Australian Government

National Skills Commission

Care Workforce Labour Market Study

Final Report

30 September 2021

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Acknowledgement of Country

The National Skills Commission acknowledges the traditional owners and custodians of country throughout Australia and acknowledges their continuing connection to land, sea and community. We pay our respects to the people, their cultures and to Elders, past, present and emerging.

Contents

Terms of reference

Without limiting related matters on which the Commissioner may report, the Commissioner should:

- examine the current profile of the care and support sector workforce, including occupation, qualifications and employment type, and the main sociodemographic characteristics, including gender, education and ethnicity
- examine the current balance of labour supply and demand in the sector, including geographic distribution and the extent to which current workforce arrangements meet community need including those in regional and remote Australia
- examine factors affecting the supply for care workers in the near term (over the next 5 years) and longer term in light of the ageing population (to 2050) including:
  - potential challenges to labour supply including, but not limited to: remuneration, employee turnover, suitability of current skills and training model, employee engagement and enablement, ability to attract and retain talent and opportunities for career progression
  - education and training pathways available to enter the care and support sector, including international qualifications
- assess the likely future growth in demand for workers in the care sector and the extent to which it can be met over the near and longer term. This should include consideration of current strategies to meet that need including workforce planning, migration settings and linkages to the education and training sectors and employment programs and services
- draw on domestic and international policies and experience, where appropriate
- have regard to the findings of the Royal Commission into Aged Care Quality and Safety, and lessons to date from the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, and implications for workforce that may stem from them
- develop a framework to monitor and assess pressures in the care and support sector workforce over the short, medium and long term.

The final report should be provided to the Minister for Employment, Workforce, Skills, Small and Family Business by 30 September 2021.

Executive summary and major findings

The Study comes against a backdrop of a rapid rise in the number of care and support workers in recent years and represents the first 'whole of sector' examination of the care and support workforce.

The demand for care and support | Part 2

The need for a care and support workforce is driven by the care and support needs of the Australian population

There are a range of essential care and support services across aged, disability, veteran and mental health. While these services are focused on meeting specific care and support needs, there are also intersections and interactions across programs, cohorts, providers and workers. Eligibility criteria set the parameters under which people can access specific programs, with care and support recipients being able to access services across programs.

The demographic characteristics of people who access care and support services across aged care, disability and veteran care sectors also differ considerably.

- The demographic and health profile of Australians also varies across metropolitan, regional and remote areas, with stakeholders consistently raising the challenges to service provision in rural and remote areas.

Australia's demographic challenge is not unique, demand will also grow

Looking forward, demographics will be the key driver of demand for care and support services, with the impact of Australia's ageing population to be significant.

Of course, Australia is not alone in facing an ageing population. Larger cohorts of older people will drive an increase in demand for aged care and support services across almost all countries around the globe.

- At the same time, the share of the working age population will decrease for many regions around the world, resulting in an increasing old-age dependency ratio (measured as the ratio of people aged 65 years and over relative to the population aged 15-64 years).

In the absence of significant technological advancements, the challenge of diverting a larger proportion of the working age population to the provision of relatively labour-intensive care and support services for the growing older population will be a challenge shared by many nations.

The needs of those receiving care and support are also changing over time. A substantial and growing proportion of aged care recipients, including people living in residential aged care, have a dementia diagnosis which further increases the complexity of care and support needs into the future. This has implications for the skills needs of the care and support workforce.

The demand for disability care and support in the future is uncertain, although the overall number of National Disability Insurance Scheme (NDIS) participants is expected to continue to grow.

The age profile and needs of veterans receiving care and support has changed and will continue to change over time.

Similarly, while the total Australian population with a mental health illness is difficult to identify, the National Health Survey 2017-18 estimated that around 1 in 5 Australians had a mental health or behavioural condition, and this has been increasing over time. Stakeholder feedback also indicates

demand is continuing to grow and may be exacerbated by the impacts of COVID-19 and related restrictions.

In addition, a range of other influences are at play in Australia's care and support landscape. These include the recently completed Royal Commission into Aged Care Quality and Safety (Aged Care Royal Commission) and the current Royal Commissions into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission) and Defence and Veteran Suicide (Defence and Veteran Suicide Royal Commission).

The care and support needs of Australians are met by a complex system

The demand for care and support is met by a complex system. Many organisations (government and non-government), businesses and people contribute to the provision of care and support, across a wide range of roles and functions in a complex environment.

The provider landscape is also complex with over 13,000 providers operating across the care and support landscape, although the bulk (around 11,000) operate exclusively within the NDIS. Just as recipients access support across programs, many providers also operate across aged care, disability, and veteran care programs.

With significant provider activity occurring across programs, it is unsurprising that a proportion of the care and support workforce also works across programs. This in turn underscores the importance of the cross-cutting approach to analysing demand and supply of the care and support workforce taken in this Study.

Is there a workforce gap? | Part 9

A workforce 'gap' is forecast, but the outlook could change

To prevent the unusual events of 2020 and 2021 from influencing the longer-term projections, the starting point used by Deloitte Access Economics for both the baseline forecasts and sensitivities presented in this Study for workforce supply are necessarily based on the 2016 Census of Population and Housing. (This differs from other estimates contained in this Study based on the Australian Bureau of Statistics (ABS) 2021 Labour Force Survey data.)

Based on the Deloitte Access Economics forecasts commissioned for this Study, it is expected that by 2049-50 the total demand for the care and support workforce will be around double that seen today.

While the care and support workforce has grown significantly over the past 2 decades, the baseline forecast anticipates that workforce supply will grow more slowly over the next 30 years.

With workforce demand expected to exceed workforce supply, a workforce gap emerges in the short-term and continues to grow. This gap is approximately 211,430 full-time equivalent (FTE) positions by 2049-50.

- Looking at the broader care and support workforce, it is clear that the anticipated workforce shortages are likely to be concentrated in the skill level 4 occupations (*Aged and disabled carers* and *Nursing support and personal care workers*) – a not unexpected result given that the majority of the total care and support workforce is currently comprised of these 2 key occupations.
- Meeting workforce demand for some skill level 1 occupations could also be a significant challenge. While the supply of Allied health professionals is expected to largely meet demand at the national level (noting that there are likely to be ongoing difficulties in the recruitment of Allied health professionals in some regions of Australia), there are expected shortages by 2049-50 for *Registered nurses*, *Health and welfare services managers* and *Nurse managers*.

A comment on the modelling in this Study and the conclusions that should be drawn

The key conclusion to draw from the modelling in this Study is not the size of any future workforce gap, but that ultimately the care and support workforce may need to look different in the future than it does today.

The modelling contains a number of assumptions. These include assumptions around inflows into the sector, wages, average hours and migration. To the extent *any* of the many assumptions contained in the model are not realised, outcomes will of course differ. It is also important to remember that part of the reason for commissioning this modelling is to help ensure that workforce gaps are avoided.

Models also fail to fully capture the complexity and the dynamic nature of a modern economy.

As a case in point, the introduction of the NDIS created the need to recruit a large workforce over a very short period of time, with concerns about a workforce shortage. However, the labour market was broadly able to manage the roll-out of the NDIS (including through attracting at the margin, more younger people and men into the care and support workforce – noting that they remain a relatively small share of the overall workforce).

It is therefore important that there is sufficient flexibility in the labour market to enable such adjustments to occur – both within the care and support sector and across the labour market more broadly.

At the moment skill shortages and recruitment difficultly exists, but that does not mean demand exceeds supply at a national level

There is limited evidence of a significant workforce shortage in the care and support sector at the national level at the current time. That said, there are skill shortages present for care and support occupations across Australia, and instances of recruitment difficulty exist, as reflected in National Skills Commission (NSC) data.

Notwithstanding the limited evidence of a workforce gap at the national level, analysis at state and regional levels adds important context to this observation.

It is important to note, however, that there is no single ratio of workforce to participants which provides a sufficient level of care and support services within a community. As a result, caution should be used when using macro-level data and indicators to understand local markets, with skill shortages particularly difficult to identify at a regional level. A place-based needs analysis should instead be undertaken in order to incorporate localised factors.

- Each region across Australia has a unique set of workforce challenges and opportunities, including for the care and support workforce. Similarly, each region has a different demand for the care and support workforce based on a number of population and socio-economic characteristics.

An overview of the care and support workforce | Part 3

The Study estimates there are around 460,000 care and support workers (excluding mental health) in Australia who are employed across a wide range of occupations and multiple industries.

- The largest occupation group in the care and support workforce is Personal care and support workers. These workers make up over half of the entire workforce (59%) and have been growing rapidly.
- Allied health professionals are the second largest group (13%), followed by Health and welfare support workers and Registered nurses (both 12%) and Health and welfare managers (5%).

Care and support occupations are characterised by a range of different skill levels.

- Nine of the 15 care and support occupations are skill level 1 (commensurate with a bachelor degree or higher qualification) and this accounts for approximately 29% of the total care and support workforce. This skill level includes all Registered nurses, Health and welfare managers and Allied health professional occupations.

- Four occupations are skill level 2 (commensurate with an advanced diploma or diploma level qualification) or skill level 3 (commensurate with a certificate III with at least 2 years of on-the-job training, or a certificate IV level qualification) and together make up approximately 11% of the total care and support workforce.
- Personal care and support workers are skill level 4 occupations (commensurate with a certificate II or III level qualification, or at least one year of relevant experience).
- All mental health occupations explored in this Study are skill level 1.

Over recent years, growth in the care and support workforce has been 3 times faster than total employment across the Australian economy. This reflects the ongoing increase in demand for care and support, and particularly the introduction and subsequent expansion of the NDIS.

Changes in technology, business requirements, and consumer preferences and needs are also driving the creation of new roles and the evolution of existing ones.

The contribution of informal carers and volunteers is significant

While out of scope for this Study, carers and volunteers make an invaluable and important contribution to the delivery of care and support. The 2018 Survey of Disability Ageing and Carers (SDAC) estimated there were around 2.6 million carers in Australia, equating to around 1 in 9 Australians. Deloitte Access Economics estimated the replacement value of informal care to be $77.9 billion in 2020.

The ABS General Social Survey, while not specific to the health sector, suggests that the overall propensity to volunteer is decreasing. The overall impact of a declining propensity to volunteer is complex as it is interlinked with changes in participation rates and demographics, but a continuing long-term decline is a potential further pressure on demand for the care and support workforce.

Demographic characteristics of the care and support workforce | Part 4

The care and support workforce is predominantly female

The care and support and mental health workforces have a higher share of female workers than the broader Australian workforce, with women accounting for around 79% of the care and support workforce, and 82% of the mental health workforce in February 2021.

The high proportion of female workers in the care and support workforce is a consistent theme across all Organisation for Economic Co-operation and Development (OECD) countries. In fact, compared with the OECD average, females comprise a marginally lower proportion of the care and support workforce in Australia.

The proportion of female Personal care and support workers (77%) is relatively lower than for most other care and support occupations, with the number of men employed as Personal care and support workers increasing by 67% from February 2015 to February 2021 and outpacing the 40% growth for women.

The increase in males (off a relatively low base), and younger people entering the care and support workforce is of interest, and has occurred against the backdrop of rapid growth in the workforce. While not wanting to overplay these recent trends, as they may not be sustained, they nonetheless suggest that the labour market may have been dynamic in finding a new supply of workers for the sector during a recent period of rapid growth.

And has a greater share of recent migrants, and is culturally and linguistically diverse

The care and support workforce is culturally and linguistically diverse (CALD) with around 40% of workers (or 183,000) born overseas – higher than the share across the overall Australian workforce (32%). This proportion has steadily increased over the last 15 years.

Other OECD countries are also heavily reliant on workers who are born overseas. While noting the considerable variation across countries, OECD analysis suggests that Australia has a relatively

high share of foreign-born workers (29%) compared with the OECD average (23%) for the long-term care workforce.

Recent migrants in the care and support workforce tend to be much younger than their counterparts – contributing to the decline in average age of the workforce in recent years. Care and support workers born overseas are also more likely to be male compared with their Australian-born counterparts.

The OECD highlights that the recruitment of overseas-born workers in a number of member countries is commonly drawn from people that have arrived through 'non-economic' visa channels. That is also the case in Australia.

The care and support workforce is slightly older than the broader Australian workforce

The care and support and mental health workforces have historically been relatively older than the overall Australian workforce, with an average age around 43 years over February 2015 to February 2021. This is slightly older than the average age for workers in the *Health care and social assistance* industry (42 years) or for all employed Australians (40 years).

- The older age profile of the care and support workforce in Australia is consistent with international trends. In 2016, the median age of long-term care workers in the OECD (45 years) was around 1.5 years above the median OECD workforce age.

That said, the average age for the care and support workforce has gradually declined over time, falling from around 44 years in February 2015 to around 42 years by February 2021. This decline in average age corresponds with a rise in the number of younger people entering care and support occupations over the same period.

The distribution of the care and support workforce by skill level differs across the age groups. While younger workers (aged 15-24 years) are most likely to be engaged in the care and support workforce within skill level 4 occupations, those aged 25–44 years are relatively more likely to be working in skill level 1 and 2 occupations.

Regional shares have remained broadly stable over recent years

The regional share of the care and support workforce has remained relatively stable over the last decade with around 39% of the workforce employed in regional areas (i.e. all areas outside of capital cities) in 2021. In contrast, the regional share of total employment has declined over the same period, apart from a recent COVID-19 related lift.

- However, the share of workers employed outside capital cities in other *Health care and social assistance* industries (that is, those outside the care and support sector) is much higher than that in the care and support sector. This aligns with the views of stakeholders, who cited greater difficulties in recruiting for care and support workers in regional areas compared with other health workers.

Labour market characteristics of the care and support workforce | Part 5

There appears to be a set of complex interactions at play that have resulted in the labour market characteristics of the care and support workforce.

While some indicators such as lower average hours worked per week and underemployment rates might suggest latent capacity within the care and support sector, the extent to which this latent capacity can be used is dependent on a range of other factors (from system settings to worker and provider preferences).

The care and support workforce tends to be more part-time and casual than the economy wide average

Around half of the care and support workforce are employed on a part-time basis.

- Personal care and support workers (61%) and Registered nurses (59%) are more likely to work part-time than Allied health professionals or the overall care and support workforce.

