Submission to the Royal Commission on Aged Care: Workforce Issues

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Contacts

UnitingCare Australia
Level 3, 42 Macquarie St.
Barton ACT 2600

Phone: (02) 6249 6717

Email: ucaremail@nat.unitingcare.org.au

Website: unitingcare.org.au

About UnitingCare Australia

UnitingCare Australia is the national body for the Uniting Church's community services network and is an agency of the Assembly of the Uniting Church in Australia.

We give voice to the Uniting Church's commitment to social justice through advocacy and by strengthening community service provision.

We are the largest network of social service providers in Australia, supporting 1.4 million people every year across urban, rural and remote communities.

We focus on articulating and meeting the needs of people at all stages of life and those that are most vulnerable.

Contents

This submission should be read in conjunction with UnitingCare Australia's submission to the Aged Care Workforce Strategy Taskforce on the development of the **Aged Care Workforce Strategy**.

> Caring for older people should not be a burden. We must place a new lens over processes, systems and attitudes. Care must add to the quality of someone's life, and the workforce must be enabled to make life for others better. The basic proposition is that our life should be better, and 'living well' concepts should apply. Notably, in living well, a consumer's clinical, functional, cognitive, cultural and spiritual needs should be met.
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> (**Pollaers Report**, p11)

UnitingCare Australia notes that local context will shape both the needs of the users of services and the availability of potential aged care workforce participants. Services, particularly outside metropolitan areas, must cater for diverse social and clinical needs associated with background and personal histories. Potential care workers will also be diverse according to pre-training education and other factors. The size and flexibility of the potential workforce will be dictated by a range of factors, including local education and training infrastructure, regional demographics, cultural and linguistic diversity and the nature of the local economy (aspects such as competing employment opportunities, living costs, housing affordability and opportunities for family members' education and employment).

The shape of the future workforce will also be influenced by the overall model of care for older people. The conversation to date about staffing models and ratios is predicated on care needs being met through a range of services that is more or less what Australia has today. Current arrangements, with few exceptions, permit organisations to operate as community and in-home services or residential facilities. Discussion of staffing models has been focused on a congregate care model of residential care that is increasingly catering to high acuity care – high needs dementia cases plus end of life care[1] – with scant attention to the needs that are referred to in the Royal Commission's consultation paper as the 'investment' phase.

Finally, in considering workforce, UnitingCare Australia wishes to highlight the importance of recognising the expertise that resides in the aged care sector. Often, the aged care sector is considered 'lacking' in clinical expertise and the solutions proposed are 'outreach' services from the health sector. UnitingCare Australia urges the Commission to consider the need for 'two- way learning' to improve the standard of care delivered to older people. Just as it is important for the aged care workforce to develop the clinical skills and expertise necessary to provide an appropriate standard of care to older consumers, it is equally important for the health care workforce to be informed by specialist gerontological knowledge and ensure the interface with aged care is effective and timely in improving the health status of individuals and meeting their particular needs. Hospital and primary care workers must be equipped to meet the needs of an ageing population, must understand the service environment, and both hospital and service environments must be able to meet the needs of older people.

[1] Uniting Care Australia. **Aged Care Data Project Module 1, Final**. December 2019, p20

1. Methods for determining and implementing the minimum staffing levels, appropriate skills mix for aged care services, including for nursing, personal care, allied health and others

Royal Commission Research Paper One[2] (Paper One) reviews best practice internationally and concludes that minimum staffing levels for residential care should reflect the adjusted resident case mix, where adjustments take into account level of resident need and local context. It is critical to note that Australia does not have, either in relation to residential or other modes of care, an agreed model of describing case mix. The work undertaken at the University of Wollongong (the Resource Use and Classification Study) makes a significant contribution towards such a model, however there are some critical elements of work that still need to be done. These include

- some form of reconciliation or adaptation of the findings to reflect the extension in care required to meet the Single Aged Care Quality Standards that were introduced from 1 July 2019
- a cost of care study, both to determine the unit cost measure, and to validate relativities such as those that relate to provision of care to Aboriginal and Torres Strait Islander communities' services in regional and remote communities, and specialist homelessness services for older people.

