part of the difficulty for us. People are very focused on the fact that they are not the same, and we need to consider different skills and different qualifications or support for those sorts of skills. Then you cannot look at the pool of people that are going into the area and just conflate them.

CHAIR: As just one amorphous mob of carers.

Ms Svendsen: Yes.

Mr Jacobson: There are some basic rules, but I just make this quick point. Disability and aged care are very different in terms of the broader nature of the work. In disability it is social validation, community integration, and people living and working in communities; in aged care it is caring and supporting people in their older years.

CHAIR: I have a question that you may want to take on notice. We have been talking about the precarious nature of the work, the uncertainty of part-time work and having a living wage. The issue that all the submissions talk about is the growing need for both people to work in aged care and disability—bearing in mind what you just said. Does that not provide us with an opportunity to start addressing the long-term, systemic nature of the issues that you have been talking about, such as the precariousness of work? Given that we need a bigger workforce, and because we have a lot of uncertainty in the workforce et cetera, what measures or steps are being taken to look at these very issues that you talked about? Are you aware of any steps being taken to address those issues while we build the workforce?

Mr Jacobson: No.

Ms Svendsen: Not from a leadership or government position. There are at industry level, and I am prepared to give you some information about that on notice if you would like. We are having conversations with employers about some of those sorts of things, but they are not being led and there is no industry-wide or nationwide process around that sort of stuff.

CHAIR: If you could take that on notice, that would be really helpful for us. Senator Polley said she has one short question. I have heard this before. If it is not short, I will ask you to take it on notice.

Senator POLLEY: We have talked generally about attracting people into the sector. We would be very remiss if we did not talk about the real challenges of attracting workers in rural and regional Australia. You were saying in your evidence that sometimes a worker will go across a number of employers. That is not the case, for instance, if you are working in Wynyard, Stanley or Smithton on the north-west coast of Tasmania. If you can give us a succinct answer, that would be great; otherwise take it on notice. And the other quick issue is penalty rates.

CHAIR: You said one question! Give her an inch and she takes a mile.

Senator POLLEY: We know that they are underpaid now. If there is a move—which we know there is—to remove penalty rates in the hospitality and retail areas, I think the next targets would be in this area. How critical would that be to this industry?

Ms Svendsen: We would lose a third of the workforce overnight. We are prepared to take that one on notice too and give you more information if you like.

Mr Jacobson: That would be devastating. There are two things that obviously are of concern to us. One is penalty rates. Our members in aged care are really concerned about penalty rates, because, whether the government likes it or not, they see it as a stalking horse—in particular, what is going on at the moment. The other issue is the level of support that the federal government provides, particularly in the not-for-profit sector, around fringe benefits and the PBI status. A lot of people rely on both of those things, penalty rates and salary packaging—and obviously overtime as well, when they can get it—to lift their wage to a sustainable level.

Ms Svendsen: We note that the Productivity Commission grouping of protected employees for penalty rates does not include care workers. They are quite specific about nurses and emergency care workers. We are happy to take that on notice if you really want us to do that.

CHAIR: That would be great. That would be extremely useful for us as well.

Senator POLLEY: I have now used up my only chance for the day of getting an extra question in.

CHAIR: There were a couple of extra ones in there. Obviously, there was the penalty rates issue.

Senator POLLEY: The regional and rural challenges.

CHAIR: The regional and remote question is really important as well. Thank you very much for your time and your submission, and for work you are going to do on the questions on notice.

EDVARDSSON, Professor David, Professor/Director, La Trobe University/Austin Health/Northern Health Clinical School of Nursing

OAKMAN, Dr Jodi, Head, Department of Public Health, and Program Coordinator of Ergonomics, Safety and Health, Centre for Ergonomics and Human Factors, School of Psychology and Public Health, La Trobe University

WELLS, Professor Yvonne, Coordinator, Healthy Ageing Research Group, La Trobe University

[09:39]

CHAIR: While you are settling in, I will get some of the preliminaries out of the way. I am just checking that all of you have been given information on parliamentary privilege and the protection of witnesses and evidence. That is the bit where we tell you all about how your evidence is protected. It would have come with your invitations. Thanks.

Welcome. Your submission is No. 237; thank you. I would like to ask you to make an opening statement, and then we will ask you some questions.

Prof. Wells: Because we responded to each of the terms of reference that we could, our submission to the Senate inquiry was a bit like a submission designed by a committee. We wanted to use this opportunity to draw some bits of our submission together, which is why we put together this diagram. I want to take you through the diagram very quickly, and then to leave it open for you to ask questions.

The purple oval on the left is there because we wanted to indicate that the aged-care system, both community care and residential care, is a system under pressure. These pressures are only going to increase—given that you are about the future of the aged-care workforce. These pressures are things like the ageing population, increasingly stringent funding models, increasing client and resident acuity, and increasing demands for person-centredness. That last point is really a place holder to indicate that, actually, models in residential and community aged care are changing rapidly. I note that you have Jewish Care coming this afternoon, and they will probably talk about their new model of residential care, but new models of community care are also being tried, which aim to put the person more in the centre of their care. The main points that we want to make are that the system is under-resourced and that the staff are too few, insufficiently trained and skilled, and not matched to demand, especially in rural areas. You will already have heard that from the people that have come before us, and also from other submissions.

We have a number of ovals which are blue, and those are to indicate that you can focus on various areas: the trained nurses, home care workers and PCAs, allied health and other skilled supports. Then you can talk about the work environment and how it is physically demanding and low status, and the risk of injury, particularly musculoskeletal injuries. That was also raised by the previous speakers. The risks, of course, of these factors are staff attrition, loss of staff, difficulties in attracting staff and sub-optimal care.

The green box down the bottom lists some of the things in our submission that we indicated might be ways of addressing the problems. Certainly, the sector needs better funding. It needs better career pathways, and our previous speakers also referred to that. There are new solutions and supports, some of which we list there: use of IT, which covers robots and other things, but also the personal experience of people working in the sector—their enriched clinical experience, quality learning environments and things like that, which actually encourage people to maintain and improve their skills and to stay in the sector.

Then there is a list of the specific training needs, which come from the Swedish model, to which I have added something at the bottom which is a specifically Australian thing: a need for training in cultural competency and trauma response, simply because of our history and the population we have.

That is a very quick overview of our main messages.

CHAIR: Thank you; that is very helpful. Thank you for the diagram.

Senator POLLEY: I agree, the diagram is very helpful for us. Can you walk us through how we need to design the qualifications and this sector to ensure that we not only attract good people into the sector but also retain them.

Prof. Wells: I am just going to make a few statements then leave it to my colleagues to expand on those. I also want to alert you to our colleagues sitting in the back there from ACEBAC who really make this their business—the training of aged care workers—so they will have a lot more detail to provide on this topic. I suppose the main points I want to make are that the skills of the staff who are currently in the aged care sector are not up to scratch. They are not up-to-date and they are not sufficient for the coming challenges, which we have tried to indicate, in

terms of changing models of care. How can this be changed? There needs to be much better encouragement and opportunities for staff in both the residential and community aged care sectors to maintain and improve their skills. I do not know that I know very much about the mechanisms for doing that. Do any of you want to say something about that?

Prof. Edvardsson: You can be inspired by this: there is a lot of research around Magnet hospitals in the US and across Europe, which pride themselves for having clear career pathways, attracting staff, having a baseline expectation about educational qualifications and continuing qualifications, and career ways with peer support and research involvement. They can be used as one example of how to attract and retain staff.

I was part of the submission looking at the Swedish model. I have been part of that and other European initiatives to look at not only the educational qualifications that we want to retain staff but also how we can provide pathways to retain staff and where the profile areas are in that setting. That is dementia and Alzheimer's disease specific knowledge, end-of-life care and also more postgraduate qualifications and career pathways to attract and retain RNs and specialist nursing roles, for example nurse practitioner roles, in addition to the more baseline expectations of personal care workers. In that model there has been some sort of baseline expectation of this is what you require if you work in aged care. You need to be on top of symptoms of dementia and how to manage those, as well as end-of-life care et cetera. The most common examples of functional impairment are eating difficulties, so some sort of certificate and baseline knowledge around that from which staff can grow and create career pathways and peer support.

Prof. Wells: You have probably been told about the lack of skills in PCWs and the basic aged care workforce. We just want to reiterate the point that the standards of the training courses are very inconsistent and often not very good. People in the aged care sector complain constantly about the lack of skills and the lack of knowledge of people coming into the sector. I just want to reiterate that point. Also, in terms of other skilled supports, the training for other professions—I am thinking about OTs, physios, psychologists, I am a psychologist by background, and other professionals—is really very patchy and inconsistent where it comes to ageing in general and aged care in particular. For example, at La Trobe University and many other universities there is almost no training for psychologists in ageing. I know because I went through the course. This is a very big hole, in terms of support staff and skilled staff in supporting the aged care sector. It is absent.

Senator POLLEY: I have the view that a step that needs to be taken first if we want to resolve the issue of attracting people into this sector is to change our culture as to how we see ageing in the community. That needs to be led by the government and also within the health area of training. We have seen that where there have been examples of training ambulance officers, nurses, doctors that go in and do some time within an aged care facility, so that they can see that this can be just as exciting as acute care. What would your perception be of the role of the Commonwealth government—the federal government—in this area of changing the public perception, the language that we use and ensuring we have the training that we need? It has to be ongoing when there is developments around dementia and how the changes very quickly, and hopefully it will continue to go in the right direction.

Prof. Wells: I agree with you that the aged-care sector is a low-status area. Really, it competes for staffing with the acute sector and private practice in the other professions, apart from nurses. So: how to make this more attractive and how to raise the status of the whole sector? While the sector is so poorly funded and is seen as a poor cousin—the Cinderella—nothing is going to change. How do you raise the status of a sector like that?

There have to be ways of seeing the sector as one which provides opportunity, and exciting opportunity, for people working in it. It is there patchily at the moment, where people are trying new initiatives to improve the care and experience of people working in this sector. But as the people before us said, there is no leadership in that from the Commonwealth government. It is led by providers who recognise that no-one really wants to go into residential care and that people resist having people going into their homes to provide community care, and that unless opportunities are there for people to see that this is actually something good, something exciting, then nothing is going to change. That actually needs—I hesitate to say this—a massive injections of funds, and we all know that is unlikely to happen.

So how else can you do it? You can do it by having messages about the critical importance of this area in people's lives, about how the staff working in this area can make people's lives so much better. This is actually an opportunity to make a really positive contribution to how older generations spend their last three decades.

Dr Oakman: One of the things we found in research that we have been doing in terms of what it offers—so, looking at the positives—is that some people choose the sector because they like working in it. But it also offers them a degree of flexibility so that they can manage their 'other lives'—so it is focusing on more of those positives. The challenge there, though, is the pay rates. They often have to do extraordinary things to manage

shifts to get enough to make sufficient money, but they like the flexibility it offers them because they can look after either parents or children, because the shifts are often odd lengths or because they are finished in time for school pick-up.

I think one of the big issues, too, is around job design. There are some real structural issues with the work. People get injured a lot—there are very high injury rates. They get injured because they often take shortcuts in what they do because they do not have sufficient time—I know that people before us were talking about that. They have insufficient time to use equipment, and make decisions about work practices because they are just trying to get things done. One of the things we found is that there are a lot of competing demands on them—so, how do they decide what to do next. We know that is a really strong predictor of musculoskeletal injuries—both the psychosocial work environment and the physical work environment. We often focus on the physical but there are a whole lot of other things.

And there are some structural, as in building, issues in many of the facilities that do not allow us to put systems in place that can help reduce those injury rates. We know what we need to do in terms of physical environment, but in many of the older facilities we cannot put those in place because the bathroom is too small or the room is too small to get equipment in. And so whilst we still have those facilities around we are left with some real challenges which, in my opinion, are almost insolvable until we are not using those particular facilities, or until we change who is in those—those who are not so highly dependent—so that the issue is about people's level of dependency.

Senator POLLEY: You would have heard the previous witnesses when I spoke to them about the cohorts of people that are now approaching or are already in residential care in relation to the LGBTI and Indigenous groups and those who come from a different language-speaking background, with the language barriers that are there quite often in residential care, and they would be also in home care. As we all age, our hearing goes and our tolerance sometimes goes in terms of not having carers we can converse with.

I was fortunate enough to visit a facility here fairly recently. Predominantly their cohort of residents has Italian backgrounds, but they also have staff that can communicate with them in Italian, which makes for a much better environment. Ultimately, if not only are your residents getting the care but you are creating the environment, you are actually saving governments a lot of money in terms of psychological issues around depression and other things. Do you have any comments to add there about the importance of making sure that we have professionals trained to be able to deal with these interest groups?

Prof. Wells: Only to reinforce what you are saying, really. It is absolutely critically important. We know that, if older people develop dementia, they often lose their English-language skills—you know this already—and revert to their previous language. Obviously for mental health it is absolutely critical to be able to communicate.

Prof. Edvardsson: I think I would add to that. That is to some extent a bit of a boutique thing if you compare it to the prevalence of dementia, which is across the board, across culture and across end-of-life issues and functional issues which will happen to everyone in ageing. So I would have thought that some of the more generalist approaches in providing high-quality care at the end of life in this environment, being highly skilled in tackling the booming prevalence of dementia and the challenges that come through these behaviours which are added on with the cultural layers and the linguistic variants—I would have thought that that would be an even greater problem with the end-of-life issues and behavioural issues in addition to cultural issues. To some extent, it is another layer of complexity, isn't it, if you do not speak the language?

Dr Oakman: One of the things that we found when we were interviewing managers and supervisors in the aged-care sector was the issue they had with dealing with cultural issues on the other side, so with staffing—an imbalance between staff expectations and resident expectations. I am talking about specific cultural values and what we do. That was a really big issue for them to which they felt they had no solutions in how to manage it, and they were really asking, when we were talking to them, saying, 'We need some tools or training in how to manage this because of where we're drawing carers from.' They saw that as a growing issue, one that was not going to go away.

Senator MOORE: I am asking questions, as you may have heard, about this concept of a pool of care workers that we now have with the growth of the NDIS, a focus on care workers for people—as we always should have, but now we are—and aged care. Do you have any comments about whether this is something we should be looking at in a wider area? That is one question.

The other one, I think, Professor Wells, is in your part of your submission, which I did find very interesting, broken into the segments. It may look like it was done by committee, but I found it very useful to read. It was in one of your segments. It talked about something that really piqued my interest, which was spirituality in care.

That is something that I am really interested in. They are the two questions. Take them in whatever order you would like.

Prof. Wells: Yes. I wanted to comment on something that the previous witnesses had said in terms of the differences between providing for younger people with disabilities and older people. They mentioned that caring for those two groups is really very different, and they characterised care for the older population in terms of care and support. While I do not want to disagree with that, I do want to say that models of care are changing and that it is not just about care and support, actually. The two areas of caring for disability and aged care are coming closer together, in terms of things like supporting existing function, the Active Service Model, and supporting older people to maintain and, in fact, regain skills and to maintain control over their life. They are concepts which came from the disability sector. They are being increasingly applied to the aged-care sector. And I think that is one of the exciting things about the aged-care sector actually—that older people are not just passive recipients of care and support. They can be actively in control of their lives and can maintain and improve their function. That is one of my little hobby horses! Does anyone want to add to that?

Senator MOORE: Could you speak to the spirituality issue, Professor? You say that there are guidelines being developed, which I find very exciting. Who is developing those guidelines?

Prof. Wells: That is actually not my particular area of expertise—

Senator MOORE: Can you take it on notice?

Prof. Wells: Absolutely.

Senator MOORE: It is just something I am interested in.

Prof. Wells: I can find out more about that for you.

Senator MOORE: I have one last question. It is about research. We know that many people have said that there is insufficient research into this area and it is an area where funding has been reducing. Can I find out about the La Trobe centre, which obviously has a particular focus in this area. We have other witnesses from other centres as well; I am going to be asking them the same question. How do you retain the funding to ensure that such a specialist area of important research is maintained? How do you, at La Trobe, manage to retain—I am trying to find the title—the healthy ageing research group. That is what we want. How does it work?

Prof. Wells: If I were facing the other way I would be grimacing at my colleagues at this point! The healthy ageing research group is a virtual group which is university-wide. There are some centres, such as mine, the Lincoln Centre for Research on Ageing, and ACEBAC, people like my colleagues sitting behind me, whose focus is on research and consultancy in these areas. The fact is: we are shrinking, and we are in danger of disappearing altogether, because both the basic research funding and the applied funding, through consultancies, has just dried up. We are absolutely struggling to keep ourselves going. You ask how we are doing it. I am saying, 'We're not doing it very well at all.'

Senator MOORE: I think it is really important to get that on the record because so many of the submissions talk about the need for this research and that it is an active area, and we have had the benefit of that by having the submissions to the inquiry. So I just want to get a sense of it from people who are working in the field. You have said that the consultancies and the funding are drying up.

Prof. Wells: Yes. We are absolutely under threat.

Senator MOORE: Do you have any comment about what is causing that? I will ask others—be prepared for the same questions at the back there!

Prof. Wells: One of the things that has happened is that ageing has disappeared from the priority areas for funding—

Senator MOORE: That is a point Senator Polley makes quite regularly—that, in terms of the importance of the focus, it has been lost. Do you know why? We are all ageing. I think it is something we all care about.

Prof. Wells: I do not know why. But the other thing is that the applied funding has also really dried up, so that commissions from all three levels of government are much smaller now and smaller in scope and fewer in number than they were five years ago.

Senator MOORE: And that is the lifeblood isn't it—to get funding for particular purposes?

Prof. Wells: Yes.

CHAIR: I want to explore a bit more the issue you commented on before, about regaining skills. I want to go to the area that we all know is the elephant in the room, and that is the 65 cut-off with NDIS and aged care. One of the points that is made very regularly to us, wherever we are, when we talk about NDIS and aged care, is that

aged care does not do rehab, whereas NDIS does and it supports people with disability to regain skills and things. So, when we are talking about regaining skills in aged care, where is that happening that you are aware of?

Prof. Wells: It is certainly happening in the community. One of the things that we have been doing at the Lincoln Centre for Research on Ageing is developing some outcome measures for the Victorian Department of Health and Human Services for agencies to be able to capture their impacts within the Active Service Model on clients in being able to maintain and regain function. We have just been piloting these outcome measures in the field, and we can prove that people do regain function if they have the support and the expertise—

CHAIR: Yes, that is where I am going to. I have no doubt that people can, but that is where I am going to. How do we fund that? You have very eloquently pointed out in both your oral comments this morning and your submission the decrease in funding—you have just been talking about it. How do we then get the benefits across of what you have just been articulating? Is there more detailed work being done in terms of—not only is this a better quality of life; it would also have an outcome in reducing costs of care?

Prof. Wells: Yes, absolutely. Where is it being done? Well, it is being done patchily. Various state governments have it as their policy. Its implementation depends on the resources put into it. The Victorian state government have been pouring resources into the active service model for a good 10 years, and it does take that kind of concerted effort to start to make some changes. Even now, 10 years down the track, we are seeing that some of the aged-care workforce in the community are able to help clients articulate goals and some of them are still a very long way off. What I am trying to say is that it is a very long-term program. It takes a lot of resource and effort. It takes training and it takes a change in the way clients, as well, see the purpose of the services that they are getting.

Another example that I just want to mention quickly—and I mentioned it in my written report as well—is the Wyndham city initiative for changing their model of home care. They are making teams of home care workers who are developing particular ways of working with clients to support function—relatively short-term interventions to assist people to meet goals and then the workers move on. We evaluated that program for Wyndham. There was evidence that, given a new way of working, gains could be made to the benefit of both the clients and the staff, who really enjoyed that new way of working. That is in the community.

In residential care, there is a whole new culture change that has got to come before that is widespread. Jewish Care, who are coming to see you this afternoon, will talk about their new model of residential care. I know about it because we were evaluating it. Again, they have got a long way to go in terms of preparing staff to work in a new way with clients and to take responsibility for the day-to-day activities that happen.

Prof. Edvardsson: Can I just add to that. It is also connected to the qualifications in this space. We have obvious examples that if you have a physiotherapist that has come regularly that can create that health-promoting model of aged care, even in residential aged care. That is the concept that is popping up at national conferences more—a health-promoting model of care, where we can see the benefit and where staff can be trained by professionals within that space like occupational therapists and physiotherapists, to implement in their daily life a more health-promoting, more proactive, less reactive model of care in these environments across the community and residential aged care. But it is connected to qualifications, career pathways and the integration of both university-prepared and lower skill level staff.

Prof. Wells: And it does require training across the board, and that requires resources.

CHAIR: That is where I was going with this. We are talking about workforce and training. What processes should be in place to then focus on these areas?

Prof. Wells: At the moment, it is just up to the providers to be able to patchwork bits of funding together in order to be able to do it. It is really difficult, and it is difficult to do it on a large scale.

CHAIR: Thank you very much. I have run us over, but we have been running over, so now we are finishing on time for us being late—if that makes sense to anybody! Thank you very much for your comprehensive submission and the diagram, which really was effective in bringing that all together. Your time is very much appreciated.

CHARLESWORTH, Professor Sara, School of Management, Centre for People, Organisations and Work, RMIT University

[10:10]

CHAIR: Welcome. Is there anything you would like to add about the capacity in which you appear?

Prof. Charlesworth: I am also an executive member of what is now the Centre for People, Organisation and Work but which at the time I wrote the submission was the Centre for Sustainable Organisations and Work; we just had a name change.

CHAIR: Your submission is 290. I invite you to make an opening statement, and then we will ask you some questions.

Prof. Charlesworth: I am a researcher who has had a long-time interest in aged-care work and aged-care workers, going back to 1993, when I took the first pay equity analysis of home-care work in Australia. I currently have a number of projects, and following on from your question to the last group, it is all what we researchers call soft money—that is, it is not ongoing funding, but these are competitive grants that are won basically from both the Australian Research Council or other international projects I am involved with.

The central theme, I suppose, of my current work is really looking at job quality in aged-care work from a number of perspectives: from a kind of regulatory analysis—I am basically a socio-legal scholar—and looking at that from a cross-national perspective and from an industry perspective in Australia, right down to a project that I have. And the research team has made a separate submission on the Quality Jobs Quality Care project. I am currently involved in another ARC project—and these are set out in my submission—where we are looking at the same issues but are particularly focused on migrant care workers, both in aged care but also, interestingly, in child care. And while I did not deal with it in my submission, that is probably of interest to the committee, because I have noticed that several submissions have raised the so-called solution of temporary migration to what is problematised as a care deficit or a looming labour shortage in aged care.

In my submission I focused on four themes, which I am happy to talk to or take questions from the committee members about, but I want to make two points before I do that. Really what underpins my submission is some frustration that despite all the Australian and international research evidence of the critical importance of the care relationship between worker and client, between worker and resident, in providing aged care, aged care policy and many aged care stakeholders in Australia talk about 'workforce' and 'workforce issues' without seeing the work and the workers who perform it. This is particularly the case with the home-care workers in community based aged care and the personal care workers in residential aged care, who make up the overwhelming majority of direct, hands-on, front-line aged-care workers.

The other related point is the link between good-quality aged-care work with good-quality aged-care services. And good-quality care is underpinned by the relational nature of the care provided and by the organisation of aged-care work. If you look at qualitative research that is focused on the client's perspective, that very much suggests that autonomy, individuality, independence et cetera are very important aspects of care quality and that, for aged care recipients, positive reciprocal relationships with workers and care tailored to individual needs that is designed to maximise autonomy are seen as particularly crucial. If we look at workers, research also suggests that for aged-care workers not having enough time to care is a consistent and critical factor in employee job dissatisfaction. Workers want to have the time to maintain and enhance the dignity of the people to whom they provide care, including through adequate staffing levels. Yet in Australia, as in most developed economies, aged-care services are increasingly organised around fragmented time schedules in home care or inadequate staff-to-resident ratios in residential services. Good quality care requires a stable workforce, adequate staffing and an appropriate staff mix, as well as working conditions that would allow workers to develop and maintain key relationships with the elderly, and, importantly, to be able to use their skills. I will leave it there, and I am happy to answer any questions.

CHAIR: Thank you very much. Senator Polley.

Senator POLLEY: I will start my questions around the area that you just touched on, and that was the importance of giving appropriate and good care in the home, which is what I would see as a necessity in terms of trying to have a stable workforce so that you can develop those relationships with those you are caring for. There is now a lot of responsibility placed on those workers to be able to report back to the provider on whether there is any change in the condition or the habits of the individual resident. How can you possibly do that if you do not have time to develop those sorts of relationships?

Prof. Charlesworth: Well, you cannot do it. I think what is happening in the UK, with the austerity cuts to the social care budget there, is an object lesson to us all. There are a number of inquiries now into the problem of 15-

minute visits, which are growing in the UK. The local authorities commission the services, but they are getting less money from the British government. So they have to cut their cloth according to their means, and they subcontract, subcontract, subcontract. As you go down the line, the time allocated in home care, specifically, is cut back, with very serious consequences. The UK Equality and Human Rights Commission has undertaken an inquiry into the problem of aged care, which was very much focused around the very poor service that is provided. I think we all ought to think about the UK as, I suppose, a place where we do not want to go.

There is not the evidence in Australia that that is currently the case, but I know from talking to home-care workers that they are constantly frustrated with the time allocated. I was talking to someone the other day, and she has to get a client up and get this client's breakfast. She is given 30 minutes. Now this is a frail, aged person. It is hard to get her ready. It is hard to get her up. It is hard to get her dressed and then to sit her down and make her breakfast. What often happens—and this is borne out consistently in the research—is that home-care workers stay a little longer on their own time. They are allocated half an hour. They know that that care cannot be delivered in half an hour, so they will stay an extra 10 minutes, an extra 15 minutes. I think it is a problem when we have organised care where the work needed to do the care is just invisible.

Senator POLLEY: You also mentioned in your submission the issue of payment for travelling between your clients. Obviously you have some evidence that that is an issue for those who are providing that important care.

Prof. Charlesworth: Yes, it is a huge issue—except if you have a local government award that covers home-care workers. There is the case of the Wyndham City Council. If they are directly employed by Wyndham City Council, they have travel time written into their enterprise agreements. All the local government enterprise agreements have travel time. The New South Wales awards that covered the 4,000 direct home-care workers that were employed by the New South Wales state government had travel time. But our social, community, home care and disability services award does not. It is simply silent on the issue. Home-care workers do not get paid that between visits. Obviously, like all of us, travel to work is on your own time. But from when you arrive at your first client you need to be paid when you then travel to your next client and your next client.

There has been some interesting research in the UK that has provoked a government change on this. An analysis was done which showed that, by not paying travel time, workers were not being paid the very meagre, British national minimum wage. As a result, the British government has now declared that travel time has to be counted in the calculation of the minimum wage—mind you, they have not provided funding to do that. This was also raised as an issue in the New Zealand Human Rights Commission inquiry into aged-care work. As a result of pressure, advocacy, the New Zealand government has now agreed to pay for travel time. They are actually funding aged-care services to cover travel time. To me, it is a practical thing but it is also enormously symbolic. Can you think of any other job where you are required to drive from client to client and you are not paid? I cannot.

Senator POLLEY: Do you think it is a cultural issue for this country that we do not value the contribution that older members of our community make—we lack that respect, so therefore it flows on to those people who are providing the care for them and they do not get the recognition first in remuneration but also, just as importantly, in respect for the job that they are doing?

Prof. Charlesworth: That is partly it. I also think it is because the work of aged care looks awfully like the work that women do for free. It is actually the reason why it is so profoundly undervalued. It is a mix. It is just seen as consistent with women's natural attributes of caring, which does not recognise them. We have been hearing about the skills that are required. It does not recognise the increasing level of skill required in this area and the fine degree of judgement needed. Senator Polley raises the example of the very important role that particularly homecare workers do in terms of monitoring the wellbeing of the clients they visit, and yet that work is not written into the award. The award is totally task based. It distinguishes only between whether or not you are providing domestic services. The moment you provide personal care you are entitled to another slightly higher level, and then you are stuck, by and large. But there is no recognition of the complexity of the work. So, once again, the New South Wales award that I imagine will be defunct now that the workers have been contracted out, has provided for a third level of homecare work which talked about complex care, which recognised that need for judgement making, that need for real skills—interpersonal skills but also physical skills in being able to deal with the different and very distinct needs of the different clients to whom services are provided.

Senator POLLEY: Over the last decade there has been a transition in the way the community has viewed early educators. They used to be seen as babysitters. Once again, work that women naturally do is rearing children so therefore you take your children to a childcare centre and they are going to be babysat. It has taken more than a decade to slowly change the way we perceive those people, who are in fact early childhood educators. My view is

that we have an enormous challenge in changing the cultural view of those people who are caring. Would you like to make any further comment on that?