The care and support workforce are much more likely to be employed on a casual basis (defined as workers without paid leave entitlements) than other Australian workers.

- In February 2021, around 28% of the care and support workforce were casual workers, compared with 19% of the total Australian workforce, 18% of the broader *Health care and social assistance* industry, and 9% of the mental health workforce.

Stakeholder feedback provided mixed views on the propensity for parts of the care and support workforce to be engaged on a part-time and/or casual basis, with some aged care providers indicating these arrangements were 'historical' and 'long standing', while other providers across aged and disability care and support indicated these arrangements were driven by system settings. That is, the shift to person-centred care, combined with market driven approaches to care, has seen providers need to adjust their business models towards more flexible workforce rostering and scheduling to cater for recipients varied and less structured needs.

Given this greater tendency toward part-time employment, average hours worked per week across the care and support workforce is below the economy-wide average. The strong increase in demand for care and support over recent years has largely been met by an increase in the number of people working in the care and support sector; not an increase in the average number of hours worked per person.

Lower average hours, but recruitment difficulties exist

The relatively low number of average hours worked across some occupations in the care and support workforce and reported underemployment sits in contrast with a relatively high proportion of employers experiencing difficulty when recruiting workers for care and support occupations.

This suggests that the shortage may be distributional in nature or arise from a mismatch in employers' needs and workers' preferences, rather than simply a lack of workers.

Employers have also reported challenges around recruiting appropriately skilled and qualified workers. This suggests people are continuing to apply for care and support occupations, but a proportion are unsuccessful as they may not be trained to an adequate standard, lack the necessary characteristics desired by employers, or may be unwilling to move to where the jobs are.

- For example, in February 2021, around 3% of the care and support workforce indicated that they would or might be willing to move interstate if offered a suitable job, while around 5% reported a willingness to move within state. This implies a relatively low propensity to relocate for work within the workforce.
- Further, more care and support workers would prefer to remain in their current jobs than change employers or occupations to work more hours – suggesting there are opportunities to increase current workforce utilisation and improve retention in the sector.

These distributional and preferential mismatches – combined with recent structural shifts in the care and support landscape – are likely to have contributed to the higher underemployment experienced by the care and support workforce relative to the broader labour force.

Many care and support workers hold multiple jobs

Care and support workers are nearly twice as likely to have more than one job than other workers. In February 2021, around 11% of the care and support workforce (or around 50,000 people) reported holding multiple jobs, compared with around 6% of the overall workforce, and around 9% of the mental health workforce.

- Almost two-thirds of multiple job holders (or around 30,000 people) in the care and support workforce are Personal care and support workers.

Stakeholder views were mixed when asked about the drivers for workers employed in multiple jobs. Unions cited lack of employment security, low average hours and the need for a living wage. In contrast, providers cited employee preference for job diversity, or more commonly beneficial tax treatment when working for not-for-profit providers which could be maximised through multiple jobs.

Given differences in occupations, incomes vary across the care and support sector

There is a significant degree of variability in incomes across the care and support workforce. This variability reflects both higher average hourly rates of pay for higher skill level occupations versus lower skill level occupations – illustrative of the wage premium typically associated with higher level qualifications; but also the tendency for lower skill level occupations to have lower average hours worked per week.

- Four out of 5 broad occupation groups considered in this Study, and representing 95% of the care and support workforce, earned below the Australian average in May 2018. The largest occupation group, Personal care and support workers, had the lowest weekly earnings, $523 below the Australian average. Allied health professionals had the second lowest weekly earnings, $268 below the Australian average.
- Health and welfare managers was the only occupation group with weekly earnings higher than the Australian average ($754 above average).

The Study also examined earnings by age. On average and across the economy as a whole, incomes tend to increase with age, peaking at around 45-54 years. However, for Personal care and support workers, there was little to no earnings variation across age groups. Higher skill level occupations in the care and support workforce do tend to see greater variation in earnings between age groups, with this being most pronounced for Allied health professionals.

Finally, while differences in wages earnt across the relevant programs have been identified by some stakeholders, the current data classifications do not allow for the disaggregation across industries to easily quantify these reflections. That said, based on available data, Personal care and support workers and Health and welfare support workers appear to earn marginally more per hour if they are employed in the *Social assistance services* industry (which includes in-home aged care, disability support and other industries) relative to the *Residential care services* industry (which includes residential aged care).

Greater average hours would boost the incomes of Personal care and support workers

The Study also compared the earnings of Personal care and support workers with a selection of other Australian and New Zealand Standard Classification of Occupations (ANZSCO) skill level 3-5 occupations outside of the *Health care and social assistance* industry.

The average hourly earnings of Personal care and support workers were higher than most comparison occupations. However, the average hours worked by Personal care and support workers were lower than most comparison occupations.

While the hourly earnings of Personal care workers and support workers are competitive amongst these selected comparison occupations, low hours worked mean the annual earnings of Personal care and support workers tend to be lower. With higher average hours worked, Personal care and support workers would see more competitive annual earnings.

Qualifications, skills and attributes of the care and support workforce | Part 6

Many providers consulted through the Study also raised the importance of the attributes and values individuals bring to care and support roles. For these providers, attributes were seen as more important than qualifications in lower skill level roles.

An educated workforce, although requirements vary

The overall educational attainment of the care and support workforce is relatively high, however there is considerable variation in levels of attainment.

- Over 80% of the care and support workforce have attained a certificate III/IV qualification or higher (in any field of education) compared with 66% in the overall labour market.
- Nine of the 15 in-scope occupations require a bachelor degree or higher as their indicative entry qualification for employment, and 4 of these occupations are accredited and regulated by Australian Health Practitioner Regulation Agency (AHPRA).

Depending upon the services being provided, the state or territory of practice, the client group and the program under which services are being delivered, a range of other requirements may apply for someone to be able to practice.

While there appears to be a direct link between education and career paths among nurses (both enrolled and registered) and Allied health professionals, the link between education and employment is less clear for Personal care and support workers and Health and welfare support workers.

Education and training pathways

The number of people entering through the higher education pipeline has continued to grow in the last 2 decades and is largely represented by women.

Enrolments in vocational education and training (VET) training pathways that lead to care and support occupations have shown modest growth, increasing from almost 275,000 enrolments in 2015 to nearly 293,000 in 2019. Although the number of enrolments in care and support qualifications has grown, the number of completions has declined overall. Domestic completions declined from over 87,000 in 2015 to just under 83,000 in 2019.

The complexity evident in other aspects of the care and support sector is also evident in the provision of VET. States and territories decide what qualifications should attract government funding and independently set subsidies (the amount of government support) and policies for student fees and concessions. As a result, qualifications of relevance to the care and support sector are funded differently in each state and territory, resulting in inconsistent student fees and prices across Australia.

While many providers saw attributes and values as more important than qualifications in lower skill level roles, the share of job advertisements specifying a requirement for a certificate level qualification is nonetheless relatively high for Personal care and support workers.

International requirements vary

Internationally, less than half of OECD countries specify minimum qualifications for personal care workers, and where they do these vary from vocational training, high school diplomas or technical degrees after high school. About half of OECD countries require nurses to have a bachelor degree or higher, as is currently required for *Registered nurses* in Australia. Many OECD countries, including Australia, do not require geriatric-specific training for nurses working in aged care.

The workforce uses specialised skills, with digital skills becoming more important

The specialised nature of much of the care and support workforce means that anyone considering transitioning into the care and support workforce from an occupation outside of health and care may have skill gaps that require bridging through formal or on-the-job training.

Along with most of the broader workforce, digital skills will likely grow in importance as technology continues to augment jobs in the care and support workforce. Stakeholders also indicated the increasing importance of digital skills among care and support workers.

Flows into and out of the care and support workforce | Part 7

Macroeconomic factors may present challenges and opportunities

At a macro level a number of factors that have supported growth in the care and support workforce over recent decades are unlikely to enable similar growth into the future.

- In particular, female labour force participation is unlikely to rise over coming decades as it has in the past; while trends in female education attainment suggest that lower skill level care and support occupations may not see the same supply of domestic female entrants as in the past.
- The competition for migrant workers may also intensify in the years ahead due to a globally ageing population.

The possible heightened competition for workers, and the smaller future pool from which to draw from highlights the importance of productivity.

- From a demand perspective for care and support workers, stronger productivity growth within the sector could contribute to lowering future workforce demand. While from a supply perspective, stronger productivity growth across the economy as a whole could increase the potential supply of workers for the care and support sector.

The education and training pipeline is important when it comes to meeting workforce needs

The supply of skilled workers through the VET training system can be viewed as a pipeline with several conversion points from enrolment to employment. Given the nature of this pipeline, to place one individual in a relevant care and support job from this pipeline (based on current state), close to 2 individuals would need to be enrolled in the respective VET qualification.

A consistent theme highlighted by stakeholders throughout the Study was the importance of high-quality training for the care and support workforce. While there were differing views on whether this should be formal or on-the-job training, all agreed there were core skills and competencies needed for these roles.

Evolving job design, emerging skills and person-centred models of practice all contribute to the need for workforce enablers, like the education and training systems, to be responsive to these changes. Stakeholder contributions to the Study highlighted that the training system might not be keeping pace with some of these workforce requirements.

- Areas highlighted by stakeholders included cultural competency, dementia, mental health, trauma-informed and palliative (end of life) care.

The Aged Care Royal Commission recommended that the Certificate III in Individual Support (Ageing) should be the minimum mandatory qualification required for personal care workers performing paid work in aged care.

- There may be a range of potential benefits associated with mandating an entry level qualification, including standardising of skills and competencies, improving job readiness and increased professionalism.
- In the short to medium term, however, introducing such requirements may limit the pool of candidates available to fill existing skills gaps and act as a barrier to staying in the workforce. Mandatory qualifications may also pose a risk of being a disincentive for older and more experienced workers seeking to transition from other sectors in the economy to work in care and support.

Global competition for care and support workers may increase in the future

Against the backdrop of increasing demand for care and support workers from global population ageing and proportional decreases in the working age population, competition for migrant care and support workers is increasing.

Most OECD countries, including Australia, do not have specific migration channels for care and support workers and tend to rely on ‘incidental’ migrant workers to supplement local care and support workforces. Despite this, foreign-born workers comprise a high proportion (around 20%) of the long-term care workforce in OECD countries.

Recognising the growing competition for care and support workers, many OECD countries have implemented measures to influence attraction of migrant care and support workers. These include simplifying recruitment and migration procedures for care and support workers (Spain, Canada and Finland), lifting quotas (Austria) or providing exemptions from quotas for certain care occupations (Italy), and recognising long-term services and support occupations on a skills shortage list (United Kingdom).

The nature of flows into and out of the care and support workforce

The number of people joining care and support occupations has increased over recent years. The number of people moving to most care and support occupations from different occupations outside the care and support workforce has also increased in recent years.

Transitions across the care and support workforce are often to higher skill level occupations, indicating workers are forging both formal and informal career paths.

- For *Nursing support and personal care workers* who left the occupation in 2017-18, almost half (48%) transitioned into a skill level 1 occupation, with a further 16% transitioning to a skill level 2 occupation. There appears to be an established pathway, in practice, between the *Nursing support and personal care workers* and *Registered nurse*s occupations.
- That said, it is unclear if those who transition into higher skill level roles, such as *Registered nurses*, remain in the care and support workforce or move to other parts of the *Health care and social assistance* industry.

Exits from the workforce are most likely to occur within the first few years, and higher skill level occupations generally see greater retention

Exits from the care and support workforce are most likely to occur within the first couple of years of joining the care and support workforce.

- Turnover in the first year is a significant challenge for providers employing people in the *Aged and disabled carers* occupation.
- A large proportion of people who reported working in the *Nursing support and personal care workers* occupation also spend a relatively short duration of time within the occupation.
- Similarly, the Welfare support workers occupation also demonstrates significant turnover after a relatively short period of time (particularly for those in the younger age group).

Higher skill level roles, namely *Registered nurses* and Allied health professionals tend to see longer duration (i.e. higher retention).

Some new workers could come through jobactive placements, although skill mismatches may present a barrier

While the pool of potential workers without a job may not have the skills and attributes to meet all care and support workforce needs, a subset could transition into these roles, particularly those with related skills and qualifications.

- There were around 13,500 job placements per financial year in a care and support occupation in 2020-21. The majority of jobactive placements into the care and support workforce were into either the *Aged and disabled carers* or *Nursing support and personal care workers* occupations.

Factors influencing retention and supply of the care and support workforce | Part 8

There are a number of aspects of working conditions for the care and support workforce, highlighted by the Aged Care Royal Commission, that can erode job satisfaction and contribute to staff turnover. These include high workloads, work pressures, inadequate staffing and skill mixes, working conditions and arrangements including pay. The Aged Care Royal Commission also highlighted the importance of good leadership, supervision and support, as well as training and skills development. Many of these issues are also evident in industry surveys in the disability sector.

The various examples provided in Part 8 across worker screening, provider regulation, pricing, awards and taxation speak to the significant complexity of operating within and across the care and support system. Given this, it is important that the workforce implications of regulatory and operating frameworks are considered both in their program specific context, and also from a

whole-of-care and support system perspective. Without this, the potential for disincentives and unintended consequences is high, and risks exacerbating service delivery and workforce gaps.

Opportunities for progression are mixed

A factor in workforce attraction and retention is the availability of opportunities for workers to grow, progress and advance their careers. Stakeholders consulted during the Study highlighted the importance of career paths for the care and support workforce. The term 'career path' was used in a range of different contexts however most can be summarised as progression through roles that lead to more pay and/or responsibility. This could be through one job or through a series of jobs.

- At higher skill levels, career paths in care and support occupations are more clearly articulated with minimum qualifications, registration, placement, supervision and ongoing professional development, advancement and transition opportunities well-established.
- This contrasts with career paths for Personal care and support workers where the benefits of accumulating skills and qualifications through additional training and professional development is not clearly linked to career progression.
- Limited career development opportunities was the most common reason cited by people who were either unsure if they would be working, or would not be working in the sector, in 5 years' time. The importance of developing career paths for direct care workers was also highlighted by the Aged Care Royal Commission.