The Royal Commission has been advised by Mr Cam Ansell of the risks associated with adoption of minimum staffing levels and/or staffing ratios. We would expect to see an evaluation of those risks in considering recommendations about specific staffing models or workforce strategies associated with future options for service delivery.

Paper One notes the current absence of specified levels of qualifications and staffing levels in the determination of minimum quality standards:

> The Department of Health does not mandate minimum staffing levels for residential aged care. Rather [...] the Aged Care Quality Standards require all aged care services to have **a sufficient, skilled and qualified workforce**[3]. This was not previously the case. Prior to 2014 aged care places were allocated on the basis of 'high' and 'low' care places according to population-based planning ratios. At this time there was a requirement for a RN to be on duty at all times for residents living in high care facilities. The removal of the distinction between high and low care also resulted in a more generalised requirements regarding staffing in the Standards.[4]

[2] Research Paper One: Eagar K, Westera A, Snoek M, Kobel C, Loggie C and Gordon R (2019) How Australian residential aged care staffing levels compare with international and national benchmarks. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.
[3] Emphasis added
[4] Research Paper One p5

There is currently a significant disparity in the standards frameworks, funding and provision of clinical care between aged care facilities and in hospitals. Some attribute this to introduction of the 'social care' concept to aged care.

> The introduction of the Aged Care Act 1997 (the Act) sought to reframe the role of residential aged care services as being people's 'homes' and to move away from the institutionalised model of care that previously dominated the sector. The Act also included provisions to underpin the expansion of community aged care services to allow older people to stay living in their own homes longer which, in turn, has resulted in people having much higher levels and/or complexity of need by the time they enter residential aged care.[5]

In many respects, aged care services – particularly residential facilities – are expected to do much more, with less.

A House of Representatives Committee Inquiry into the Quality of Care in Residential Aged Care Facilities concluded that 'implementing a mandatory minimum level of staffing and/or skill mix may help to ensure quality and safety across the aged care sector' and recommended 'a minimum of one Registered Nurse to be on site at all times'.[6] UnitingCare Australia has generally argued against mandatory minimum levels of staffing as the models proposed to date (which solely relate to residential care facilities) provide no standardised approach to ensuring that the needs of residents are taken into account. We continue to believe that measurement, benchmarking and potentially reporting of agreed resident outcomes, including through the quality and safety regulatory arrangements, represents a far better approach to ensuring that the staffing arrangements in a particular facility are appropriate to meet the needs of the residents. This approach is also an enabler of evolution in job design, which will be essential to meet the need for flexibly skilled workers to deliver community and home care services.

Paper One notes that full implementation of the Australian National Aged Care Classification (ANACC) – a case mix classification – would facilitate determination of staffing requirements across classes and allow for the systematic measurement and benchmarking of quality within the sector.

Paper One also notes that substantial additional funding would be required for:

- pay increases to attract and retain suitably qualified staff;
- funding increases to improve viability in the sector;
- an increase in overall staffing of 20% to achieve minimum quality standard of 3 stars under the US rating system, 37.2% to achieve a 4 star "good" rating and 49.4% to achieve a 5 star, best practice rating – although these figures do not include ancillary staff;
- an increase in overall allied health staffing of 175% to achieve British Columbia's best practice standard of 22 minutes of resident care per day, compared with the current Australian average of 8 minutes.

[5] op.cit. p3
[6] House of Representatives Standing Committee on Health, Aged Care and Sport 2018b Recommendation 4.

Paper One makes the point that:

> Debate regarding staffing levels in aged care homes is premised on evidence in health services where a direct relationship between nursing staff mix and quality of care has been established. As with health care, quality in aged care is impacted not only by staffing levels. It is also driven by organisational culture, skill mix and consistency in staffing personnel.[7]

UnitingCare Australia cautioned against adopting staffing level benchmarks in isolation from a meaningful suite of quality indicators in its submission to the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018[8]. We note that a critical aspect of organisational culture is the ability of staff at all levels to create an environment in which they, residents and their families feel valued, safe and able to form the relationships of trust that are essential to quality care. Quality of aged care must be judged against outcomes in all aspects of the individual's life, however nurse led models in particular underemphasise non-clinical and allied health skills that must be available for holistic wellbeing to be supported.