Prof. Charlesworth: I would agree with you absolutely, and it is very interesting that in this project we are looking at the different policy rationales that sit behind child care and aged care, and it is very clear that what has been very persuasive in terms of the professionalisation, although not yet the remuneration, of childcare workers, or early childhood educators, has been the recognition that we need to invest in our young people. So we take an investment approach. We do not take that with older people. We do not take that approach when people are getting aged. As previous witnesses have raised, it is more a matter of care and support. I would agree that we need to change. I mentioned briefly a very interesting study done by the UK Women's Budget Group, commissioned by the International Trade Union Confederation, which makes an argument for more government investment in what they call the care economy but particularly the kind of investment not only financially but also recognising that towards the end of our lives we would like to be supported in living those lives out with dignity, with autonomy, maximising our potential even in late age. I suppose it is going to require a fundamental cultural shift in the way we view ageing as somewhere we put people when they reach the end of their life as opposed to really developing them. It is a noble ambition but I think we are a long way from there.

Senator POLLEY: In relation to the way we perceive the whole issue of ageing, most female politicians will say that once you are of middle age you become invisible in Parliament House, but there is the concept that we see this as a negative. Instead of seeing the glass half full, it is half empty—this is a cost burden. In fact, it is an economic driver. I do not think most people—certainly in this government—would see the opportunities we have. It is not just about this sector and about providing for care, although there is care there; we need architects, accountants and management. There are a whole range of opportunities there that I do not think the community, let alone the government, understands. Do you have any comments on those views?

Prof. Charlesworth: In my view, government has a role to drive that. When we look at the predictions of the growing occupations, what are they? They are aged care and disability care. Yet, as you say, we are not really focused on that. They are seen as an aside. We worry about the decline of the mining industry or if the construction industry is affected by various downturns, but we do not really look at the potential. I think once again that ITUC study is very interesting. It makes the point that, beyond providing good-quality care, it can have really important economic and employment ramifications. It can then hopefully attract a diverse range of people into the sector who cannot consider it at the moment because they certainly could not afford to work in aged care.

Senator MOORE: Thank you, Professor. I really enjoyed the information from the industrial perspective that you have put through. Some of your work has been in the area of home care workers and disability workers, as well as aged care. I am asking general questions about a concept of having a pool of care workers in Australia. In my mind I have a view, as many of the professions do, that you have a core basic skill and then you go into specialisation. That is what I am thinking about. Is that something that you think would work?

Prof. Charlesworth: As we have got it at the moment—and I tried to make that point, perhaps not explicitly enough, in my submission—there is just a very simple thing: under the relevant award, disability support workers have to be paid two hours minimum engagement when they are casual, and home care workers only one hour. So I hear anecdotally—for example, down at the City of Greater Geelong and around there, which is one of the pilot sites for the NDIS—that there have been real concerns as workers who have been paid as disability workers are moved, essentially, onto home care worker conditions.

Senator MOORE: For lower pay.

Prof. Charlesworth: Not necessarily lower pay.

Senator MOORE: Less conditions.

Prof. Charlesworth: They are poorer conditions. But also, if you talk to disability support workers, they feel very strongly that there is a status issue. They do not have that same history. A lot of disability support workers have come out of an institutional framework, and they will regard—rightly or wrongly—their work as different and more complex, precisely because they are looking at that more development model, that investment model: how do you help someone reach their full potential if they have a disability? There are odd, bizarre things happening because the old HACC scheme also funded respite for families with children with disabilities, and that has now been pulled over into the National Disability Insurance Scheme. So home care workers who were providing those services cannot, unless they now go and get employed by someone else. If they are working at the City of Greater Geelong, there are much better conditions than the conditions offered by the not-for-profits and the for-profits that are working in the area, in terms of hourly wages. So I think that there are some structural issues.

We have done training so poorly and provided support so poorly. Training has been raised as an issue. Quite a few good-practice aged-care providers do not pay their workers for training. Either this has to be done in their own time or they have to come in. It is quite extraordinary. Once again, who else does on-the-job training they have to pay for out of their own time or do in time out of work? This is a common practice across the sector.

In terms of ensuring we have training to develop different types of skills, I think theoretically it is possible. I think we have a long way to go, for cultural reasons and for industrial reasons which are sitting there in the award. Why should disability workers give up their marginally better conditions? As I also pointed out, they are covered by the equal remuneration order. Home care workers are not.

Senator MOORE: Yes, you mentioned that particularly.

Prof. Charlesworth: Increasingly, there is going to be a differential between their wages. So I suppose there are a whole lot of industrial issues. It does not mean that they could not be ironed out in the future. What I always find interesting in talking with aged-care workers is that people who work in home care might have some criticisms about what happens and the way in which work is organised, but they like doing home care work. And residential aged-care workers like doing residential aged care—not least because they can get enough hours. Underemployment is far less a problem in residential aged care. They are incredibly busy and they feel they are overworked, but they need the security—and the relative security—of knowing that they are going to have a regular income, which you do not necessarily have if you are a home care worker.

If you talk to aged-care providers who have both home care workforces and residential aged-care workforces, they say that they are very distinct workforces. It is very hard to think of them being aggregated, even though on the face of it you think in aged care, 'Well, why can't you just substitute a home care worker with a personal care worker, given that a lot of the work they are doing is the same kind of task based work—although it is being done in a very different environment?'

So I think that there are practical problems. It is something worth thinking about, but it cannot just be decreed. As you would probably have heard, or you will hear, in evidence from New South Wales, this is what the New South Wales government is aiming to do—to create this pool.

Senator MOORE: Absolutely.

Prof. Charlesworth: But beyond saying that there will be a pool, nothing has been put in place to make sure that it results in either good-quality care for people with disabilities or older people or, indeed, decent working conditions for the workers who provide it.

Senator MOORE: It would not be one of these inquiries if we did not get onto data.

Prof. Charlesworth: Yes.

CHAIR: We knew you were going to go there! We just knew it!

Senator MOORE: And you have given it a focus in your submission—around the fact that it is very difficult even to make a judgement, because the data on which you have to base it is so diverse.

Prof. Charlesworth: Yes.

Senator MOORE: You have asked particularly about the classifications. At the moment they are all over the place, from what you say.

Prof. Charlesworth: Yes.

Senator MOORE: To get real information about what is happening is difficult. You also talk about working with the Bureau of Statistics on the particular process. Have you had a chance to talk with them at any time, to point out the rationale as to why what they are doing is not providing for the need that we have?

Prof. Charlesworth: Not explicitly. I have made similar comments. The ABS run a gender indicators project. I have raised the issue of the general social care workforce as something that they ought to consider. But as you would be aware, the ABS has been subject to severe government cuts—

Senator MOORE: Yes, massive cuts.

Prof. Charlesworth: which affects getting them to do anything in addition to what they do. Really, I suppose, I am looking at both the industry and occupational classifications, which are done jointly with New Zealand. That really requires some conceptual reframing. I would argue that it is increasingly important to do so.

I will just give you one very tangible example why: I am doing a small project with a colleague in the Law School at Melbourne university, John Howe, looking at enforcement of minimum standards in aged care. The Fair Work Ombudsman has been incredibly helpful; he—she, now—has provided us with data that lists the number of complaints that she has received. The ombudsman can do that for residential aged care, because there is actually

an industry classification that catches residential aged care. But because any home care worker who might make a complaint would end up in this basket of 'other social assistance', we have no idea about them. They are in there with workers from homelessness services, refugee settlement services et cetera.

So they cannot tell us that information, which is a real pity, because the ombudsman's work in monitoring compliance and in encouraging compliance is based pretty much on the complaints that they receive and the kinds of hot spots that might be coming through their inquiry line. It is not always so—they do their own research. Increasingly, I have been trying to interest them in this sector—in being a bit more innovative. But in fact they have done a number of audits in residential aged care, including surprise audits. They worked together with the not-for-profit aged-care employers when the Aged Care Modern Award came out, to have a more detailed annotated version of that, so that was very positive.

It is very hard for them, because they use ABS industry categories, to be able to focus on home care. Home care is going to be the growing area. It is in every other developed country. It is explicit government policy that we are going to slowly put the weight of our formal aged-care system into community-based care. I think data is incredibly important and much underrated.

Senator MOORE: I have one last question. It is in terms of the issue I see that there is an expectation in the government that anyone can be a care worker, and that they will under the Newstart programs we have now, where people are required to go into work and training—which is okay in principle. There seems to me to be a perception that since the growth area of employment, as you have just said, is going to be in care you can change anybody into a care worker. I am just interested, in terms of your experience, about whether you agree with that or whether there should be care taken about making people care workers.

Prof. Charlesworth: I think there are two things that really underlie your question. The first, which I know has been raised already in many submissions, is the quality of the training. I think it is really deficient. You can have excellent-quality training and you can have appalling-quality training.

Senator MOORE: We have both.

Prof. Charlesworth: The number of aged-care providers that say they do not care if someone has cert III from somewhere else and that they have to train them themselves is indicative of that.

The other slightly more complex issue is that I think there is a view out there, along with, 'Anyone can do care work'—and this is something aged-care providers talk about, and it worries me very deeply—is, 'We just need the right person. We actually do not need the skills. Let's not worry about skills; we need to find the right person.' Increasingly, large aged-care providers are employing psychometric testing to find that right person. The problem with that is it undervalues the skills that the person brings. If somebody has got specific interpersonal skills, a high level of responsibility and judgement, it is learnt; it is not innate. I think that we really run the risk of underselling the skills required.

I do know from talking to aged-care providers—particularly one large local government provider here in Melbourne—and talking with both the workers and the section that runs their home care that they have a very diverse, multicultural area, they are wanting to bring in more men and they want to have their home care workforce representing their community. They bring in people through the long-term unemployed programs, but they never last. They never last because they really do not have much choice about going into aged care. They are pretty shocked by the nature of the work and the physicality. One home care worker I was speaking to said that she gets to train these people as they come through and to shadow them initially when they go out. She said, 'The first thing I say to them is that you have to be fit. You can't do this job unless you're fit.' She said that after two or three weeks people younger than her have got back injuries or they are sore and hurting.

I do not think the aged-care sector can have the sole burden of meeting the needs of the long-term unemployed. That does not mean that I do not think that there are not young people out there who would go into this. We have anecdotal information that working holiday-makers are being used in aged care. International students are being used in aged care, maybe or maybe not in excess of their visa terms of working 20 hours a week. I think that there is no doubt that the aged-care sector needs and can cope with a diversity of workers, but they need to be trained and prepared.

Senator MOORE: Consistently in the evidence, as you have seen, it is about the quality of training. You said some of the providers are using particular testing on their workers. Is there any data or evidence of that? That is certainly something I have not heard. It just piqued my interest. If you have got anything, it would be useful.

Prof. Charlesworth: I do not know if it is there in the public domain. A couple of these providers have actually made submissions to your inquiry. They have told me.

Senator MOORE: When we have any providers, it be just a general question to see whether they do that. That is something we have not come across yet.

Prof. Charlesworth: There is this idea that there is the right worker somehow. It is pretty unclear because they have to take responsibility, but they have to be obedient enough and responsive to direction. When you talk to home care workers a lot of them are frustrated particularly with the CDC. They say, 'It is as though it is not what we have been doing all along.' However, we are not given the autonomy to make decisions with clients because we are being managed in a very minute way, so there are real tensions around what we expect workers to have. I think it might be a good idea to ask providers whether the training that they provide is on paid time or not. I think you will find for the lower paid classifications, that in a lot situations, it is not.

CHAIR: I would like to pursue issues around training and particularly focusing on dementia. This committee has done an inquiry into complex behaviours with dementia. We saw some very good models that are pretty resource intensive, but also require people to have an understanding of cognitive behaviour and how to support somebody with dementia without having to use restraints, for example. It seems to me the right person can be great in terms of caring, empathetic and all that, but unless they have that degree of specialist support and training, they are not going to be able to provide the sorts of supports that someone, particularly with complex behaviours, is going to require.

Subsequent to that inquiry, I have had a number of providers contact me and say, 'Can you tell me how we do this?' They did not know where to go to get the support and to implement some of these systems. I am wondering, as care gets more complex, as you were saying, where do we go for that overarching approach to training?

Senator POLLEY: We have the flying squad now.

CHAIR: We have the flying squad, but I am using that as an example. That is just one example. This morning we have been talking about end of life care as well, and if we are expecting people to be trained on their own time, as you have just been talking about, where do we go?

Prof. Charlesworth: I do not think we should be expecting people to be trained on their own time.

CHAIR: I got that completely and I agree, but what should we be recommending as an approach that we could be taking, for example?

Prof. Charlesworth: There are a number of aged care providers who are trialling quite innovative approaches to dementia care.

CHAIR: Yes, and we saw a number of those—some really good programs.

Prof. Charlesworth: But even in terms of work organisations, so I am thinking of two in our Quality Jobs Quality Care Project—and I am not going to name the actual provider or the providers. One, for example, is recognising that care is becoming more complex. So how do you deal with this? They have come up with a system of having a buddy mentor, so that when somebody is assessed, for example, in community based aged care as having complex care needs, that a highly trained care worker—sometimes it might be a nurse but somebody who is quite trained—will go out with them initially and be taught, literally with that person, how to be able to work with that person. This particular provider is actually paying workers above the normal level to be this kind of buddy mentor if they are a carer. An example was given before, of innovative approaches to work organisations where you might actually have a couple of workers go out in situations so then you can have a meaningful discussion, 'How do you meet this particular person's needs?' because once again, with dementia, we assume it is this blanket thing, but it manifests very differently in different individuals. The care has to be designed around that person.

Another provider as part of this project—and this project is about trialling low-cost innovative work practices that increase both job quality and care quality, and the other provider has been testing something specifically around designating some of its home care workers as part of a dementia team. This is to provide consistency of care for one particular site that a large aged-care provider has. It has four or five trained home-care workers who have been specifically trained. I think there are only about 12 clients in this particular group; but, once again, how do you respond to their needs? They have not looked at increasing remuneration at all but certainly in terms of deepening expertise. So that is at the provider level.

At a larger level, one thing—and this is pretty much off the top of my head—is that if we are recognising this as an area then it also needs to be recognised industrially. If we are creating a career path then why can't we have a career path where someone has advanced skills? As I said, under the New South Wales award they have a home-care worker level 3, which is dealing with complex care needs. I think you can continue unpacking the skill level, and that is something I mentioned in my submission. I think that, if we are serious about providing good-

quality employment, we need to have a career that is very much tied to training and the recognition of the skills that are required.

Senator POLLEY: And competencies.

Senator MOORE: In that area, this committee has had the privilege of being involved in a number of really interesting inquiries. One of the ones we did—I think we were all involved—was the palliative care one. When we are talking about this field, particular skills in palliative care are others that should be acknowledged and for which there should be specialist support training as well.

Senator POLLEY: Yes. You have to change the way people perceive people who are living with dementia. You could live within your community while also going through the transition of dementia and how important it is for that community to engage with that individual and their family. There is a lot of work, so I really appreciate your contribution in relation to the structure of home carers and what we need to do there. Thank you.

CHAIR: Thank you very much for your submission and evidence today.

Proceedings suspended from 10:46 to 11:00

BAUER, Dr Michael, Senior Research Fellow, Australian Centre for Evidence Based Aged Care, La Trobe University

FETHERSTONHAUGH, Dr Deirdre Marie Anne, Director, Australian Centre for Evidence Based Aged Care, La Trobe University

RAYNER, Dr Jo-Anne, Senior Research Fellow, Australian Centre for Evidence Based Aged Care, La Trobe University

WHILE, Mrs Christine, Research Fellow, Australian Centre for Evidence Based Aged Care, La Trobe University

WINBOLT, Dr Helen (Margaret), Senior Research Fellow, Australian Centre for Evidence Based Aged Care, La Trobe University

CHAIR: Can I just check with everybody that you have received information on parliamentary privilege and the protection of witnesses and evidence. I am seeing lots of nodding. Fantastic. Your submission was No. 174, so you got yours in early. I invite whoever wants to to make an opening statement—I am presuming that you have got that worked out between yourselves—and then we will ask you some questions.

Dr Fetherstonhaugh: Good morning. I am speaking on behalf of ACEBAC. I am going to make three main points and I have some evidence around what we are talking about. The primary role and commitment of ACEBAC is to improve the quality of care provided to older people, predominantly to those living in aged-care services. We do this by undertaking research, education and quality improvement activities. The five of us here today are also registered nurses and have significant clinical experience.

Our submission and evidence today address criterion e of the inquiry's terms of reference and are based on what we have learnt about the aged-care sector and its workforce through the research we have undertaken, particularly in the last 10 years, and the education programs we have had to develop and deliver to meet the needs of the varied aged-care workforce to ensure that they in turn meet the needs of older people living in residential aged care. These educational programs, in particular, were developed to fill gaps in skills and knowledge and build capacity for aged-care staff to provide evidence based, quality aged care.

The first point I want to make is around the recognition of the health status and the needs of people living in residential aged care. The number of people moving into residential aged care in Australia increased by 25 per cent in the 12 years between 1999 and 2011, with the largest growing group being those over 85 years of age. From data collected using ACFI, which is the Aged Care Funding Instrument, we know that, in 2014, 83 per cent of permanent residents required high-level care. In the same year, one-quarter were appraised as being high in the complex healthcare domain and of which 69 per cent died within one month of admission.

About 53 per cent of all permanent residents in Australian government subsidised aged-care facilities from 2009 to 2010 had a diagnosis of dementia. We know that there are probably more people with dementia that have not been diagnosed. Other common diagnoses of older people in residential aged care include hypertension, heart disease, arthritis, vision problems, diabetes and cancer, and some also have a psycho-affective disorder such as depression. Residents are also likely to have several of these diseases and be on multiple medications.

Apart from the likelihood of multiple comorbidities and frailty, older people living in aged care are exposed to a number of clinical risks, which, if not recognised, can cause significant harm and even untimely death—for example, choking, which can be immediately life threatening, dehydration and unplanned weight loss, just to name a couple. To provide the high level of care these older people with complex needs require the aged-care workforce must be educated, skilled and competent.

The second point I am going to make is around the current aged-care workforce. According to *The aged care workforce: final report 2012*, 26.4 per cent of the aged-care workforce were made up of enrolled and registered nurses, with the majority of the workforce comprising of non-registered staff, namely personal care attendants. In a project called Strengthening Care Outcomes for Residents with Evidence—another acronym called SCORE—that ACEBAC was contracted to undertake for the Victorian Department of Health—I have to say the aged-care branch of the Victorian Department of Health is very proactive—we piloted the implementation of evidence-based care processes as areas of clinical risk for older people in six aged-care facilities; for example, around constipation, choking, depression, delirium. We found that the nurses in these facilities did not have the skills to undertake the comprehensive health assessments that are required to implement evidence-based care. This indicated an enormous skills gap in the current workforce.

Following on from this, again with a Victorian Department of Health funded project, we developed and delivered a four-day education and training program in the comprehensive health assessment of older people. Comprehensive health assessment is the foundation of clinical practice, in that it identifies care needs, actual and potential risks, and informs care planning, decision making, treatment and interventions to meet care needs and manage risk. The safety healthcare outcomes and quality of life for residence within aged-care services are directly related to the quality of information gathered and acted upon through evidence-based comprehensive health assessments.

Fourteen hundred mainly Victorian nurses, both enrolled and registered, have now attended this education program, with the majority stating that they had never previously been taught comprehensive health assessment. To us, this was hardly surprising given that nurses currently working in the aged-care sector tend to be older and, especially for the registered nurses, are likely to have completed their initial nursing training under the hospital-based apprenticeship model. There are also very few opportunities for nurses currently working to upgrade their qualifications and skills with post-graduate courses in aged care or care of older people, and even fewer which prepare specialist practitioners in the care of people with dementia. We would advocate that at a minimum all nurses currently working in Australian aged-care facilities need to be educated and skilled in the comprehensive health assessment of older people.

As I said before, the majority of direct care for older people in aged care is provided by personal care attendants. While there are nationally recognised vocational level courses for PCAs, such as cert III and IV in Individual Support, and as mentioned by other submissions and other presentations today, there can be a great deal of variance in delivery standards between training organisations in the states. Although it is increasingly common for aged-care providers to require nonprofessional care workers to have a qualification such as a cert III or IV, there is there no regulatory impetus for them to do so. Consequently, there are large differences in skills and knowledge between workers.

Given the increasing resident acuity, which I mentioned in the first part of the presentation today, it is actually really essential that aged-care workers—PCAs—are able to recognise and report changes in residents' health to the nurses who have the knowledge and skills to appropriately respond to a change in older person's health status. Again, in response to a gap in knowledge and skills identified through research, ACEBAC has developed and are currently finalising an eight-module, 10-hour educational package for Australian PCAs in the recognition and reporting of changes in residents' health status. We believe that this type of education is essential, especially given the large reliance on nonprofessional aged-care workers to provide care to old, frail people.

We also believe that the aged-care sector requires clear competencies and requirements for both nonprofessional carers and health professionals, particularly nurses, to enable individuals to understand the knowledge and skills required and be able to assess their own practice against these standards and a nationally consistent coordinated approach to education, training and practice improvement.

The last point I want to made today is around the future aged-care nursing workforce. Today, all preregistration preparations of registered nurses takes place in universities and TAFEs. However, the vast majority of curricula does not provide sufficient exposure to aged-care environments or the complex healthcare needs of older people. Few undergraduate curricula provides students with the knowledge and skills necessary to prepare them for practise the aged-care sector.

Of the six universities in Victoria offering an undergraduate Bachelor of Nursing, it appears that only one offers a core unit of study on nursing the older person. Nursing students complain that in the aged-care placement, generally the first placement, they are they are unprepared. They have often never visited an aged-care service, or even know an older person with dementia. They are often unsupported and unsupervised. This is an observation-only placement, and the lack of registered nurses working in aged care means that student nurses are often placed with aged-care workers—PCAs— and exposed to bad practices. We would suggest that the purpose and timing of aged-care placements in undergraduate nursing curricula be reviewed to reflect aged care as a specialist area of practice, which requires specific skills and knowledge so as to better prepare nurses to meet the complex needs of older people.

Senator POLLEY: Thank you for your submission. I know you have been engaged and listening, because you have all been nodding along with a lot of the evidence and, I think, agreeing with a lot that has being given today, let alone within those written submissions.

It is pretty obvious from your submission and from your evidence that you have already given in your opening comments that there needs to be a national standard of training. Yes, it is hard to believe that out of six universities, there is only one that gives any insight into what is a growth area in terms of medical care, for allied

health professionals as well as nursing et cetera. How do we go about doing that? How difficult is it going to be to get universities to change the way that they train our health professionals of the future?

Dr Rayner: Nursing curricula are governed by the Australian Nursing and Midwifery Accreditation Council, so there are certain core criteria that have to be taught in undergraduate Bachelors of Nursing. I cannot speak for the TAFE sector because I do not know that sector. There are certainly some areas that are mandated. So student nurses have to do 800 hours of clinical practice. Most recently, there has been a change in that there is a mandated core subject on Indigenous health care, which is very important. There is no mandate around the care of older people. Because there is a lot of work to jam into three years for student nurses, and they have to get 800 hours as well. So often the argument is that they embed the care of older people in other subjects around, especially, chronic health conditions and things like that.

I think a good step would be to actually making sure that this is a nationally important—actually, a globally important—area of study for student nurses and all health practitioners is that certainly ANMAC should be lobbied, or whatever the process is. I would like a core subject. Often there are postgraduate subjects offered. Certainly, at our own university there is an elective that Mark is developing. As you alluded to previously, aged care is not a high priority generally in the community and it is certainly not in nursing curricula.

Senator POLLEY: For instance, the University of Tasmania with the Wicking Dementia Research and Education Centre have an online course around dementia now. It is amazing the number of people that are engaging from around the globe. This is not something that is unique to us, but it is something, obviously, that we need to actually give a lot more direction to. That is where comes back to, from my point of view, that the federal government has to show leadership on this. There is no other way because we cannot leave it to the sector, and obviously, we cannot leave it to the training institutions.

I was concerned with your comments about the lack of a high degree of competency and training that is available to us. Do we need to have a standardised national approach to this? Do you agree that there needs to be registration of all those working in the sector?

Dr Winbolt: I would say, yes.

Dr Bauer: I would agree with that.

Senator POLLEY: In terms of the comments being made in relation to the training of those who are not professionals, that that has to be undertaken in their own time, that is obviously a disincentive for those people who are already lowly paid. We have had evidence about the need to employ the right people. Have you got any further evidence to give on the comments from witnesses previously?

Dr Bauer: Certainly skills and education for care workers is vitally important. There is also some evidence about how care staff interact with residents has some bearing on quality of care, quality of life-care outcomes. There needs to be an attribute I guess—that residents are treated with empathy and humanely. It has been shown that when staff interact with residents and show those attributes a resident's mood improves, functional dependence is delayed and food intake increases. So whilst core skills, education and knowledge around how to care for people is important, I think there is also the need for other qualities apart from those more bed and body work tasks I guess, if you want to call it that.

Senator POLLEY: We have had evidence today and I was able to ask a further question. We know that there are enormous issues in attracting people to work in the aged-care sector. Let us look at somewhere like Melbourne. It is a little bit easier in the major cities but in rural and regional Australia it is magnified when you are talking about, firstly, attracting people and, secondly, the age of the workforce. Do you have any comments in relation to your experience around regional Australia and the effects this is having on their communities?

Dr Fetherstonhaugh: We have found there is continuity. I suppose that is because there are not as many options for employment. Whether that is a good thing or a bad thing I do not know. We have done quite a bit of research in rural and regional Victoria and we actually find that the staff attrition rate is often not as high in those sorts of places. Also in those communities they often know the people who have moved into residential care. They may have been their Scout leader, their Brownie leader or the local pharmacist. So there are some different issues around all of that.

Dr Bauer: I think we need to see aged care as a viable career option and destigmatise some of the views that exist around aged care and the value that is associated with it. I think that starts with dealing with ageism that is quite endemic within society and the sort of stereotyping that also exists. I think that has to start at the community level. I think it probably needs to start at a very young age in fact and be dealt with in primary and secondary schools—to value older people and to see working with older people as a career option. There needs to be a

pathway for people. I think one of the earlier speakers mentioned that at the moment if you enter aged care then 40 years later you will still be in the same role.

Senator POLLEY: Absolutely. I did it in reverse in terms of discrimination. I spoke at a conference in Brisbane a few weeks ago. At the break I went to a cohort of younger women—they would have been under 35—and asked them, 'Why are you working in this sector?' Some of them had trained in nursing, had left the sector to work in acute care—they had been there while they were studying—but decided to come back because they liked the holistic approach to caring. I think it comes down to the comments. It is about your experience with training. If you go into a residential care facility and you get a good experience with support then you are more likely to stay. I am wondering if you want to add anything further around that issue.

Dr Rayner: Certainly there is evidence around that shows that student nurses do not have ageist attitudes or more than you would generally expect from the community before they start their training. It is often once they have finished their education. Generally the research I have read says it is related to their clinical experience, as Deirdre noted, which is often unsupervised. A lot of them have never been into a residential aged-care facility or know someone with dementia. It can be very frightening for someone just out of school with no-one to go to and no registered nurse as a mentor. Some nursing students have terrific experiences with personal-care workers who are very caring and good at their job. They are good mentors, but they are not meant to mentor student nurses. I think that is an area that really needs to be addressed. Some of those attitudes towards not working in aged care are a direct result of student nurses' experiences.

Senator POLLEY: This may be a little bit out of your area of expertise, but I think it is very important and it has been raised in other submissions. How do we embrace and train up our volunteers, who are able to substitute, given the lack of workers and lack of time? I spent some time working in an aged-care facility as a senator a couple of years ago now. In terms of getting a resident out of bed, you have to know their routine. One gentleman would not get up unless you put his slippers on first. If you did not that, he would not get out of bed. It is about time, but volunteers play an integral role in most residential aged-care facilities. Does anyone have any comments in relation to how you would train them?

Dr Fetherstonhaugh: I would say that they should have more of a role. I am also a bit familiar with palliative care, and the use of volunteers in palliative care services is, to me, a much more fostered thing. But I think that, yes, there is room for more volunteers to work there.

Dr Winbolt: I am aware of a couple of health services with subacute wards in Victoria that have run programs training volunteers around the care of people with dementia and spending time with people with dementia, so there are programs happening out there.

Senator POLLEY: I will hand over to someone else and come back if I have some time.