Training and professional development are important for workforce capability

Ongoing professional development was consistently highlighted by stakeholders as a key enabler of the care and support workforce. This was considered especially important given the evolving and complex work context in which care and support workers are required to practice.

Stakeholders noted several features of care and support work that necessitate structured ongoing professional development, including high levels of regulation and compliance, changing policy and legislative landscape, interpersonal interactions with individuals with complex needs, and work settings which required independent application of knowledge and skills under limited supervision.

For some care and support roles, such as the occupation group Personal care and support workers, ongoing professional development is not formally required. Some stakeholders also noted that when professional development is offered it may be linked to compliance measures and regulatory/policy changes, rather than focused on workforce capability uplift.

Person-centred approaches are shaping and changing the job roles in the care and support workforce but are yet to be fully captured in articulations of job design. Throughout the Study, stakeholders pointed to job design as an enabler for defining career paths, dispelling negative perceptions of working in care and support roles, ensuring training is well suited to job requirements and ongoing professional development, and underpinning better understanding of scopes of practice within and across care and support occupations.

A range of other factors can impact turnover

Turnover can be related to aspects of a person's work as well as unrelated factors.

For example, for experienced workers in the residential aged care sector, moving away, or moving to a different location is a common reason for leaving a care and support role. Some care and support work can be physically demanding, and for those in older age groups, their own health or physical capacity may impact upon their ability to continue in a caring role.

Research suggests early career allied health workers and nurses are at risk of worker turnover, while stakeholders often spoke of high turnover among new Personal care and support workers, indicating the need for tailored retention strategies for younger, or early career cohorts.

- In this regard, attraction and retention strategies are often closely intertwined and for some providers, retention strategies begin even before recruitment. Many stakeholders spoke about

ensuring that the right candidates with a passion for the job are recruited and that students are appropriately supported during training.

Regional and remote areas face unique challenges including workforce retention.

- The importance of developing a local Aboriginal and Torres Strait Islander workforce was reiterated strongly during the consultation process, including engaging with the local Aboriginal and Torres Strait Islander community to link people to health systems and of attracting community members with the right skills to the care and support workforce – a workforce that is local, embedded with cultural capability and understanding of the place-based context.

Negative perceptions need to be addressed and worker sentiment collected

Persistence of negative perceptions about working in care and support may drive an undervaluing of the care and support workforce and be an ongoing barrier to people: understanding the wide variety of opportunities, job roles and careers available; considering and being attracted to a care and support role as a career of choice; and remaining in the care and support workforce.

Internationally, campaigns have also been implemented to improve the public perception of working in care and support roles.

While Australian workforce strategies recognise the need to incorporate feedback from recipients of care and support into workforce planning, the lack of data on the perspectives of care and support recipients (which would provide valuable insights into their needs and preferences) is a challenge. Methods and frequency of collecting worker sentiment are variable across programs, with no detailed cross-cutting data available.

Technology will drive change

Advances in technology will expand the range of interventions available to Australians, increasing their choices around health care as well as how they receive care and support.

That said, occupations in the direct care and support workforce tend to inherently need human contact to listen and respond to diverse and changing client needs, making these roles less likely to be automated. However, this does not imply that these occupations are not subject to task change and augmentation.

- For example, in the care and support workforce, administrative tasks in managing client records can be streamlined through software and business automation tools.

Stakeholders also viewed technology as a useful tool to improve the quality of care and the data used to determine individual care and support needs.

- Innovations in smart-home monitoring and integrated technology using sensors, GPS tracking and artificial intelligence may improve the overall quality of patient care, and assist in personalising individual's care and support needs.
- Technology may also have a positive impact on care and support workers as improved outcomes of clients may boost overall job satisfaction and general wellbeing.

Technology may therefore ultimately have the potential to reduce the high labour intensity in care and support work.

The award system plays a significant role in the care and support workforce

Although most care and support workers are employed on a collective agreement, the award system is a substantial driver of wages and conditions in the sector, as noted by the Aged Care Royal Commission.

However, the current award system does not entirely reflect the distinct roles and responsibilities of workers in care and support settings. For example, the Aged Care Award is an industry award which covers many different occupations under a single title: 'aged care employee'.

- This means the same minimum pay rates and conditions apply for a wide range of roles, including cleaners, maintenance workers, pay clerks, personal care workers, gardeners, drivers, and cooks.

As a result, the Award does not recognise the skills or responsibilities that may be specific to personal care and support, cleaning, gardening or food services in residential aged care, nor does it take into consideration whether these roles should attract different minimum pay rates.

The award system can also be complex, and it can be difficult for employers and employees to understand its interconnections with care and support programs. With the introduction of person-centred care models such as in the NDIS, there are elements of tension with award arrangements which pre-date these models.

- Under the Social, Community, Home Care and Disability Services (SCHADS) Award, casual workers are entitled to a 2-hour minimum engagement period. In an NDIS trial site in October 2015, 78% of service requests were at or less than 2 hours. This can have implications for workers, providers and participants.
- People with disability may choose to seek support services at the beginning and end of their day. Under the SCHADS Award, workers who have a break between shifts (other than a meal break) are entitled to additional allowances. This can mean it is more cost effective for providers to employ multiple disability support workers to provide services to one participant.

As with broader regulatory and system alignment, effective workforce utilisation also requires stronger alignment between the industrial relations system and changing job roles, participant needs and evolving job design.

The Study notes that matters such as minimum engagements and broken shifts are currently before the Fair Work Commission (FWC) as part of the 4 yearly modern award reviews.

Other elements of system design can impact workforce arrangements

Stakeholders pointed to the shift to person-centred care and the interaction with program funding and pricing settings as incentivising providers to employ workers on short-hour casual or part-time contracts – leading to the rise of an 'on-demand' workforce. This approach ensures there is sufficient workforce coverage to meet the increasingly complex and diverse consumer needs, as well as keep operating costs low within an increasingly competitive market environment, and enables scaling of operations in line with the incremental rollout of the NDIS.

The Study is not – of course – suggesting that workforce considerations should override issues of system design which are focused around needs of participants; but rather that there are relationships between the two.

Fringe benefits tax (FBT) concessions can be an attractive feature of the care and support sector for some workers, improving its competitiveness against other parts of the economy. Many non-profit organisations, including care and support providers, are eligible for the FBT exemption and can pass on to their employees a proportion of their wages as a reimbursement of personal expenses. Salary packaging often features in online job advertisements for Personal care and support workers, highlighting the use of non-wage benefits providers use to attract workers.

The regulatory environment also matters for the workforce

The regulatory environments for aged care, NDIS and veteran care programs are often disconnected from one another, creating different and separate requirements for workers and providers in each program. This also introduces a range of incentives and disincentives to operate in each program market. The workforce implications of this system complexity and misalignment of regulatory environments are significant and create barriers to workforce mobility across programs.

- The NDIS Worker Screening check is recognised under both the aged care and NDIS legislation, however the police check requirements for workers in aged care is not recognised for NDIS purposes, as police checks are point in time and not as comprehensive as an NDIS check.

- That said, the *NDIS National Workforce Plan* recognises the need to further align worker regulation across care and support programs, and the Australian Government announced funding in the 2021-22 Budget to implement a care and support code of conduct and a nationally consistent pre-employment screening process across aged, veteran and disability care and support services.

Regulation is, of course, an important and necessary part of the delivery of care and support services to ensure quality service and outcomes for those Australians who rely on these services. However, many stakeholders suggested that regulation is biased toward measuring compliance and may not incentivise innovation in care and support.

Ensuring regulatory settings have the appropriate checks and balances, while ensuring quality outcomes are achieved, and productivity and innovation enhancements are not dampened, is a significant challenge which impacts workforce utilisation (and may matter more into the future if workforce gaps arise).

Care and support in mental health | Part 12

While the mental health workforce shares many similarities with the care and support workforce, as highlighted through this Study, there are several differences and increased complexity which are significant and warrant separate consideration.

Like the care and support system the mental health landscape is complex. Policy responsibility for mental health is shared across Australian, state and territory governments and a range of different departments and agencies. There are also a broad range of non-government organisations that operate across community mental health services.

Informal care and support also makes a substantial contribution to the provision of mental health services, with the Productivity Commission estimating the value of care and support provided by family and friends to be worth around $15 billion per year in 2018-19.

Data gaps are an even greater issue across the mental health landscape

Data availability is a major challenge in estimating the demand for mental health services and programs. Data collections focused on mental health in Australia's population are infrequent and based on self-reported observations.

Further, administrative and service level data varies in availability and has a number of limitations, making it difficult to establish a comprehensive picture of demand and usage of mental health services. The 2020 Productivity Commission's Mental Health Inquiry identified a range of data gaps across the mental health system.

Prevention and early intervention initiatives can take place in a range of settings, and again, there is no way to accurately assess demand or identify the range of occupations which may contribute to the delivery of preventive and early intervention supports.

Defining the mental health workforce is also challenging. In part this is due to the continuum of mental health and the scope of activities and services that are linked to this, as well as the absence of agreed definitions and data limitations. Notwithstanding these challenges, the mental health workforce is growing and new roles are emerging.

Which has meant the Study has adopted a different approach

Given these complexities, the Study has provided an illustrative analysis of the mental health workforce, with a focus on 7 key occupations (across 2 occupation groups – Medical mental health workers and Non-medical mental health workers) that have a direct connection to delivery of mental health services as part of their role.

The 4 Non-medical mental health occupations are of similar size, with *Welfare, recreation and community arts workers* being the largest, followed by *Psychologists*, *Social workers* and *Counsellors*. *Registered nurses* and *General practitioners and resident medical officers* are the largest Medical mental health occupations, which is unsurprising given their role in the broader health sector. *Psychiatrists* is the smallest occupation.

- The 4 Non-medical mental health occupations considered in the Study have grown considerably since 2005. Among Medical mental health occupations, *Registered nurses* and *General practitioners and resident medical officers* have consistently grown since 2005. *Psychiatrists* was the only occupation to decline in size over the same period, which may be due, in part, to a combination of higher average age and retirements.

The demographic profile of the mental health workforce has some similarities with the care and support workforce

Like the care and support workforce, the mental health workforce has a much higher concentration of employed females (82%) than the overall workforce (48%) – primarily driven by a high prevalence of females in Non-medical mental health occupations.

The mental health workforce is culturally and linguistically diverse with around 40% of the workforce born overseas (similar to the care and support workforce).

- Within that there is a greater share of overseas-born workers among Medical mental health roles, compared with non-medical roles where a higher proportion of the workforce are born in Australia.

Mental health workers, similar to care and support workers, are typically older than other Australian workers. The average age of the mental health workforce has also been increasing over time, in contrast to the care and support workforce, which has a declining average age.

- The age profile varies considerably across occupations with *Psychiatrists* more likely to be older (with an average age of 49 years) and *Welfare, recreation and community arts workers* more likely to be younger (average age of 42 years).

Labour market characteristics are different, though

Mental health workers are less likely to work part-time than those employed in the care and support workforce. In February 2021, around 45% of the mental health workforce (or 35% not including *Registered nurses*) were employed on a part-time basis, compared with 52% of the care and support workforce.

Mental health workers also typically work more hours per week than the care and support workforce but less than the total workforce. Medical mental health workers (other than *Registered nurses*) work more hours than non-medical staff.

The overall underemployment ratio (share of employed) for the mental health workforce, which stood at around 6% in February 2021, is much lower than for the total workforce (9%) or the care and support workforce (13%).

Incomes vary significantly by occupation, with the workforce highly qualified

The wage income of mental health workers varies significantly by occupation, with medical occupations mostly earning more than non-medical occupations. Only 2 occupations earned less than the Australian average: *Counsellors* and *Welfare, recreation and community arts workers*.

The mental health workforce is highly qualified, with education pathways predominantly associated with higher education.

All mental health occupations considered in this Study are skill level 1 – commensurate with a bachelor degree or higher. This distinguishes the mental health workforce from the care and support workforce where the skill level profile is mixed, with the majority of the workers employed in skill level 4 roles.

- That said, other skill levels are likely represented in the broader range of mental health occupations that sit in the areas of prevention, early intervention and mental health care and support.

Enrolments for higher education qualifications for mental health occupations have increased by almost 160% between 2001 and 2019, higher than the growth in all higher education enrolments which increased by 90% over the same period.

The mental health care and support landscape is changing, and may overlap more with the broader care and support sector in the future

Throughout the Study a range of job titles have also been used by stakeholders to identify the occupations within the mental health workforce that do not align precisely with occupation titles in ANZSCO, including lived experience (peer) workers, psychosocial support workers and allied health assistants.

With the exception of allied health professionals providing care and support within a mental health setting, it is notable that the skill and qualification level of workers in these emerging (lived experience (peer) workers) and potentially emerging (psychosocial support workers) mental health roles is comparable to that of the general care and support workforce.

This suggests that, in the event of increased demand for care and support, these systems will be drawing from similar pools of workers which could further increase workforce pressure in both the care and support and mental health workforces.

Mental health skills are also growing in importance across a range of different occupations, which will add to broader demand

Online job advertisements suggest employers are increasingly looking for workers with mental health skills across a range of occupations. Between 2014 and 2020, the percentage of online job vacancies mentioning mental health skills grew across a number of health and welfare occupations, including *Social workers*, *Enrolled and mothercraft nurses* and *Welfare support workers*. Mental health skills are also becoming more prevalent in advertisements for *Aged and disabled carers*, the largest care and support occupation. This reflects the growing need for, and importance of, mental health skills in the delivery of health and welfare services.

- The draft *National Mental Health Workforce Strategy* also recognises the broader workforce has a role in supporting people experiencing suicidality, mental distress and/or ill health, and includes training initiatives to support the development of basic mental health skills across a range of care and support occupations (including aged care, disability services and allied health workers).

Mental health skills are also becoming more common in job advertisements for roles outside of health and welfare occupations and settings (for example, job vacancies for *Student counsellors*, who work predominantly in education settings) reflected by an increase in mentions of mental health skills.

As awareness of mental health issues increases, it may be expected that skills in these areas will increasingly be required for a wide range of jobs, particularly in service-based industries, including care and support and to support early intervention and prevention.