Below in point form are elements of the approach suggested in Paper 1 and the difficulties that will need to be resolved.

Staffing levels	Issues to be resolved
Given that facilities cater for residents with a wide range of clinical and personal care needs, best practice is to require a Registered Nurse to be present on site 24/7 or for staff to be able to access nurse consultation in an appropriately timely way.	Additional funding and technical support for the introduction of the necessary technology for remote RN supervision and specialist clinical intervention that might be necessary in cases of local skill shortage. Ensuring best practice without compromising the capacity of services to provide the full range of allied health, personal care and non-clinical services to residents. Difficulty of adapting to a model based on a 'continuum of care' service model.
The *Nursing Home Compare* system developed in the US has been identified as the best system currently available[9] for assessing and comparing case mix adjusted staffing levels.	*Nursing Home Compare* does not include ancillary services and would need to be adapted to the Australian context including staff resource availability for relative cost of labour e.g. the balance between nursing and other disciplines.
The Australian National Aged Care Classification is a case mix classification that could enable benchmarking of staffing levels.	Review the proposed ACC against appropriate international standards and case studies presented to the Royal Commission.
Levels of staff by category should be determined by facility managers in accordance with a benchmark adjusted case mix minimum	Implementation of minimum case mix adjusted staffing levels will need to be supported by supplementary funding in many, if not most, cases. Currently 50% of the sector is

[7] Eagar K, Westera A, Snoek M, Kobel C, Loggie C and Gordon R (2019) **How Australian residential aged care staffing levels compare with international and national benchmarks**. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong, p1

[8] **Submission 39**

[9] Ibid.

that reflects complexity of resident needs and local context.	experiencing viability problems. We note also that staffing costs (wages plus on-costs) are not nationally consistent, and higher staffing costs are particularly prevalent in outer regional and remote areas. Removal of incentives for profit gouging by implementation of adjusted case mix benchmarks. Continued growth in the ratio of PCA to clinical staff may reflect perverse incentives in the current funding arrangements. Note that there is experience in the sector of past similar system, which were considered to have failed, namely the 'Cam', 'Sam' and OCRE systems.
Additional clinical expertise by video link may need to be brought in to handle specialised treatment areas such as wound healing, mental health treatment.	Additional funding would be needed to support the introduction of the relevant technology. We note however that there is a shortage of specialist expertise in all areas (not just remote areas) that must be addressed. It is critical that scarce resources be effectively deployed across aged care, primary health, acute care areas of practice.

Training	Issues to be resolved
Establish a set of competencies and align VET sector training with them nationally. Standardised training is needed for PCA workers to ensure they have the necessary skills and competencies to cope resiliently with the with the range of resident needs.	Training must be flexible and 'fit for purpose', enable innovative models of care, and encompass specialties such as dementia care, end of life care, and remote care. .
Cert 3 is the minimum desired qualification for direct care. However, formal qualifications alone are insufficient: personal qualities - aptitude, empathy, service focus, resilience – are critical.	Reliable techniques and tools for selecting PCAs with requisite personal qualities need to be developed. Query whether assessment tools would substitute for values-based employment training, which offers the chance to see workers in action. It is important to retain some flexibility where formal educational qualifications are an impediment to recruitment e.g. create alternative strategies to recruit and train members of Aboriginal and Torres Strait Islander communities to provide supports locally.
Flexible pathways to enable selection for on the job training of individuals without formal qualifications who are otherwise suitable for personal care employment in terms of experience and personal attributes.	Development with VET sector of training programs that could be integrated with on the job experience. Any registration process of direct care workers will need to incorporate individuals without formal qualifications e.g. recognition of prior learning and experience.
UnitingCare Australia's Values Based Employment program offers training,	Further investment in values-based employment schemes across health, disability and aged care.

experience and guaranteed employment opportunities in aged care for individuals with personal qualities that are suited to work in care.	