Senator MOORE: You heard the questions and the kind of areas I go into, so tell me: how does ACEBAC survive?

Dr Fetherstonhaugh: We have been lucky, I think. As I mentioned before, we do quite a bit of work for the Victorian department of health. The aged-care branch there is very committed to improving care for older people. We have done a lot of work and we have won a lot of competitive tenders around that. But the piece of the funding pie is shrinking. I think when dementia became a national research priority—

Dr Winbolt: We host the Victoria and Tasmania Dementia Training Study Centre. That is funded by the Commonwealth Department of Health.

Senator MOORE: So that is a solid contract into the future?

Dr Winbolt: Until 30 September this year.

Senator MOORE: That is great—

Dr Winbolt: The Department of Health has gone to market and talked a lot about career pathways. The new program will be a national training program, with one provider taking people right through from pre-accredited vocational level. So it is about a pathway. That is how I see the approach to market for the new program.

Dr Bauer: Just to pick up on Deirdre's point: if it were not for the core funding that we receive from the Victorian department of health and human services, we probably would not exist.

Dr Fetherstonhaugh: We are also a partner in the Dementia Collaborative Research Centres Carers and Consumer, which we have done a lot of work for in the last eight years. But that too is about to morph into something else, and we do not know how that will pan out for us. But, yes, as Yvonne—Professor Wells—said previously about the pieces of money, and given that it is a growing area—

Senator MOORE: It is one of the things that a number of submissions go to. There needs to be research in this area, and there is a concern that the research funding does not seem to be flowing in the area. We need to have that on record.

Dr Rayner: It is not that we do not apply. We apply for just about everything that is going. We often put in for multiple, different areas because we all have different areas of interest and expertise. But it is just so difficult. As other people have said, it is just impossible—

Senator MOORE: And there are fewer contracts—

Dr Rayner: especially with the sort of research that we do. If we were doing genetic research into dementia, we might have a little bit more—

Dr Bauer: There are more and more people applying for a smaller slice of the pie.

Dr Fetherstonhaugh: In the field of dementia the funding seems to be more about looking for a cure rather than the fact that we have lots of people who have dementia. It is really important that they have the best quality care and support. Obviously a cure would be fabulous, but we have this group of people with dementia now.

Senator MOORE: And we are learning that there are ways—I think as Senator Polley said earlier about working with people and dementia—that people can have a life. I think in the past we have just closed them away or left it to families. It has been a traditional area. You have a great focus on nursing. Is that right?

Dr Fetherstonhaugh: It is the implementation of evidence based practice because that is the name of our centre. For the most part it has been within the nursing workforce. We have now developed this education for PCAs and we will see what happens with that.

Senator MOORE: All the data shows that that is the growth area in the field. We saw from the last data collection that there are more and more PCAs. In your submission you say:

...perusal of the Quality of Care Principles 1997—

Which does seem to be a while back—1997 was a good year.

documentation does not reveal what an appropriate level of skill and knowledge should be for the personal care worker ...

And you go on to list the actual skills for appropriate care. Can you elaborate a bit on that important point, that the principles talk about behaviours, and about workplace health and safety as you have listed in this submission. You made the point that there does not seem to be anything quantified around what an appropriate level of skill and knowledge should be.

Mrs While: I was feeling quite passionate about that.

Senator MOORE: Good. You never know when you ask a question whether or not you are tapping a button.

Mrs While: Again, it comes back to the fact that what we are seeing from the vocational education and training sector are high variants in the quality that people are coming with. I am seeing from research we are doing with people in the sector that a lot of the focus on training is around the mandatory elements of what staff need to know such as work health and safety, diversity—all wonderful—but we are also hearing that dementia care and palliative end of life care are high ticket items, and they are where some of the soft skills of what we need to learn in just caring for another human being come in. A lot of that learning is actually done in the workplace.

I think the problem is that while we are not specifically specifying what level of competency, skills and knowledge are in those areas then they are being overlooked or not funded or not addressed at the care level by the organisation. Some of those issues come back to resourcing. We are hearing about staff, particularly care workers, not having time, not being released from work, having to do training in their own time. Registered nurses are generally knowledge brokers; they are the ones that will take the evidence based practice and then teach their care workers how to put into practice with the resident and they do not have time—there is not enough of them; there is not enough time.

It would be good to see a breakdown of what we expect perhaps in line with a framework of practice, a scope of practice—I do not know—but certainly a better unpicking of those competencies and skills that we need to see, that are not just those lifting and mandatory skills.

Senator MOORE: Do you mean some control documentation so that you can tick the box?

Mrs While: Yes, that is right.

Senator MOORE: So you need to widen that base.

Mrs While: Often that only happens once a year. So if you have got a staff base that are quite transient, in some areas there is a lot of staff turnover. In some areas you have got a higher than average number of staff with

English as a second language so they need to have their learning and training adapted to help support them to learn. A lot of the staff we see from the evidence are part-time and we see a high use of agency staff, where the organisation is not responsible for their training because they are coming from somewhere else.

Senator MOORE: When people are churning through, it breaks down the relationship element too.

Mrs While: Absolutely.

Dr Fetherstonhaugh: But we also find in the not-for-profit and private sectors that there is not much of a handover between the morning and afternoon shift. If you are in the acute sector or the public sector, there is a period of time during which—if you were to provide education—there is a double up of staff but in parts of the sector there is hardly any time at all for that.

Senator MOORE: So that is not built into the way that they operate?

Dr Fetherstonhaugh: No.

Senator MOORE: I have just one last question, Chair. Can anyone be a care worker? As it has been clearly acknowledged that care is going to be one of the growing employment areas across country—no-one denies that, and it is a good thing—I am concerned about the current way that our social welfare process operates. People are being streamed into areas of need. I am just wanting to get some kind of feel from people who know the industry about whether people can be automatically streamed into being a care worker, and to get your view about that. I do not know if *Hansard* got that communal shaking of heads! I want to get something on record because when we have an area where there are jobs—and there are jobs—and we have people without jobs, there is a bit of a tendency to say, 'Well, we'll just transfer that number of people into that number of vacancies.' I have a personal view about it, which is one thing. I am just wanting to see whether people in the industry and who know the industry have any views about that kind of temptation.

Dr Winbolt: Can I respond to that bee in my bonnet? I think we are all, as you say, shaking our heads. We have talked about the attributes, and employers are now moving to, 'Give us the attributes and we'll teach the skills.' Others see it the other way around. But they are equally important. I would desperately say 'no'. People need the right attributes, personality traits—whatever you call them—combined with a higher level of knowledge and skills. The bee in my bonnet is: age care is seen as basic care. This is why the nursing students get sent to aged care as a first placement. It is seen as washing, dressing and 'feeding'. And I use that word in inverted commas. You may be meeting basic needs in many instances, such as washing, dressing, nutrition, but the skills required and the knowledge required to do that—and Deirdre talked about choking; so to be able to do swallowing assessments while you are helping someone with their meal—are there. And they need to be there. So you may be meeting basic needs, but it is a skill set. In particular in my area of dementia. To get someone with dementia to take their tablets, the skill! And it may be communication skills rather than technical skills, but you need to have those skills.

Senator MOORE: This is why I was talking about that kind of thing which is not listed. How do you list that? Anyone else?

Dr Rayner: I think the other thing is: certainly, when we were doing the research to prepare the education package that we have developed for personal care workers, we around regional and metropolitan Victoria talking to personal care workers, nurses and managers about what they thought the areas were that they needed. We certainly found that personal care workers were very hungry for more education. In some instances, they were doing it. But we also found a large group of personal care workers who were there because they had to have a job. They were studying something else or they did not plan to stay there. They clearly did not enjoy it. So that has huge ramifications for the people that they are caring for. I am not saying that these people did not give the best care that they could. Some of them could not even speak English. How do you communicate with someone with dementia if you have a very poor grasp of English yourself? On the flip side, I remember interviewing a man who worked in finance in another country, and he was actually blossoming. He loved it.

Senator MOORE: There are good stories.

Dr Rayner: So there are some good stories, but I think that when people are pushed into an area they do not want to be in there are consequences.

Dr Fetherstonhaugh: I think it is also about having a passion. We have worked with a lot of aged care facilities. You can actually sense it when you go in about people who are passionate about what they do. I think someone mentioned—I think it was you, Senator Polley—about the glass half full rather than the glass half empty. In the media, we only ever see things that are really, really negative about aged care. Why aren't we pushing the really positive stories, either from residents, their family carers or the staff who work in these facilities, about what is fabulous about working there, rather than always seeing the negative?

Senator MOORE: A crisis.

Dr Fetherstonhaugh: Yes.

Senator POLLEY: How many—

CHAIR: Hang on. We are way over time. You can put someone on notice if—

Senator POLLEY: I was just going to make the point very briefly: how often do we see an aged care carer, or someone working in that sector, acknowledged by either their local government or state with any honours list?

Dr Fetherstonhaugh: No.

CHAIR: We will leave that there. Thank you very much for your time today and for your submissions. It is very much appreciated.

STIRLING, Dr Christine Mary, Vice President, Board, Australian Association of Gerontology

WENCK, Dr Beres, Chair, Expert Committee, General Practice Advocacy and Funding, Royal Australian College of General Practitioners

[11:36]

Evidence from Dr Wenck was taken via teleconference—

CHAIR: Good morning. Have both of you received information on parliamentary privilege and the protection of witnesses and evidence?

Dr Wenck: Yes, I have.

Dr Stirling: I do not think I did. I am not sure. I have been travelling. That is fine.

CHAIR: Okay. Thank you. We have both your submissions; thank you very much. I would like to invite you both to make an opening statement, and then we will ask you some questions. Dr Wenck, we will go with you first.

Dr Wenck: Thank you for providing the Royal Australian College of GPs with the opportunity to speak to the committee. The RACGP is Australia's largest professional general practice organisation and represents over 30,000 members working in or towards a career in general practice. The college is responsible for defining the nature of the discipline, the scope of the profession, and we set the standards and curriculum for quality general practice education and training. We also maintain the standards for quality clinical practice and support GPs in their pursuit of excellence in patient care and community service.

GPs play a central role in disease prevention and treatment, chronic disease management, palliative and end-of-life care, and mental health treatment. As the primary providers of medical care to older people living in the community and those in residential aged-care facilities, we are a key part of the aged-care workforce. There are not enough GPs providing care in residential aged-care facilities, and I am sympathetic to those providers who report difficulty in attracting and retaining GPs to provide care to their residents. However, there are a number of longstanding barriers to the delivery of GP services in residential aged-care facilities and in the community. The table we provided in our submission summarises the issues GPs face when providing care in residential aged-care facilities. Similar issues affect GPs who undertake home visits. While it is not the only issue, the volume of unremunerated work GPs do for their patients in residential aged care is hugely significant and a large disincentive to providing this crucial care.

The GP workforce in aged care is itself ageing. Younger GPs tend not to take up aged-care work due to the issues we have identified and their limited exposure to providing care in those settings during their training. The health issues faced by residential aged-care patients are different to those that GPs deal within the community. Patients in residential aged care tend to be more complex than those seen in the community, and skills in palliative and end-of-life care are important for ensuring good outcomes for these patients. As successive governments look to keeping older people living in the community for longer, the role GPs play in achieving this will become increasingly more important. Our role in the workforce needs to be recognised, and the barriers to our widespread participation should be addressed.

Lastly, our members tell us they are concerned about the lack of qualified nursing staff in residential aged-care facilities and the effect this is having on the delivery of high-quality care for older patients. For some GPs, this is the main barrier to them taking on this type of work. However, I am hopeful that this inquiry will raise awareness about the issues facing Australia's aged-care sector workforce and will lead to significant reforms, where GPs, the cornerstone of an efficient primary healthcare system, are better supported to be able to provide essential healthcare services to Australia's most vulnerable patients. Thanks again for the opportunity to speak to the committee. I am happy to answer your questions.

CHAIR: Thank you. Dr Stirling?

Dr Stirling: The Australian Association of Gerontology is Australia's peak national body linking professionals across the multidisciplinary fields of ageing. It has been established since 1964. We connect professionals with an interest in gerontology to help them collaborate and exchange information on ageing. Our goals are to expand knowledge of ageing in order to improve the experience of ageing. So we have a very broad focus on ageing. We are not really representing a siloed group. We have over 1,000 members across every state and territory in Australia. Our members include geriatricians, academics, researchers, nurses, policymakers, allied health professionals, social workers, consultants and other gerontology specialists.

The multidisciplinary nature of our association is one of our key strengths. In our submission, which I will not read out—obviously you have that—we focused on some key areas that we felt may not be represented by other

groups. Firstly, we endorsed the National Aged Care Alliance submission, the NACA submission. We are a member of NACA and a sponsor. They called for an integrated approach to workforce planning and remuneration across all of the sectors, including health, aged care and disability, to prevent competition in the sectors and make a nice, equitable field, I guess.

We ourselves put forward that we felt that, while most of the submissions to the inquiry seem to be focused on the paid aged-care workforce, we wanted to recognise the significant work of the unpaid aged-care workforce, and that can be carers and volunteers. We were really promoting the need to consider the contribution that unpaid carers and volunteers make and recommend adequate funding to implement the Productivity Commission's recommendations.

One of the reasons I have been asked to represent here is given my background in research in volunteer matters. I think it is really important that we recognise that volunteers do form part of a tiered type of workforce and they are delivering a large number of hours. I know that reports going back to 2009, with the Access Economics reports that Alzheimer's Australia commissioned, really highlight that we are going to be going into a shortage of millions of hours of volunteer time in the aged-care sector. Like the paid workforce, we are facing a significant shortfall in carers and volunteers in the sector.

Our third point was around continuing professional development and training for aged-care workers—a more multidisciplinary framework and people being able to have access to that type of support. We ourselves provide things like webinars. We are really looking at knowledge translation with our conferences. You need venues and avenues for multidisciplinary focus on ageing that is not really around illness. We have very much a focus on a wellness model and positive ageing. We suggest that you consider the contributions that peak bodies and professional associations make to the education, training and skills development of aged-care workers, and recommend adequate funding to support them.

Our final key point was to really look at those special interest groups and their needs. We mentioned the ATSI—Aboriginal and Torres Strait Islander—groups, CALD groups and LGBTI people. We have special interest groups that promote their interests. Our recommendation was around considering the additional time and resources required to create that culturally competent, culturally safe place for those groups, to cater for the different care needs and to get the aged-care workforce to be competent in that space. They need avenues for their collective voices as well. Those special interest groups do need to have access to a collective voice, otherwise they really are lost in the system. Those are the main points of our submission that we would like to make today. Thank you for the opportunity to talk to you.

Senator POLLEY: If I can turn to issues around GPs, it is obviously acknowledged by the committee that GPs are an important key element of caring for older people, whether it is while they are still residing in their own homes or in residential care. Is the issue for GPs, and for the younger GPs that are coming into practice, that they do not get enough exposure to residential care through their training? Is that partly the reason why they do not take on responsibility for visiting aged-care facilities, or is it purely based on a monetary factor?

Dr Wenck: I think it is the first one that you mentioned—that is, they have very little access to residential care during their training, because a lot of training is hospital based. Most interns spend a maximum of eight weeks in a GP practice, some a bit more, and if they are not in a GP practice where residential care patients are looked after, then they would have no exposure during that time.

The remuneration is also a huge issue. I have probably spent the last 15 years trying to do something about the remuneration for GPs in residential care. Just about all of our patients are—we have a large number who have dementia or serious chronic problems. A lot of the patients I look after and other GPs look after in residential care are palliative.

One of the reasons that younger doctors do not see residential care patients is that the actual clinical care needed is quite substantial for palliative end-of-life patients. They may have serious neurological problems, often Parkinson's. There are often multiple complex problems. You really need to be a highly trained and experienced GP to be working in aged care, or have access to a GP that does. Of course, the remuneration issue is there as well, because the amounts for rebates have only changed a little bit. One of the biggest problems is the law of diminishing return, where MBS rebates diminish for each patient seen when consulting in an aged-care facility. That does not occur for consultations within GP consultation rooms or for any other specialty. It is only for GP visits to residential aged care facilities. The remuneration issues plus the complexity of care needed means it is much easier for a GP to sit in their consultation room, see patients and be remunerated more highly.

One of the other big problems is the unpaid work. Both the college and the AMA have done estimates, and about 50 per cent of work that GPs do for residential aged care is unfunded. I have daily phone calls, faxes and

emails from residential care. If I put a patient on a medication by phone I have to be at the facility within 24 hours to sign off on that phone prescription. There are a lot of barriers to GPs looking after patients in residential aged care.

Senator POLLEY: Could you elaborate a bit further in relation to your recommendations around rural GPs and how we should be engaging them in caring for older people in residential care? What are some of the barriers that are in place, particularly in rural and regional areas, that we need to overcome?

Dr Wenck: The first barrier is of course the lack of GP numbers and their high workload. One of our reports shows that rural GPs tend to see most of their patients in their consulting rooms rather than home visits or, for those in residential care, in settings where a relative can bring them into the GP's consultation rooms. It is probably the lack of numbers in the rural areas—the lack of numbers of GPs significantly adds to the problem.

Senator POLLEY: Have you got anything to contribute from the observations of your organisation of those who are currently working, particularly those in residential facilities but also those who are undertaking support for people who are still living in their home, in terms of their skill levels and the professional training that is available to those workers?

Dr Wenck: To workers in, for example, residential care?

Senator POLLEY: Yes.

Dr Wenck: That is one of the huge problems—the number of workers in aged care, especially with nursing staff. The Productivity Commission report showed the disparity in particular—this is going back to remuneration issues but it is important—between nurses working in hospitals, who are paid the highest, then nurses working in general practice, and then the lowest rung on the ladder, who are nurses working in residential care. So you do not really have nurses working in residential care unless they have a love for looking after complex, elderly patients who require a lot of care. Another big problem is, because of the lack of staff, agency nurses who come in and do not feel that they have a great responsibility to the patients they are looking after. Then of course you have the 457 visas. The residential care place I go to has an enormous number of 457 visa nurses and personal care workers for whom English is their second language, and that actually contributes to a lot of the difficulties I have in looking after patients. Education wise, the College of GPs provides quite a bit of education for its potential trainees, and GPs can have access to training. I am not sure I can speak for the nursing profession or for the personal care workers.

Senator POLLEY: Dr Stirling, do you want to make any comments on the issues?

Dr Stirling: I do not have a lot of experience in the aged-care sector. I have been involved in a research project introducing improvements in the palliative approach to dementia in aged-care facilities. That did give me some insight. I heard the previous people discussing the thirst for continuing professional development in that space. The PCAs are really looking for that sort of development, and the nurses as well. Also, yes, there is variety among the nursing staff and PCAs in that some people are very engaged and love working with older people, and some people—which you get in every industry—are just there for a job. You really do need systems that provide protections. Whether everybody has to be registered I am not quite sure but you really do need oversight mechanisms, because older people can be quite vulnerable. I do think there are issues there. Further to the skills base of some of the registered nurses at the moment, it is very much that some of the people who are self-directed in that space and quite motivated can be well skilled but other people can just be going along with a skill set that is 20 years old. So I think there really is a need to make sure there is a continuing professional development framework in that sector and that group.

Senator POLLEY: I will ask both of you and if you could each make a contribution. We spoke with previous witnesses about the need to change the culture of how we see ageing in this country and about our attitude towards getting older. We all recognise that there is a crisis when it comes to encouraging more people to come and work in this sector. What should the federal government's role be? What would the federal government's responsibility entail in not only changing the mindset of Australians towards older Australians but also ensuring that this sector is seen as an economic boost for the economy rather than a drain on society?

Dr Stirling: I think there is a big role there for the industry sector to market positive ageing. People do have a negative view of that work environment, but people who are working in it can feel quite passionate about it. So there is actually a marketing role there. But in terms of what the federal government can do, we need to be careful to avoid the illness focus ourselves in terms of policy directions and really use a strengths-based model around wellness, even though clearly people are getting older, and highlight the trajectory to death as a normal trajectory for all of us—we are all on that road—and make quality of life a prime factor on the journey.

Dr Wenck: A report by the Institute of Health and Welfare showed that 40 per cent of people in residential care are really complex and chronic. I know residential care places do a lot to try to encourage wellness and participation in events within the facility. As I said, I have spent 10 or 15 years trying to give suggestions for ways that we can get better care and GP involvement in residential care, but they have virtually gone unheeded. This group is not recognised. They are recognised more as a burden on the community and the taxpayer.

One of the great difficulties I have as a doctor attending is the demands of the patient's relatives. I will often say, 'I think one of the best you things you can do is see your local member and actually describe some of your concerns with the care of your relatives.' A lot of relatives demand the world with regard to the care of the patients, but they do not realise how difficult it is for all the workers in residential care to be able to provide this care.

Dr Stirling: I think there is some very inspiring work happening in the industry sector. I do not know if you have come across some work, say, that Colin McDonnell is generating on the Central Coast. It is really inspiring; taking people out of a secure dementia facility to a childcare creche once a fortnight. They have made a video of that and evaluated it. It is so inspiring. That is the kind of work that is happening in pockets, but that could really reframe the ageing experience in an aged-care facility. I do think that positive approach to ageing is needed, even though people are complex. I agree with you, Dr Wenck, that there still is capacity for people to be having quality of life even as they deteriorate towards death. There are some pockets of excellence that have been happening in the industry.

Dr Wenck: They have certainly done that in Canada too where a residential aged-care facility and a childcare centre are geographically together. One of the great things with wellness in older patients is seeing the delight on their faces if a little dog is brought into the facility. With one of my palliative care patients, one of the personal care workers had a little dog and, if the little dog came in, her day was much happier. Dogs can be very simple things that can improve the life of people in residential aged care.

Senator MOORE: Dr Wenck, thank you for your submission. My first question is about the detailed survey that you attached to your submission from the RACGP. Were you happy with getting 450 responses?

Dr Wenck: For our survey?

Senator MOORE: Yes. I read it, and it was a detailed survey that you were asking people to do. I think at the beginning it said that you sent out 8,261 and you got 450 back.

Dr Wenck: No, we were not happy with the response. It is more a time factor for GPs who are working in community and going to residential care. I remember trying to fill it out and I even forgot to put in the fact that it sometimes took me 45 minutes to travel in traffic to the residential aged care. I rang quite a few GPs—just blindly, people I knew—to say, 'Could you fill out the survey?' and I heard, 'I've given up; I'm not doing that work anymore. It is too hard.' For all the reasons I have been talking about today, a huge number of GPs have stopped doing the work. So, no, we are not happy with the response, but at least it showed some of the issues.

Senator MOORE: Are you confident that the data that you got from 450 genuinely reflects the issues?

Dr Wenck: Very confident.

Senator MOORE: That was what I wanted to know. I understand that it is complex and you talked about time. But, for people reading the evidence, I just wanted to have that on the record.

Dr Wenck: I am very confident of the result we got from the survey.

Senator MOORE: In your submission you talk about the inability to get information on Medicare rebate claims for the more complex work of GPs undertaking in residential aged-care facilities. Can you explain to us the difficulty in doing that? It is a particular point when making an assessment of the whole process and what is going in residential aged care. You made the point that you cannot get data from the Medicare process. What is the problem?

Dr Wenck: If I remember correctly, I think that was referring to getting data on the number of comprehensive medical assessments that are done or some of the other item numbers that can be utilised other than consultation item numbers.

Senator MOORE: So you cannot—

Dr Wenck: We can get information on the consultation item numbers. It is the other item numbers that we have difficulty getting information on.

Senator MOORE: So they are there and you cannot get the numbers? I just want to know whether the Medicare items are there and you cannot get the information, or whether the Medicare items do not reflect the work effectively. What is the problem?

Dr Wenck: The Medicare items are there, but we cannot get the information on how many are done. That was the inference from that.

Senator MOORE: Has the department told you why you could not get that data?

Dr Wenck: I cannot answer that. I can take that question on notice. I would have to find out that information.

Senator MOORE: We will follow up as well. It just seems that you should be able to look at what Medicare is doing. They will probably say that there are too few and some reason and you would be able to work out who it is, but we should at least find that out.

We did an inquiry many years ago—and I forget which one it was—and one of the major reasons that doctors said that they had difficulty providing services in residential aged-care facilities is that they did not have a room to do their consultations. That point has been put in your submission.

Dr Wenck: That point still exists.

Senator MOORE: It seems to me to be the most remarkably ridiculous barrier. What is the problem? Is it that they will not provide you with a room or is it that they do not have the right equipment?

Dr Wenck: All of the above.

Senator MOORE: It is so frustrating.

Dr Wenck: They do not have a dedicated room. They do not have the right equipment. It is almost impossible to do some examinations in a patient's room—you need a bed that can be adjusted; a height-adjustable bed. And a lot of the patients' mobility is such that they are full-hoist, and in chairs as well. It would be much easier if you had a room for the examination of the patients who are less complex. But for some patients, even providing a room would not really assist the GP. For instance, I am often asked—someone might need their ears syringed. It is a great difficulty to do that in residential care. It is a great difficulty, if someone has a laceration, to do any suturing. All those sorts of things that are easy to do in a consulting room are not easy to do in residential care.

CHAIR: As Senator Moore said, I am pretty certain that that was the inquiry that Senator Polley chaired all those years ago. Some of the issues that you have raised today are not new, are they? They are issues that you have been trying to address for a while.

Dr Wenck: They are not new. I was President of AMA Queensland in 2000. I did coordinated care trials. I was the medical director of two large coordinated care trials. The second one showed that we actually reduced hospital admissions by 30 per cent. We have government saying that, 'isn't that wonderful,' but they still will not put any extra funding into general practice to be able to do the coordination of the care that you need for a very complex person. It often takes lots of time in general practice—this is more for people in the community—ringing up, talking to residents and registrars in hospitals, and getting information back from someone who has been in hospitals and in private hospitals. There is a lot the federal government could do to assist in the better care of aged people in the community and in residential care, but they do not want to spend the money.

CHAIR: Yes. That is the bottom line.

Dr Wenck: That is the bottom line.

Senator MOORE: We have got that point, Doctor, in the submission. It will probably be yet another recommendation, but we have picked up on it.

Dr Wenck: And you did say, you remember that from old things. As I said, I have been harping on about these things for 15 years. I spoke to a Senate inquiry in 2013, I think, and nothing came of that. So I will be very hopeful if something comes of this one at this point in time—very hopeful.

Senator MOORE: I have had the same discussion with Dr Kidd at regular times in Queensland on exactly the same issues. We understand and we will try. Dr Stirling, from those same inquiries, I remember that there are very few gerontologists in Australia. People have raised with us that encouraging people into the specialty is a difficulty as well. What are your numbers at the moment? I am happy to take that on notice.

Dr Stirling: Yes; we will take that on notice. But I would say—with my other hat on—in the nursing discipline where we have a postgraduate program, there is a building interest, but it is still not comparable to the acute care interest, for nurses to do follow-on study around aged care—gerontology. But I think there is a lot of scope there for improving that and getting that type of education out there.

Senator MOORE: In my experience in Queensland—and it could touch on Senator Polley's experience in Tasmania—in regional centres, the visits of the gerontologist are not enough, and they are booked out before people can blink. It seems to be the major way that the service is provided in regional areas, by the regular visitation schedule. It is probably the one that is booked out most quickly. Is that the experience you have had?

Dr Stirling: Yes. Another project that I had was one of the aged-care nurse practitioner projects that were piloted in Australia. Have you heard much—

CHAIR: Yes; we are aware of those.

Dr Stirling: In Tasmania one of those went on to have a really good model of the nurse practitioner having particular mental health expertise—psychogeriatric experience—and being able to go out to those rural centres and have some really significant impacts on people who you might call frequent flyers, or those with chronic complaints that have never really been addressed, partly because of the types of need for phoning and sorting that could never really be got to the bottom of. Having someone with that capacity turned into a really good model. It has extended to three other regional sites as well. So in that model with nurse practitioners we should not forget that that extra level of expertise could be really beneficial in this space, even though obviously, a bit like funding for the GPs, that trial did not adequately fund—with the Medicare items it was not a living wage. That was the weakness in that trial, largely.

Senator MOORE: So after the trial ends there is nothing beyond it. We hear that a lot. You have pilots and then at the end of the pilot nothing happens. Thank you very much for the carers information. Unpaid carers is something that we all understand. You did mention that you had another research hat: volunteers. We have not got time to go into that much but we are very interested in the issue of volunteers, so if there is any information that you would like to give us on notice—particularly that information. I just picked up, when you gave your evidence, that you mentioned that that is another area. If we could get something on notice from you about the importance of volunteers, what they do—any of the work you have done—the committee would appreciate that.

Dr Stirling: We will do that.