As with the care and support workforce, a range of factors impact supply

Similar to the care and support workforce, there are a range of factors influencing the supply of the mental health workforce. Indeed, there is a considerable degree of overlap between the issues identified for the care and support workforce, and those facing the mental health workforce.

- Strategies to address these workforce challenges are reflected in the draft *National Mental Health Workforce Strategy.*

Delivery of mental health care and support services is complicated by shared roles and responsibilities across governments and the non-government sector. Stakeholders cited fragmentation of the mental health system and a range of factors that may be contributing to this complex environment, including variable policy settings and governance across jurisdictions and programs multiple service delivery models which are not well-integrated, and various funding approaches.

The workforce and service delivery implications of fragmentation can impact the remuneration and conditions of mental health workers differently across occupations and settings.

- With many different funding sources, such as the NDIS, state and territory health systems, and the community sector, the pay settings and entitlements of workers can differ widely based on the context and setting in which they work.

Estimating demand and supply is more challenging across mental health, although there may be unmet demand

The Productivity Commission estimates that around one million people with mental illness are receiving no clinical care and noted many people do not receive the treatment and supports that they need, or at the level that they need them.

Further, on the supply side there are indications of workforce shortages in some mental health occupations:

- The Productivity Commission found that there was a shortage of psychiatrists in Australia, particularly those specialising in the treatment of children, adolescents, and older people.
- *Psychiatrists, General practitioners and resident medical officers* and *Psychologists* are identified as being in shortage on the NSC's Skills Priority List.
- Analysis undertaken to inform the draft *National Mental Health Workforce Strategy* also estimated that the current mental health workforce is significantly below the national target levels in the 2019 National Mental Health Service Planning Framework.

Combined, these insights support a view that there is a degree of pressure in the mental health workforce.

Mental health occupations are likely to see ongoing growth, and workforce gaps could emerge

As noted earlier, mental health occupations have experienced employment growth in recent years, and this is expected to continue over time.

- Projections derived from Deloitte Access Economics' broader macroeconomic forecasts see that *Registered nurses* will experience the largest growth over the 10 years to 2031, followed by *General practitioners and resident medical officers* and *Psychiatrists*.
- Continuing growth is also expected across all Non-medical mental health roles, with *Social workers* expected to be the largest Non-medical mental health occupation by 2031, followed by *Psychologists* and *Counsellors*. The lowest growth rate is anticipated for *Welfare, recreation and community arts workers*.

Given the unclear starting point for demand and supply across mental health, it is difficult to quantify whether there is currently a gap between workforce demand and supply for mental health, or the magnitude of any such gap into the future. That said, a number of indicators suggest a degree of pressure on the workforce.

While the many data constraints present in mental health make workforce planning and development much more challenging, the conclusions from the care and support workforce modelling are likely to also prove salient in the mental health context.

To the extent that a workforce gap and pressure currently exists for mental health occupations, any increase in demand will exacerbate any underlying workforce shortage and will be cumulative over time. Shifts in societal attitudes, particularly increased awareness of the importance of mental health, are also likely to lead to increased demand for mental health services.

For mental health occupations at skill level 1, the supply of workers will be both a function of enrolments and completions in higher education and skilled migration levels. Negative trends in either of these supply changes will exacerbate any gap, noting that the education and training for some occupations takes many years to complete.

- The age profile of *Psychiatrists* presents some risk to this occupation in the mental health workforce.

Acknowledging the demand for mental health workers at lower skill levels is not yet well understood, it is possible that the emerging mental health occupations and those providing early

intervention, prevention, and mental health care and support may have similar skill level characteristics to the majority of the care and support workforce.

As the gap is most acute at these skill levels for the care and support workforce, this may also be where the largest workforce gap may emerge, particularly if all programs and services across aged, disability, veteran and mental health care and support are competing for the same pool of potential workers.

A framework for monitoring the care and support workforce | Part 11

For this framework to be successful it will need to consider the workforce from a cross-program perspective. Workforce implications need to be given active consideration in policy development and decision making across all care and support programs in light of the risk that workforce gaps could emerge in coming years.

Program-specific views, while important and necessary, also need to take account of how policy implementation is likely to influence other care and support programs, and consequently the broader workforce providing these services.

The monitoring framework could be adopted to examine and understand the pressures in the care and support workforce. The framework has 3 components:

- regular snapshots which provide point-in-time assessments of the care and support workforce
- re-baselining the demand and supply models to revise future forecasts
- regular assessment of the impacts of new policy on the demand for and supply of the workforce.

Together, these elements provide an assessment of the here and now, the likely future profile of the workforce (that is, are future gaps increasing or decreasing), and provide a structured way for workforce implications of policy decisions to be considered across the broader care and support landscape.

A range of sensitivities based on different modelling assumptions | Part 10

The sensitivities presented are not designed to model alternative policies or government decisions. Instead, they provide insight into the workforce implications, should different assumptions be incorporated for any of the key variables.

The sensitivities highlight that there is no single solution to closing the forecast gap between workforce demand and supply.

While the sensitivities reflect some levers that influence the workforce projections, this Study has also highlighted a range of other supply and demand factors which present future opportunities and risks for the care and support workforce which are not able to be modelled.

Less tangible, but not less important, are factors like public perception, new articulations of job design and architecture, technology adoption and innovation rates. These all reflect opportunities to influence the care and support workforce gap.

Beyond these factors, the role of the wider economy and its capacity to contribute to the supply of the care and support workforce is a relevant consideration. While outside the terms of reference for this Study, opportunities may exist in other parts of the economy to improve productivity and hence increase the potential flows of workers to the care and support workforce from other sectors.

The Study's approach | Part 1

The Study comes against a backdrop of a rapid rise in the number of care and support workers in recent years and represents the first 'whole of sector' examination of the care and support workforce.

In this context it is important to note that a program-driven approach to workforce planning may not adequately consider that care and support workers are unlikely to fall exclusively within

delineated programs. Care and support workers are known to transition between, or even work concurrently in, different parts of the care and support workforce.

A substantial focus of existing workforce plans and strategies is therefore arguably aimed at growing and drawing upon the same pool of workers.

Further, while some workforce definitions exist, these typically focus on either a particular aspect of care (such as clinical care) or a particular program (such as the NDIS). A comprehensive cross-program definition of the care and support workforce does not yet exist.

Definitions used in the Study

For the purposes of this Study the key considerations that have informed the selection of occupations are:

- Cross-cutting – those occupations that are common across aged, disability and veteran care and support (given the purpose of the Study is to provide a holistic view of the care and support workforce).
- Direct role – occupations with a direct role in resident, client, participant or patient care. Ancillary occupations with a limited or indirect role are out of scope, as are roles employed almost exclusively in medical and hospital settings.
- Data availability – the Study uses ANZSCO as the basis for exploring occupations. To a lesser extent, the Study leverages other data sources, where possible, to supplement and explore different aspects of the workforce.

Fifteen ANZSCO occupations (at the 4-digit level) have been selected as the care and support occupations in scope of this Study. To better reflect the care and support workforce, these occupations have been arranged into 5 occupation groups. These groups are:

- Personal care and support workers
- Health and welfare support workers
- Registered nurses
- Allied health professionals
- Health and welfare managers.

By applying both an occupation and industry lens, the Study attempts to provide an accurate view of the care and support workforce; noting that a comprehensive cross-program definition of the care and support workforce does not yet exist.

- For example, while many *Registered nurses* are employed in aged care, most work in hospitals. It is therefore important, yet difficult, to differentiate the workforce not just by occupation but also by industry.

For the majority of the analysis conducted for this Study the following three 3-digit industry codes within the Australian and New Zealand Standard Industrial Classification (ANZSIC) have been considered in scope:

- *Residential care services*
- *Other social assistance services*
- *Allied health services.*

Data limitations exist

The Study has identified a number of data gaps and limitations through the course of its work. Greater levels of granularity in occupation and industry disaggregation for the care and support workforce is important for workforce monitoring, planning and development, as well as job design, career progression, training investment and remuneration. Identifying workforce developments and trends at a regional level is also a challenge.

One way to provide a more complete picture of the care and support workforce across programs (and also industries and occupations) could be through a 'Satellite Account' – similar to the

Tourism Satellite Account that the ABS has compiled for the tourism sector. That said, there would be resource implications for the ABS in undertaking such a task and data gaps might limit the completeness and feasibility of any such account.

Acknowledgments

Thank you to the organisations and individuals who made valuable contributions to the Study, including the stakeholders who met with the Care Workforce Labour Market Study Taskforce or made a written submission (Appendix A).

I also extend my gratitude to the members of the Taskforce for their assistance in conducting the Study (Appendix E) and the agencies that provided support and feedback to the Study (particularly those that provided secondees to the Taskforce).

The dedication and passion of so many that work across the broad care and support sector is also acknowledged, and deeply appreciated.

Adam Boyton
National Skills Commissioner

Glossary of terms

Term	In this Study means
Aged Care Royal Commission	The Royal Commission into Aged Care Quality and Safety established on 8 October 2018 and final report presented on 26 February 2021.
Defence and Veteran Suicide Royal Commission	The Defence and Veteran Suicide Royal Commission established on 8 July 2021 and due to present its final report by 15 June 2023.
Demand	The workforce required to meet the needs of individuals for (aged, disability, veteran and mental health) care and support services, based on a projected outlook of the key programs delivering these services.
Disability Royal Commission	The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability established on 4 April 2019 and due to present its final report by 29 September 2023.
DVA Gold Card	The DVA Gold Card entitles the holder to DVA-funded services for all health conditions, whether they are related to war/military service or not. Several different eligibility criteria are associated with a DVA Gold Card, covering qualifying service and service history, disability and service pension requirements and a range of other factors. Further information is available on DVA's website: www.dva.gov.au/health-and-treatment/veteran-healthcare-cards/veteran-gold-card.
DVA White Card	The DVA White Card provides the holder with medical treatment for accepted service-related injuries or conditions, and all mental health conditions (for veterans with continuous full-time service or certain reserve service). An individual may be eligible for a White Card if they are: a current or former Australian Defence Force member, including reservists and cadets, with a service-related injury or condition accepted by DVA; or a Commonwealth or Allied veteran with a service-related injury or condition accepted by their country of service.
Long-term care	Long-term care, as defined by the OECD, consists of a range of medical, personal care and assistance services that are provided with the primary goal of alleviating pain and reducing or managing the deterioration in health for people with a degree of long-term dependency, assisting them with their personal care and living independently. Long-term care workers are defined as those who provide care to long-term care recipients at home or in long-term care institutions (other than hospitals). Formal long-term workers comprise 2 main professional categories: nurses and personal care workers. While there is broad alignment, the definition used by the OECD is not identical to those used in this Study.

Term	In this Study means
Person-centred care and support	Care and support that focuses on the needs of the person rather than the needs of the service. Key dimensions include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care.
Skill level	Within this report, skill level is defined as a function of the range and complexity of the set of tasks performed in a particular occupation based on the ANZSCO classification. In general, the greater the range and complexity of the set of tasks, the greater the amount of formal education and training, previous experience and on-the-job training required to competently perform the set of tasks for that occupation. In this report references to lower skilled occupations relate to skill levels 4-5 while higher skilled occupations relate to skill levels 1-3. It is important to note that skill level is an attribute of occupations, not of individuals in the workforce or of particular jobs. It is also not a measure of the value of particular occupations.
Study	The Care Workforce Labour Market Study.
Supply	The workforce available to meet the needs of individuals for (aged, disability, veteran and mental health) care and support services. This is not necessarily equivalent to future employment in the relevant sectors, but rather the number of people willing to supply their labour at the relevant point in time.

Abbreviations and acronyms

Abbreviation	What it stands for
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Organisation
ACLD	Australian Census Longitudinal Dataset
ACWC	Aged Care Workforce Census
ACWIC	Aged Care Workforce Industry Council
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
ANZSCO	Australian and New Zealand Standard Classification of Occupations
ANZSIC	Australian and New Zealand Standard Industry Classification
AQF	Australian Qualifications Framework
ASQA	Australian Skills Quality Authority
ATO	Australian Taxation Office
CALD	Culturally and linguistically diverse
CHSP	Commonwealth Home Support Programme
CNP	Community Nursing Program
DESE	Department of Education, Skills and Employment
DSS	Department of Social Services
DVA	Department of Veterans' Affairs
FBT	Fringe benefits tax
FOE	Field of education
FTE	Full-time equivalent
FWC	Fair Work Commission
HESTA	Health Employees Superannuation Trust Australia

Abbreviation	What it stands for
HSSO	Human Services Skills Organisation
IGR	Intergenerational Report
LFS	Labour Force Survey
LLFS	Longitudinal Labour Force Survey
MADIP	Multi-Agency Data Integration Project
MBS	Medicare Benefits Schedule
MM	Modified Monash
NACWCS	National Aged Care Workforce Census and Survey
NCVER	National Centre for Vocational Education Research
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDS	National Disability Services
NERO	Nowcast of Employment by Region and Occupation
NGO	Non-government organisation
NILF	Not in the labour force
NSC	National Skills Commission
OECD	Organisation for Economic Co-operation and Development
PHN	Primary Health Network
PIT	Personal Income Tax
REOS	Recruitment Experiences and Outlook Survey
SA4	Statistical Area Level 4
SCHADS	Social, Community, Home Care and Disability Services
SERA	Survey of Employers who have Recently Advertised
SPL	Skills Priority List
TEQSA	Tertiary Education Quality and Standards Agency
VET	Vocational education and training
VHC	Veterans' Home Care

Part 1
About the Study

This Part of the Study outlines the broad approach taken with respect to scope and coverage in delivering on the Terms of Reference.

The Study comes against a backdrop of a rapid rise in the number of care and support workers in recent years and represents the first 'whole of sector' examination of the care and support workforce.

In this context it is important to note that a program-driven approach to workforce planning may not adequately consider that care and support workers are unlikely to fall exclusively within delineated programs. Care and support workers are known to transition between, or even work concurrently in, different parts of the care and support workforce.

A substantial focus of existing workforce plans and strategies is therefore arguably aimed at growing and drawing upon the same pool of workers.

Further, while some workforce definitions exist, these typically focus on either a particular aspect of care (such as clinical care) or a particular program (such as the National Disability Insurance Scheme (NDIS)). A comprehensive cross-program definition of the care and support workforce does not yet exist.