2. Who should be covered by a registration scheme for non-clinical staff in aged care, and how such a scheme might be implemented, administered and funded

Registration options	Issues to be resolved
Aged care employees should be registered as 'being fit for work in the age care sector' in the same way as individuals are registered for work in the disability sector. Where an employee has proved unsuitable in one jurisdiction that should be transparently available to potential employers in others.	State/Territory compliance differences may inhibit a national approach. It is important to distinguish between a threshold test of suitability (as per professional registration) and screening/creating the capacity to bar an individual from working in this or other similar sectors.
	Potential for registration to act as a disincentive to working in the sector if it is excessively onerous or expensive, noting that aged care workers are amongst the lowest paid workers in the community.
Establish a national compliance and certification database for non-registered staff to facilitate transparency of previous employment histories of sector employees and to record current certifications and compliance records. This could be similar to the mechanisms used with NDIS and APRA.	Natural justice needs to be afforded to anyone who is a subject of an adverse report.
	Funding should be shared between the Commonwealth and the states/territories.
The data base should reflect the growing intersectionality of disability and aged care clients	Need for protocols for database usage and penalties for abuse. Important to be clear as to purpose – recognition of overlap in client safety needs should not reduce recognition of the need for aged care- specific training and mandatory qualifications at VET level in aged care specifics.

3. Options to resolve low remuneration and poor working conditions, including how the remuneration and working conditions of aged care workers can be aligned with their counterparts in the health and disability sectors

Addressing low remuneration	Issues to be resolved
Wages for aged care workers are currently too low and workers in the sector deserve significant pay increases. Subsidies tied to wage increases and training outcomes should be given to providers in order to bridge the gaps identified in the Pollaers Report (e.g. 15% deficit in wages for care staff)	Conflict between the way wages are set in services sectors and prevailing theory that constrains wage rises to a 'quid pro quo' for productivity increases. Evidence before the Royal Commission demonstrates the importance of personal interactions for quality care. It is not possible to increase the 'efficiency' of this area of delivery, which represents the major proportion of costs. 'Baumol's cost disease' is often used to describe consequences of the lack of growth in productivity in the public services sector of the economy. Labour-intensive sectors that rely heavily on non-routine human interaction or activities must be recognised as such, and must be funded on the basis that staff costs will rise with wages inflation elsewhere in the economy.
Low remuneration may be offset with Commonwealth, state or local tax breaks or other social wage benefits especially in regional/remote roles	Unwillingness by Government to provide sector-specific conditions. Moreover, sector specific incentives may exacerbate the 'competition' for workers between health, disability and aged care sectors. If tax breaks for regional or remote areas are needed, they should be applied uniformly to all low-income workers. There is a fundamental link between the major cost driver for the sector being staff costs and the funding or resources available to provide care. The issue of pay cannot be considered in isolation from staff levels and funding. These connections have greater impact in regional/remote areas.

Government-managed portable long service and other leave benefits, to enable staff to move between public and private sector aged care employers.	Unwillingness of Government to provide sector-specific benefits. In any case benefits should apply to health, disability and aged care. This would also move LSL accrual to an annual payment irrespective of years of service which would need to be resourced.
Few new workers are job-ready, and many existing staff lack the necessary skills. There is a need for on-the job competency assessment and remuneration linked to such assessment.	Cost of onboarding is significant and the sector often has high turnover of staff. Need for ongoing review and enhancement of competency specifications and development of assessment tools and related pay scales. These should also reflect personal qualities workers exhibit in their approach to their work.
Reduce number of industrial instruments in the aged care sector to simplify and equalise terms and conditions across NFP, Government and Private sectors	Constraints of traditionally lower-paying sectors on increasing wages and conditions, particularly where revenue is limited by Government funding/regulation. Available instruments do not reconcile flexibility needs and standards expected in the service environment e.g. need for continuity of care for the individual.