Senator MOORE: Thank you very much.

CHAIR: I just have one question before we wrap up. It follows up on an issue that Senator Moore raised about nurses going on to work in the gerontology area. The beauty of being on the same committee for a long time is that you build up a certain level of knowledge through the various inquiries that we have done.

Senator MOORE: There are not always results, Dr Wenck, but we do get knowledge.

CHAIR: People were talking about the issue of some of the barriers to subsequent study. I particularly remember a nurse talking about that area. Is the cost of further training still an issue?

Dr Stirling: Not with our particular program, because we offer scholarships and it has very flexible online delivery. We have really good access in that way. I think it is still about the recognition of that space. There is a growing positive feeling around it but it is in small pockets. I guess that that demonstrates the potential for a positive gerontological focus for nurses and most other aged care professionals.

CHAIR: Thank you, Dr Stirling and Dr Wenck. I know it is particularly hard to sit at the end of the phone answering questions and giving evidence. Thank you very much.

Dr Stirling: Greatly appreciated.

Dr Wenck: Thank you for the opportunity. I hope something comes of it.

BENNETT, Dr Michelle, National Aged Care Working Group Member, Speech Pathology Australia

CARTWRIGHT, Dr Jade, National Adviser Aged Care, Speech Pathology Australia

COLES, Dr Tony, Chief Executive Officer, Audiology Australia

CORDOBA, Mr Sebastian, Representative, Allied Health Professions Australia

DEWBERRY, Ms Margaret, Member, Audiology Australia

LEWIS, Ms Amy, Representative, Allied Health Professions Australia

OKE, Ms Lin, Executive Officer, Allied Health Professions Australia

ROUFEIL, Dr Louise, Executive Manager (Professional Practice), Australian Psychological Society

STOKES, Mr David Lewis, Acting Head, APS Institute, Australian Psychological Society

[12:13]

CHAIR: You have all had information provided to you on parliamentary privilege and the protection of witnesses and evidence. Thank you, everybody, for coming. We thought it would be a good idea to get together a group that is working in the allied health space, because often things will come up that are common to everyone and we would then like to seek other people's opinion on the same issue. I understand, Ms Oke, that you are kicking off?

Ms Oke: Yes. We will all do our short key presentation points and then be available for questions. Allied Health Professions Australia is a collegial group of 19 allied health associations. There are five here with AHPA today. I would like to acknowledge that we are on the land of the Wurundjeri people of the Kulin nation and pay my respects.

I will lead off with three key points from Allied Health Professions Australia. There are very few allied health professionals utilised in aged-care services. Quality aged-care services require the specialised knowledge and skill of allied health professionals to contribute to care, especially of those older people with complex needs. Thus, from our perspective, we see that there is a need for a commitment to the funding for allied health services in aged care, as well as requiring recruitment and retention strategies to bring into the service area allied health professionals with skills and experience in aged-care services.

The challenge, though, is that as there are few allied health professionals engaged in aged care, and those who are engaged are often in sole-practitioner positions or part-time positions, this does not support student training. Without exposure to the sector students are then less likely to get the experience and feel attracted to work in that area for aged care. So I think there is an issue ahead in the workforce area.

We see that some smart clinical education strategies that do not overload those few aged-care allied health clinicians and facilities need to be implemented—so: looking at smart-telly health technology utilisation; the introduction of mentoring and peer support for the less-experienced allied health professionals to support them in their role; and also looking at career development and progression, so that you have the experienced ones who are then able to provide that support to others.

Briefly, also, for effective consumer-directed care: older people need to be informed of and have access to allied health services. They need to know. We cannot assume that everybody knows the benefits of being able to be seen by one of the many allied health professionals. Related to this is that front-line staff in the aged-care facilities require education and training to understand and get a better knowledge of the allied health services so that they can identify where a person might benefit from seeing an allied health professional. Those are my key points.

CHAIR: Thank you. We are in your hands for who is going next!

Ms Lewis: Thanks for your time. The Dietitians Association of Australia is the peak professional body, with around 6,000 members. Well, active, older Australians are less likely to experience chronic disease; 16 per cent of the burden of chronic disease is estimated to be due to diet. Frail older Australians experience malnutrition. We see malnutrition rates of eight to 15 per cent in the community and 30 to 50 per cent in residential care. Poor nutrition accelerates entry to residential care and contributes to issues such as falls, pressure injury, dysphasia and reduced independent living. So it is important that the workforce have nutrition skills and knowledge to support older Australians.

The introduction of the My Aged Care call centres and regional assessment services provides an opportunity to improve nutrition for frail older Australians. On-the-job training is needed for aged-care support workers to be

able to effectively identify nutrition issues using the National Screening and Assessment Form and to refer consumers to the most appropriate services. Training is needed for health professionals, including APDs—accredited practising dietitians—to interface effectively with My Aged Care.

DAA is concerned that the aged-care support workforce trained in the VET sector is not adequately prepared to meet the nutritional needs of older Australians. DAA reviewed VET sector courses for certificates III and IV in aged care, mental health and disability and found that nutrition is not considered a core subject. So it is important that certificate courses include basic nutrition knowledge and skills and how to refer clients to APDs for individual supports.

DAA would like to see adequate recognition for self-regulated professions such as dietetics and social work, which are not registered under the Australian Health Practitioner Regulation Agency, as DAA is aware of discrimination in employment because of not being registered under AHPRA. This is also seen as a barrier.

Thank you. I will hand over to Sebastian.

Mr Cordoba: As one of the 19 allied health associations comprising AHPA, the Australian Association of Social Workers is the professional body representing more than 9,500 social workers throughout Australia. Social workers have a long tradition of working together with older Australians towards active ageing, with a strong commitment to self-determination, dignity and respect. It is the position of the AASW that the current composition of the aged-care workforce does not adequately provide services that consider the full range of psychosocial needs of older Australians, including mental health, relationship issues, grief and loss, trauma, family violence and elder abuse.

There is significant research and literature demonstrating the importance of addressing the social and mental health needs of aged-care residents, as they have a direct impact on all other aspects of their physical and emotional wellbeing, including care needs. The AASW believes that the integration of allied health professions in the aged-care sector needs to occur at all levels of the sector's workforce, as it will lead to enhanced consumer outcomes and increased market efficiency. Thank you.

Dr Roufeil: I think we are next. I am representing the Australian Psychological Society. It is the largest professional association for psychology in Australia. We have over 22,000 members. We are the largest mental health profession and the largest of the allied health professions.

There are three things I wanted to talk about in our short period now. One is access to a workforce to deliver evidence-based treatment for mental illness, the second is access to a workforce to diagnose neurocognitive disorders and manage challenging behaviours, and the third is the need to build capacity of the psychology workforce to meet those challenges.

In relation to mental illness, I want to talk first about residential aged care. I am sure we are aware of the statistics that over 50 per cent of residents in residential aged care have symptoms of depression. The existing government funding mechanisms for residential aged care are rarely used for the delivery of evidence-based psychological interventions. What we are seeing is an intense reliance on pharmacological approaches, with the concomitant consequences of that. Residents in Commonwealth-funded places in aged care are unable to access Medicare-funded psychologists and are stuck in that catch-22 situation that funding is available but not for psychological interventions. In terms of home care, the need for a workforce that has increasing capacity to meet the mental health needs and quality-of-life needs of people who wish to stay at home is going to put an increased demand on the workforce.

The second point is about neurocognitive disorders, particularly dementia, and the management of challenging behaviours. Currently we are seeing some, but very limited, involvement of the psychology workforce in this space. That is happening despite the high diagnostic capabilities of psychologists, particularly in terms of supporting general practice and ensuring adequate differential diagnosis between depression and dementia. The potential to improve early detection is really important, and has the capacity to make a significant difference to the quality of life of aged people. Like in mental health, we are still seeing a dominance of pharmacological approaches to neurocognitive disorders, both in the home and in aged-care facilities. I am not sure if you are aware, but currently services for the assessment of neurocognitive disorders and the development of behaviour management plans are not funded under Medicare, and certainly not available to most residents of aged-care facilities.

There is a significant role for psychologists in terms of increasing the efficiency and effectiveness of aged-care services in the home; in terms of improving diagnostic capacity for neurocognitive disorders, developing behaviour care management programs, and supporting carers at home to manage their family. In aged-care facilities there is also a significant role in terms of diagnosis, developing behaviour management plans,

implementing them, and supporting aged-care workers to oversee those programs. The potential to decrease polypharmacy is significant, as is the potential to decrease restrictive practices.

I want to finish by talking a bit about the capacity of the psychology workforce. I want to reiterate Lin's comments that we clearly have a problem in terms of psychologists being trained adequately in aged care: because of the lack of positions for interns, the lack of student placements, the absence of senior psychologists to provide supervision for those placements and, as we have mentioned in the earlier session, the lack of sexiness of working in aged care, but also the lack of jobs—there just are not jobs for psychologists in the sector, so why would you do it? There are also almost no career opportunities at the moment in aged care as well. So we certainly see this hearing as an opportunity to address those concerns and to see some significant changes in those areas.

Dr Coles: Thank you for the opportunity to present. Audiology Australia is the peak national body representing audiologists in Australia. We have about 2,500 members and represent about 98 per cent of the profession. Audiologists themselves are university-trained, hearing healthcare professionals who deal with identification, diagnosis and rehabilitation of people with hearing loss, and that includes tinnitus and balance disorders as well.

Currently, one in six Australians has a hearing loss. That is set to increase by 2050 to one in four. That is not due to an increase in prevalence but due to an absolute increase in numbers, and that is to do with an ageing population. Presently for those aged 65-plus, it is one in three that have a hearing loss. Go up to 75-plus, and it is one in two, and above. It affects older Australians in a significant way and, obviously, when it comes to residential aged-care facilities, there are complexities to do with comorbidities that go with that as well.

Audiology Australia believes that audiologists should be an integral part of the aged-care workforce and dealing with clients within residential aged-care facilities. Presently there is no need for having a screening—to do with their hearing—when a resident enters an aged-care facility, and this presents problems in and of itself. There is the possibility that hearing loss could be confused with—possibly—a cognitive decline, if the resident is not understanding directives or questions; or if they are not responding to directional questions, they could be seen as having behavioural problems. So there are issues with that, as well as confusion with balance disorders, such that it may be seen as an issue to do with sarcopenia or frailty, rather than being perceived as actually having a problem with a vestibular disorder and inner ear hearing health.

Audiology Australia believes strongly that we need a better response to engaging with the aged-care workforce, and we advocate strongly for having hearing screening upon commencement of entrance into residential aged-care facilities. This can be done at a relatively low cost and there is not a great deal, necessarily, that is required in order to do that initial screening to get that assessment going.

There should be consultation between audiologists and the aged-care workforce regarding communication needs and abilities of care recipients. This includes individual hearing and communication plans for care recipients, as well as their families and carers, involving all those people within that gamut, with clear instructions as to how the aged-care workforce can manage care recipients' audiological needs.

We recommend the use of hearing aids only in those circumstances where the client is experiencing hearing and communication difficulties, the need cannot be addressed appropriately through other means and the client is likely to cope with a hearing aid. This is an issue in that the government currently, through the Office of Hearing Services, has a voucher scheme that enables pensioners to access hearing aids, within a range, free of charge. The service is conducted by an audiologist. However, the audiologist is not paid to go out for that service but just for the service itself, which in itself presents problems. But the problem within the aged-care facility is that it becomes an easy way to say it is the individual's problem, rather than looking at it holistically and considering the environment.

The aged-care provider should arrange for consultation between audiologists and the aged-care workforce regarding possible environmental changes to enhance communication, such as visual displays, captioned TV, amplified telephone, acoustic shielding and other assistive listening devices. There should also be education for the aged-care workforce in how they can better meet the hearing and communication needs of clients.

Overall, we really want to focus on the residential aged-care facility—on how we can work with the aged-care facility better, and the workforce better, to look more holistically at what we can do for residents. At the end of the day, communication problems and hearing loss can lead to issues that have corollary effects associated with isolation, depression and even cognitive impairment. Thank you.

Dr Cartwright: Thank you for asking us to appear before you today. I am a speech pathologist who works in aged care. I also hold an academic position at the University of Melbourne. Today, I am representing the

association as the national aged-care adviser. I am also joined by Dr Michelle Bennett, who is a member of the association's national aged-care advisory group and an academic at the Australian Catholic University. I know that many of you are aware of our profession through your 2014 inquiry into communication impairment and speech pathology services. However, for the *Hansard*: Speech Pathology Australia is the national peak body for speech pathologists, representing nearly 7,000 members. Speech pathologists are university-trained allied health professionals with expertise in the assessment and treatment of communication and swallowing problems.

Today, we want to focus our statement on the issues that are very specific to our profession—in particular, regarding access to our expertise for older Australians. In order to achieve quality participation in all aspects of life, effective communication is essential. Whilst communication and swallowing problems can emerge at any point in a person's life, the prevalence and complexity of these problems increase with age. Both communication and swallowing functions are vulnerable to the natural ageing process, and problems are highly prevalent in people living with conditions such as dementia, Parkinson's disease and stroke. Even subtle age-related changes in communication skills have a significant impact on a person's everyday life and social participation. This has serious repercussions for the ability of people to remain in their homes and in community-based settings. It has serious repercussions for consumer-directed care approaches if an older person is unable to effectively communicate their wishes, preferences and decisions. Speech pathologists should be essential members of the care and support teams for older Australians. Unfortunately, our services are spread very thinly in Commonwealth-funded services, and, when we are involved, it is usually only to provide assessments of swallowing.

Our profession was encouraged by your committee's bipartisan recommendations relating to our role in the aged-care workforce through your former inquiry. Specifically, your committee recommended that the federal government investigate the service delivery model of speech pathology services in residential aged care, with a focus on contracting arrangements. Importantly, you recommended that a cost-benefit analysis be completed that considered the current funding model of speech pathology services in the aged-care sector. Whilst it is unfortunate that we are still awaiting a government response to your final report, we want to assure you that our association has valued your work, and, over the past year and a half, has invested our member resources to address some of your recommendations that were able to be advanced without government support. Many of these are within the aged-care space.

I would be happy to speak with you about these; however, I will now hand over to Dr Bennett to highlight some workforce challenges identified in recent research, which we co-led, into the speech pathology aged-care workforce.

Dr Bennett: Although we are still waiting for publication in peer reviewed journals, preliminary results indicate that speech pathologists working in the aged care sector have identified a number of challenges to ensuring that older people have access to our expertise. Critical barriers to services include current funding and service delivery models that emphasise swallowing assessment and do not fund communication intervention. Staffing ratios are so low and case load pressure is so high that care can be compromised. These pressures often lead to ineffective adherence to the clinical recommendations for aged care clients. This is made worse by the prevalent subcontracting arrangements whereby speech pathologists are largely unable to influence policies and procedures within a facility and have restricted opportunity to engage in interdisciplinary care.

As the rollout of the aged care reforms progresses, we are growing increasingly concerned about arrangements that appear to further restrict, rather than enhance, access to speech pathology services for older people, particularly for those with communication problems and those within community and home based settings. This has repercussions on workforce planning within our profession. We know there is significant demand for our services but there are persistent barriers to supply. We are still seeing a lack of awareness of the need for communication interventions in residential aged care and funding for these services. We know the entry point to the aged care system relies heavily on an understanding of communication and swallowing problems and the need for referrals to speech pathologists by regional assessment service assessors.

Subcontracting arrangements for private providers are growing increasingly complex and problematic for our private sector. Furthermore we are still experiencing significant difficulty in getting all speech pathologists listed as providers on the My Aged Care website. We believe that Australian government leadership is crucial to progressing aged care workforce planning in the context of the aged care reforms. While the sector has an important role to play in identifying and improving workforce planning for the aged care sector broadly, in a competitive marketplace it is unrealistic to expect the sector to determine the solutions in isolation from government. We are certainly a profession that would welcome concrete support from government to help our workforce planning and design.

Senator POLLEY: Thank you all very much for your submissions and for coming before us today. There is an enormous challenge facing the sector. I know that because I have just been through the process of developing the Opposition's policy that we will be taking to the election. We know a lot about what the problems are but it is about how we are able to resolve them. Knowing that there is a restriction on the budget and also that it is not a sexy area for policymakers when they are looking at issues around ageing and aged care, how are we going to address this? I made notes as each of you gave your address this morning. Your comments are so vital for older Australians. How, realistically, can a federal government make sure that you are more involved in this sector? It is going to save future federal governments a lot of money, basically. It is open to each of you to make a comment if you can.

Dr Cartwright: Thank you very much. One quite specific point, which Michelle touched on in her opening statement around access to speech pathology services, is the point regarding the challenges that we have had in getting speech pathology listed on the My Aged Care website as part of the service finder. There are examples like that where, if an older person is not able to find information about our services, there is a real risk of those services not being accessed or available to them. This has been an issue that we have had ongoing discussions about with the department via the National Aged Care Alliance. Within the last week or so we have had confirmation that our profession currently is not displayed on the My Aged Care website. So I think there are more immediate practical solutions that could potentially be addressed to make our services more accessible. That is one example.

Dr Bennett: I found the discussion prior to our coming in very interesting—surrounding a request for government to support a wellness and enablement model. I think, if consumer-directed care is going to have any place within this space, we are going to need to support an enablement and a wellness model, and to do that allied health services are critical.

Just touching on the communication needs which Audiology Australia also brought up, if we cannot assess a person's communication needs at entry to the aged-care system then that person may not be able to make an informed decision about the services that they would like to acquire and what their priorities are, which means at that very entry point we are going to end up with a potential mismatch between that person's priorities and their care needs. As that care continues, that gap in their needs and what is currently provided will get larger and the burden of care for that client will increase because we have had a mismatch from the start. I think, going back to some of the current policy and where policy is headed, discussions regarding wellness and enablement and participation feature across policy in this space, but enacting those means that we have to actively incorporate a more holistic approach to the care of older Australians.

Dr Roufeil: The Australian Psychological Society has made numerous submissions to the federal budget for almost 10 years that have included piloting a model of student placements for psychologists in aged care. We understand the financial imperatives at the moment, but a model such as that could be implemented fairly cost efficiently because it only requires supervisors to be provided into aged-care facilities to allow students to come in on placement to at least provide a supervised service to residential aged-care facilities. That would offer a pilot program that could, if evaluated effectively, be rolled out in a fairly cost efficient manner.

Mr Stokes: Can I point out that our submission was about postgraduate students—they were in the specialties of clinical psychology, clinical neuropsychology and health psychology—all of whom are graduate students. Therefore, they would bring expertise and experience, and a free workforce, to the aged-care sector, but it does take some cost in terms of providing the supervisors into that context. There could be a turnaround each semester of students in a particular facility from a university training course.

Dr Roufeil: I think the benefit of that, as well, is that the residential aged-care facilities will actually see, themselves, the impact of having psychologists in the workspace. I think it is very hard to convince aged-care facilities to look towards psychology when they have had a history of no experience with that workforce.

Ms Oke: Maybe I could make a suggestion for a cost-efficient strategy that deals with access to advice and guidance from senior clinicians in the allied health field in aged care to support incoming new graduates working in the aged-care area, and maybe also in the student area. I mentioned earlier the smart use of telehealth technology—you could fund a panel of senior clinicians who could be partly working in aged care but partly available for consultation by their colleagues. You could use telehealth technology very well to do that regardless of where you are in Australia. It would be a cost efficient strategy but, again, it needs some funding to support that. It certainly builds on the wonderful availability of information technology these days.

Ms Lewis: Certainly in dietetics, often by the time there is a referral to the dietitian malnutrition, for example, could be quite well along. We are encouraging more support to the aged-care support workers in training them up so they can identify it early, and put in place processes that perhaps prevent people getting to that stage.

Obviously, the cost of managing someone who is already malnourished—who will have difficulty with mobility and self-care, and extra complications such as pressure injuries and poor wound healing—can effectively be reduced by early intervention. We would really like to see that there is more training and support for the aged-care support workers across the sector in that area.

Mr Cordoba: I agree completely with what Amy and Lin have identified: that it is about incorporating allied health more into the space in, at this stage, any capacity. At its core, as has been identified by previous witnesses, there needs to be a substantial reconceptualisation about how we understand ageing in Australia. This idea that you cannot provide effective support services if you are not focusing on the holistic needs necessitates allied health professions. I think it seems like a substantial endeavour, because the focus at the moment is not necessarily on understanding older Australians as complex individuals with multifaceted needs that are currently not being addressed.

Dr Coles: I would agree that introducing allied health up-front in residential aged-care facilities and getting people talking about it and understanding it is really important. With that screening, as I mentioned before, if we go back to audiology, for the residents themselves it can be a really confusing time. Often they are going in with dementia or cognitive impairment. They may have come from a background where, in their own environment, in their own house, they were actually hearing just fine, but, going into that residential aged-care facility, it may be a big, open space and a noisy environment. Not having ceiling tiles to dampen sound and things like that may cause all kinds of problems for that person. That could be dealt with really easily up-front if you had the audiologist come in early. Once again, take a holistic approach to that rather than just pathologising the individual and seeing it as an individual health issue. It is a bigger space issue there that I think needs to be addressed.

Ms Oke: If I could just throw one in from my personal experience with my mother in aged care, it was the family's responsibility to clean her glasses and the family's responsibility to put the batteries in her hearing aids. There was a period of time when she broke her glasses—so she was without her normal visual input—and the batteries had run down, and my mother became quite psychologically distressed and cognitively impaired. I looked around the nursing home at the people who were distressed. My mum did not have dementia. But I looked at the number of distressed people and I wondered, 'Do you need your batteries changed in your hearing aid or do you need your hearing aid in? Are your glasses clean enough to see through?' I wondered if the staff in the aged-care facilities had enough time that part of their responsibility on a daily basis was to do a check—I mean, it is a simple check—to make sure that the person's sensory input is adequate.

Senator POLLEY: Ms Dewberry, did you want to make a contribution?

Ms Dewberry: Just in relation to hearing. There is actually an Australian government Hearing Services Program, and I know we have a very knowledgeable committee who understand that. But the problem with it is that it is focused on an individual with a very standard suite of services. The research evidence shows that that is probably the worst way you could approach the person's problem. As Dr Cole has been saying, you need a more holistic approach. The other side of the Hearing Services Program that looks at the community service obligations component actually has a model, based on research, that takes exactly that approach. The Hearing Services Program is in a state of review, because of the introduction of the NDIS. So, in thinking about influencing policy for the future, it seems an opportune time for that type of thing to be reviewed at this point and to say, 'Well, okay, moving forward, let's have a better model which is more cost effective, more cost efficient and makes better use of the professionals' time.' It does rely on setting up an entire program and having a preferred provider, rather than multiple providers coming in, which then gives the staff a single point of contact. In larger organisations, it can rely on the volunteer program that often exists in larger establishments, training them about hearing needs, changing batteries and that type of thing to help support the residents. It is very timely that we are talking about that right now.

Senator POLLEY: I picked up on a number of key points and there was a lot of overlapping there. You get a tick—you are the first person today, Dr Cartwright, to actually mention the My Aged Care website, which has failed. I think it is fair to say that the way that has been implemented has been a failure. But it all comes back down to how we train up those people who are working day-to-day in the sector so that they can recognise when somebody needs pathology or hearing or, in fact, nutrition—that comes to mind. Whether it is in residential care or, more importantly, when people are still being supported to live at home, it is very easy—as experience has taught me—to have meals delivered, but there is nobody to check the refrigerator to see that there is still five days' worth of food and some of that is outdated; no-one is actually checking, if there is no immediate family around, whether that individual is actually eating or whether, if they are suffering from the onset of dementia, they are forgetting to eat.

We have heard evidence today, and there is a stack of submissions—this is only today's—saying that it comes back down to training and whether or not it is adequate for people to be working with a certificate III or IV—that is without the professional people that are working. I think from the evidence you have already given in your opening statements, quite clearly it is not. Does somebody want to make a contribution about where we need to go, about having uniform standards, and about whether those providing that training and skill set are legitimate and have the qualifications to be able to deliver that important training?

Dr Cartwright: I think I may provide a specific example of some work that we are doing in this space at the moment through Speech Pathology Australia, but it may lead into a broader discussion around ensuring that nationally consistent approach. The association has initiated a training scheme, so we are looking at hosting pilot training for the regional assessment services around speech pathology services. This includes looking at understanding of the role of the profession, but also upskilling the regional assessment service to be able to support older people with communication difficulties through the assessment process and ensuring that they are adequately supported to have choice around the range of service options available to them. We have established a partnership with NSW Health, and we will be running a pilot session with three of the local health districts in New South Wales. It will be an hour training session. We see this as an opportunity to pilot how well that form of training is received. Ideally, we would like to see some level of government commitment to look at funding that kind of model into the future to ensure that it is sustainable. We are conscious that it needs to be nationally consistent and aligned with standards, wherever possible, but I present that as an example of work that is currently underway. We certainly do, I think unanimously, feel that the understanding that the other health professionals have around our respective roles is limited, but then, when you get down to the level of the general public, we know that that awareness is even less.

Dr Roufeil: I just want to make the point, firstly, that we agree totally that there is a greater need for training carers and those working with the elderly around identifying, so early intervention can happen. I have to say, though, for psychology: even if it was identified at the moment, there are very few routes via which people can access it, so it is an access and a training problem for us. For residents in aged-care facilities, unless they can self-fund, there is no capacity to access evidence-based psychological interventions for mental health, or for behaviour management or diagnosis around dementia. In the community, there is only access for mental health conditions; dementia is not available for either diagnosis or treatment under Medicare.

Mr Stokes: Can I add to that by saying that we are currently working on an online learning program for support and nursing staff in aged-care facilities to sensitise staff to mental health issues and the simple things that they might be able to do to assist as a beginning point in the process. We are trying to devise a program that would be accepted by aged-care providers to help with their staff training. That would certainly be a way of sensitising staff to the sorts of issues that we are concerned about.

Dr Bennett: I would add one more thing on that point, in support: in looking at the rollout of the training that we are piloting, we have specifically looked at our workforce and whether or not we are able to then support services if we are able to increase the education. From the data from the survey that we just completed, we know that almost half of those speech pathologists working in Australia with older clients work in the hospital setting and the smallest proportion of those speech pathologists work in the community. So we certainly know that access is an issue for the speech pathology profession as well.

Mr Cordoba: Elder abuse has really come up as a consistent area of concern for many of our members and also from my practice experience. I think what is happening in relation to family violence across Australia, especially with a lot of the recommendations of royal commissions, highlights that these recommendations are not really happening in the elder abuse space, which is about training to understand the dynamics and the complexities of that issue. While great progress has been made in family violence more broadly, in relation to the specific dynamics and complexities of elder abuse there is still a long way to go.

Ms Dewberry: One point related to hearing is in-service training, which this frail elderly protocol does support. Unless that training is actually embedded in the initial training of people working in the aged-care workforce, there is such a turnover of staff you are constantly going back and retraining and retraining. If you could embed it in the initial training then you would only need some refresher training, which would be less time intensive.

Senator MOORE: At the beginning of this week we had some data about the recent study that was done about the number of people working in the residential aged-care workforce, and it listed the professions. 'Allied health professional' was the group that had reduced most in that period of time—in fact, by a really big percentage. Then they had 'Allied health assistant' counted in the 2012 survey. What is an allied health assistant?

Ms Oke: An allied health assistant can be a variety of people. There are some courses to train allied health assistants. Some of the training is for a generic role to enable them to work with a number of different allied health professionals, and then there is some other training, or on-the-job training, where a person might work quite specifically with a physiotherapist, or a podiatrist, or an occupational therapist and others. I do not know about speech pathology. An allied health assistant can carry out routine tasks and programs that have been designed by an allied health professional and they can be supervised.

Our biggest concern is where a number of facilities say that they have allied health services for their clients but the allied health services are provided by allied health assistants and the allied health assistants are not working to the supervision and direction of allied health professionals. It is a concern that it is not an accurate description of what services are available, or of the quality of services available.

Senator MOORE: It is a grouping I have not heard of before, and in the survey in 2012 they counted over 5,000 of them and they only counted 2,648 allied health professionals.

CHAIR: Who supervises them?

Ms Oke: That is the problem. If you have an allied health assistant working at a facility, and if you have an allied health professional who is there at the facility—who, say, comes in one day week—for it to work well the allied health professional would assess and determine what services could be provided in a routine way. For example, a physiotherapist might be encouraging a person to do some exercises to maintain their strength and range of movement and mobility skills. The allied health assistant could be shown by the physiotherapist how to support the person, and the physiotherapist could direct them and set out the quality of service they are watching for. Each day they could have a half-hour session with the individual, and the physiotherapist every now and again could be checking in on how well they are managing that client and others.