The care and support workforce is not a homogenous group of people. This Study estimates there are around 460,000 care and support workers (excluding mental health) in Australia who are employed across a wide range of occupations and multiple industries.

Definitions used in the Study

For the purposes of this Study the key considerations that have informed the selection of occupations are:

- Cross-cutting – those occupations that are common across aged, disability and veteran care and support (given the purpose of the Study is to provide a holistic view of the care and support workforce).
- Direct role – occupations with a direct role in resident, client, participant or patient care. Ancillary occupations with a limited or indirect role are out of scope, as are roles employed almost exclusively in medical and hospital settings.
- Data availability – the Study uses the Australian and New Zealand Standard Classification of Occupations (ANZSCO) as the basis for exploring occupations. To a lesser extent, the Study leverages other data sources, where possible, to supplement and explore different aspects of the workforce.

Fifteen ANZSCO occupations (at the 4-digit level) have been selected as the care and support occupations in scope of this Study. To better reflect the care and support workforce, these occupations have been arranged into 5 occupation groups. These groups are:

- Personal care and support workers
- Health and welfare support workers
- Registered nurses
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- For example, while many *Registered nurses* are employed in aged care, most work in hospitals. It is therefore important, yet difficult, to differentiate the workforce not just by occupation but also by industry.

For the majority of the analysis conducted for this Study the following three 3-digit industry codes within the Australian and New Zealand Standard Industrial Classification (ANZSIC) have been considered in scope:

- *Residential care services*
- *Other social assistance services*
- *Allied health services.*

Data limitations exist

Identifying the mental health workforce is a particular challenge. Like the care and support workforce there is no consistent definition of the occupations comprising the mental health workforce, but unlike the care and support workforce an industry lens is unable to be applied to further identify the workforce, as there are no mental health specific industries within ANZSIC. Consequently, the analysis in this Study is at the whole-of-occupation level and includes all industry settings for that occupation not just mental health specific settings.

Due to these limitations, this Study has considered the mental health workforce separately and adopted an illustrative approach to analysis of the mental health workforce. However, this is supplemented by the in-depth analysis of the care and support workforce, who may provide mental health care and support as part of their roles, such as Allied health professionals and Health and welfare support workers. Registered nurses are included in both the care and support workforce and the mental health workforce analysis, given the role of nurses in mental health.

The Study has identified a number of data gaps and limitations. Greater levels of granularity in occupation and industry disaggregation for the care and support workforce is important for workforce monitoring, planning and development, as well as job design, career progression, training investment and remuneration. Identifying workforce developments and trends at a regional level is also a challenge.

One way to provide a more complete picture of the care and support workforce across programs (and also industries and occupations) could be through a 'Satellite Account' – similar to the Tourism Satellite Account that the ABS has compiled for the tourism sector. That said, there would be resource implications for the ABS in undertaking such a task and data gaps might limit the completeness and feasibility of any such account.

The treatment of COVID-19 in the Study

The COVID-19 pandemic has had tragic implications for people all around the world.

As the COVID-19 pandemic is anticipated to be a relatively short-term shock (in the context of the time frame considered in this Study) a pre-pandemic perspective of the care and support workforce has been used as the starting point for key assumptions that are likely to have been impacted by COVID-19. To do otherwise would be to assume that the dramatic disruption seen on account of COVID-19 and associated responses would linger through the rest of this decade and following decades.

1.1 The terms of reference

The scope of the Study is outlined in its Terms of Reference.

Terms of Reference

Without limiting related matters on which the Commissioner may report, the Commissioner should:

- examine the current profile of the care and support sector workforce, including occupation, qualifications and employment type, and the main sociodemographic characteristics, including gender, education and ethnicity
- examine the current balance of labour supply and demand in the sector, including geographic distribution and the extent to which current workforce arrangements meet community need including those in regional and remote Australia
- examine factors affecting the supply for care workers in the near term (over the next 5 years) and longer term in light of the ageing population (to 2050) including:
  - potential challenges to labour supply including, but not limited to: remuneration, employee turnover, suitability of current skills and training model, employee engagement and enablement, ability to attract and retain talent and opportunities for career progression
  - education and training pathways available to enter the care and support sector, including international qualifications
- assess the likely future growth in demand for workers in the care sector and the extent to which it can be met over the near and longer term. This should include consideration of current strategies to meet that need including workforce planning, migration settings and linkages to the education and training sectors and employment programs and services
- draw on domestic and international policies and experience, where appropriate
- have regard to the findings of the Royal Commission into Aged Care Quality and Safety, and lessons to date from the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, and implications for workforce that may stem from them
- develop a framework to monitor and assess pressures in the care and support sector workforce over the short, medium and long term.

The final report should be provided to the Minister for Employment, Workforce, Skills, Small and Family Business by 30 September 2021.

Along with an overview of the demand for care and support services (Part 2) and an in-depth profile of the care and support workforce (Part 3-Part 6), this Study also provides a unique examination of the wide range of challenges affecting the broad supply of care and support workers (Part 7 and Part 8).

Importantly, this Study takes a holistic look at the care and support workforce across the provision of aged, disability and veteran care and support services, and models the workforce demand, supply and emerging gap (Part 9). While analyses of the care and support workforce have previously been undertaken for specific areas, such as aged care or disability, a detailed examination across the broader care and support workforce has not. This is a key contribution of this Study.

The Study considers a range of opportunities and risks, including modelled sensitivities for productivity, wages, retention, hours and migration, which could influence the size of the workforce gap into the future (Part 10). Further, the Study outlines a framework to monitor and assess current and future pressures in the care and support workforce (Part 11).

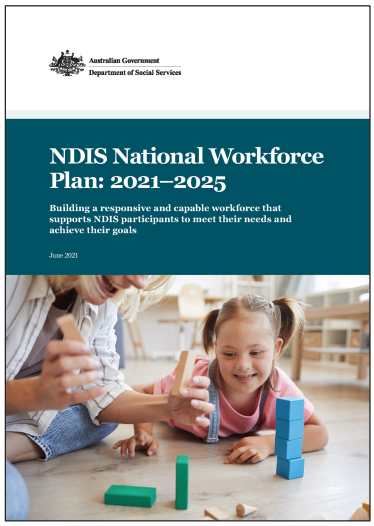
Issues relevant to the care and support workforce in the context of mental health are explored in Part 12.

Consultation with stakeholders occurred throughout the Study. The Study's stakeholder consultation process is detailed in Appendix A.

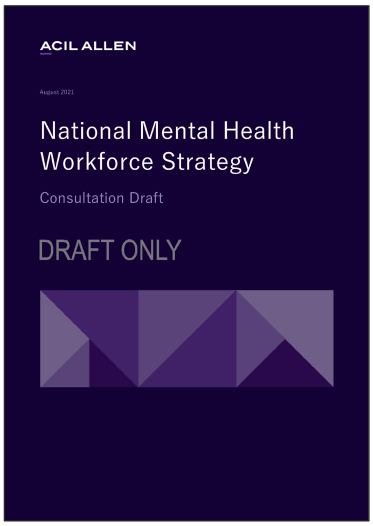
1.2 Multiple initiatives and workforce strategies

Provision of care and support is delineated by government program areas – aged care, disability support, veteran care and mental health care and support. Workforce planning generally follows these program lines.

A Matter of Care – Australia's Aged Care Workforce Strategy
(released September 2018)



NDIS National Workforce Plan: 2021–2025
(released June 2021)



National Mental Health Workforce Strategy
(consultation draft released August 2021)

There are also a number of workforce plans at the state and territory level which intersect with care and support programs, such as *Keeping our sector strong: Victoria's workforce plan for the NDIS*, and the *NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022*.

Accordingly, these workforce plans focus on the strategic actions and initiatives that are required to attract, retain and develop a skilled workforce in the respective program areas.

However, a program-driven approach to workforce planning may not adequately consider that care and support workers are unlikely to fall exclusively within delineated programs. Care and support workers are known to transition between, or even work concurrently in, different parts of the care and support workforce. A substantial focus of existing workforce plans and strategies is therefore arguably aimed at growing and drawing upon the same pool of workers.

For this reason, an overarching and holistic view of workforce planning across care and support is important to:

- build a more complete picture of the challenges affecting supply and ways to address them, taking into account the differences and interconnections across the care and support environment that affect the workforce.
- develop a more comprehensive estimate and understanding of the differences between workforce demand and workforce supply (i.e. workforce gaps) across the care and support workforce.
- inform coordinated and well-targeted strategies that take account of the interconnectedness and do not amplify the propensity for churn in the care and support workforce.

Similarly, an initiative or policy change within a specific program can have effects that ripple through other parts of the care and support landscape.

For example, different funding and pricing models across aged care, NDIS and veteran care programs have flow on effects to the care and support workforce and can drive flows to one part of the sector at the expense of another.

Further, regulatory differences, such as worker registration processes, can act as barriers that make it more difficult to effectively utilise the care and support workforce across programs.

1.3 Defining the care and support workforce

1.3.1 Identifying and defining the care and support workforce is a challenge

The care and support workforce is not a homogenous group of people. This Study estimates there were around 460,000 care and support workers (excluding mental health) in Australia in early 2021 who are employed across a wide range of occupations and multiple industries.[1]

This estimate is based on the number of people working within the in-scope occupations and in-scope industries (defined in Part 1.3.2) from recent Australian Bureau of Statistics (ABS) data. While other estimates of components of the care and support workforce may exist based on alternate surveys and databases, the Study has used this figure as a base in order to provide detailed analysis and inform the forecast assumptions across the full care and support workforce, not just program-specific workforces, using comprehensive and contemporary official statistical data. The use of these data sources has also been chosen to enable regular and consistent monitoring of the size and characteristics of the whole care and support workforce.

- For example, while the recent Aged Care Workforce Census (ACWC) may provide more robust workforce measures for the relevant aged care programs (and include a broader scope of occupations not in scope in this Study, such as those that provide ancillary services like cooking and cleaning in a residential aged care facility), the lack of consistent data for the NDIS and veteran care, together with its relatively infrequent collection, mean that labour force data has instead been used for this Study.

A comparison of data from the ACWC and Longitudinal Labour Force Survey (LLFS) is included in Table 12.

While some workforce definitions exist, these typically focus on either a particular aspect of care (such as clinical care) or a particular program (such as the NDIS). A comprehensive cross-program definition of the care and support workforce does not yet exist.

The line between direct and indirect care is blurred, and often differs between programs and settings. In residential aged care, cooks and cleaners play an important but indirect role in the care of residents. For in-home aged care, these roles are less common, with preparing meals and cleaning tasks often performed by a single worker who also has direct care responsibilities (such as assistance with mealtimes and dressing).

Many care and support occupations are also employed in other workforces. For example, while many *Registered nurses* are employed in aged care, most work in hospitals. It is therefore important, yet difficult, to differentiate the workforce not just by occupation but also by industry.

These definitional challenges and data gaps are discussed in more detail at the end of this Part.

1.3.2 Defining the care and support workforce

While there are many occupations connected to the care and support workforce, for the purposes of this Study the key considerations that have informed the selection of occupations are:

- Cross-cutting – those occupations that are common across aged, disability and veteran care and support. The purpose of the Study is to provide a holistic view of the care and support workforce, and as such, roles unique to a particular program are generally out of scope.
- Direct role – occupations with a direct role in resident, client, participant or patient care. Ancillary occupations with a limited or indirect role are out of scope, as are roles employed almost exclusively in medical and hospital settings. It is acknowledged that unpaid and informal carers make an important and valuable contribution to the care and support landscape, however for the purposes of this Study the care and support workforce refers to those workers in paid and formal employment.

[1] ABS, Longitudinal Labour Force, Australia [Microdata], 2021

- Data availability – the Study uses ANZSCO as the basis for exploring occupations. To a lesser extent, the Study leverages other data sources, where possible, to supplement and explore different aspects of the workforce.

Where possible, the Study has also sought to align its workforce definitions with those used in the aged care and NDIS workforce plans.

Ideally, the care and support workforce would be defined by reference to a specific group of ANZSCO occupations combined with ANZSIC industries exclusive to care and support. Ultimately, the occupations and industries selected as in-scope and outlined in Part 1.3.2.2 are the 'best fit' taking into account the focus of this work and data limitations.

Data using only an occupation lens should be interpreted with caution as the definition will capture some workers not engaged in the care and support workforce (for example, *Registered nurses* working in hospitals).