4. How to raise the overall skill, knowledge and competencies of all care staff (existing and new entrants) in working with vulnerable people, especially those with age related conditions and illnesses

Raising skill and competency of PCAs in working with the vulnerable	Issues to be resolved
See also responses to question 2 on training and question 3 on registration	Framework for monitoring and evaluating quality of RTO and VET courses.
Establish a framework with aged care national industry standards of skills, knowledge and competencies for each care role, clinical and non-clinical under the direction of an Aged Services Industry Council (Pollaers Report)	Reaching sector agreement on acceptable skills standards.
New PCAs are not work-ready and do not have the competencies required to meet the increasingly complex needs of residents. To be registered for work in aged care potential workers need person centred training programs that enable them to meet the care requirements of the resident population. Programs should be based on fundamental harm prevention and well-being promotion through: • Hydration & nutrition; • Prevention of falls & pressure injuries (skin care, recognising and responding to deterioration; • Dementia, mental health, and dealing with challenging behaviours, including de-escalation. • Infection prevention and management. • End of life care. • Medication management. • Communication, supported decision-making & relationship-based care.	Lack of consistent competency standards and training programs.
New RNs and ENs are not ready for their roles in aged care and have little exposure to some of the key demands. They may be placed in charge of a shift without experience in, or preparation for, leading a team. The sector framework, training and competency standards should include training requirements (perhaps supervised in-house) for RNs on • dementia; • challenging behaviours;	Transition to professional practice is a challenge in any sector. State governments have invested with the tertiary sector in Transition to Professional Practice programs for acute care but made no such investment to support such an initiative in aged care. Could be linked with a Teaching Research in Aged Care recognition model that also connects with undergraduate placements.

• mental health; • communication; • clinical leadership and governance; and • managing a team.	Establishment of appropriate training programs at tertiary institutions, or in-house programs delivered by qualified staff, with appropriate assessment techniques would require a resource to underpin supervisory roles and pathways to safely build experience. The concept of a Transition to Professional Practice year for graduates of nursing or other allied health areas should be further incentivised in the non-government sector.
Significant upskilling of the current workforce is required in order to meet resident needs and to provide adequate standards of clinical leadership & governance. Many current staff need training in the areas mentioned above as training pre-requisites for new PCAs.	Lack of financial resources for up-skilling, lack of suitable training courses, and lack of accountability and outcomes measures to assess the need for further training.
Dr Clare Skinner's evidence to the Royal Commission proposed a program for treating a range of conditions in age care facilities through a team of contracted staff who could be brought in as required and who would train facility staff to undertake some procedures, such as changing intravenous feeding tubes.	Insufficient sense of shared responsibility between hospitals and aged care facilities and absence of additional funding where required to support such initiatives. Currently both systems are structured to incentivise saving at the expense of the other. Previous initiatives have worked but not been sustained as they require ongoing supplementary funding which has not been made available. This relates to a need for a national coordinated COAG examination of the interface between health and aged care and primary care, acknowledging the key roles each provide in the outcomes individuals experience, and cooperation to remedy the current situation.
Promote the use of continuing staff to improve the quality of relationships between staff and residents and their families.	Perverse incentives for employers encourage the use of short-term contract staff.
Establish a Continuing Education Points standard for care workers to ensure training remains current and enable time at work to apply practice development for registered and non-registered staff.	Limited budget to backfill in order to release staff for training (no paid study leave).