Senator MOORE: Are they regulated in any way?

Ms Oke: No.

Senator MOORE: So anyone could claim to be an allied health assistant?

Ms Oke: I presume so.

Senator MOORE: It is a term I do not know. The fact that they actually have their own status under the process of looking at who is working in aged care came as a bit of a shock.

Ms Oke: I think a lot of aged care facilities are very pleased to be able to say they have allied health services.

Senator MOORE: That is where I was just about to go.

Senator POLLEY: Talking about the University of Tasmania—the Launceston campus—I have been lobbying for years to get more allied health professionals going through the university there instead of having to go to Victoria or South Australia. Yet the university says the call, particularly from those in physiotherapy, is that they want assistants trained. They want an undergraduate course for their assistants. You could have a physiotherapist in a practice trying to service four or five clients and just having their assistants go around and take them off machines or supervise them. While I think we need more professionals, that seems to be the trend. They just want assistants. It comes down to money.

Mr Cordoba: We have been working quite a bit in this space and have found a lack of regulation. Many of our associations have position statements around what we believe their roles to be.

Senator MOORE: Do you have allied health assistants for social workers?

Mr Cordoba: They are forthcoming, yes.

Senator MOORE: What are they going to do?

Mr Cordoba: We are still in a consultation process around clarifying that.

Senator MOORE: I am sorry to be so direct.

Mr Cordoba: No, of course—but that is one of the issues. For example, with social work assistants it depends on the organisation employing them. Mainly hospitals hire them. There is usually the expectation that they will be supervised by a social worker, but that depends on the organisation.

Mr Stokes: That is the risk really. You have employed an allied health assistant, and they are being asked to do other roles within allied health apart from the ones for which they may be supervised—may be.

Mr Cordoba: That is the issue. To address the point, there is a lot of support within many professions for the roles. It is not a question around whether allied health assistants have a space. It is that we need to be very clear about what their scope is. There are quite a few studies of what happened in the UK, for example, when social

work assistants were introduced. There was a slow creep of a substitution model, because for the price of one social worker you could hire two social work assistants. That is where the regulation comes in.

Dr Roufeil: There has been a lot of work done in psychology to try to figure out what they do. The outcome of that work is generally that what they could do cannot be articulated, so it has not progressed.

Senator MOORE: And actually it is the other box: what they cannot do.

CHAIR: But it obviously is progressing.

Dr Roufeil: Not in psychology.

CHAIR: Not in psychology but in some areas. The concern is that if I am a medical provider, 'Acme Care', I can say I provide allied health support when I have an assistant who is not regulated and potentially not supervised.

Mr Stokes: Absolutely.

Senator MOORE: Mr Cordoba, you said there is work being done. Could we get some information about where that is being done, to expand the knowledge of the committee—particularly as it is now being counted and, I imagine, costed? I tried to get on to the My Aged Care website, and all of you are listed. It is just that when you press the thing nothing happens. But you are all listed. I can assure you that My Aged Care does have a list for all of you—but they did not have allied health assistants—but nothing happened after I picked the box. Why that is so, Dr Cartwright? I seek the service as a potential person—

Dr Cartwright: We have been trying to clarify the process for allied health professionals to register their service information with the My Aged Care service finder. Initially we had been informed that if all practitioners were to register with the National Health Service Directory the service information would be drawn directly from that and would then appear in My Aged Care. So we had informed our members that that would be the case but, with continuous checking, it just has not happened. The functionality has not been enabled. We have made continuous calls back to the help centre to try and seek further clarification about when the functionality would start. We have just recently—within the past week—received confirmation that only a subset of allied health professionals are being brought across in a first phase. It does include physiotherapy, occupational therapy and podiatry. But the other allied health professionals are not being brought across unless—

CHAIR: How is the decision being made?

Dr Cartwright: they also deliver one of those other services. So it does mean that a small proportion of speech pathologists are appearing, but only if they work within a bigger organisation. We have sent an email back to the department, via the National Aged Care Alliance, just to seek clarification on how that decision was made and whether there is an intention for—in the response, it did say that, into the future, other professions may be drawn and brought across to My Aged Care but there was no guarantee that it was going to happen.

Senator MOORE: If it is not going to be there, why put it on the website? If I am seeking a service, then I press the button and it will come up.

Dr Cartwright: It does apply to non-Commonwealth-funded services. The Commonwealth-funded services would appear but, as we know, very few of our professions would receive Commonwealth funding.

Senator POLLEY: They sound like great questions for estimates.

CHAIR: I was just thinking that. We are running out of time so we will have to put some on notice.

Senator POLLEY: We will have to put a lot on notice.

CHAIR: We will have to put this on notice, to ask how the decision was made and who is there—because it sounds like, even though they are the Commonwealth-funded ones, it is not all of the various professions.

Dr Cartwright: It is not. And the search functionality is just not working well currently. Would I possibly be able to just briefly feed on to the allied health assistance topic as well?

CHAIR: Yes.

Dr Cartwright: Only to say that I think, as a profession, we have seen allied health assistants work well, within the right support structures, in more of a hospital-based setting where there is the full complement of an integrated interdisciplinary team. But we do feel that it is premature yet to be looking towards that model without qualified allied health professionals in place. But again, if you are looking for evidence, there may be additional frameworks that we could provide.

Senator MOORE: That is literally the first time that I have heard that term—we have talked about a bit about how many inquiries we have done into this area, and that has never popped up before. Would you say an allied health assistant for audiology? Does it have to have that subset beside it?

Dr Cartwright: You can have an allied health assistant working across—

Senator MOORE: Is there a certificate in allied health assistance?

Mr Cordoba: The Certificate IV in allied health assistance has 16 units—it may be 17—eight are core, which are sort of generalist skills, and then the remaining eight are electives, and that is where they pick their specialisations. At this stage, the highest level of qualification for an allied health assistant would be a Certificate IV and, upon completing, they would have a specialisation in a minimum of two allied health professions. And 2016 is the first year that there is a social work unit. So they could specialise in physiotherapy and social work—and so forth.

CHAIR: One of the questions that we need to be asking is: what are the restrictions? Say I am ACME Care and I am providing services in physiotherapy, or social work, or speech therapy—that is your allied health delivery. I am pretty sceptical about this, I am sorry.

Senator MOORE: If we could get some more information that would be—

Mr Cordoba: It is slightly dated now, but in 2014 the Industry Skills Council did a scoping document of up-and-coming professions. It is a nationwide study of our allied health assistants; in what states and in what professions are they actually working. I will send that through.

CHAIR: If you could send us through any information you have on that, that would be great.

Senator MOORE: I have got one last question for Ms Lewis. In your opening statement you said that, in your profession—dietitians and social work, I think—you said that there had been some discrimination because you were not part of the national regulatory body. Can you just give us a little bit more information about how you see your profession? Because you are not in that national group, what impact does that have? How does it work?

Ms Lewis: That we are not in that group?

Senator MOORE: No; the discrimination.

Ms Lewis: Sorry, can you say that again?

Senator MOORE: You said in your opening statement that you felt that your profession—and I am pretty sure you actually said social work as well—as you were not in the national regulatory APH whatever it is, had suffered some discrimination. I would just like to know what that means.

Ms Lewis: We have had situations where quite senior dietitians who had been acting in a particular role had applied for a position which was exactly the same position—they were able to demonstrate they had the experience and the ability to do the role—and when they went to submit the application they were told that their application was not going to be accepted. They were not eligible to apply because they were not a registered profession—they were self-regulated. At that point, we cannot even get an application in.

Senator MOORE: So these are positions that are not based on being a dietitian, but they are management positions or something like that? So because you were not a registered profession you could not apply.

Ms Lewis: This particular case was managing an aged-care facility.

Senator MOORE: So it was a management position and if you had been one of the regulated professions that would have counted as your having the qualification but you were just wiped out—not you personally, but because you are a dietitian you are just wiped out.

Ms Oke: I think commonly the status of being a registered health profession or registered health professional is seen as the standard to assure competence and yet there is quite a large number of allied health professions who are self-regulated and not in the registration scheme. The professions credential the members of their profession to ensure that they are maintaining the currency of their knowledge and skill and have that credential as the way of assuring the consumer of quality of standards and yet unfortunately in quite a number of situations the requirement of being a registered practitioner is utilised. A number of the Medicare Local boards in the past had a requirement that to be on their board you needed to be a registered professional so you could then provide clinical advice in the development of services. Again we have had to make representation and fortunately the department added to the representation on behalf of the self-regulating professions by letting the PHNs know that they should not restrict membership to only registered allied health professionals but include the self-regulated as well.

Senator MOORE: Last year there was a change and Health Workforce Australia ceased to exist. We were told that the department was now going to subsume the work that they had done. Workforce Australia had been working on some of the elements of allied health and their distribution across the country. Without giving any kind of personal opinion, in terms of the relationship and the interaction with your professional organisations and

the department, has there been ongoing work from your perception on these issues of workforce need through the department taking on that role?

Ms Oke: I think they have been limited by their limited resources. Some of the professions might speak in detail, but I think generally speaking from the self-regulating professions perspective that was the challenging area that Health Workforce Australia was starting to address. My sense is that that is on the backburner now that that functionality is in the department. Others might be able to speak more specifically.

Mr Stokes: There has been nothing for psychology, and it is a sad loss because HWA was making real progress in coming to grips with workforce issues. It has been a devastating loss.

Dr Roufeil: Particularly in rural and remote.

Dr Cartwright: And clinical placements.

Dr Roufeil: The impetus for the placements model came from HWA, and all that money has gone now.

Dr Cartwright: And a lot of the innovation has not been catered for either, so we think it has been a real loss—we would agree.

CHAIR: This is a significant issue.

Senator MOORE: And you would be aware that we were provided with evidence to say that this work would continue and that there would be no loss of focus on the issues of workforce by this transition. I am keen to hear from the professional groups about your interactions.

CHAIR: In our discussions today we have been very focused on residential care and, of course, some of you have been here when we have been saying that bulk of the care is actually happening in the home and not in residential care. Do the same sorts of issues that we have just been talking about—access and your ability to provide support and services—apply in the home care situation?

Dr Cartwright: For Speech Pathology Australia, we actually see additional concerns within the community sector. It is, as Michelle mentioned, the proportion of our profession where we are least represented. But certainly, with the direction of government being towards increasing the focus on community care, the wellness and re-enablement approach and the ageing in place initiatives, I think there is a real mismatch in how our speech pathology services are currently being delivered. So we do see that there are unique and very specific issues that do apply to community.

Mr Stokes: From a psychologist's perspective, we do have a large rump of private practitioners and, working with GPs, geriatricians and specialists in neurology and rehabilitation, do get a flow of patients from the aged-care area. But we are conscious that those agencies which are responsible for planning and managing aged care once again suffer from the lack of knowledge of the options available for referring them, perhaps, in the same sort of way in their work with aged care. Just like residential aged-care staff are not aware of the options, likewise we get that same problem with the organised aged-care facilities or arrangements.

Senator MOORE: People in the community who are not in an aged-care facility can have access to better access and ATAPS.

Mr Stokes: Some of them.

Dr Roufeil: Only if it is a mental illness, and dementia does not count.

Senator MOORE: We know with depression and with those things that if you are in residential aged care you cannot get that.

Dr Roufeil: Unless you are in a self-funded bed.

Senator MOORE: That is right. That is a limitation if you are in an aged-care facility, but if you are in the wider community you can get those kinds of Medicare approved options.

Mr Stokes: Indeed.

Dr Roufeil: The exclusion of dementia is really disappointing, because GPs are left with diagnosing and the difficulty of untangling depression and dementia in early stages. GPs could be enormously helped with one or two sessions from a neuropsychologist, and it just does not happen.

Ms Lewis: I know in Victoria there is HACC funding for community health services, and that would supply, say, a dietitian who would be able to go into that person's home, and that is fully covered; the dietitian is employed. I am not sure what is going to be happening though in the future, with HACC funding being adjusted.

Senator MOORE: In the brave new world.

CHAIR: We will keep chasing that.

Ms Dewberry: The Hearing Services Program does allow for home visiting as well, although there is no incentive for the provider to go and do that and it is time consuming to get to some residences. It is quite difficult to actually deliver the service, in that you do not get the same support around you of volunteer services or of the staff of that facility to help support the person that you do in an aged-care facility. So it is much harder to draw on a significant other if there is not one around that actually lives there to help that person, because they often need help.

Senator POLLEY: I am responding to the contribution that has been made around dementia. It is one of my peak interest areas because it is on the increase. I was wondering whether there has been any consultation with any of the professional bodies about what they need to incorporate in the training of everyone who works in aged care, because, as you rightly said, early diagnosis makes a significant difference, and quite often it can be overlooked, even by GPs.

Mr Stokes: From my point of view there is certainly adequate training in the specialty courses for psychology: clinical neuropsychology, health psychology and clinical psychology. Our concern is always that the information does not spill through to general practice adequately enough and they sometimes walk that path alone when they could be explicitly assisted in the process of diagnosis. There is no question that the cognitive assessment done thoroughly and comprehensively can clarify the diagnosis much more than just a general bedside or clinic assessment. We would say yes, the training is there, but the access, once again, is the limitation.

Senator POLLEY: Has there been any consultation with those who are training the people that are working day to day in aged care?

Dr Roufeil: As David was saying, we have a training institute and they are looking at providing some training now, but it is voluntary. It should be in the program but, as someone pointed out earlier, it is top-up training.

Senator POLLEY: Dr Cartwright, help me out.

Dr Cartwright: Again, I think it is a real area of need for our profession. We see across allied health that dementia training does need to be increased. In our recent survey, initiatives like the Dementia Training Study Centres were a very small proportion of respondents to the survey that were linked into those sorts of initiatives. There are a range of options available, but how we disseminate that to the workforce can be a real issue. We know that speech pathologists often do not identify with dementia as being an area of practice, whereas we would strongly assert that it is core business for all health professionals working in the aged-care setting.

Senator POLLEY: Thank you very much, everyone.

CHAIR: Thank you very much. Thank you very much for your time today and for your submissions. It has been extremely helpful.

Proceedings suspended from 13:21 to 14:05

ARMSTRONG, Ms Jaci, Principal Policy Adviser, Guide Dogs Australia

CHAPLIN, Mr Rikki Bernard, Advocacy and Policy Officer, Blind Citizens Australia

FITZSIMMONS, Ms Haylea, Policy and Advocacy Coordinator, Vision 2020 Australia

CHAIR: I welcome representatives from Vision 2020 Australia, Blind Citizens Australia and Guide Dogs Australia. You have all had information on parliamentary privilege and the protection of witnesses and evidence. We have your submission. I invite one or all of you to make an opening statement, and then we will ask you some questions.

Ms Fitzsimmons: On behalf of my colleagues representing Blind Citizens Australia, Guide Dogs Australia and members of the Vision 2020 Australia independence and participation committee, who are not here today, I would like to begin by thanking the chair, Senator Rachel Siewert, and members of the committee for this opportunity to speak to you directly about this important matter.

There are over 575,000 people living with blindness or vision impairment across Australia. The majority of these are aged over 65 years. It is estimated that, by the year 2020, close to one million Australians will be vision impaired. This rapid increase is due to the ageing population and the fact that the risk of eye disease increases threefold for each decade over the age of 40. The growing diabetes epidemic is also expected to dramatically impact Australian eye health. Thankfully, with the right supports and services, people with unavoidable blindness or vision impairment can develop skills to regain their independence and live the life they choose.

In Australia, there are more than 40 specialist blindness, vision impairment and rehabilitation service providers who predominantly deliver services to clients aged 65 years or older. Yet, while a majority of clients are aged 65 years and older, only a fraction of the funding for blindness and vision impairment services is derived from government-funded aged-care streams. Our members provide services to people who are blind or vision impaired across the age spectrum and do not differentiate services based on age or funding. The blindness and vision impairment services sector is predominantly comprised of staff with specialist skills—particularly in health and allied health roles, at 59 per cent. These include orientation and mobility instructors, assistive technology consultants, optometrists and orthoptists.

The recent snapshot of blindness and low-vision services in 2013 found that the sector is struggling to recruit and retain specialist staff in these roles. The study found that more than one quarter of organisations reported that they had to refuse service to clients and more than half of organisations surveyed reported that service wait times had increased in the previous year. The data suggests that the sector is experiencing shortages in workers with specialist skills. This is of significant concern, as we know the anecdotal and empirical data that specialist providers achieve better outcomes for consumers. This strain is expected to worsen as the population ages and as the sector adapts to changing policy environments. For example, a shift to a consumer-directed care approach in aged care would mean that the sector would need to move to flexible workforce arrangements in order to meet the needs of individual consumers.

Vision 2020 Australia recognises that difficulties in recruiting to the blindness and vision impairment services sector are due, in part, to remuneration issues combined with a lack of educational pathways, professional development and training options required to obtain and retain required expertise. For example, qualifying as an orientation and mobility instructor often requires completion of an undergraduate degree followed by a graduate diploma in orientation and mobility, requiring significant practical experience. The graduate diploma is offered and primarily funded by a small number of not-for-profit institutions, limiting the number of qualified graduates. Experienced orientation and mobility instructors can then go on to apply for guide dog cadetships to become guide dog instructors. This additional training can take several years of on-the-job training.

We believe that the blindness and vision impairment services sector must work with the Australian government to develop a sophisticated, overarching strategy for future workforce growth in the sector. A macro-level industry development strategy led by the Australian government service providers and consumers will map out how the projected demand for blindness and vision impairment services will be met in the medium to long term to ensure workforce, financial and policy harmonisation. Such a workforce strategy would result in three things. Firstly, it would provide further opportunities for education, training and skills development and competitively remunerate its staff, resulting in a workforce that is sufficiently skilled, appropriately qualified, attracted, retained and respected for their work in the blindness and vision impairment services sector. Secondly, it would build on the capacity of people who are blind or vision impaired, and people with disability more broadly, by directly supporting increase in workforce numbers, education and training programs. Finally, it would develop a sustainable workforce to ensure that people who are blind or vision impaired are able to access the appropriate specialist supports and services that they need to remain independent and engaged in the community.

We know that the demand for services outweighs supply, and this is only expected to worsen as the population ages. An industry development strategy is required in order to plan for the future and deliver services to the nearly one million Australians that are expected to have vision loss by 2020. We thank the committee for your time today and welcome this opportunity to explore what is an important matter to the blindness and vision impairment services sector.

CHAIR: Thank you.

Senator POLLEY: Thank you for your submission and for coming before us today. I just wondered if you could walk us through the challenges for those with vision impairment who have to transition from being fairly independent going into the aged-care sector, whether it is in residential care or with other support. Where do you see there is inadequate skills and training of those people caring for people who are visually impaired?

Ms Fitzsimmons: Jaci, did you want to answer?

Ms Armstrong: Sure. As we know, with home-based care being a priority, that is where we focus a lot of our services. From a Guide Dogs Australia perspective and a broader service provider perspective, we do spend a lot of time working with residential care providers to provide specialist support and training to their staff members. Obviously, at the moment this is primarily unfunded and done voluntarily to assist our consumers who are residents in those facilities. As I am sure you can all empathise with, a loss of vision creates a significant impact on people's independence and their confidence, and they are often left feeling quite isolated. Traditionally, people with significant vision loss have been assessed as high-risk for falls and have therefore been requiring probably a little bit more restrictive access to the broader community. That is changing, but there needs to be a lot more work done, a lot more advocacy and a lot more investment in providing that specialist knowledge and specialist skills. We know that when people living in residential care or even within their own homes are provided with appropriate orientation and mobility services, even within their living environment, it increases their independence, their ability to navigate around the facility or their home, to dress themselves, to make a cup of tea and to participate in reading and accessing their own mail and activities. I am sure you appreciate that it makes a significant difference to a person's wellbeing and also their ability to retain and, in some instances, regain their independence and confidence.

Senator POLLEY: What are the key issues that you can identify for us with the crossover from disability workers and carers as opposed to the aged-care sector?

Ms Armstrong: I am generalising here. Across the spectrum there are some very good examples of where there is great intervention. Traditionally, vision loss and blindness have been seen as a natural progression of ageing rather than a specialist disability subset. We know that particularly in the age cohort of 65 to 75 people are wanting to remain more active, often still participating in the workplace, in voluntary activities or in childcare roles. To do that with a significant vision loss you are going to need that specialist training and that specialist level of knowledge to provide those assistive aids of daily living, such as a monitor to help you make a cup of tea or a piece of equipment to access your mail. A lot of that has not traditionally been available under the aged-care sector under the funding streams. We are hoping that with the move to consumer-directed care and the combination of the home care packages that there will be greater flexibility, with people being able to choose to have specialist orientation and mobility services or to have specialist aids and supports that will enable their independence. We are working closely with the government and policymakers to ensure that that is not overlooked.

Senator POLLEY: You have had some regular consultation with the federal government around the aged-care sector and making that transition?

Ms Armstrong: Yes. We are continuing to engage. Across the sector we are all making quite an effort to participate in any policy discussions and certainly in submissions. As I think all of you are aware from various discussions we have had in different forums, we are concerned about the discrepancy between those services and supports that are available under the NDIS and those that are available under the aged-care stream. But we are hoping, as I said, that with the change to consumer-directed care and the combination of the Commonwealth Home Support Program and the home care packages, we may see greater flexibility and greater choice in what services can be funded through those streams.

Senator POLLEY: From your experience, can you give us any evidence in relation to whether there are more challenges for people living in rural and regional Australia? Generally there are, across the aged-care sector and so many others. Can you outline to the committee the sorts of challenges facing your organisations and, more importantly, those living with vision impairment?

Mr Chaplin: I would like to focus on the situation for people in regional and rural areas in particular. While it can be a tough experience for everybody, people in areas where there are fewer staff available to attend to their needs are not necessarily made aware of the information, of the technology that they can access and the training that they can access from the specialist staff. There are often long waiting periods for people in those sorts of areas to access those staff, and they are probably more dependent on being able to access those specialist staff to develop the skills that it would take for them to continue functioning at their full capacity. It may even be that people in these sorts of situations are at greater risk of entering aged care earlier than they would necessarily have to, because in those regional and rural areas there are not the staff at a generic level with the specialist knowledge to be able to assist them. So it is critically important that we increase the level of staff in those areas who have training around technology and around occupational therapy as it relates to vision impairment. It is also critical that we can provide training for staff in aged-care facilities around vision impairment so that people can function in whichever environment they are living to their greatest capacity.

Senator POLLEY: In the sector there is a real challenge, I think, in relation to CDCs being able to give people the options. Do you think that there will be additional challenges for your clients in regional areas to have those services available to them?

Mr Chaplin: I think the critical thing is lack of information for those people. We are talking about people who do not necessarily access technology to the same level. When you lose your vision you often have to be retrained in how to use the sorts of technology that can facilitate information provision, so a lot of people do not even know where to start when they lose their vision. They do not know where to go or who to contact. They are often given a diagnosis by a specialist and are told, 'I'm sorry that we can't actually do anything for you'. Traditionally there has been a lack of referral to service providers who can assist people. Again I stress that it is even more the case in regional and rural areas.

Senator POLLEY: Do you think there is a requirement that the federal government have an education program rolled out, and advertising? I am hearing that people are not aware of the CDC and what that will actually mean to them. Would that be useful for your sector?

Mr Chaplin: I think it would be for the entire population, because the stigma around loss of vision, and the fear that that generates, is way out of proportion to what it actually needs to be. So many times, as people who are blind and vision impaired, we hear, 'Oh, how could you possibly cope?'. If an education program were rolled out around how people with vision loss are able to continue living their lives, where to get information and what technology is available, it would better prepare people in the longer term. We do know that vision impairment can come with ageing, but it would put people in a better position to be able to cope with the situation in which they might find themselves, yes.

Senator POLLEY: Thank you.

Senator MOORE: Your submission talks a lot about employment and is not peculiar to people with vision impairment. You actually make recommendations about the fact that employment strategies should be developed for Aboriginal and Islander people, for LGBTI and for people from a non-English speaking background. I am interested to know why Vision has decided that their recommendations should be looking at inclusion across the board as opposed to focusing just on your own area. It is good to see—it is just wonderful—but your recommendations cover a lot of other areas of need.

Ms Armstrong: As you say and as we are aware, vision loss does not just affect one sector of society. As we briefly canvassed with rural and regional areas, culturally and linguistically diverse communities have similar challenges. There are different approaches that need to be taken, whether we develop staff training that is sensitive to those additional needs or provide services in an alternative manner that makes it assessable in rural and remote areas. It is important that we make sure that we are providing services for lots of people who are blind and vision impaired regardless of their additional needs.

Senator MOORE: I will quote your submission:

In terms of remuneration, the average salary of a professional working in the blindness and vision impairment services sector is \$65,000, please note this excludes optometrists.

And I bet it does not include ophthalmologists either. Can you tell me about whom are you speaking? Who are the people working in this area who are really, at the moment, for the kinds of professional skills they perform at such a limited level of remuneration?

Ms Armstrong: As you say, they are significantly skilled individuals. They have a masters level of qualification and in most instances have trained as long as a doctor or a lawyer. The remuneration is, unfortunately, capped because of the limitations of the sector, which is primarily not-for-profit and charitable

donations, which limits the salaries available. There are differences across providers. Some have more government funding than others, but traditionally it is capped due to lack of funding.

Senator MOORE: It goes to budget. What kinds of professions are we talking about?

Ms Armstrong: We are mainly talking about orientation mobility specialists, occupational therapists and those specialists who have done that specific skill based training. They are very specialised in their areas but they work for specialist organisations with limited budgets.

Senator MOORE: And it is a particular stream of occupational therapy that focuses in this area, isn't it? It becomes quite specialised around the area of mobility.

Ms Armstrong: Absolutely. It is quite complex to teach someone who has no vision or very low vision to navigate around the community either using a long cane or a guide dog. It is quite a lengthy process where they need specialist understanding of the impact of vision loss and the social, psychological and emotional issues that come along with that as well. It is quite an in-depth and complex process where a lot of time needs to be taken getting to know the individual and providing an effective program that is, essentially, of an episodic nature. It is a short-term but quite intensive process where specialist knowledge really is required.

Senator MOORE: My last question is to do particularly with the issues of working with ageing. Most of us know that, with ageing, eyesight is one of the areas that does weaken in many ways. Mr Chaplin, you also talked about people's fear around issues of sight. It is very real. There are other sensory issues, but it is around sight that I know some people get very afraid. Does Vision have particular programs or work with ageing, in terms of working particularly with people who are working through those issues as opposed to an accident or medical conditions—just the fact of ageing? In particular, we talking about the different forms of ageing, including people in residential care and also people who stay in the community. Does Vision have a particular role in or program that works with those areas?

Ms Armstrong: I can speak on behalf of Guide Dogs Australia and our various programs.

Senator MOORE: Yes.

Ms Armstrong: We provide programs whenever they are needed—so home based or community based or residential care. It is where the consumer requires that support and that intervention. As Haylea mentioned, nationally, over 60 per cent of our clients are over 65 and fit within that cohort. Yes, specialist services make a significant difference, as we said, in that 65 to 75 age group where they still want to remain active and most people are still in their community, in their workplace and in their home. But it does also make a significant difference, when there is a transition into residential care and frailer ageing, in maintaining your ability to remain active, which we know has benefits for your overall health as well.

Senator MOORE: Do you market your services to people who are in that circumstance as well?

Ms Armstrong: From a guide dog perspective, 90 per cent of our services are philanthropically funded, so our service delivery model is what the consumer needs and where they need it.

Senator MOORE: Do you know whether there is any problem having your dog in any of our aged-care facilities?

Ms Armstrong: There should not be. It is covered by access laws.

Senator MOORE: I am wondering whether it is an issue.

Ms Armstrong: We do know there are some residents who move into residential care facilities with guide dogs—and, certainly, into independent living villages, where people are relatively younger and more active. We do have some of our retired guide dogs who have also moved into facilities, more as companion dogs.

Senator MOORE: They have gone into homes as well.

Ms Armstrong: Yes, absolutely. It is a second career for them.

Senator MOORE: They would be perfectly trained, wouldn't they?

Ms Armstrong: They are, and they get fed an awful lot! Obviously, while access laws apply, certain sensitivities need to be taken into consideration regarding the impact on other residents, but we have generally had very positive experiences there.

Senator MOORE: You are not aware of anyone having a problem. It is just that—

Ms Armstrong: Occasionally, there is a lack of clarity and a few concerns, but they can usually be worked through pretty easily.

Senator MOORE: Lovely. Thank you.

CHAIR: I want to go back to the CDC issue. Ms Armstrong, I think you said you are more confident that you might make some progress under CDC—

Ms Armstrong: We are hopeful, yes.