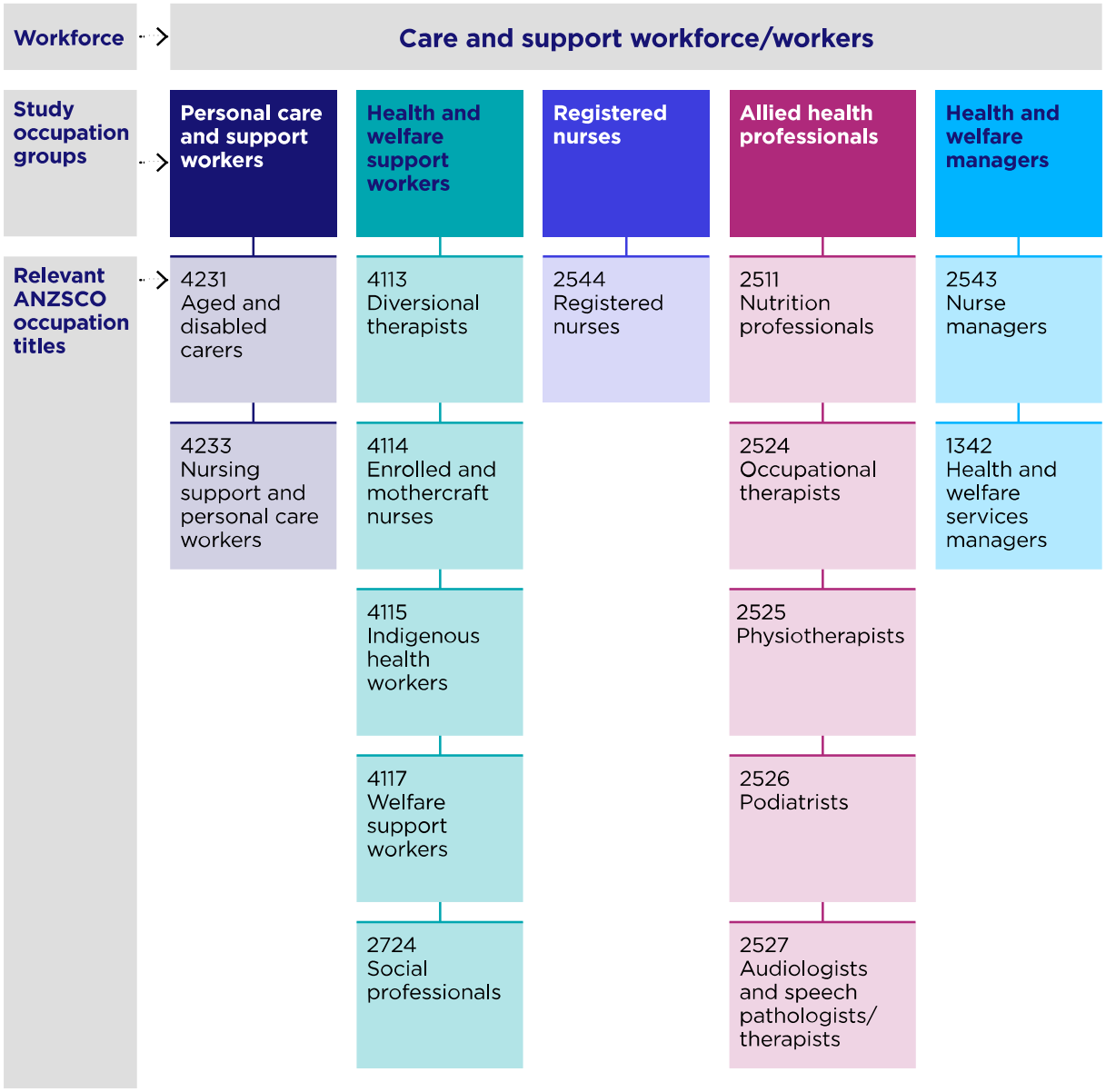
1.3.2.1 Occupations

Fifteen ANZSCO occupations (at the 4-digit level) have been selected as the care and support occupations in scope for this Study. To better reflect the care and support workforce, these occupations have been arranged into 5 occupation groups (Figure 1). These groups are:

- Personal care and support workers
- Health and welfare support workers
- Registered nurses
- Allied health professionals
- Health and welfare managers.

> The 5 occupation groups listed above form the basis of the Study and represent the broad structure of the care and support workforce. These occupation groups are groups of occupations which currently exist within ANZSCO, some of which may not align with more common usage by stakeholders across the aged care, NDIS and veteran care programs.
>
> For example, while *Aged and disabled carers* (an occupation within the Personal care and support workers occupation group) is used within ANZSCO, workers are more typically referred to as aged care and disability support workers. Similarly, *Indigenous health workers* (an occupation within the Health and welfare support workers occupation group) is used within ANZSCO, however should more accurately be referred to as Aboriginal and Torres Strait Islander health workers. See Appendix B for definitions of relevant ANZSCO occupations.

Figure 1: Care and support occupations analysed in this Study



Source: ABS, ANZSCO (Version 1.3), 2013. *Throughout this document, ANZSCO occupations are denoted with an initial capital and italics (e.g. Aged* and disabled carers) and the Study's occupation groups are denoted with an initial capital but no italics (e.g. Personal care and support workers).

1.3.2.2 Industries

Where possible, the Study has also applied an industry lens to the analysis to further refine the scope of the care and support workforce. Many of the occupations identified as being part of the care and support workforce, such as *Registered nurses* and Allied health professionals, are employed within a range of different environments (Figure 39).

By applying both an occupation and industry lens, the Study attempts to minimise the existing limitations within each classification and provides a more complete and accurate view of the workforce.

For the majority of the analysis conducted for this Study the following three 3-digit industry codes within ANZSIC have been considered in scope:

- *Residential care services*
- *Other social assistance services*
- *Allied health services.*

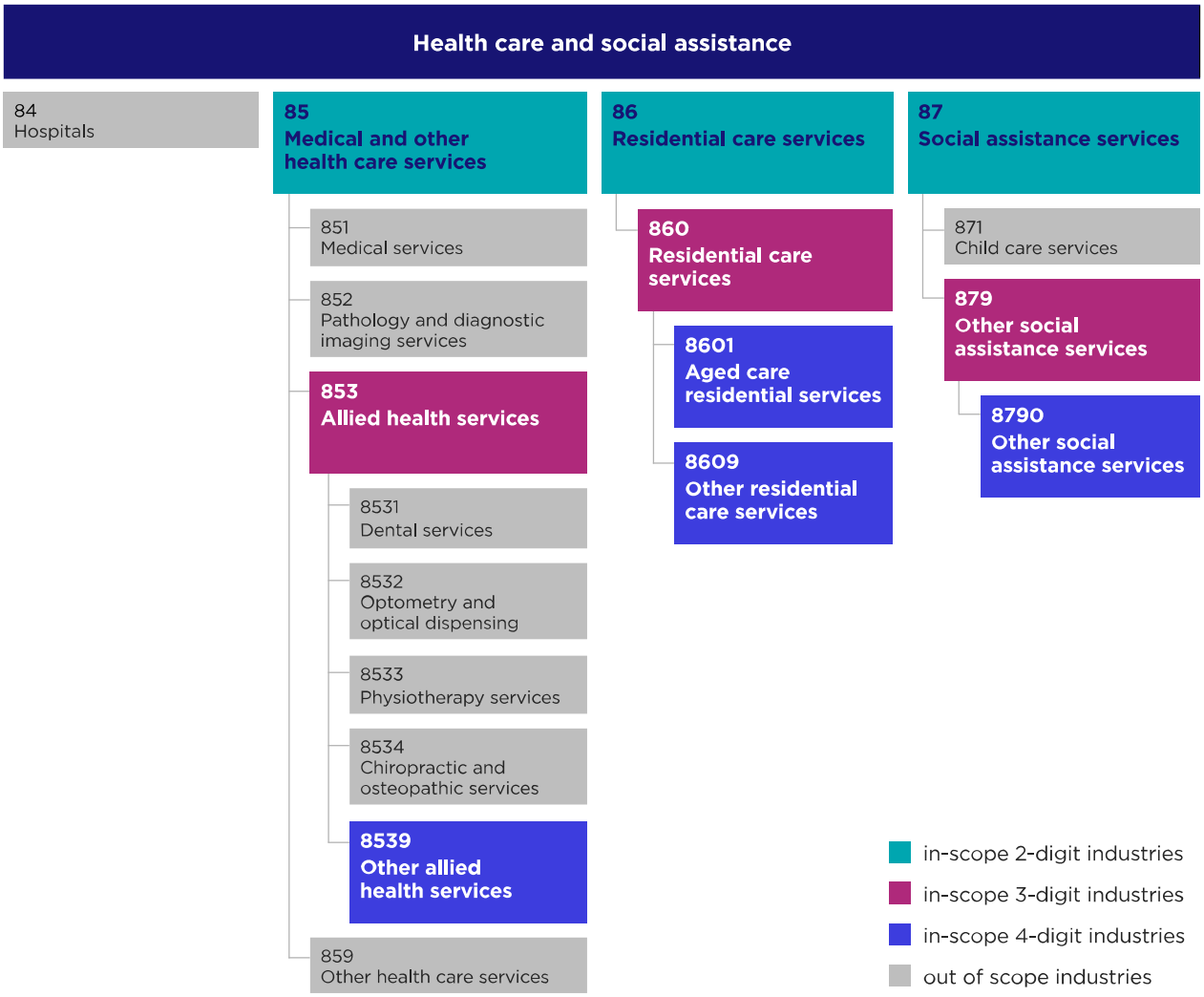
In some instances, 2-digit or 4-digit ANZSIC has been used depending on data availability (Figure 2).

Several key data sources – including the published monthly LFS and Multi-Agency Data Integration Project (MADIP) – do not have a readily available occupation and industry cross-tabulation. Additional microdata assets with both detailed industry and occupation information would assist the capacity to undertake additional analysis of the care and support workforce.

It should also be noted that the reporting of an industry by an employer rather than an employee in some data sources may complicate the interpretation of the data around the activities of individual employees. For example, an agency nurse working in an aged care residence may be coded to the *Employment services* industry, which is part of the *Administrative and support services* industry. This is a result of ABS and other key industry statistics recording industry based on the main activities that the business is engaged in rather than the specific activities or functions of the part of the business that an employee works in. This is particularly relevant for larger businesses which may operate across different industries and sectors.

The *Other social assistance services* industry may also present some challenges, as it combines many disparate services into a single industry. For example, in-home aged care services currently shares the same industry code with soup kitchens, alcoholics anonymous and marriage guidance. As a result, the capacity to separately analyse the workforce for in-home aged care and disability assistance is restricted.

Figure 2: ANZSIC industry structure, care and support workforce



Source: ABS ANZSIC (Revision 2.0), 2006. Throughout this document, ANZSIC industries are denoted with an initial capital and italics (e.g. *Residential care services*).

1.3.3 Defining the mental health workforce

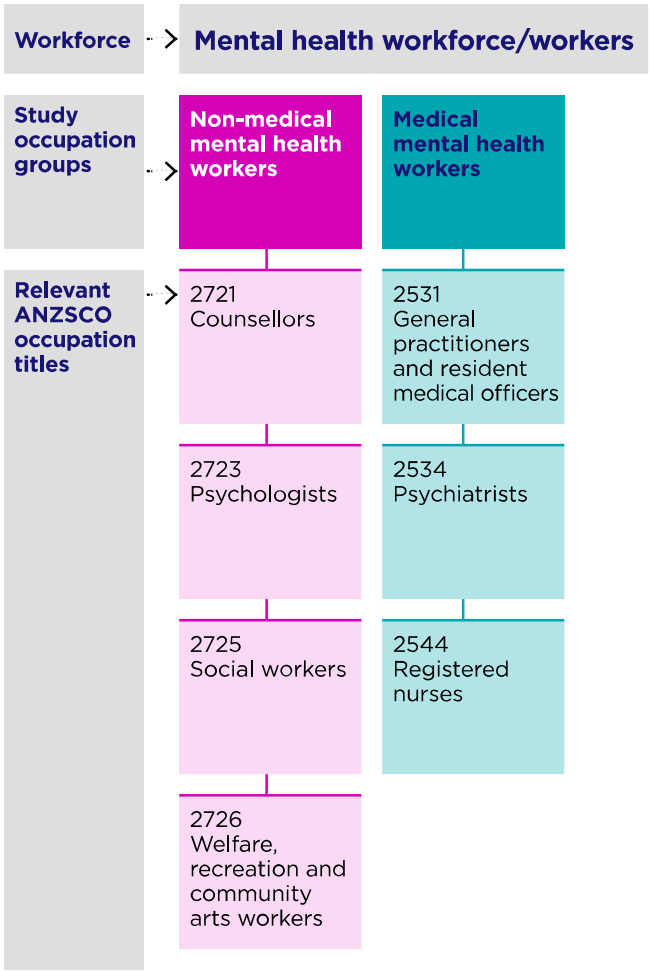
Identifying the mental health workforce, and more specifically the care and support mental health workforce, is also a challenge. Like the care and support workforce there is no consistent definition of the occupations comprising the mental health workforce, but unlike the care and support workforce an industry lens is unable to be applied to further identify the workforce, as there are no mental health specific industries within ANZSIC. Consequently, the analysis in this Study is at the whole-of-occupation level and includes all industry settings for that occupation not just mental health specific settings.

Further, mental health is inclusive of a continuum from mental wellbeing through to severe mental illness. As such mental health services, and the workforce associated with it, crosses boundaries including outside of the *Health care and social assistance* industry (for example, *Student counsellors* in an education setting).

Due to these limitations, this Study has considered the mental health workforce separately (Part 12) and adopted an illustrative approach to analysis of the mental health workforce (Figure 3). However, this is supplemented by the in-depth analysis of the care and support workforce, who may provide mental health care and support as part of their roles, such as Allied health professionals and Health and welfare support workers. Registered nurses are included in both the care and support workforce and the mental health workforce analysis, given the role of nurses in mental health.

Where appropriate relevant references to mental health are also included throughout other parts of this report.

Figure 3: Mental health occupations analysed in this Study



Source: ABS, ANZSCO (Version 1.3), 2013. Throughout this document, ANZSCO occupations are denoted with an initial capital and italics (e.g. *Psychologists*) and the Study's occupation groups are denoted with an initial capital but no italics (e.g. Non-medical mental health workers).

1.4 A note about forecasts

This Study provides forecasts of both the demand for, and supply of, the care and support workforce to 2049-50 (Part 9).

Forecasts are, in their nature, exercises involving uncertainty. No model, forecasting technique or set of forecasts will ever capture the complexity of the real world and the true complexity of the underlying dynamics.

That is especially true of an area of the workforce as complex as the care and support sector.

While the forecasts in this report and associated analysis reflect the best judgement of the modellers, outcomes will differ from the forecasts. Sensitivities in the real world will also differ from those generated out of models, including the models used in this report.

This is, of course, true of any modelling or forecasting exercise.

The forecasts and sensitivities contained in this report should therefore be taken to be illustrative. They provide a sense of the likely gaps that could emerge in the future based on current settings. The sensitivities provide an assessment of what interventions might be effective in addressing potential workforce gaps. They also highlight the importance of some key assumptions.

Ultimately, a combination of more detailed data on the care and support workforce and the monitoring framework outlined in Part 11, as well as rigorous evaluation of strategies and policies designed to address workforce issues, will prove to be just as useful as forward-looking modelling.

1.5 The treatment of COVID-19 in the context of this Study

The COVID-19 pandemic has taken a heavy toll including the tragic loss of life, particularly among older Australians. Across the country many people have experienced increased rates of psychological distress with reported increases in use of crisis support and mental health services through the pandemic period (Part 12.1.3).