5. How to ensure service providers develop a culture of strong governance and workforce leadership

Fostering culture of strong governance and workforce leadership	Issues to be resolved
Assessment at Board and senior management level is needed to provide a clear picture of governance and workforce leadership, particularly in the area of clinical governance. The following are relevant: • relevant experience among Board Directors and the Executive; • reflective practice and a culture of continuous improvement; • investment in quality & risk management; • escalation of critical incidents and remedial action; • culture of careful financial management & resource; • focus on leadership and workforce strategy. This type of assessment is beyond the scope of the current Quality Commission and should perhaps be outsourced for biennial assessment by a competent external agency.	The Aged Care Quality Commission's Standard 8 is completed at facility level and does not get to the heart of a proper assessment of a multi-site organisation's maturity and governance. Lack of appropriate governance assessment tools in the sector. A significant lack of experience and understanding of governance with Commission staff who assess Standard 8 as it relates to the broader sector knowledge of governance in organisations. Need to extend culture of learning from critical incidents to Board members to ensure that there is no disincentive for high quality individuals (many of whom receive no or a minimal fee for participation) to contribute to management of organisations providing care.
Foster industry collaborations to share innovations.	Unwillingness to collaborate with competitors in a market based environment. No incentive to share benefits from investment in innovation.
Establish a centralised, national compliance check data base to align compliance standards and to enable employee state and interstate mobility.	Legitimate State/Territory compliance differences may prohibit a national approach.

6. Any institutional changes needed to ensure that the Commonwealth fills its role as the system steward and exercises leadership in workforce planning, development and remuneration.

UnitingCare Australia has previously highlighted the importance of the Commonwealth assuming leadership in addressing systemic ageism in Australia. Ensuring that all Commonwealth strategies are genuinely human-rights consistent would be a first step. The current situation, where the experience of access to health services (including palliative care) and other supports for daily living can differ significantly due to age must be addressed.

If Australia is to be successful in building a health and care system that both respects and defends the human rights of every individual, the Commonwealth must work with other levels of government to create a purposeful strategy to this end. Governments must be held accountable, for example through a COAG agreement, against meaningful and measurable outcomes.

A perennial issue in the sector is that there has been no assessment of the actual cost of care relative to revenue that can be sourced through Commonwealth subsidies and co-contributions from consumers, which are also capped at levels set by the Commonwealth. This places providers in the position of having to seek 'efficiencies' which, as noted above, is severely challenging in a sector where expenses are dominated by workforce costs and where those costs relate to 'human intensive' activities that cannot be made more efficient (in economic terms 'Baumol's cost disease' or 'Baumol's effect'). Seeking to meet workforce 'benchmarks' as though every service has the same operational requirements is not consistent with supporting relational care approaches.

UnitingCare Australia believes that a shift is needed from 'supply driven' to needs or demand driven approaches to services that promote health and wellbeing throughout the lifecourse. The alternative is continuing Australia's over-reliance on permanent, intensive, out of home care at the end of life.[10] This change is where we see the opportunity for efficiency, not in driving down the cost of employing skilled, values driven professionals in the sector.

In its review of best practice in out of home residential care for children,[11] UnitingCare Australia developed 12 Principles of Best Practice that are set out below. Given the many parallels between the situation of children living in out of home residential care and residents in aged care facilities, we propose that analogous principles could be applied to policies and practices that influence delivery of services and supports to older persons. In particular, principle 12 goes further than the current aged care standards in that it requires that, if providers or potential providers cannot resource services that meet each of the other principles they must not engage in the sector.

[10] Uniting Care Australia. **Aged Care Data Project Module 1, Final**. December 2019, p20
[11] Seth-Purdie R (2019) **Review of Best Practice in Out of Home Residential Care**, UnitingCare Australia.

The sector must have some way of breaking the cycle whereby the hours of care and attention able to be provided to individuals is dictated by funding rather than need.