CHAIR: Can you expand on the hopefulness, in terms of the level of discussions you had with government? Those discussions sound like they are looking promising.

Ms Armstrong: The overall premise of CDC is that there is greater flexibility in services that consumers can choose. There will be a lack of boundaries as far as set programs and set providers. Obviously, with quality and safeguard standards there will be—and I believe it has not quite been finalised as yet—eligibility standards that providers will need to reach. We are twofold, really. I suppose we need to focus on educating consumers—as Rikki has spoken to—so there is that information and they are aware of their choices. But we also understand that with that flexibility in consumer care, as long as providers are accredited—however that may look, because we are not sure at this stage—and there is a reasonable evidence base for the value of the services, there will be greater flexibility for the consumers to exercise their choice for specialist services. Again, there are still a few questions to be ironed out, but it is looking a little bit more promising than was previously.

CHAIR: This is, then, dealing with the issue that, once they have been deemed eligible for a home care package, what happens in between would come back to that dreaded 65 cut-off process. So there is still going to be a group of people—is there not?—between 65 and when people are eligible for a home care package.

Ms Armstrong: That is one of our challenges, yes. Traditionally, speaking on behalf of Guide Dogs Australia, and it probably applies to a lot of Vision Australia services as well, our services fit more within that Commonwealth home support package, which is a lower level package. There are limits, as you would be aware, on the value of any assistive technology—as Rikki has spoken to—as far as what is available that way. With the combining of the processes and the packages, we are hoping that there may be a lowering of the eligibility and less of a focus on frailty. That is what we are hoping, with the recognition that early intervention and the provision of specialist services and supports at a lower level will prevent or delay that requirement for higher level funding.

CHAIR: That is where I was going.

Ms Armstrong: That has been a discussion. I think it will be an ongoing education process for the policymakers and for the community, as far as recognising that that relatively small investment earlier on and keeping people in their own homes and keeping them active within the community will, hopefully, delay that progression to frailty and a higher level need for care support.

CHAIR: I notice you said again you are hopeful. Does that mean there have been in productive discussions with government about that issue?

Ms Armstrong: From what we have seen of some of the policy guidelines and some of the documents that have come out, they appear to be broad enough, but until it is implemented we cannot say for certain.

CHAIR: That is what worries me: the horse has bolted once it is starting to be implemented.

Ms Armstrong: Yes, and that is why we appreciate the opportunity to keep coming in and getting our message across.

CHAIR: Returning to the quality guidelines you were talking about—and I am coming back specifically to the workforce now and your specialist expertise in orientation mobility—does that mean you are confident that under that process there will be specific guidelines for specialists in orientation mobility? Have I understood what you said earlier?

Ms Armstrong: It is a specialist area, and at the moment it is not accredited or aligned under the current allied health stream. That is something we are working on. It is a masters level university qualification and there is recognition that the skills align, but there is no formal recognition that it is an allied health qualification at the moment. That is something that we are also working on, but we have been told by the Department of Health and the Department of Social Services that there is recognition that an orientation mobility specialisation is equivalent to—and, in some areas of specialisation, exceeds—occupational health more generally.

CHAIR: So you do not think there is going to be an issue there?

Ms Armstrong: Time will tell. We are more positive than we have been over the last few years, but, as you say, we will have to wait and see.

Senator MOORE: We are very hopeful.

Ms Armstrong: We have to have hope.

CHAIR: Our time has run out. Basically, we will need to continue to watch that space, won't we?

Ms Armstrong: And we appreciate you keeping an eye on it as well.

CHAIR: Thank you for your time today. It is very much appreciated.

COOKSON, Ms Julia, General Manager People and Culture, Jewish Care Victoria

LAU, Mrs Marion, Deputy Chairperson, Ethnic Communities' Council of Victoria

MICHAEL, Ms Penni, Manager Business Development, DutchCare

PETROV, Ms Ljubica, Manager, Centre for Cultural Diversity in Ageing

ROB, Ms Daniyela, Implementation Manager, Person Centred Approaches, Jewish Care Victoria

SEMPLE, Ms Jenny, Chief Executive Officer, Southern Migrant and Refugee Centre

TSIGARAS, Mr Elias, Deputy Director, New Hope Foundation

[14:33]

CHAIR: I welcome representatives from DutchCare, Jewish Care Victoria, the Centre for Cultural Diversity in Ageing, and the Ethnic Communities' Council of Victoria. Representatives from the Southern Migrant and Refugee Centre and the New Hope Foundation are also here as representatives of the Ethnic Communities' Council of Victoria. Has information on parliamentary privilege and the protection of witnesses and evidence been provided to you all?

Unidentified speaker: Yes.

CHAIR: Welcome, and thank you everybody. We had a panel this morning on allied health, and we find having panels very effective, because not only do we hear from you as individual organisations but there tend to be similar questions that come up, and then we can get all your views, which tend to ping off each other once we get a bit of discussion going. Thank you for agreeing to participate. I now invite anyone who would like to make an opening statement to do so, and then we will ask some questions.

Mrs Lau: Today I represent the Ethnic Communities Council of Victoria, known as ECCV; I am speaking in my role as the deputy chair. On the ECCV board, I represent the Chinese Community Society of Victoria. I also convene the aged-care policy subcommittee of our board. Today I am here with my colleagues, Jenny and Elias, who are willing to provide further explanation as they have also provided detailed input into our original submission. We are here together as a collective team. We appreciate this opportunity to present to the Senate Community Affairs References Committee on behalf of Victoria's culturally diverse communities.

ECCV is a state-wide, member-driven, peak policy advocacy body representing ethnic and multicultural organisations and communities. ECCV member organisations include ethno-specific and multicultural service providers and aged-care agencies. ECCV emphasises the importance of a whole-of-organisation approach in the aged-care industry, to deliver staff training and provide care that is culturally inclusive. It is imperative that we develop strategies for Australia's aged-care workforce that are inclusive of the wide-ranging cultural, linguistic and spiritual diversity of people working in the aged-care industry and its older clients. In Australia, 20 per cent of people aged 65 and over are from non-English-speaking backgrounds. Ongoing feedback provided by members of the ECCV aged-care policy subcommittee shows that seniors from non-English-speaking backgrounds usually have a preference for workers that speak their language, understand their culture and respect their spiritual beliefs. Bilingual aged-care workers trained in ethno-specific and multicultural agencies have invaluable expertise in facilitating the access of seniors from non-English-speaking backgrounds to the service systems.

As you are aware, ECCV has already made a submission to the Senate Community Affairs References Committee as part of the inquiry into the future of Australia's aged-care workforce—hence why we are here, I suppose. It included some strategies and recommendations with a focus on 'creating a culturally competent and inclusive aged-care workforce; attracting and retaining a culturally competent and inclusive workforce; cultural competency of workforces in rural and regional towns and areas; and the role and registration of RTOs'.

We recommend four key steps to build a culturally inclusive aged-care workforce. Firstly, to establish bilingual certificate training courses in aged care, through partnership and input from education providers and ethno-specific and multicultural agencies. Secondly, to design certificate training courses in aged care that have an inbuilt cultural competency unit as a minimum requirement. Thirdly, to provide certificate training courses in aged care that include practical placements in culturally inclusive agencies, coupled with job support. And finally, to conduct industry-specific research focusing on the cultural inclusiveness of workplaces and on industry best practice in training aged-care workers in meeting cultural and linguistic preferences of clients.

ECCV further recommends that aged-care providers develop diversity plans to create a culturally inclusive work environment that encourages diverse viewpoints and promotes a welcoming work culture. ECCV is

concerned about the lack of culturally appropriate services and resources in rural and regional towns and areas and therefore recommends more resources for training on culturally inclusive practices in regional and rural areas.

In terms of the role of RTOs, we hold the view that in some cases organisations have not been fulfilling training standards as stipulated by the Australian Skills Quality Authority standards. There have been cases of RTO providers delivering certificate IV courses in aged care in a significantly shorter period than regulations require. This has impacted on the quality of education, as well as on the standard of care these workers will be providing. I have very specific experience of receiving some of these products from the RTOs, being a service provider. RTO courses need to be audited comprehensively, including by obtaining feedback from current and past students from non-English-speaking backgrounds on their employability.

Finally, it is important that migrants have access to comprehensive English language training before entering training courses in aged care. I know that not many of them have that opportunity. On behalf of ECCV, I thank you for the opportunity to be present here today. My colleagues and I welcome any questions you may have.

Ms Semple: Chair, do you have the submission from the Southern Migrant and Refugee Centre?

CHAIR: No.

Ms Semple: I will add some parts from our submission to further enhance what Marion said, just so I do not repeat that. Under the policies necessary to create a culturally competent and inclusive workforce, we believe that organisations should develop diversity plans. But those plans should not be limited to cultural diversity but take into consideration all forms of diversity. It becomes embedded in the organisation's culture, so it starts from the board of directors and goes through the CEO to management and to staff. We have a cultural diversity plan in our organisation. We also believe that the HACC funding body in Victoria develops diversity plans and requires that of some providers. Mainstream organisations see this as a significant motivation for them to recruit staff with language skills and cultural knowledge and understanding as well as the professional qualifications.

However, we do not believe that an organisation should recruit somebody just because of their cultural background. If the person is not skilled and competent in the area of the position that they are doing, then the work is not going to last and the quality of the service is compromised. These people should not be used to show that the organisation is diverse if they are not skilled for the role. It is not fair on that person. It can be seen as tokenistic, and that happens quite a bit.

In relation to attracting and maintaining culturally competent staff, we have a personal care program where we have 130 bilingual trained aged-care workers who go into the home and do personal care. They speak 45 to 50 languages. Recruiting and maintaining staff who are culturally competent is not linked to a specific sector. It is actually about the people. Our organisation provides aged care and also settlement services to refugees. It is about the culture of the organisation, the management, the behaviours and the values within the organisation, regardless of whether they are working in aged care, child care or whatever.

About the RTOs, I have got some case studies. I will not go into them now. We find that a lot of our refugee clients go to a jobactive provider and are told that they have to get a job or do training. They become very anxious, nervous and worried, so they go into the training. As Marion said, literacy is not often considered at all. I have got a case study where a young woman was put into a diploma level of child care and had to have a translator in the course translating and interpreting. So clearly she was not assessed for English at all and she was put into a diploma course through a private RTO. We see that as a huge issue—that the private RTOs are not checking on language at all. We also see people who have been to an RTO and have a certificate. Some aged-care providers will not look at them because of where they have got the training from because that organisation has such a bad reputation. So it is actually creating another level of unemployed people. Statistically, you could say they have got a certificate and they have done training, but if they are unemployable then it is just another level of unemployment.

Senator POLLEY: Can I just ask if you would be prepared to list those training providers?

Ms Semple: I have not got them.

Senator POLLEY: Would you be able to take it on notice if that is a possibility?

Ms Semple: I am not sure.

CHAIR: You can provide it in confidence.

Ms Semple: I would have to go back and talk to the staff about that—if they have got them. I will finish at that, and I will let Elias talk.

Mr Tsigras: Following on from Jenny, we have very similar situations with our clients in terms of the home and community care program that we deliver, as well as the settlement services program. As to the RTOs, with

the deregulation in the industry there are a number of them out there that are touting for business. The people that we work with in the settlement space are the potential employees of the Home and Community Care Program, the package program and residential care placements as well. Unfortunately, the quality of the training is suspect in some situations. I cannot give you specific providers, but I could provide that confidentially further down the track. It is about people not really having the language skills to be able to participate in a course of six months which requires a level of English that is sufficient to be able to deliver a service. When you are a trained individual going to a workplace, you need to have English ability. That has been an issue for many of our people. The other problem with that is that, when they do their certificate III, they can only get subsidised for that once. If it is not quality driven, then they have lost their training place and they are left behind in the unemployment stakes.

It requires a lot of work with individuals to get them to that space. As to the 510-hour English language program that we deliver through settlement, there may be potential to review that program and think about how we might be able to have a vocational stream that leads to foundation vocational—for example, to have 510 basic English as the foundation, with a stream to a vocation in aged care—pre-certificate. It might take some time, but I think these things are worthy of consideration.

We really want to skill up our people, who I see as our clients, who are desperate to work. They are reliable; they are competent; they are trustworthy and hardworking people. They have languished in refugee camps for many years and just want an opportunity to get on with their lives. Aged care is an area that they can probably get into. They have a caring attitude—I can specifically talk about the Burmese community that we work with, who are very giving in their cultural affinity, and they are attracted to work like this. We have, as an organisation, been trying to develop programs to assist their skill development to get access to training places. Yes, at some point they may need some support with language, but I think that if we can tackle that at the 510-hour pre-certificate vocational training, it will enhance their prospects for the future.

I think organisations also need to have diversity plans, where the board and governance of the organisation has a level of understanding of their client groups: who they are targeting, the work that they are doing and the workforce requirements to do that work in a culturally competent manner. That is fundamentally important. Our organisation does that; I know that many of our partners have that embedded, and I think organisations across the country need to have. They could review their practices and say, 'These are our client groups; we need to engage with them. What do we need to do? We need a competent workforce. We need to train individuals who have bilingual skills as well.'

Let us harness the diversity of the nation. We have got about 30 per cent of our people who have come from all sorts of backgrounds—who have come from refugee communities. There are also migrants with high-level skills. But have the entry point into aged care so that people want to be there. I think it is important that the aged-care industry thinks about the remuneration. I think we have had those discussions about: 'Why would I want to do that? Yes, I can do the work, but if I am only going to get \$18 an hour—it is pretty hard to look after my family on \$18 an hour.' So we need to think about those issues as well.

That is probably where I want to leave it. I am happy to answer other questions at some point.

Mrs Lau: Chair, can I refer you back to your question about identifying the number of these agencies? About five or six years ago, through the Australian skills and qualifications authorities, a number of these organisations were identified. Some of us were approached by a number of potential students who were not granted an opportunity to continue with their program because of their lack of English. They came under the impression that they would be provided a course in English to enable them to understand the program. Unfortunately, the agencies did not do that, and they used that as an excuse for not continuing with the program. As a result, the students were kicked out and told that their visas were also removed from them. So there was a whole lot of work done through the Australian nursing federation, the immigration department and also the Australian skills and qualifications authorities. I do not have any specific data to tell you, but I can refer you back to the skills authority because they should have that on file.

CHAIR: And those are the same organisations—

Mrs Lau: They are no longer there.

CHAIR: But is it still going on?

Mrs Lau: Yes. Others have come up.

CHAIR: If anybody could provide any more information—in confidence, if that needs to be the case—it would be appreciated. Thank you for that lead.

Ms Semple: Can I just add one more thing? We have actually had people that go through an aged-care course for six weeks, not six months. The other thing is that people are not getting information about what the course is and, as Elias said, they can only have one certificate and that is it. They are not being given the basic information even about what they are enrolling for. We had two women who thought they were enrolled in an aged-care course, and they ended up enrolled in a painting course.

CHAIR: It sounds like that is something we obviously need to confirm.

Ms Michael: Thank you for the opportunity. I am going to follow on from these previous speakers and just add information. When we talk about bilingual and bicultural staff, what we are discovering at DutchCare is that we also need people who have experience of the migration process in order for them to understand some of the grief and trauma that is displayed in aged care. The bilingual and bicultural staff become very critical in the home and also in residential care where it is 24/7 and there are a whole range of access, choice and even basic human rights issues that need to be addressed.

When we look at DutchCare staff we are currently running at 60 per cent. That is because we have a process or program in place where we actively communicate with universities in the Netherlands. We encourage students, we fund student placements, we run television, radio and media programs, and we encourage sister organisations and visitors. Through all that work we have been able to attract new migrants, Dutch speakers, trained up in aged care. That has worked beautifully. Where we are seeing problems—and this is the irony—is in the Italian community. For the last eight months we have not been able to employ one Italian-speaking personal care worker. If anyone knows of anyone, let me know.

Ms Semple: We do, but we employ them, and you are not going to get them!

CHAIR: During this process, no-one is to pinch anybody else's staff, okay?

Ms Michael: The other two areas we are pursuing at the moment are the Indian community and the Arabic community. The Indian community has been exposed to Western types of cultures—with the British, for instance—and they are familiar with aged care. Nursing personal care is not foreign to them. With the Arabic community we are miles away from it.

When we look at the obstacles we are saying the obstacles are sometimes around culture and language. I certainly concur with the issue around English being an absolute necessity. There are two areas we are identifying where we are going to source these staff. One is that if they exist in other like industries we can coax them and bring them across. The other is within the communities themselves, which means there has to be high level of community education to break down the barriers. How is that work going to be done and where is that work going to be done?

The second barrier we have is that these people are sourced from lower socioeconomic situations within Melbourne and there are numerous obstacles—I will not go into those—so we have to overcome those. The last obstacle is usually one related to their age and their health condition. We are finding that we are still attracting much older staff into the workforce. That means that we have reconsidered our work-life balance issues and employment structures to enable these people to be able to work with us and in the industry.

The second thing is that we have found that because English is difficult for them, we have trained 30 of our senior staff in cert IV training and assessment. So we can actually offer on-the-job training and upskilling. We get them to a stage where we know they are going to be successful in the next level up, which is either cert IV or diploma, or we then get them into ENs and RNs. We have so many examples where we have processed staff through that program.

The last thing is that we are also identifying that cultural responsive care is not always about understanding what the cultural specifics are, but challenging one's own attitude and response to the older person. We run, on an annual basis, what is known as 'cultural intelligence' training. If you are looking at a fundamental component of training, that is a good one. That program is about your own biases, your openness, your ability to discuss and your ability to leave your own culture at the door sometimes when you are addressing the culture of the other person. We have some young Dutch people who constantly tell us that they feel as though this is not Holland when they come to DutchCare. They do not recognise it because, for us, DutchCare is Holland of the 1950s.

It so often happens. I will leave it there, thank you.

CHAIR: Thank you. Who is next?

Ms Rob: Like everyone else, I am very thankful for the opportunity today. Our submission was a collaboration of a number of people who work in our organisation, so we are fortunate to have that breadth of knowledge. Jewish Care provides services predominantly to the Melbourne Jewish community—although we do

service some non-Jewish clients; we have to do that because we are government funded. We have 365 residential beds and 242 home-care packages, so our home care is growing.

We are currently piloting a new model-of-care concept within one of our facilities, which we call 'Hand In Hand'. It is person centred and relationship centred, with a focus on enablement for our clients—keeping them connected to the things that were familiar to them at home and helping them retain a sense of purpose. It is based on some small-house models that have been successful in America, but also means a refining of the skill set of our aged-care workforce.

We would like to take the opportunity to outline the issues we currently see as important within the workforce., It is an ageing and older workforce, and there has been no growth in people under 35 entering the workforce since 2003—obviously, that is an issue for future requirements. This is also impacted by recognised and perceived skill shortages within aged care: people do not see it as a very attractive career, so they will not come into it. This has already been mentioned: the reasons for completing a certificate III in Individual Support are varied, and sometimes not necessarily aligned with what the personal care worker role is.

Our own experience shows that direct-care staff have more than one employer; so they are working more than 38 hours a week, which obviously impacts on work performance, work health and safety, engagement and the primary employer. There is clearly a requirement for industry and government to work together to attract younger, well-suited and competent people into aged care. With the sector moving towards customer-directed focus and more providers adopting a person-centred care model, the skill set of staff needs to shift. A lot of that focus, recruitment and training needs to be on the softer, less tangible skills of empathy and emotional and social supports for people, and conversations and assessments around enablement and potentiality within people. So how do you train for those and then how do you assess and gain competency?

We would also welcome a registration framework for direct-care staff, to ensure not only that competency is maintained but that professional growth is encouraged. This would also provide avenues for reporting serious misconduct beyond a provider's own internal mechanisms. Often, someone might be performance-managed out but they will go to work somewhere else, which is not ideal at all.

To address GP shortages, there needs to be greater support for providers and individual registered nurses to upskill to nurse practitioner qualifications. I think there are only two nurse practitioners in geriatrics in Victoria, despite it being around for 13 years now. In addition, nurse graduate programs within aged-care need government support over a long period of time. Career paths are not well defined or articulated for most aged-care workers and there is an inconsistent approach between providers as well.

We have also mentioned RTOs. We have a partnership with an RTO which works well for us. We provide input into their course content, which assists us in terms of Jewish ethos. That has been very successful for us and we do believe that those who genuinely wish to work in aged-care should be supported to improve their English language skills before undertaking the qualification which has already been mentioned. Work placement hours are a core component of the personal care worker qualification and this means that people are buddied-up or mentored with an existing personal care worker, who might not have the skills to do that. There need to be resources around upskilling our own staff so that we have got a student that has a well-rounded experience and is job ready at the end of that.

Again, there is no clear vision or capacity building for the sector and the government must work together including peak bodies. Additionally, there needs to be work towards changing public perceptions about work in aged care and making it more attractive for people to come into and work in. We also need continued funding for programs that have proven outcomes. The Graduate Nurse Program was a good example. We were part of that. It was a two-year program and then the government funding that was pulled. We were successful in employing two registered nurses from that program who have done really well in our organisation. As a provider to the Jewish community, all of our staff undergo full ethos training on orientation, and that continues also when we have high holidays and festivals. Staff are trained in that. Obviously that is an extra cost for us, being a CALD provider, that we are not compensated for. Finally, we are concerned with the cuts to the aged-care workforce, because it means a decline in access to mentor specific expertise and upskilling for staff in general.

Ms Cookson: My role is general manager of people and culture in Jewish Care Victoria. To give you an idea of how hard it is to resource care workers, on an average we get a three per cent success rate when we are trying to place staff into personal care or as residential care workers. We might get on average, say, 330 applicants for a role and be able to place only 30 of them. That is the sort of churn rate we are getting. As Daniyela mentioned, one of our strategies is to have a relationship with a specialist RTO. We have a fit-for-purpose program that they are running for us, but we do have to spend an awful lot on additional training once we have got a candidate in. A

large cohort of our residents are Russian speaking, so we are trying to get Russian-speaking care workers and that is a little tricky.

Senator MOORE: Sorry, my brain is not working. Does that mean that if you advertise you get 300 applicants for 30 jobs? Is that what you mean?

Ms Cookson: No.

Senator MOORE: I thought I had got that wrong.

Ms Cookson: Of 300 applicants we can place 30 at max, and that is ten per cent. That is the top level—that is, 10 per cent. Most of the time we are getting three per cent that we can place anywhere between being suitable for our—

Senator MOORE: So, if you have positions people apply, and they are applying for everything because that is what they have to do. That gets me. I was just trying to think what the argument was.

Ms Cookson: Most of the time it is about three per cent, which says something about the job readiness of these candidates.

CHAIR: Ms Petrov, I will ask you to make an opening statement and then we will go to questions.

Ms Petrov: Thank you for the opportunity to present today. Being behind all these other speakers, most of the points they have made are the points that I intended to cover as well, and I think I agree with everything everybody said. For the past 18 years, the Centre for Cultural Diversity in Ageing has been providing consultancy and professional development to the aged-care sector in the delivery of a culturally inclusive service provision. We are funded by the federal Department of Health. There is an organisation in every state and territory that does similar work. I will not say our work is token, but it is very small compared to the needs that are out there.

From our experience we have gained substantial grassroots knowledge of the challenges that the sector has in addressing diversity. The category that most people have mentioned already is the one of capacity building or skills in addressing diversity. One of the things that is quite often assumed, and I would like to stress it here, is that everybody needs culturally inclusive service provision training or cultural intelligence training, as Penni mentioned. Quite often, there is the assumption that if a worker is from a non-English speaking background, they do not need the training. For instance, here in Melbourne we know that all aged-care facilities in the western and southern regions have residents who prefer to speak a language other than English. We also know that staff are not provided with initial training or professional development, as was outlined, in how to carry out the work that provides the services in a culturally inclusive way.

Language mismatch between staff and residents remains the largest challenge. One of the things that has not been mentioned so far is that in Australia there is a very low profile for learning a second language for the Australian born population. That is something that I think needs to be explored in the future, because we need more bilingual people who will meet the diversity of language needs in the aged-care sector. Also, there is an underutilisation of available support services such as interpreter services or language services using interpreters.

Capacity building is currently not systematically addressed and one of the ways that that can be overcome is by people developing cultural diversity plans, as was mentioned earlier. Access to professional development in the field of cultural and linguistic diversity is not mandatory in the aged-care sector. You can be employed to work in a very culturally and linguistically diverse workplace and client base and not have any training in that area.

The second important consideration I propose to this inquiry is the duty of care that the sector has to its workforce. Just like the consumer population, the workforce is becoming more and more ethnically heterogeneous. According to the Department of Health's report *The Aged Care Workforce, 2012—Final Report*, a quarter of the aged-care workforce were born in non-English-speaking background countries—that is, around 35,000 people in residential care and 25,000 people in home care. The need for managers of aged-care services to be skilled in recruiting, supporting and managing a diverse workforce is vital. What this means is that the workplace should be free of discrimination and racism and there should be commitment in staff support and development that is not only informed by consumer needs but also by workforce needs as well.

Unfortunately, in the aged-care sector when diversity is discussed about the workforce it is quite often addressed with a deficit model. It is quite often reported as something negative. Quite often, the aged-care sector will blame many of the ills of the aged-care sector on their culturally and linguistically diverse workforce. I think there is a need for a bit of a shift in thinking with regard to that. More broadly, how the aged-care sector addresses diversity at leadership and policy level also needs to be looked at. I think there needs to be greater uptake of leadership in this field in order for it to be seen as important as it ought to be. Now, it seems to be considered mainly at grassroots level. Management does not see it as relevant to them.

Senator POLLEY: Where do I start? Thank you all for your submissions and for your comments. It has been very helpful. My question is really directed at all of you. You can fight over who goes first. We have identified the problems. First, it is hard to recruit good people. We know that diversity is not the priority it should be, whether it is as a provider or whether it involves those people who are working in the sector. We have seen an enormous amount of money cut out of aged care. We saw the money around training and staff development. We know there is not a career path. Can you elaborate for us on where you see the role of the federal government. At the last round of Senate estimates, when I asked the minister about the workforce and the workforce supplement and the road map going forward in this sector, she said that it was not the government's role to lead. I have a different view, obviously, and I want to hear what your views are as far as the leadership that is needed from the federal government is concerned.

Mrs Lau: I think that it is the government's role to lead, and this is the beginning of our problems and our challenges. If the policymakers and rulers of the day just decide it is not their responsibility, they are gone. I would like to formally disagree with that statement and I would also like to stress that if the government keeps continuing to say that it is not their role, they should stop harping about the increasing number of people who are getting older. Once you have acknowledged that your community is getting older, you should then be able to find resources and support to look after the community. We are also discouraging people from taking up aged-care residency and other aged-care services as well as retiring too early. If you do not want the community to retire early then you must have opportunities for them to continue in the workforce. As we have all indicated, it is very challenging for anybody—it used to be over 65, now it is over 45. It is very challenging for someone over 45 to find a job. We have big challenges here and I would like to see us plan for those two challenges of having an ageing workforce and having a much older population that requires care. There needs to be additional support, which we have all articulated in different ways, for the older population who want to continue on in the workforce to be trained and prepared and supported, given all the issues that we have highlighted, in providing care to their elders who then are much older and will need more care. That is one thing that government and the community can work together on.

We also have an increasing number of people who have come from other countries who are now getting older, and they need care. We have articulated the reasons why they want care and how they need it, and we should be able to provide support. We have plenty of expertise in some of the younger members of our community who can provide the cultural competency. I want to challenge people who say to me that I have bilingual staff so they should be able to cope. They are bilingual staff but they are not necessarily bicultural. There must be bicultural and bilingual as well—they need to understand the culture as well as the language.

Ms Rob: We have this focus on having an ageing population and how are we going to care for them, and the government has to lead or at least coordinate some response to that. They need to be strategic and work with the sector. I agree totally with what Marion has said.

Ms Semple: One of the issues with the RTOs is the deregulation, and there is no monitoring. That is definitely a role for government. At the moment people who want to get into the sector are coming up against these rogue RTOs and not getting where they want, which is absolutely cruel and devastating to these people, whether they are migrants or refugees or not. I think the government has a big role in that area, and that is getting people trained to move into aged care. If there is a stumbling block there, it is very hard to increase and improve the workforce if they are not able to train.

Ms Michael: We would be interested in some sort of retrieve over the past two or three years for those people who have done cert III courses that are not deemed appropriate to be able to reapply with the same amount of funding. We had to put through one lot of staff at our own cost because their qualification was no longer recognised. That is a very practical, short, limited response to something that has happened. I am not suggesting that it is ongoing.