The pandemic has also had a significant and immediate impact on Australia's labour market, including in the care and support workforce. Restrictions, such as not being able to work across multiple sites in aged care, and requirements for frequent testing of essential workers as a condition of working, have temporarily influenced work patterns across care and support. Increased demand from pandemic-related health services across virus testing, vaccine rollout and hospital admissions has been cited by stakeholders as drawing workers from the care and support workforce into the health workforce. Further, closed international borders have paused the flow of migrant workers into the sector, increasing reliance on the domestic workforce.

The short-term impacts of COVID-19 are important and where relevant, analysis and reference to these impacts are noted throughout this Study.

As the COVID-19 pandemic is anticipated to be a relatively short-term shock (in the context of the Study's outlook to 2049-50), this Study uses a pre-pandemic perspective of the care and support workforce as its starting point for key assumptions that are likely to have been impacted by COVID-19, for example average hours worked and part-time rates. To do otherwise would be to assume that the dramatic disruption seen on account of COVID-19 and associated responses would linger through the rest of this decade and following decades.

To the extent that the response to COVID-19 implications have brought forward the emergence of any gaps in the care and support workforce, or temporary shifts endure for longer than anticipated, this would have a cumulative effect on the size of the workforce gap over time, however it would not ultimately change the trajectory.

1.6 Definitional challenges and data gaps

As noted earlier in Part 1, a comprehensive cross-program definition of the care and support workforce does not yet exist.

Several issues contribute to the difficulties in identifying a workforce definition that applies in multiple contexts, these include:

- limitations of existing occupation and industry classifications
- level of disaggregation of occupations and industries relevant to care and support
- data collection keeping pace with an evolving economy
- other data limitations.

1.6.1 Limitations of existing occupation and industry classifications

Workforce definitions are, of course, much more useful if they align with available data. In Australia, most labour force data is coded to ANZSCO and ANZSIC. ANZSCO and ANZSIC provide consistent structures for classifying occupations and industries, respectively, although the existing classifications are not without limitations.

For example, the largest occupation in the care and support workforce is *Aged and disabled carers* and within this occupation it is impossible to distinguish between workers who work in aged care, disability support or both. This limits the level of detail this Study can analyse for a set of occupations within the care and support workforce.

The ANZSIC industry classification also has limitations when analysing the care and support workforce. For example, allied health professionals provide important services to veterans, older Australians, and people with disability. However, these services are mostly provided in hospitals, rehabilitation centres, community health centres and private practices. It is difficult to distinguish between the services provided to this Study's cohort from those provided to the general public. Therefore, this Study has had to consider allied health workers across all industries and settings, not just those within care and support settings.

In addition, there is limited alignment between the existing ANZSIC industries and the key programs in scope for the Study. While there may be some alignment between residential aged care and *Aged care residential services* (noting the potential issues with industry coding described below), the in-home care and support programs delivered by the aged care sector, together with the majority of NDIS and veteran care services delivered under the NDIS and veteran care are currently grouped into *Other social assistance services*. No further breakdown is currently available within the classification (and therefore the majority of published data). The *Other social assistance services* industry also incorporates adoption services, alcoholics anonymous operation, marriage guidance services and the operation of soup kitchens.

ANZSIC does not identify mental health as its own industry segment. This limits the ability to analyse the mental health workforce, as does the absence of a consistent definition of the occupations comprising the mental health workforce.

The use of industry as a classification of where people work can also be problematic for the care and support workforce. While occupation is a characteristic of an individual and reflects the tasks which they perform, the industry of employment is categorised based on the main goods or services produced by the employer (or business). For example, some providers may operate across both aged care and the NDIS, with the industry coded to the main services produced by the employer. Similarly, issues may arise in the identification of agency staff who may be employed by businesses in the *Labour supply services* industry (not included in the scope of this Study). The collection of 2 data points for industry – the industry of operation of the employee, and the industry of operation of the employer/business – would significantly increase the ability for detailed workforce analysis to be undertaken for the care and support workforce.

The current ANZSCO and ANZSIC inadequacies have also led some stakeholders, including Australian Government departments, to adopt bespoke approaches to care and support workforce data. For example, the NDIS Demand Map, which is being extended to include additional programs, includes roles which do not align with ANZSCO because existing ANZSCO

codes do not fully capture the different roles within the occupation. While on a program by program basis, bespoke approaches may have appeal, non-consistent definitions limit the comparability of data and make it even more difficult to analyse the workforce *across* programs.

Where possible, the Study has incorporated both an occupation and industry lens to define the care and support workforce. However, it should be noted that several key data sources – including the monthly or quarterly LFS and Multi-Agency Data Integration Project (MADIP) do not have a readily available occupation and industry cross-tabulation. Data using only the occupation lens should be interpreted with caution as the definition will capture some workers not engaged in the care and support workforce (for example, *Registered nurses* working in hospitals). Further, the attribution of an industry to an employer rather than an employee in some data sources may complicate the interpretation of data (for example, an agency nurse working in aged care may be coded to the *Employment services* industry (Part of the *Administrative and support services* industry).

The collection of industry-related data may also introduce challenges, as the industry associated with an individual is typically the industry of main activity for the business which employs them. This may introduce complexities, particularly for large businesses, where the industry associated with the business is not directly associated with the industry in which the individual typically operates. For example, a facility may be operated by a government entity (and coded as such), while the individual works directly in the *Residential care services* industry. Further, employees who are engaged in work via labour hire firms (i.e. agency staff) may not be captured by the scope outlined for this Study as labour hire is not included as an in-scope industry.

Occupation titles also have an important role in the collection of labour market data. Although *Aged and disabled carers* are defined as providing assistance, support and care *within* the home, many are coded to working in the *Aged care residential services* industry. This may indicate that occupation definitions and occupation titles are not well understood in the care and support workforce and may have implications on how workers and employers define their roles in a particular setting. For example, in a residential and hospital setting, *Nursing support and personal care workers* and *Aged and disabled carers* may refer to their job titles interchangeably when their roles are defined to be distinct (Appendix B).

Another key limitation associated with data collected on an occupation basis is that, like any self-reported occupation, data informed by labour market surveys (such as the LFS and Participation, Job Search and Mobility) isn't likely to align perfectly with the ANZSCO definitions. In particular, the *Aged and disabled carers* occupation may cause some confusion as this occupation is defined as working in non-residential settings only (i.e. outside of a residential care facility). Occupation data collected across different sources may also differ for the same individual (for example, self-reported labour market data and sector-specific surveys) with caution required when comparing occupation counts across multiple sources.

1.6.1.1 Disaggregation and granularity of occupation and industry in care and support

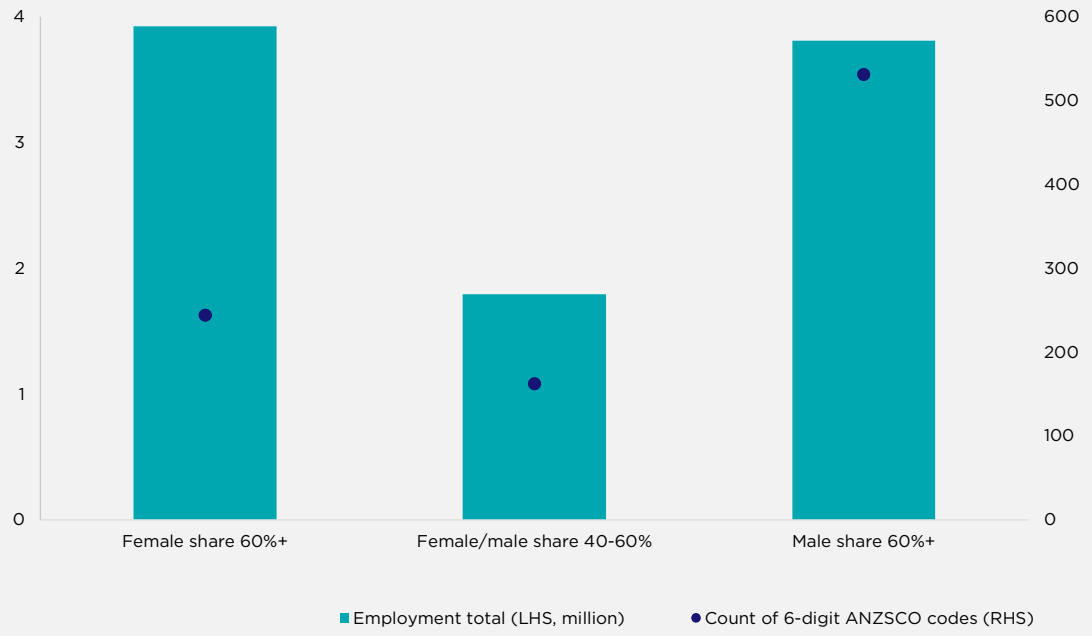
Disaggregation of occupations in ANZSCO is inconsistent and typically provides significantly more detail for occupations and industries where the majority of the workforce is male. For example, *Aged and disabled carers* is a 4-digit ANZSCO occupation that employs more than 235,000 workers which is not further broken down into occupations at the 6-digit level. Such a large group of workers in a single homogenous 4-digit code ignores important distinctions in this occupation, such as aged care being distinct from disability support across a range of in-home (i.e. non-residential care facilities) and community settings. Comparatively, the level of granularity for other 4-digit occupations, such as *Outdoor adventure guides* which employs approximately 5,300 people, is further broken down into seven 6-digit occupations including *Trekking guides*, *Mountain or glacier guides*, *Whitewater rafting guides*, and *Fishing guides*.

Gender clustering of occupations in ANZSCO

Occupations with a male majority are disaggregated to a significantly greater extent than female majority occupations (Figure 4). Based on the 2016 ABS Census of Population and Housing, there were:

- 244 ANZSCO 6-digit occupations with a female labour market share of greater than 60% (26% of occupations).
- 531 ANZSCO 6-digit occupations with a male labour market share of greater than 60% (57% of occupations).
- 162 ANZSCO 6-digit occupations where the male/female labour market share was between 40% and 60% (17% of occupations).

Figure 4: Distribution of ANZSCO 6-digit codes, by gender, 2016



Source: NSC analysis, ABS 2016 Census of Population and Housing (unpublished data).

Inconsistencies in the level of granularity are also evident in ANZSIC. *Health care and social assistance* is one of the fastest growing industries and employs more than 1 million people. However, the industry is only divided by 16 sub-industries, and sees in-home aged care (i.e. non-residential aged care), soup kitchens, alcoholics anonymous, and marriage guidance combined under one industry code. *Manufacturing*, by comparison, has a workforce less than half of the *Health care and social assistance* industry, yet it is divided into more than 140 sub-industries.

As a result, there is significantly less data available for female majority occupations and industries than male majority occupations and industries, including for the care and support workforce, which is majority female.

For this Study, the limited disaggregation in both classifications has constrained analysis and the capacity to observe important interactions and differences within the care and support workforce. For example, as the *Aged and disabled carers* occupation cannot separately identify workers who are involved in delivering aged care or disability support, any differences in wages, retirement rates, or regional availability of these workers cannot be adequately observed. This has implications for identifying worker transitions across different care and support settings.

Greater levels of granularity in occupation and industry disaggregation for the care and support workforce is important for workforce monitoring, planning and development, as well as job design, career progression, training investment and remuneration (discussed further in Part 8.1).

The limitations of both ANZSCO and ANZSIC are widely recognised. The ABS has commenced a program of work in partnership with some government agencies including the National Skills Commission (NSC) which will deliver a program of rolling updates to ANZSCO. This will ensure that it better reflects the contemporary labour market and the issues raised by this Study will be taken into account in a future update. The ABS is also developing a strategy to update ANZSIC, noting that this is a large program of work and the ABS has indicated it will require additional resourcing. While this work is being progressed, however, the 2 classifications will continue to have limitations for analysis of the care and support workforce particularly in the near term.

National Satellite Accounts: measuring selected areas of interest within the national economy

National satellite accounts are designed to allow for an expansion of the existing national accounts[2] for selected areas of interest, while maintaining the key concepts and structure of the core national accounts.

The Tourism Satellite Account is an example of a satellite account which the ABS uses to present a comprehensive view of the performance of the tourism sector. While tourism activity is implicitly included within the national accounts, the existing industry structure is defined on the basis of the goods and service which businesses produce, while tourism is defined according to the status of the consumer.

The development of a Care and Support Satellite Account may present an opportunity for enabling the estimation and analysis of economic activity and employment within the sector, which is not readily apparent within the existing industry structure given that activity within the Care and Support sector is determined by the characteristics of the care and support recipient, rather than the good or service produced.

1.6.1.2 Keeping pace with an evolving economy

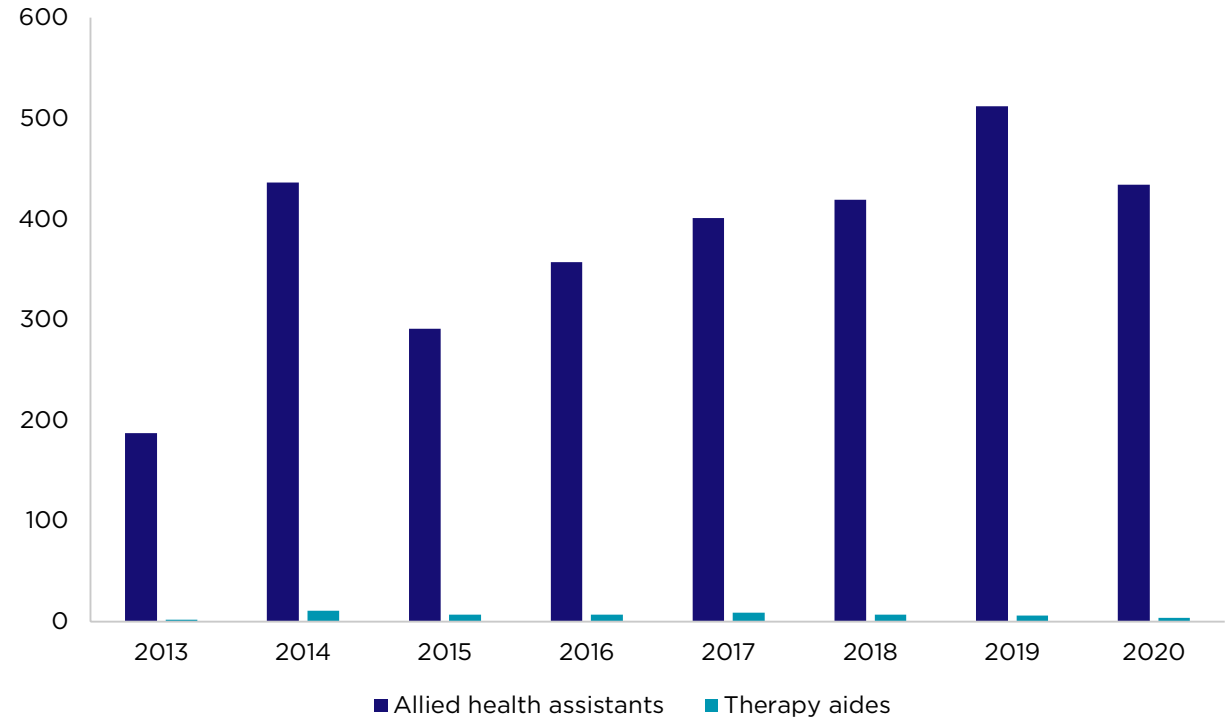
It is challenging for any classification to keep pace with a constantly evolving economy. ANZSCO (last updated in 2013) and ANZSIC (last major review in 2006) are subject to this challenge. Many new and emerging occupations and roles are also not yet captured in ANZSCO. While the Study has also considered emerging occupations (in Part 3.4), this analysis is constrained by data limitations and is less detailed than the primary workforce analysis.