1. Uphold the Rights of the Child as set out in the UN Convention;
2. Do no harm and keep children safe: use trauma-informed care and Child Safe Principles, including operation of a child-friendly complaints mechanism, to reduce risks to residents;
3. Be responsive to the voice of the child in the life and culture of the service: this means more than inviting participation in formal consultation – it means encouraging their agency in everyday life and decisions about them;
4. Forge and maintain strong links with families, significant others, communities and culture, fostering a strong sense of identity and belonging;
5. Assess and monitor the developmental health and wellbeing of residents, noting any history and ongoing consequences of trauma, and recording subjective indicators of health and wellbeing that reflect the child or young persons' aspirations for their best self;
6. Develop, deliver and modify as necessary individually tailored, developmentally focused therapeutic treatment plans aimed at promoting normal growth and development, including skills, knowledge and competencies, sense of (cultural) identity, agency, and the ability to form positive relationships;
7. Identify and utilise adaptable, evidence-based models or strategies for practice that are capable of achieving good outcomes for residents, families and staff.
8. Recruit and retain staff with the necessary professional and personal skills to provide Therapeutic Residential Care (TRC) through provision of appropriate working conditions and personal support.
9. Ensure that the residential facility is free of hazards and conducive to TRC;
10. Draw on evidence, reflection and feedback to enable continuous improvement;
11. Adopt systems thinking: Out of Home Care needs to work in harmony with a strong, community orientated family support and child protection system.
12. Only provide residential services developed, resourced and implemented in conformity with the above principles.

The aged care workforce does not exist in a vacuum. The Commonwealth must use its influence to ensure that knowledge about community services generally, and the importance of social supports, is recognised from the ground up – through education and engagement with schools, RTOs and universities about the ageing process, the importance of intergenerational communities and the value of everyday interactions with older individuals.

There are a range of aspects of general learning that contribute both to the holistic development of the individual, and the engendering of respect for older individuals in the community. These include understanding the nature of life and ageing, how we contribute as individuals to community and family life, the importance of healthy and active lifestyles throughout life and understanding the needs of frail and vulnerable older people and the importance of service and the community. Valuing the professions who work with older people begins with valuing diversity – including age diversity – in the community.

Methods	Barriers
Appoint a Minister for Ageing in Cabinet.	Government recognition of the significance of the issues.
Development of a protocol to compensate for the potentially perverse outcomes of market based provision e.g lack of consistency in service approaches within and across the multi-provider system.	Competition between providers militates against cooperation and information sharing to achieve best practice. Countervailing incentives need to be provided.
Long duration block funding to best practice providers to enable stability, quality jobs and investment in training.	Government preference for short term funding. Funding and policy tied to short terms of Government.
Promote a social change campaign to promote the aged care sector as a desirable employer (Pollaers Report)	Unwillingness to allocate budget. Need for Government to affirm the importance of aged care work in the community and make funds available to close the pay gap.
Establish an Industry Code of Practice (Pollaers Report)	Potential resistance from the sector for additional oversight, compliance burden, notwithstanding voluntary nature.
Promote the development of an aged care industry skills and qualification framework (Pollaers Report) through tied intergovernmental funding via VET providers	Lack of sector agreement about framework.
Review of visa arrangements to encourage immigrants willing to work in the aged care sector, including regional and remote work stipulations	Unwillingness to make sector-specific immigration policy exceptions
Review of possible tax benefits for aged care employees in Government, private and NFP employment	Unwillingness to provide sector-specific benefits
Review of training subsidies for employers and employees to attract staff to the sector	Unwillingness to provide sector-specific benefits
Creation of portable long service and other leave provisions similar to Health sector, to encourage employees to remain in the industry.	Need to work across governments and, challenges related to providing sector-specific benefits without resourcing to support this outcome Unwillingness to fund a governing body.
Provide remote worker subsidies and support innovative service delivery methods (e.g. the expansion of Kinship care into aged care service delivery)	Scale of remote-specific costs outweigh benefits

Establish faster overseas qualification recognition mechanisms (especially in medical, nursing and allied health roles) to enable qualified immigrants to begin work faster	Resistance from professional bodies to review current mechanisms
Fund innovation programs to develop technological applications to increase efficiencies in service delivery, corporate services and improved consumer outcomes	Unwillingness to provide sector-specific benefits
Provide further subsidies for the employment and training of aged care employees from vulnerable or under-represented groups including Aboriginal, CALD, mature-aged and disability groups	Unwillingness to provide sector-specific benefits
Support the development of Australian-specific workforce management systems that cater for the complexity of award conditions	Unwillingness to provide sector-specific benefits