The second thing is, there are also secondary structural issues around Centrelink payments—if I go back to that socioeconomic issue—where the loss of the health card prohibits them from being fully employed. You cannot have it both ways. If we are employing people from a group of the population who are interested in this type of work, we cannot penalise them for full employment by taking away something that is actually quite valuable to them. Again, there has to be some looking at that. I know it is a big ask but, if you are asking for significant obstacles, this is the second one.

Senator POLLEY: We have heard evidence this morning, and it is also throughout the submissions, that the training is also expensive for those people who are on lower incomes.

Ms Michael: It is.

Senator POLLEY: It is a barrier for them to do that. There is also the issue around the fact that any ongoing training is done on the employees' own time, which is an issue because you can understand providers are also pressed. Do you have any solutions as to how we can address that?

Ms Michael: The issue around cost is whether trainers are prepared to come to a place of location—and there are regional locations. In the south-east there was a consortium that was actually funded by the Commonwealth, maybe two years ago. We conducted training, so we reduced costs by getting the trainers. We also negotiated with the trainers and got it down as low as we could, and organisations partly subsidised it. It took a year's worth of negotiations to get us to that point. We have not been able to repeat it because of the cuts in universities and TAFEs. There was something we worked very hard at developing that was just removed. We had a solution, but it was cut from underneath us.

The other thing we tried to do in the southern region, again funded by the Commonwealth, was another consortium which looked at pooling staff. If a staff member was trained for, say, infection control or fire safety in one facility, there was a service agreement between these organisations that that would then apply to them, so we were able to reduce their training hours and increase their working hours.

Thirdly, for not-for-profits, there is an advantage in their staff working in more than one location because of the salary sacrifice component, and why would you want to take that away from them given that it is such a low salary? That consortium was specifically looking at how to increase people's take-home pay without any additional costs to the organisation, and providing that work-life balance.

Given some support, funding short term, the solutions are within the industry. I just do not understand why that does not continue and why they are being decimated in the process. You cannot do it off your own back. We see that, constantly in aged care, as soon as you get clever with ACFE ACFE changes, so any amount of money you are able to raise the—

Interjection—

Ms Michael: That is right; we are rotting the system—thank you! With the consumer directed care, there is absolutely no money left whatsoever for community education. People talk about it being marketing, but marketing to whom? We are applying corporate or business models in a system that has not yet reached that level of sophistication, so we are just jumping. The transition is not happening. We are just jumping from one service model to another. When we talk about capacity building, I think everyone around the table recognises that there is industry and service capacity building, as opposed to individual or organisational capacity building, yet the emphasis seems to be on the latter. Yet the demonstrated models that I have just given you from two consortiums is that it works best in an industry based model, not in an individual service or organisational model. You have to pool resources if you are going to make this work, because the money is shrinking and consumers do not want to pay for something they do not have to pay for. We are seeing that all the time.

Senator POLLEY: I will just mention Jewish Care, who made the observation that your RTO had a fair bit of input into their training but even when those workers came onsite they still had to do additional training. Would it be a fair assumption for me and the committee members to have that we need to have national training and that we need to ensure that those people providing that training have the necessary qualification skills and certifications? And do we need to have a registration—I think that has already been alluded to—for all people who work in the aged-care sector, so that we can overcome some of these issues about people being managed out of one employment situation who will go elsewhere? Because there is a desperation out there. Anyone who has a bit of training will grab those and not necessary have the best people.

Ms Michael: There is a crossover, too, with disability services.

Senator POLLEY: Yes, we would like to hear about that as well. There is a pool of talented people out there, and both the disability sector and the aged-care sector are vying for those individuals. We do need a lot more people. In my home state of Tasmania over the next five to 10 years we need, alone, an extra 5,000 people to work in this sector. We have to change the culture. We have to see it as a positive—that this is an economic driver for this country if we seize the opportunity. There is a big challenge there for us.

Ms Semple: I think also jobactive have a role in this. At the moment, they are saying to our clients, 'You need to work or study and that's it', but they are not giving the details of the courses, they are not talking them through. Also, how much are they selling working in aged care? I would say they are probably not selling it or promoting it at all. They have a big role to play, because they are the people that are the gateway to training and jobs. I just wonder what they are saying to the clients about aged care.

Senator POLLEY: Can I just jump in there. How many people are you getting that have come through from jobactive through training into aged care?

Ms Semple: I would say most of them, because they would have started off in jobactive.

Senator POLLEY: So they are doing that? Are jobactive providers doing that?

Ms Semple: Yes, but sometimes we will employ people who have already been in the sector before. We are right near the Chisholm TAFE. They have a reputable program, so we would employ people who do their six-month courses. It just depends where they are coming from, but most of them would be jobactive and then to an RTO or TAFE.

Senator POLLEY: Then what you are saying is that some of the RTO providers are not providing adequate training for you to be able to employ.

Ms Semple: Yes. Also, I am asking: how do jobactive actually promote working in aged care? We are talking about promoting it as a good job to have and I do not know that they are. And they are the gateway for people. We also have some people who have walked in and said that they found a job and it said 'aged-care worker', or whatever. It looked like a job advertisement, but when they looked closer it was an actual RTO just advertising training. So they went to the RTO assuming it was a job, but it was not a job; it was training. One of our staff went closer and there was little fine print about what it actually was. It is just straight-out deception for people who are very vulnerable.

Senator POLLEY: Have jobactive actively approached any of your organisations to work with you to develop an understanding of what you need and to see if you can start a bit of a pathway?

Ms Semple: Could I just say, quickly, none at all. We have nothing to do with jobactive.

Senator POLLEY: You are very clear about that one.

Ms Semple: Yes, I am very clear on jobactive providers. If you asked them that, they would say to you or to me: 'We are not funded to do any of that work. We do not have funding to go around and talk to agencies and partner with agencies and do what you are doing with an RTO.' They do not get funded to do that and that is why they do not do it.

Senator POLLEY: They do not want better outcomes.

CHAIR: I would like to know where all our money that we spend on it goes.

Ms Cookson: We have had a situation in Jewish Care Victoria. We have a whole division that reports through to me and actually does the role of a jobactive provider for the marginalised in the community. It is horrendously expensive for the return rate, but we value it as one of our social justice initiatives. So I would concur with what Jenny is saying:—no.

Mr Tsigaras: If I can add to that, jobactive does not really do a lot of work with the client group that we work with, but I was very interested to see that in the state budget of Victoria, Jobs Victoria is being reconstituted and resurrected as an identified gap in the type of people we are talking about, and their needs, because jobactive cannot do it. We ran these programs in the past. They were called workforce participation programs and were funded by the state government of Victoria. They delivered really good outcomes with the very people that we are talking about that are being shafted by jobactive and private training providers. And it worked—it worked. I am really heartened to see that is back on, and Victoria will start thinking about that gap to complement the fact that jobactive does not prepare people for the work that we are talking about.

CHAIR: We will make sure we follow that up.

Ms Semple: Just on that, I do not understand why the state government is doing it. Actually, I do understand why, but they should be taking that up with the federal government. There are other programs that are funded, even through the federal government, that are complementary to jobactive. There are all these gaps in jobactive where they are not delivering what they should. The states are picking up that gap, and other funding from the federal government is picking up that gap. That never makes sense to me. Never.

Senator POLLEY: Thank you. That has been very interesting. I would like to direct my question firstly to DutchCare. I was most interested to hear how you recruit people into your organisation. Do you think that part of that is a cultural issue? My observations are that, as Australians, we lack the respect for older Australians. We see this whole sector as being a burden, a financial burden, and we have the attitude of: it would just be better if you went over there in the corner somewhere and were quiet and we will feed you every now and then. Is there a different culture in the Netherlands that actually gives respect to this sector, and is that why you have some success in bringing students out?

Ms Michael: The short answer is probably yes, but I would say the Dutch have a different perspective on innovation per se. They are interested in being forerunners. You can look at their architecture and their dams. It is not just about the age; it is a cultural issue. They are also very pragmatic in their approach, which is: we need to

care for our elders because they cared for us. That is the cultural aspect. The other thing is, at DutchCare we recognise what it is that our workers are really interested in. Many years ago, our CEO defied the whole paradigm around professionalism. She said, 'You are to establish relationships with these people, you are to talk about personal issues, and they are to be important to you and you are to worry about them.' We have a reputation for long stayers because of the way we structure our workforce. The emphasis is always on relationships. Where we cannot pay, we do the added value things to ensure that people know they are valued. Is not just about the Netherlands; it is not just about the Dutch culture; it is also about the model of service delivery and care for staff at DutchCare.

Senator POLLEY: Thank you. I had better let someone else ask a question.

Senator MOORE: I have only two areas. One is for Jewish Care. Professor Yvonne Wells said that you would tell us something we needed to know. I have actually read your submission, and there is lots of stuff in there. Do you know what Professor Wells was actually so—

Ms Rob: We have a partnership with La Trobe University.

Senator MOORE: That is what I wanted to get out.

Ms Rob: Part of our hand-in-hand model, which I spoke about in the opening statement, is that we are partnering with them to get an evidence base around whether our interventions actually work. We might think they are a good idea. Again, it is about that enablement model—upskilling the personal care worker to be more multiskilled, to be more able to manage the day-to-day goings-on of the home and, as our CEO likes to say, so they can have more opportunities to say yes rather than having to go and find out from someone else. I guess I alluded to that a little bit. There really needs to be a refinement in that model of what the skills are for those workers.

Senator MOORE: How are you funding it?

Ms Rob: At the moment we are funding it ourselves. It is still very early on in the pilot phase, but the draft training module that we have looked at, that would be on top of the certificate III, is 40 hours of theory based work, plus additional hands-on work for what you are looking at.

Senator MOORE: Plus on the job—

Ms Rob: Yes.

Senator MOORE: So this whole area of effective placement comes up all the time—how you can train people.

Ms Rob: Yes. It sounds like DutchCare are probably already doing it very well. It has to be relationships. It is not just person centred; it is relationship centred. But how do you teach that? Or how do you recruit for that? How do you know that someone is actually going to be effective?

Ms Michael: And encourage it.

Ms Rob: Yes—encourage it.

Senator MOORE: The other thing that was in your submission that was in partnership—and DutchCare also mentioned it—was the skill pathway. You could take people from working at one level in the organisation and then, with support, end up having them in professional qualifications. You mentioned that particularly in the submission from DutchCare.

Ms Michael: That is right.

Senator MOORE: And in your submission, Ms Rob, you said that there was no more money—that you were doing that in collaboration with a special program but that the funding for that had dried up. Given that the funding dried up, are you still working in that space?

Ms Rob: We are still doing it. For example: in one of our aged-care homes we had a personal care worker who was training to be a registered nurse. She has now completed that qualification and we are actually supporting her to do her graduate nursing here within our organisation. We have set it up so that she works over a couple of facilities, and possibly over home care as well. Again, we were fortunate enough to have the person now working for us who was the previous driver for that graduate nurse program with the peak body.

Senator MOORE: So she has brought that skill with her?

Ms Rob: Yes, that has been really beneficial.

Senator MOORE: And you have had that experience in DutchCare as well? You particularly mentioned where somebody has been able to work through the system and then benefit the whole industry by that upskilling.

Ms Michael: Absolutely, that is right. We even start at our volunteer base—that is where we start. As soon as we recognise a volunteer who has certain skills we do our darndest to find employment for them. And when someone approaches us for employment we also have the attitude to look very hard to find employment—even if it is part time—in order to get them into the culture of the organisation.

Senator MOORE: Particularly if you are Italian!

Ms Michael: Do you know someone who is Italian! I could put it out in Queensland!

Senator MOORE: The other area really touches on a few of the discussions that we have had from another area. There is the view that anyone can be a care worker, and that under the current organisational process in Centrelink—and also, I think, a little in migrant services—the expectation is that people will get a job. They are being streamed into employment or else they will lose their entitlements. So, you have an option: you have to study or you have to get a job.

We have lots of data that says the growth industry in Australia is care. Senator Polley referred to that when she was asking questions. I have a fear that we now have a pot of jobs and a pot of people who need jobs, and the temptation will be, 'We'll just pour them into the same bucket.' I would just like to hear from all of you who work in the industry about whether you think that works?

CHAIR: Sorry—just keep it fairly short if you could, because we are now running over time.

Senator MOORE: Can you say 'no' shortly? No!

Ms Lau: This is already happening: I have often had people come from different industries, like firemen, accountants and even people from the hospitality industry. People come and say to me, 'Our dad is about 60 but he still wants to work, and he would like to become a personal care attendant. Can you tell us where he should go to study?' So we already have a lot of people doing that. I try to dispel the myth that anybody can become a personal care worker.

That is that step. The other is—again, coming back to another controversial area that I hoped not to touch!—women whose children have grown up and gone away.

Senator MOORE: Because they can 'care'—they have raised kids.

Ms Lau: That is what they feel and that is what they think. Not only do they want to be personal carer workers on cert III but they think that once they do they will be on a step to becoming a registered nurse. This is why they want to enrol and do the six weeks or six months, depending on how lucky or unlucky they are. So, yes, there is the concern that I have, as a registered nurse by profession and having then gone on to do other things. It worries me an awful lot that the way we had to go through and be trained to be a registered nurse was very different to everybody else who goes and sits in the lecture room for so many hours and comes out with a certificate and calls themselves a registered nurse division 1. So I have a concern.

Senator POLLEY: In summary, there is real concern within your organisations about the lack of leadership by the federal government in this area in relation to the workforce and the challenges that are facing us.

Senator MOORE: Ms Petrov, on notice can you give us some information about how much money is given to your organisations in every state? I want to find out what the allocation is and how many staff you have. Could you put that on notice?

Senator POLLEY: And whether you have been cut recently, which I expect you have.

Ms Petrov: We will be soon.

CHAIR: Thank you very much for your time today. It has been very helpful and informative.

GRIFFITHS, Ms Bronwen, Manager, Strategic Reviews, Australian Skills Quality Authority

ROBINSON, Mr Christopher, Chief Commissioner and Chief Executive Officer, Australian Skills Quality Authority

[15:36]

CHAIR: Welcome. I remind witnesses that the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given a reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. You have been given information on parliamentary privilege and the protection of witnesses and evidence. I invite you to make an opening statement or comments, and then we will ask you some questions.

Mr Robinson: I thank the committee for the opportunity to appear before you in your deliberations about the aged-care workforce in Australia. I will make a few opening remarks to try to set the scene so that you understand where we fit into the quite complex set of arrangements that exist in this sector—as I am sure you have been finding out. The Australian Skills Quality Authority is the national vocational education and training regulator. That role is to regulate the registered training organisations, RTOs, which include TAFEs and private providers of training. We were established in 2011 to replace eight different regulatory approaches by the states and territories. Our establishment occurred under quite a rare event, which was a referral of powers from state parliaments to the Commonwealth government to allow regulation to occur nationally. Two parliaments of Australia, however, did not refer those powers: Victoria and Western Australia. So we have a situation where we regulate 4,000 of the 4,600 registered training organisations in Australia, and the two state regulators regulate the other 500-odd providers. But we do coordinate our activities closely, and nobody is regulated by both of us; they are regulated by either one or the other. We do regulate most of the providers in Victoria anyway, because we regulate the providers that have overseas students or work across state borders, and we also regulate slightly under half of the RTOs in Western Australia. So we regulate the bulk of them and we regulate most of the big providers in the country. That is just to let you know the background.

How we regulate is set by our act, the National Vocational Education and Training Regulator Act 2011. That sets the powers of the regulator, which is the three commissioners, of which I am the chief commissioner. We make the regulatory decisions according to that act. That spells out where our, if you like, remit stops and starts, as is the wont of these things. So we do not set the standards by which we regulate RTOs; they are set through a group called the Australian Industry and Skills Committee, and they set it with the ratification of the ministerial council responsible for vocational education and training. That is the Commonwealth and the state ministers for training—they are the representatives on that council. So that is the body that oversees the actual setting of the standards.

The other thing that is really important to mention is that a key part of that is also that we do not set the content of courses or the matters which courses are to discuss or to cover, but we do regulate against whether RTOs are delivering according to those, and they are called national training packages. They are set through the Australian Industry and Skills Committee, and that is where they consult with industry to check the relevance and appropriateness of the content of training. The theory is that it is supposed to be meeting the contemporary job needs of employers and that people are getting courses that are geared to those job needs. They come in at various levels, so you can have a certificate program or a diploma-level program—the certificate IIIs and IVs—and most of the qualifications in the aged-care sector are certificate IIIs or IVs.

There are some training pathways that fall outside of our remit as well, because they are higher education pathways. You were talking to someone earlier who was a registered nurse, for example. Registered nurses are trained through higher education through the university and higher education sector. Enrolled nurses are trained through the VET sector. So they have, I think, a certificate IV program that they do. There are quite a lot of people in both of those professions who are employed in the aged-care sector. There are also allied health professionals, some of whom are trained in VET and some of whom are trained in higher education. So there is a bit of a mixture in the workforce, but the overwhelming majority of people in the aged-care workforce are going through the VET system and through registered training organisations.

That is just a little bit of background about how the system works. Our job is to ensure that the RTOs are complying with the required standards for their registration, and that includes meeting the requirements of the training packages that have set the curriculum or the content to be covered—the job skills to be covered—through a consultation with industry. So RTOs develop their own curriculum, but it is based on the specifications of the

training packages, which look at the job skills you need to do the various jobs. So we are not a body that directly contributes to what the content of training is; we look and see whether people have done it.

The last thing I wanted to say is: two years ago we did a national review of training in the aged-care industry. I will make sure that you have got that—

Senator MOORE: That would be really useful.

Mr Robinson: report available electronically. We have also prepared a short statement for tabling now—

CHAIR: Okay. That would be great.

Mr Robinson: which gives an update of what has happened since that review was done. We have copies of that. We will send all this to you electronically as well, so that it can be distributed to you later.

CHAIR: Thank you.

Mr Robinson: I wanted to say that, if there are further questions you have after looking at this material, we would be very happy to provide further answers or to meet with you again if that were necessary, if there were any further queries you had. We did this review. We have the capacity to do national strategic reviews, a bit like the tax office; they identify a priority area and look at that area in detail. We did that with training in the aged-care and community-care sector, and we released this report in 2013. The Productivity Commission did a major report in 2011 on the industry and, in that report, some considerable issues were raised about people's concerns with the consistency of quality and the training in the aged-care sector and a number of other factors.

We decided it was necessary to follow up and do a much more detailed look at what is actually happening in the training industry. A lot of the material that came through to the Productivity Commission was based on hearings like this and people making submissions, but a lot of it was ad hoc. So we have gone and had a much more thorough look at what is happening with training in this sector.

The last thing to say—this is where this report covers some of those issues—is that we made quite a number of recommendations in that report, but quite a number of things have happened since that report to improve training that we have been following through on. As I said, we are happy to provide further information after this hearing this afternoon.

CHAIR: Thank you. Ms Griffiths, did you want to add anything?

Ms Griffiths: No thank you, Chair.

Senator POLLEY: You were in the room when the former witnesses were giving evidence. We have had evidence this morning. We have a lot of submissions—hundreds and hundreds of submissions. There is concern about the lack of properly skilled and trained people entering into the aged-care workforce. Can you give us a synopsis of what has changed since this report and the Productivity Commission report, and what is still left to be done?

Mr Robinson: Obviously, the number of older Australians is growing quite significantly.

Senator POLLEY: We cannot stop that.

Mr Robinson: No. In fact, I think it is projected to increase by fourfold between now and 2050. So there is a lot of demand out there. The whole nation has had trouble meeting that demand with properly skilled workers. I think that is one issue. When we did our review in 2013 there were just under 500 providers of aged-care training in the country, and it is now getting towards 650. More providers have entered the field to try to meet some of that demand, and there has been an increase in the number of people undertaking VET courses. We found in our review that there was a considerable variation in the quality of the training being provided by providers. In fact, we have deregistered some as a result of our work.

Senator POLLEY: I think you are being quite generous in your terminology.

Mr Robinson: We are not that generous. We have actually deregistered 10 per cent of the entire VET sector since we started in 2011, which I think is a pretty large body of work. I do not think there is a regulator you would find anywhere that would have deregistered 10 per cent of the providers in the sector in 4½ years. I do not think we are generous. I am saying there is a big variety in the quality of training. We found that in our report. We found that over 80 per cent of people were not fully compliant with the standards required for training providers when we initially audited them. That reduced to under a quarter being fully compliant by the time they had had a short period of rectification to meet the problems we identified. They get 20 days to deal with the issues we raise, otherwise we take further regulatory action. As I say, we have been taking action to deregister some 10 per cent of providers. So there are quite a few people who were providing training in this sector before who are no longer in the sector. We have put a priority on aged-care training because of the issues we have found. When we audit a

training provider we do not necessarily audit all of their courses, but when we audit a provider that has aged care on its books, we always look at the aged-care program in particular because we have found that there have been quite a lot of issues with it.

Senator POLLEY: From the evidence and from the submissions there seems to be a general thrust that even those people who go on and complete their training—in fact, one of the organisations has a fairly good working relationship and has input into their training provider—are not work-ready when they go on to the workplace. What can we do? Is there a role for your organisation and the federal government to take some leadership in this and making sure that the standard is raised and that we have uniform qualifications and certificates in the sector?

Mr Robinson: When we did this work we found there were problems in the way they were doing the assessment. We found there was a particular problem in the workplace element of training. With some training providers there was not enough of a workplace component. We have made recommendations to the people who set the training packages and the content of training, and they have brought in a new qualification that has addressed some of these issues, including having a minimum amount of workplace training. It is a considerable improvement on what was there before. Whether it is enough or not, time will tell.

We also found a great variety in the length of training courses, which worries us quite a lot, but we have a competency based training system in Australia and there are no mandatory requirements for how long a course should be. We discovered that 33 per cent of the offerings in this sector were under 15 weeks, and we were concerned about that. But there has not been a change in policy to require minimum course lengths. With the strategic reviews that we have done as a skills authority, as a regulator, we have certainly been arguing to make sure courses are of a certain length so people do get the competencies they are supposed to be getting, particularly if they are not an experienced person already. It is okay if someone has been out in the workforce and they have some of the skills already—they can have their skills recognised and they might not need to do as long a training program as someone who has come to the area completely new. We are concerned that some of the courses being offered are too short for people to get properly skilled.

Senator POLLEY: Can you identify the key types of noncompliance that were found by your investigation?

Mr Robinson: We had a lot of concerns about how well the assessments were being done—whether the training package was meeting all the requirements. Last year new training standards were developed and they came into effect on 1 April 2015—just over 12 months ago. Those new standards increased the requirements on RTOs about how they undertake assessment. And that was for all forms of training. That work was quite significantly informed by our national review of this industry sector and some other industry sectors that we did in 2013 as well. We are an active regulator in the sense that we regulate against our charter but we do also propose reforms and improvements to the arrangements where we find problems and we publish our national strategic review so that people can see what we have found. We are very transparent about the problems that we have uncovered, and we make recommendations about addressing those. Some of the issues have been addressed.

We did find in some cases problems, where there were workplace placements involved, with people who were supervisors doing the job of assessors, who need to be qualified and trained. Some RTOs were taking a kind of tick and flick report from workplace supervisors rather than properly assessing whether students had the competencies themselves. Some of the assessment forms we recommended went to that matter. As I said, we found there were insufficient work placements involved in the training in some cases, and the assessments did not always include proper observable behaviour. We were quite concerned about the way some of these assessments were done, and in particular we got quite a lot of changes to the standards around the assessment being more detailed in telling RTOs what they need to be doing to make sure an assessment is valid and reliable.

Another area where we found some concerns was with the English language skills of some of the workforce. People were mentioning earlier the cultural awareness and other language skills that people have but we also found there were issues to do with English-language skills with some workers in the sector whose first language was not English. Training courses do not particularly cover that issue at the moment, which is a factor in some people's training.

Senator POLLEY: What percentage of the providers you have deregistered are on, for the want of a better term, a watch list of providers who are not quite there?

Are the majority doing what they need to do and doing it well, or would there be 50 per cent or 30 per cent that are still under par?

Mr Robinson: I think there are around 25 per cent that are offering courses that are still too short, and I do have a concern about that. Even though we have a competency based system, my concern is that for new learners competencies do not materialise out of thin air. There needs to be a quality training program, and if the courses

are not long enough people will not get all the skills they need to get, even though they might get quite a lot of them. Some of the short programs are not all low quality, but I do have concerns that some of them are just not long enough to properly equip new learners.

We find that there is a 10 per cent problem in the sector where people are not up to scratch and we take actions to deregister them. I think that is quite high. I do not think you would find many regulators that are deregistering 10 per cent of their regulated community. There have been problems with the quality of training in the Australian VET sector, and we have taken a more stringent line than our predecessor agencies took. It is partly to do with the fact that since it has become national regulation we have a national act that provides an enhanced set of arrangements for us to work with—we have some stronger tools to use and we certainly have not been afraid to use them in cases where we think it is necessary. There have been some really bad examples of people who are more interested in making some money out of training than actually doing it. I want to stress that it is not the majority of providers—it is the minority, but some of them are very poor. We have acted strongly on many of them, but we still acknowledge there are more of them to get to.

We have some cases where people do enough to demonstrate compliance. We follow up on those ones within a year if we have concerns about them. We have the ability not to wait until the next time they come up for re-registration—we can go and look at the higher risk providers. We get complaints from students and employers. When we get those complaints we go and follow-up on those providers, so we do have people on our watch list, if you like, who we follow up much more regularly. We are gradually eliminating the worst providers using that process. But I would not for a moment suggest that it is all sorted yet.

Senator MOORE: We have just had evidence from a number of people who work in the multicultural area. They were talking about concerns they had, particularly with courses being run in their area which may or may not have been effective for their client group. Do you keep complaints statistics about people who contact you with concerns about different forms of training?

Mr Robinson: Yes, we get about 1,500 complaints a year. About 40 per cent of those come from students—nearly half of them.

Senator MOORE: From students who are unhappy with situations?

Mr Robinson: Yes. Most of the rest would come from other training providers or staff with training providers who are concerned about what their training provider is doing. We do get some from industry itself. Since we have done this work on the aged-care industry, from time to time we have been meeting with the employer associations—the peak bodies in the aged-care sector—and we have asked them also to identify particular RTOs that they are concerned about so that we can follow them up if they do have those concerns. But there has been a reduction in the number of complaints per enrolment that we have been getting about the aged-care sector since we have done our work. We are not getting a huge spate of new complaints from the employers. We have already dealt with some of the worst cases of RTOs that they were concerned about. We have dialogue with them, and we speak with the national aged-care regulator body as well with these employer groups to try and identify if they have ongoing concerns about particular providers.

For us, as a regulator, getting specific information about specific organisations is the way we can do something about it. Telling us generally that training is no good or something does not help us much. We need to know names, ranks and serial numbers, and then we can go out and have a good look at them.

I have a staff of about 200. About half of those are direct regulatory officers, so we go out and audit their training. We do not do financial accounting audits, we do audits of their training and assessment. They are qualified people who can look at the training and assessment systems that RTOs have and, if we have complaints about RTOs we run the risk based regulations. So we look at the people who are worrying us the most and the people where concerns are being raised through complaints. We make those the key trigger points for who we look at and when. We put a high priority on people where we are getting complaints, and we have a good look at their assessment training and the way they are dealing with their students—those sorts of issues.

CHAIR: Can I just check over what the time period is that would you take those complaints? You said you prioritise where you are getting a higher volume of complaints—over what time period?

Mr Robinson: We get about 1,500 every year.

CHAIR: Yes, but in terms of a specific RTO?

Mr Robinson: It depends on how we assess the risks, and also the numbers of complaints and the kinds of complaints.

CHAIR: That is what you mean. What is the number where you go, 'Oh, actually,?' Is there something that—

Mr Robinson: We do not have a hard-and-fast number, because it is partly to do with the nature of them as well. But if we think they are going to the core issues of how well they are doing training and assessment, we give a high priority to getting out there and looking at them more quickly.

CHAIR: Right, so it is the nature and the number, not just the number?

Mr Robinson: We have conducted almost 6,000 RTO audits in four years, so we are quite active over the population of 4,000 RTOs that we regulate. We do get out to them quite frequently, especially if they are of concern to us. Sometimes, as I said, they can use review processes for the Administrative Appeals Tribunal to—if I can use this term—'scrape back into the system'. If they have gone through a process and struggled to finally demonstrate some compliance, we go and look at them again within a year to make sure they are maintaining that compliance or taking further action at that point. We are very much risk based, so we do use complaints information and intelligence from the industry as a key process for focusing on who we look at and how quickly we look at them.

Senator MOORE: There were 10 recommendations that you made in the report. Have all 10 been done?

Ms Griffiths: Not quite. There has been good progress on the majority of them and, as the chief commissioner alluded to, the training package has been updated. A lot of the recommendations went to the content of the training package and getting more specificity around the work placement requirements. We are broadly happy that the training package changes have picked up the majority of the recommendations.

Some of them were for ASQA. We continue to monitor a mandatory inclusion of those qualifications. We are working with the aged-care peak body to ensure that work placements are available, which is another issue for the RTOs. The main one, which the chief commissioner has also alluded to and that has not had much movement, is the volume of learning. That recommendation has been common across the six strategic reviews we have put out about the need for the training packages to address the issue of including some amount of required learning for the qualification. That is the one that—

Mr Robinson: For new learners.

Ms Griffiths: Yes, for new learners—that is right.

Senator MOORE: Recommendation 10, which is the one that talks about all the powers and all the groups that need to be involved—peaks, employers, unions, industry representative bodies, Victoria and Western Australia—to do an overhaul, how is that one going?

Ms Griffiths: As the recommendation alludes to, setting that is not done by us. It needs to be done by industry, and so getting those groups together is done through the Industry Skills Councils.

Mr Robinson: It is not really our role to do that; although we were arguing that there needs to be—

Senator MOORE: That it should be done.

Mr Robinson: benchmarks for volume of training built into training package machinery. We believe that the current system, which does not have that, leads to a situation where it is too optional for an RTO to run a course that is too short. The problem we see with that is that people do not always get the skills and competencies they should get, to the level they should get it. We find that with our audit work. It also means that the RTOs that are investing in a product of a certain quality are under pressure, because other people can undercut them by offering a shorter and cheaper course.

Of course, people who are enrolling to do a course look it up on the net. They can see that someone else is offering a course that takes less time and costs less in fees, so they opt for that instead of going for the course that might be of better quality and that might take longer and cost a bit more. We are concerned that there are not sufficient parameters at the moment to deal with the variation that we have found in the length of training. Length of training is not the only parameter for quality—it is not even necessarily the main one—but, if you have too many providers offering courses that are so short, unless the people already have many of the skills that they need, that training will not be sufficient to ensure that they gain the skills and competencies that they need. That is what we have found in our regulatory work.

Senator MOORE: You explained that really well, and we have had that evidence all day. You recommended that the—

Mr Robinson: We recommended that. It has not been picked up in the system as yet. It is an issue that we, as the national regulator, are continually concerned about.

Senator MOORE: We have way too much experience as a Senate committee in seeing recommendations not taken up but, in terms of the process, you have recommended that publicly. To whom do you go to to say, "This should happen"?

Mr Robinson: Ultimately, the people that specify the machinery for the training packages is the state and territory Commonwealth ministerial council.

Senator MOORE: Does your recommendation go to them?

Mr Robinson: It has been to their bodies. There is some work going on to explore it and the like, but it has not happened yet. This is not unique to aged-care training. We have found it in the other areas of training that we have been looking at. The problem, I think, is that, in a competitive training market, if people do not fully understand what constitutes a high-quality product compared to a poorer quality product, the consumers gravitate to things like shorter and cheaper, because it is more convenient for them and they believe they are getting the same product. But, of course, they are not quite getting the same product in some of these cases. I am not saying that length of training is the sole determinant of quality but, with courses that are too short, I think we have enough evidence to show that people are not really getting the skills and competencies they should get.

Senator MOORE: What I am really asking is: how much clout does your recommendation have?

Mr Robinson: It is certainly an issue that people have on their agenda to consider but, as I say, it has not happened yet. Some recommendations we have made relate to other bodies doing other things. A lot of those have been taken up. There has been a new version of the training package released, which has taken account of these things. There was a change in the whole national standards for registered training organisations, which picked up the bulk of our concerns about the assessment issues that we found. So there is a lot more specificity around the standards now about what RTOs are to do to comply with the standards around assessment. I think we have had quite a lot of influence in these things, even though we do not set those things.

Ms Griffiths: It is worth making the point that the chief commissioner has also announced, in the last couple of days, that one of the issues in ASQA's next strategic review will be short courses, generally.

Mr Robinson: Yes, across the whole sector. We will be putting out a report later this year that will look at the extent to which short courses are a problem across all industry areas in the VET sector, across the whole VET sector. Hopefully, that report will also go to what some of the solutions to deal with this issue in a more general way can be. It is not just an aged-care training issue.

Senator MOORE: The other issue, which was raised by the previous witness, is the fact that in their area people get one shot at doing a training course which is paid for by the government. They firmly believe—and they put evidence in front of us—that some of the training providers were taking people on board for courses and churning them through, but the people who were being taken on had no English. There was no consideration from the training provider as to the need of the participant to have English comprehension, language or literacy. In your review, was that an element of the consideration?

Mr Robinson: In this national aged-care training review, we did look at the issues of English language. They were raised with us at that time as well. On that issue more generally, some of the funding comes from state governments and some from Commonwealth programs. We are not the funding body in either case, but what we are doing this year is setting up enhanced arrangements with funding authorities so that we can share information and pinpoint poorer providers earlier.

CHAIR: And get funding in the first place?

Mr Robinson: Yes. If they are starting to be concerned about someone, we want to hear about it early, and they with us as well—early, rather than later on when we have come to the point of making a decision about it. We are going to do a lot more work on coordinating our information sharing and having direct arrangements with each funding authority around the country to pinpoint some of these problems. But some of those issues that you relate to go to broader policies like entitlement programs and the like, and that is a broader VET policy issue that is really outside our remit.

Senator MOORE: That is not the point. The point about who actually gets it and whether they should only get one go or something—that is a broader policy issue. The quality of the provider must certainly be whether they are taking on people whom they know are not capable of doing it. That is purely a training provider issue.

Mr Robinson: I know. It is. The standards go to that issue as well, and that is one of the things we look at with providers. And, of course, you would have heard that some of the VET FEE-HELP providers, for example, were engaged in some nefarious recruiting practices. Early in this process, we started a high-priority review targeting problematic providers. Last year we looked at 21 of those. We have deregistered four of them and we put conditions on another 10. Some of those issues very much related to the way they recruited students and whether they were capable of doing the programs that they were recruited to. We are doing a second round of VET FEE-HELP work this year and we are looking at a further 18 providers that are of concern to us right now. We will take further actions as that work gets completed.

It is an important issue, whether or not people are capable. The standards are about RTOs doing proper assessment of a student, as part of the enrolment process, before they enrol them, to ensure that they are capable of completing the courses that they are signing up to. Because VET FEE-HELP was geared at the diploma level or higher, there were cases of people that were not able to do courses at that level being signed up to those courses nevertheless, because of the availability of funding. This goes to the issues to do with how funding programs are designed and the requirements they have. But, at the same time, nefarious behaviour does affect the standards that they operate under, the national standards that they are supposed to meet. That is where we come in, and we do look at RTOs in that context.

Senator MOORE: When I read the full report, will I find anything in your report from 2013 on that issue?

Mr Robinson: We have identified the issue about English language courses, but I do not believe that that has been changed in the training package. You would have to ask the training package designers about that issue. There are English language programs around, but whether people do those or not, in conjunction with these other vocation courses, falls outside of our remit. We identified it as an issue and highlighted it in the report, but it was beyond our capacity to deal with it directly. Where we find RTOs that have recruited people who do not have sufficient English language skills to do the course they have enrolled them in, we can take some action. If there are specific examples of that, we would be keen to get that information, and we can go and have a look at those people.

CHAIR: Good. Thank you. There are two issues that come out of that. One is obviously following that up in terms of whether they have been doing that, and potentially taking some action. But the point that was being made to us by some of the aged-care providers was that what they want to see there is an opportunity for the people that have been through the process, and have done their dough, to actually get—I forget the term—

Mr Robinson: They have exhausted their entitlement.

CHAIR: They have exhausted their entitlement. Through no fault of these people, they have signed up to a course that they—

Senator MOORE: And they get a useless qualification.

Mr Robinson: That whole issue has to be addressed by the funding bodies, because the entitlement programs were about them getting a shot at a certain level, and that was it.

CHAIR: You could report to them that these people, for all intents and purposes, have a useless qualification and they have been duded. They may not use that term. I will use that term. They have been left high and dry, to a certain extent.

Mr Robinson: We do not regulate the students, and we do not assess whether the students have all the skills and competencies they should have.

CHAIR: No, I understand that.

Mr Robinson: We regulate the provider, but we do interview students or we look at particular student issues at times. We have recalled the qualifications of approximately 600 or 700—I cannot remember the exact number of students over the time we have been operating—but our focus is on stopping the RTO from going forward. We are not a student regulator as such.

CHAIR: Yes, I understand that, but would you play a role then in providing some evidence of the fact that the RTOs have not fulfilled their requirements?

Mr Robinson: When we audit them, it is at the time of the audit. We cannot retrospectively deal with this issue. Six months ago, they may have been fined. We do not know. We are auditing them now.

CHAIR: The upshot is that students have little recourse, because their entitlement has been used up for a worthless course.

Mr Robinson: That can happen, and, as I say, if we have very firm evidence that they, for example, were given a certificate without having done any training or assessment, we do, in some cases, recall those qualifications or require certain things to be done. But, by and large, we are not out there testing the skills of all the previous people they put through. Our job is to test compliance of the RTO with the standards and, if they are not compliant, to take action either to ensure they are or to deregister them if it is serious and they are not. We do not have the capacity to go and test all the students. We are not an RTO. We are not testing all the students.

CHAIR: What I am trying to look for—and I will have one more go—is: if I am a student and I have now been told by the person that I was going to work for that my qualification is useless, I have used up my entitlement and I am now stuck, where do I go? Obviously not to you, but you can provide some of the evidence base—

Mr Robinson: Possibly not. Only in some cases.

CHAIR: Possibly, in some cases.

Mr Robinson: By and large, people have to raise this with the state training authorities or the Commonwealth department. These matters go directly to the policies that are available, or the policies and funding that are available. We interview students, we look at student experience and we get complaints from students that we investigate, and the like, but, by and large, we are not the body to deal with those particular student issues. It is really for us to gather that information to make the case around the registration of the RTO. After all, if we deregister an organisation, we are ceasing their opportunity to exist as a business or to employ people, and it is a pretty drastic step. We do that in cases where we think what they are doing is seriously short of what is required and they have not rectified it.

Senator MOORE: Mr Robinson, what we are trying to get from you is an acknowledgement that, if a complaint is made to you about an organisation and you investigate that organisation and you have a finding that they are not fulfilling their requirements, a student of that authority would be able then to go to the funding organisation and, as part of their case, would be able to say, 'The ASQA has actually found against Acme Training.' You would not have any personal role with that student, but your finding against that provider could well be used by that student.

Mr Robinson: It might be, and in fact we have a process of notifying those bodies on all occasions when we take any regulatory action.

Senator MOORE: That is good.

Mr Robinson: By and large it will be the state training body, for example, that might set up a process to deal with the displaced students if we take an action to close down a body where students are still enrolled. There are some schemes around the place like the TPS, the Tuition Protection Service, for example, which is run by the Commonwealth government, for overseas students that are displaced and for whom there is no other placement. State training authorities have processes in place to varying degrees where they will pick up students who have been displaced by these processes, and there are some tuition protection schemes run by the Australian Council for Private Education and Training and TAFE Directors Australia where they place students in other courses or give them refunds if they cannot be placed. So there are some arrangements, and we liaise with all those bodies when we are taking regulatory decisions.

Ms Griffiths: Can I add one further point to that. In January this year, the Department of Education and Training released a discussion paper around this issue about assessment and training. It included discussion around recall of student qualifications. That process closed in March, and I do not think there is an outcome of the process yet, but there was a broader discussion paper released by government.

CHAIR: Thank you.

Mr Robinson: The point is that if that were to become a bigger feature of what happens then there need to be arrangements in place to deal with those student issues, and there are some there—quite a few—but there may be more that needs to be done in that space.

CHAIR: Thank you. We have run over time and now we are behind time again. Thank you very much.

HOUSTON, Ms Annette, Manager, Indigenous Development, Australian Unity

McMILLAN, Mr Derek, Chief Executive Officer, Independent and Assisted Living, Australian Unity

[16:22]

CHAIR: I now welcome representatives from Australian Unity. While you are settling in, I will just check that you have been given information on parliamentary privilege and the protection of witnesses and evidence.

Mr McMillan: Yes, we have.

CHAIR: Excellent. We have your submission; it is No. 206. I invite one or both of you to make an opening statement, and then we will ask you some questions.

Mr McMillan: Thank you. I would like to make a statement, and then Annette would also like to make some personal reflections as well, and then we are open to questions.

CHAIR: Excellent.

Mr McMillan: Australian Unity is a mutual organisation, 175 years old, and some of you may know us as a health insurance or investment provider, but we also provide a range of aged-care and disability services, home care and retirement communities. We have about 6,000 staff who work in the retirement and aged-care part of our business, which I am responsible for. We talk about social infrastructure—the hard and the soft assets. Australian Unity not only develops retirement villages and aged care but also owns hospitals and other infrastructure as well. We call those the hard assets, but we also spend as much time thinking about the soft assets, which is the way that we deliver services and the way that we work.

One point I would like to make is that I think it is important for us to ensure that the training that is provided matches the skills that people actually need for today and for tomorrow.

In particular I would like to make the point around the mix of the workforce. I have read a number of the other submissions, and a lot of focus is placed on personal care workers and the nursing staff. However, I have provided a handout to you which represents our workforce last year. The size of each of the blocks displayed represents the relative size of the workforce. The darker colour is our forecast for where we see the greater growth coming in the future, particularly with person centred care model and consumer directed care. The point I wanted to draw your attention to was that in fact the range of workers that are required is significantly greater than nursing staff and aged-care workers. In fact, there is a whole range of workers who are focused on re-ablement: OTs and physios but also workers who help people live a better life or even help them live a more ordinary life such as event organisers, occupational therapists and so forth. I wanted to draw your attention to the vast variety of workers who are actually involved in the workforce. It is more than just aged-care workers, personal care workers and nursing staff.

Senator MOORE: What is in 'other information and organisation professional'? It is one of your really dark blue boxes.

Mr McMillan: For example, we are starting to think about our home care clients in particular. Many of those clients might have an iPad, might wish to Skype their grandchildren or may in fact be involved in telehealth. We think we need to train our aged-care workers to be able to support those clients in the home. As the clients have more control of their funding and are asked to contribute more in terms of a co-contribution—which I think the future will be—clients themselves will be more demanding of staff and more demanding of value for money. Part of that value for money will be multiskilled staff and people who are able to do a range of different services. That is one example.

I might keep rolling on that theme because that was another introductory comment I wanted to make. If clients are looking for more flexible, multiskilled staff then the training of the workforce will need to reflect that. One simple example that is not too far a stretch to consider is that a single care worker could provide laundry services, food preparation and, say, personal care, and yet two of those three are not provided for in terms of the basic certificate training for community care workers. We think that, in the future, the courses need to be much more oriented towards the skill mix that people will want tomorrow, not the institutional model that a lot of these courses are based around.

By the same token, for our residential aged-care we have developed a model called Better Together, which is essentially a home-style model for residential aged care. That shows that, when we survey our clients, their quality of life—their self-reported wellbeing—is about 30 per cent higher under that model than it was under the traditional, more institutional medical model. That is where the second handout comes into play. That is the breadth of skills that we believe a multiskilled care worker in aged care does need in order to provide true person

centred care. We were unable to find any RTO that was able to provide training for all of those skills. In fact, most could only provide about a third of the skills that we needed.

They are probably the two key opening points I wanted to make around training in particular. The other opening comment I wished to make was in relation to Indigenous services. Annette is going to talk a little bit more about that. Australian Unity is a relatively recent participant in Indigenous-specific care. That has happened since we acquired from the New South Wales state government the Home Care Service of New South Wales, so we now provide services to around 3,000 clients of Aboriginal and Torres Strait Islander heritage. We have provided in the submission a number of suggestions which relate to supporting staff training, development and retention, particularly around culturally competent training and inclusiveness training. We are particularly concerned that, without that, a number of the clients are not actually receiving the quality of care that they deserve, because if the staff are not culturally aware of what the requirements are then they will not be able to provide those services that are required. We have put some positive suggestions into the submission but, if we can, I would like us to hear a few comments from Annette in relation to both her personal experience and also some of the work she has undertaken with other agencies.

Ms Houston: I would like to start off with my own story of my aged mother, who was diagnosed with dementia, and the process that we went through with the ACAT assessment through to the service provider, and now that she is in residential care. At no point through any of that was there an Aboriginal worker that I could talk to—there was nobody within the ACAT and certainly the service provider had no Aboriginal staff, which made it really difficult trying to get the best outcomes for mum. Mum is not that forward—she will not speak up about what it is that she wants—and that was made even harder by having non-Aboriginal staff asking questions that mum thought to be quite intrusive, and that I believed to be intrusive. So I found myself being a buffer—being an interpreter. That placed undue pressure on me as a carer.

When mum progressed to a stage where we were no longer able to care for her at home with the support of an organisation, the time came to look for residential care for her. I live in south-western Sydney, which has a large Aboriginal population. We visited probably 10 organisations and, again, there was not one Aboriginal staff member—not one of the care staff, the geriatricians or the social workers was Aboriginal. And, again, the barriers and the constant conversations in trying to see what care facility would be best placed to care for my mother have been a minefield. Even just having a social worker—again, somebody to act as a buffer so I could say, 'This is what we would like for our mother; this is what she has told us'—in all the lead-up to here would have been useful to me as the carer. I was the voice of my mother, but there was nobody to interpret for me or to help me navigate that pathway so I could have the best result for my mother. While my mother is still in residential care now, I do not believe that they are providing the best care possible. It has been a number of years and we have made some progress, but it has been a very hard journey.

I suppose I would like to talk about my experience of when I worked for the New South Wales government with Ageing, Disability and Home Care. The agency had very few Aboriginal staff in the care area, and so the leadership of that organisation took it upon themselves to increase Aboriginal employment. With the help of various funding sources plus their own funding they put together what they called the *Let's See It Through: Aboriginal Employment Strategy*, which committed the organisation to recruiting, developing and retaining Aboriginal staff. A key component of that was traineeships. Those programs were run over four years. We had care support for home care, we had disability support workers and an assistant in nursing. Over that four-year program we were able to recruit 300 individuals, and we retained 270 of them. The model that we used was around targeted recruitment, job-seeking agencies, going out and being present in the community. Talking about RTOs, we found that there was no RTO suitable so we had to engage and skill up that RTO to deliver what we thought was appropriate for our care staff.

The program was held over a 12-month to two-year period that provided on-the-job training and the qualification. It provided mentoring as well, both cultural mentoring and on-the-job mentoring. Those that knew the industry or knew that particular worksite provided that insight. The cultural mentor helped the individual to bridge the cultural gaps from an organisation or a work location that was not culturally competent.

One of the barriers that we identified with one of the traineeships was around the driver's licence, which is a requirement for home support. Many Aboriginal people have outstanding fines or they do not have the means to acquire a licence so we built that into the program so that, by the end of it, not only did people have a licence but they also had finance for a car, a qualification and an ongoing job. They then provided a richness and a different skill set to that organisation. What else can I add?

CHAIR: You will probably think of more as we ask you questions.

Senator POLLEY: I appreciate your submissions and these are most helpful. What I want to ask you is what I have asked all the witnesses—that is, what should the role of the federal government be in providing leadership in the aged care and ageing sector?

Mr McMillan: One issue that I have had with the accreditation model is that the accreditation tends to measure inputs rather than outputs. It does not tend to measure the quality of life and therefore it is easy for organisations to provide, for example, a clinical setting that does not actually provide a good quality of life but they feel and believe that they are providing the right outcome. I think that part of attracting people and having the right people in the workforce is actually having a more enjoyable workplace. A more enjoyable workplace is actually where not just the residents have a better quality of life but where the staff feel more fulfilled as well. One of the pleas I would make would be to say let's review the accreditation standards to ensure that they better reflect quality-of-life outcomes for clients because in pursuing that we will find that staff will enjoy their work more and it will be easier to attract and retain staff as well.

Senator POLLEY: As has been the experience elsewhere and will continue to be, we have an ageing population so we need to have an aged care workforce development plan. I would suggest that the government has a leadership role in that. The minister at the last round of estimates said it was not the government's role to take that leadership but to work with the sector. I was just wondering what your views are in terms of how you see the leadership and the plan going forward? Who has the responsibility for the development of that plan?

Mr McMillan: No doubt there would be some shared responsibilities but my feeling is the government should be setting the standards and the outcomes that society would expect and then enable the providers to actually work towards those standards. For example, career development is sometimes challenging for providers because many providers are not making any money or such little money that to backfill staff off the floor actually can be quite a costly exercise for a training program. So we tend to find that a lot of our training is done in small bites in the person's own time because it is too expensive, which means that that can prolong training outcomes and skill outcomes. I think the role government can play is to support professional development, where there are defined pathways that people are pursuing, and actually subsidise to provide that training. The subsidy should go with the care worker—I do not mean to the provider—so that we can still backfill but not have to pay, for example, a second care worker at the same time. That is the type of role the government can play.

I think also that the salaries in aged care and home care are quite low. The challenge is of course that you cannot increase the salaries without increasing the package value for the clients because, particularly in home care clients control the funding. If we do not increase the funding level but we increase the cost of that care then all that is going to happen is you are going to get less care for the same dollar. I think another area of leadership is: ask what is the right cost of care and match that up with the package value.

Senator POLLEY: I refer to your submission and what I got out of it was there is a lack of understanding of this issue within the broader community. Would you then support the view that has been expressed today—that is, the government has a leadership role in educating the community about the challenges that we face with the workforce and in making sure that people from different cultures, our own Aboriginal people and the LGBTI community are catered for. We still have a long way to go for the community to understand that we have got a huge crisis facing us in workforce. Do you see that as the government's responsibility or is that jointly between the sectors as well?

Mr McMillan: That is a very good point. I think that the government can play a very positive role in promoting and understanding the diversity of the clients and the diversity of the workforce and ensuring that their clients have a better outcome by ensuring that it is not just technical training that is provided but also a range of other skills that people have in order to support people from a range of different backgrounds. For example, I was just talking to some of our management team yesterday about how we are going to increasingly see now clients who will be coming through the aged-care system who will be refugees from war and other horrors. Maybe they are living within their community today but in five years time that will become more and more prevalent so how well placed are our staff to recognise that? For example it could be people from Vietnam or Cambodia. I think that cultural diversity is a particular issue that the government should be taking more leadership on. I agree with that.

Senator POLLEY: In some of the facilities I visited over the years in northern Australia, there have been some specialist facilities for our Aboriginal brothers and sisters but there are some huge challenges there in carers that are non-Aboriginal understanding the cultural differences. I was wondering if you wanted to add anything more in relation to the challenges there and in understanding the cultural differences.

Ms Houston: While I can speak about perhaps what is relevant in New South Wales, I cannot really speak about what is relevant in northern Australia. Generically, there are cultural aspects around spirituality, even just

basic things around food. What is appropriate food? I may be able to get something off the shelf or out of the supermarket but that is not appropriate on all occasions. The use of bush tucker is appropriate. Cultural awareness is not quite enough. It is around cultural immersion and that does not occur by attending a few information sessions; it is a lifelong learning. Like my own spirituality and my own Aboriginality, it is something I learned over a period of time. Employing Aboriginal staff brings that cultural awareness and diversity into the workplace and the interaction between the Aboriginal and non-Aboriginal staff is a way to build that cultural understanding.

It is something that is going to take a period of time; it is not something that is going to happen overnight. You were talking before about the quality standards—home care support, attendant care or residential facilities. I believe there should be measures there that talk about all that organisations need to perform or show they are working towards. Cultural competency or targets around the Aboriginal workforce are things the government can do. They cannot make people do it, but one area where government can do it is through the standards.

It is through having different mixes of people within the workforce. That is what is going to build that cultural understanding. More broadly, those issues exist outside aged care. It is a challenge across the nation.

Senator POLLEY: Generally, from the evidence that has been provided today and in the submissions, there is real concern within the sector about the adequacy of the training that people have—that they can come onto the floor or go out into somebody's home after doing their certificate III or IV but they are not actually job ready. What has your experience been, Mr Macmillan?

Mr McMillan: That is entirely right. In fact some of our management team say that all the training does is identify who is interested in the sector rather than who is competent to provide the services. For example, our Better Together model was a three-week training model that we undertook for the staff in order to train them in that person centred model. It included all those competencies that we would have expected many of them would have had from their RTO. That was an additional three weeks of training before they actually went onto the floor which we needed to provide ourselves. So I absolutely agree with you.

Senator POLLEY: How do we change the culture that I believe we have in this country to one where we value older people and value those who are working in this sector?

Senator MOORE: That was only a simple question!

Senator POLLEY: It was! We need answers.

Mr McMillan: To me, it comes back to the principles around wellbeing—their quality of life and understanding that what we should be doing is working out with the client what their goals are. Do not assume that if they have moved into aged care they have no more goals in their life. Try to help them achieve what they wish to achieve in the two, three or four years of the rest of their life. By starting at that point you then start to understand them as a person. That respect then becomes a powerful thing in terms of the rest of the workforce and the enjoyment that staff get. As I mentioned, when we undertook the first pilot for this Better Together model a number of staff were reluctant to pursue it, but their job satisfaction went up so much as they understood what caring really could be like. People would say, 'It's more like I'm feeling like I'm looking after my mother or my grandmother than looking after a client.' That is the feeling that we want to get for the sector—that people feel a personal connection to the client.

CHAIR: Ms Houston, I either missed the answer to this or it has gone in one ear and out the other: how long has it taken you to develop the processes and approach that you have now put in place and the staff that you have now recruited?

Ms Houston: There was probably a good 12 months lead-up towards that. It was around the funding sources, who we were going to target, who were going to be our partners and where vacancies existed, because that was the challenge within the organisation. It was not about having temporary roles; it was about having full-time, ongoing roles and working with business units to identify where those would be—undertaking cultural awareness, gearing up the units where these trainees would be going to. We tried to minimise all that, even though we were not always that successful. It was around: why are we having specific Indigenous recruitment programs?

CHAIR: So it took you 12 months to set it up.

Ms Houston: Yes.

CHAIR: How long has it been running?

Ms Houston: It ran for a period of four years. There was a dedicated three-year program, and then the agency carried it on for a further 12 months.

CHAIR: Has there been any measurement of the outcomes?

Ms Houston: As I said, around 270 are retained. The outcomes for clients—

CHAIR: That is where I am going.

Ms Houston: The experience of an Aboriginal resident in a family group home—there was no Aboriginal worker there—was that, for the first time, that resident was able to talk to somebody about their Aboriginality. They were able to engage in activities that were relevant to them, so their life was enhanced by having somebody who understood what their needs were and was able to help them access those activities—celebrations and so forth. The outcome for the individuals is that they have full-time employment. Without that program, it was highly unlikely that they would have entered that sector or found employment anyway.

CHAIR: Some of the strong take-home messages are that you have to be in it for the long haul—

Ms Houston: Yes.

CHAIR: You have to dedicate resources. There is not off-the-shelf training where you can go to an RTO and do this; you actually have to really engage—

Ms Houston: Invest.

CHAIR: and invest, find somebody who you can partner with and really commit the time and resources.

Ms Houston: And the leadership.

CHAIR: And the leadership, yes.

Ms Houston: I suppose coming new to Australian Unity was that government did that. That was part of their role. Within private industry, that is not necessarily seen as something that they take carriage of or that should be part of their business. I think it is because they see it as a cost to the business, and it is, but rather than being seen as a cost it should be seen as an investment, because we need the workforce. Aboriginal people are great workers, but there needs to be some incentive for employers to do that. We used to access Department of Education and Training funding, but we also had to contribute to that. It was not all Commonwealth government funding; there was a contribution from the agency as well. So that is an important fact. But there are those things around whether or not it is safe for employees to work there, and the use of reconciliation action plans and Aboriginal employment strategies.

CHAIR: So you actually have to put all those building blocks in place as you are doing it.

Ms Houston: Yes.

CHAIR: Again, it takes leadership and a well-thought-out plan. It is 12 months in the making, just getting the process to put it in place and initiate it.

Ms Houston: Yes.

CHAIR: Thank you for your evidence today. We very much appreciate it, and the handouts really help. Thank you.

That is the end of our hearing today. Thank you to all our witnesses today. Thank you to the secretariat and Hansard. We are not sure yet when we are having our next hearing; there is a certain thing called an election coming up.

Committee adjourned at 16:53