Consumer preferences, changing technology, business requirements and policy settings influence the evolution of existing occupations and industries and potentially create new roles and industry segments. These trends can impact how occupations may evolve in relation to task change but also how they might change in their distribution across different care and support settings. More importantly, how data is collected and categorised on these occupations and industries of employment may not reflect these changes.

Some occupations are not necessarily emerging jobs driven by emerging skills, but rather emerging job titles of existing ANZSCO occupations. Although alternate job titles are common and easily aligned to ANZSCO titles, it may still pose challenges in analysing the care and support workforce. When comparing descriptions of allied health assistants on job advertisements to ANZSCO and the Australian Skills Classification, it is likely that this is an alternate title to the ANZSCO job title of *Therapy aides* who usually specialise in assisting allied health therapists. Allied health assistants is a job title which has more than doubled since 2013 in online job advertisements (Figure 5), while the number of job advertisements for *Therapy aides* has remained very low. This suggests that allied health assistants is the more widely accepted job title by employers and industry, but not easily identifiable in ANZSCO.

[2] Australia's national accounts statistics are a measure of Australia's gross domestic product (GDP) and its components. Australia's national accounts statistics are compiled in accordance within international standards.

Figure 5: Number of job advertisements for Allied health assistants compared with *Therapy aides*, 2013 to 2020



Source: NSC analysis, Burning Glass Technologies.

1.6.2 Other data limitations

The capacity to define the workforce using other variables is also constrained. For example, while it is possible to identify the expenditure associated with care and support programs, it is not possible to separately identify within these amounts the components which are specific to the care and support workforce. Also, with different funding mechanisms applying across care and support (including block funding, fee-for-service and grants), undertaking direct workforce comparisons based on funding is also difficult.

Compounding this can be the variety of approaches to geographic classification used by care and support programs, including the Modified Monash (MM) Model, Aged Care Planning Regions, as well as the Australian Statistical Geography Standard Remoteness Areas.

Part 2
The demand for care and support

The need for a care and support workforce is driven by the care and support needs of the Australian population.

There are a range of essential care and support services across aged, disability, veteran and mental health.

While these services are focused on meeting specific care and support needs, there are also intersections and interactions across programs, cohorts, providers and workers. Eligibility criteria set the parameters under which people can access specific programs, with care and support recipients being able to access services across programs.

The demographic characteristics of people who access care and support services across aged care, disability and veteran care sectors also differ considerably.

- For example, aged care consumers, particularly those accessing residential care services, tend to be older and are more likely to be female, while the current NDIS participant profile tends to be relatively younger and more likely to be male.
- The demographic and health profile of Australians also varies across metropolitan, regional and remote areas, with stakeholders consistently raising the challenges to service provision in rural and remote areas.

Australia's demographic challenge is not unique, demand will also grow

Looking forward, demographics will be the key driver of demand for care and support services, with the impact of Australia's ageing population on the demand for care and support to be significant.

Of course, Australia is not alone in facing an ageing population. Larger cohorts of older people will drive an increase in demand for aged care and support services across almost all countries around the globe.

- At the same time, the share of the working age population will decrease for many regions around the world, resulting in an increasing old-age dependency ratio (measured as the ratio of people aged 65 years and over relative to the population aged 15-64 years).

In the absence of significant technological advancements, the challenge of diverting a larger proportion of the working age population to the provision of relatively labour-intensive care and support services for the growing older population will be a challenge shared by many nations.

The needs of those receiving care and support is also changing over time. A substantial and growing proportion of aged care recipients, including people living in residential aged care, have a dementia diagnosis which further increases the complexity of care and support needs into the future. This has implications for the skills needs of the care and support workforce.

The demand for disability care and support in the future is uncertain, although the overall number of participants is expected to continue to grow.

Similarly, while the total Australian population with a mental health illness is difficult to identify, the National Health Survey 2017-18 estimated that around 1 in 5 Australians had a mental health or behavioural condition, and this has been increasing over time. Stakeholder feedback also indicates

demand is continuing to grow and may be exacerbated by the impacts of COVID-19 and related restrictions.

In addition to the demographic drivers of demand highlighted previously, a range of other influences are at play in Australia's care and support landscape with potential to influence demand now and into the future. These include the recently completed Royal Commission into Aged Care Quality and Safety (Aged Care Royal Commission) and the current Royal Commissions into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission) and Defence and Veteran Suicide (Defence and Veteran Suicide Royal Commission).

The care and support needs of Australians are met by a complex system

The demand for care and support is met by a complex system. Many organisations (government and non-government), businesses and people contribute to the provision of care and support, across a wide range of roles and functions in a complex environment.

The provider landscape is also complex with over 13,000 providers operating across the care and support landscape, although the bulk (around 11,000) operate exclusively within the NDIS. Just as recipients access support across programs, many providers also operate across aged care, disability, and veteran care programs.

With significant provider activity occurring across programs, it is unsurprising that a proportion of the care and support workforce also works across programs. This in turn underscores the importance of the cross-cutting approach to analysing demand and supply of the care and support workforce taken in this Study.

2.1 A range of services

There are a range of essential care and support services across aged, disability, veteran and mental health care and support. While these services are focused on meeting specific care and support needs, there are also intersections and interactions across programs, cohorts, providers and workers.

2.1.1 Aged care

Major Australian Government programs include the Residential Aged Care Program, the Home Care Packages Program (HCPP) (both subsidised) and the Commonwealth Home Support Programme (CHSP) (grants-based). Both the Residential Aged Care Program and HCPP are place based programs, effectively capping the number of recipients. Before receiving subsided aged care, individuals must be assessed as eligible.

2.1.1.1 Residential care

Residential care provides care and accommodation for those who can no longer live independently in their own homes and need help with everyday tasks. Residential care has fewer recipients than the major in-home care programs, but levels of service are far higher as the care is 24 hours a day and includes access to nursing and general health care services. A residential facility, while having these services, is importantly also a resident's home.

2.1.1.2 In-home care

Care at home is predominantly provided through 2 programs: the CHSP and the HCPP. Both programs provide similar services, such as domestic assistance, personal care and other care-related services. CHSP also provides services such as nursing, transport and home modifications. The HCPP has been growing rapidly in recent years and will continue to do so as additional packages are released over the next 2 years.

2.1.1.3 Respite care

Respite care supports individuals and carers by providing a short break from usual care arrangements for a few hours, a few days, or longer depending on needs and eligibility. Respite can be accessed in-home, out in the community or in a residential aged care facility.

2.1.1.4 Other flexible aged care

Smaller aged care programs in place to address specific needs outside the main programs above include:

- Transition Care – goal-oriented and therapy-focussed care on a time-limited basis for older people after a hospital stay.
- Short-Term Restorative Care – similar to Transition Care but without the need to have been in hospital.
- Multi-Purpose Services – flexible and integrated health and aged care services to small rural and remote communities.
- National Aboriginal and Torres Strait Islander Aged Care Program – flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their home and/or community.

2.1.2 Disability support

The NDIS provides support to eligible people with permanent and significant intellectual, physical, sensory, cognitive and psychosocial disability aged under 65 to help them in their daily life and help them participate in the community and achieve their goals. Early intervention supports can

also be provided for eligible people with disability or children with developmental delay to reduce the impacts of disability or developmental delay and to build their skills and independence.[3]

Each NDIS participant has a tailored plan and a budget to match that plan. Individual plans can cover a wide range of supports including assistance with daily personal activities, therapeutic supports including behaviour support, and home modifications. Funding is allocated to participants and not directly to providers.

2.1.3 Veteran care

Eligible veterans and war widows/widowers can access specialised care and support services under Veterans' Home Care (VHC) and the Community Nursing Program (CNP).

The VHC is focused on low-level care to support independent living in an in-home setting by providing practical care across domestic assistance, personal care, safety-related home and garden maintenance, respite care and social assistance. The CNP provides nursing and personal care services by nurses and support staff. Veteran Gold Card or Veteran White Card holders with a service-related condition, or a non-liability mental health entitlement, may also be eligible for a range of Department of Veterans' Affairs (DVA) health and rehabilitation services, however these are not in scope for this Study.

2.1.4 Mental health

There are a range of services provided or funded by the Australian, state and territory governments that are specifically designed to meet the needs of people with mental health issues. The key services are:

- Medicare Benefits Schedule (MBS) subsidised mental health specific services that are partially or fully funded under Medicare on a fee-for-service basis and are provided by general practitioners, psychiatrists, psychologists, or other allied health professionals under specific mental health items.
- State and territory government specialised mental health services (including treatment for severe mental illness and suicidal distress), which includes admitted patient care in public hospitals (specialised services provided to inpatients in stand-alone psychiatric hospitals or psychiatric units in general acute hospitals).
- Community-based public mental health services, comprising:
    - ambulatory care services and other services dedicated to assessment, treatment, rehabilitation and care
    - residential services that provide beds in the community, staffed onsite by mental health professionals.
- Not-for-profit, non-government organisation (NGO) services, funded by the Australian, state and territory governments focused on providing wellbeing, support and assistance to people who live with a mental illness.
- The NDIS, which supports eligible people with a psychosocial disability arising from mental health conditions to access mental health services and supports if required.[4]

2.1.5 Cohorts and providers overlap across programs

Eligibility criteria set the parameters under which people can access specific programs, noting that it is possible for care and support recipients to be accessing services across program lines. For example, people under the age of 65 can access residential aged care services under the NDIS with around 4,100 people under the age of 65 currently living in residential aged care.[5] That said, it should be noted that the Australian Government has accepted the Aged Care Royal

[3] NDIA, *Report to the COAG Disability Reform Council Quarterly Report: 30 June 2018*, 2018

[4] Productivity Commission, Report on Government Services: Section 13, Services for mental health, 2021

[5] NDIS, *Quarterly Report to Disability Ministers: 30 June 2021*, 2021

Commission's recommendation that there be no younger people in residential aged care, except in exceptional circumstances.

Veterans can also access the Residential Aged Care, HCPP and CHSP programs, provided there is no duplication in services. There are around 17,600 veterans currently in residential aged care.[6] Eligible veterans can also access NDIS supports and services, again provided there is no duplication in services.

A range of allied health and mental health services are accessible within these programs. Allied health forms an important part of service provision with respect to maintaining and improving client function and independence. These services are also generally available to the broader population on a private access basis.

Providers also operate across aged care, disability, and veteran[7] programs. In 2019-20:

- 31% of aged care providers delivered NDIS services
- 11% of aged care providers delivered veteran services
- 6% of NDIS providers delivered aged care services
- 1% of NDIS providers delivered veteran services
- 78% of veteran providers delivered aged care services
- 50% of veteran providers delivered NDIS services.[8]

With significant provider activity occurring across programs, it is unsurprising that a proportion of the care and support workforce also works across programs. This underscores the importance of the cross-cutting approach to analysing demand and supply of the care and support workforce taken in this Study.

[6] Productivity Commission, Report on Government Services: Section 14, Aged care services, 2021

[7] DVA expenditure used in this analysis includes only community nursing, home care, allied health (new providers only) and rehabilitation appliance program claims. Providers are aggregated on an ABN basis, which will differ to the definition of provider in other sections of this Study.

[8] Department of Health, *Service Delivery Across Social Policy Programs, unpublished*, 2021

2.2 Characteristics of care and support recipients

This section outlines a high-level summary of select characteristics of care and support recipients.

The number of care and support recipients varies across programs. During 2019-20, there were 244,363 people in permanent residential care and a further 66,873 in respite care.[9] In addition, there were 839,373 CHSP care recipients nationally, and a further 173,743 clients of HCPP.[10]

Around 7.6% of people with disability under the age of 65 (based on the 2018 Survey of Disability, Ageing and Carers (SDAC) estimate of people with disability) were accessing services through the NDIS in 2018.[11] As at 30 June 2021, there were around 466,600 active participants in the NDIS.[12]

In 2019-20, an estimated 37,735 veterans aged 65 and over were approved for VHC services, and over 13,842 veterans received CNP services.[13]

The demographic characteristics of people who access care and support services across aged care, disability and veteran care sectors also differs considerably. Aged care recipient, particularly those accessing residential care services, tend to be older and are more likely to be female, while the current NDIS participant profile tends to be relatively younger and more likely to be male. The profile of veterans reflects Australia's defence history in conflict and advancement of strategic interests.

2.2.1 The age profile of care and support recipients differs across programs

As shown in Figure 6, Figure 7 and Figure 8, there are significant differences in the age profile of recipients across the relevant programs, reflecting the eligibility of various cohorts of the population. While the age profile of care and support recipients is important in understanding the type of supports and services required by each population group, the distribution of program recipients by age group is also a key input into forecasts of future participants and associated workforce requirements. For example, the propensity for each age group to access services provided by the care and support workforce supports planning activities, particularly when integrated with future population projections.

[9] Productivity Commission, Report on Government Services: Section 14, Aged care services, 2021

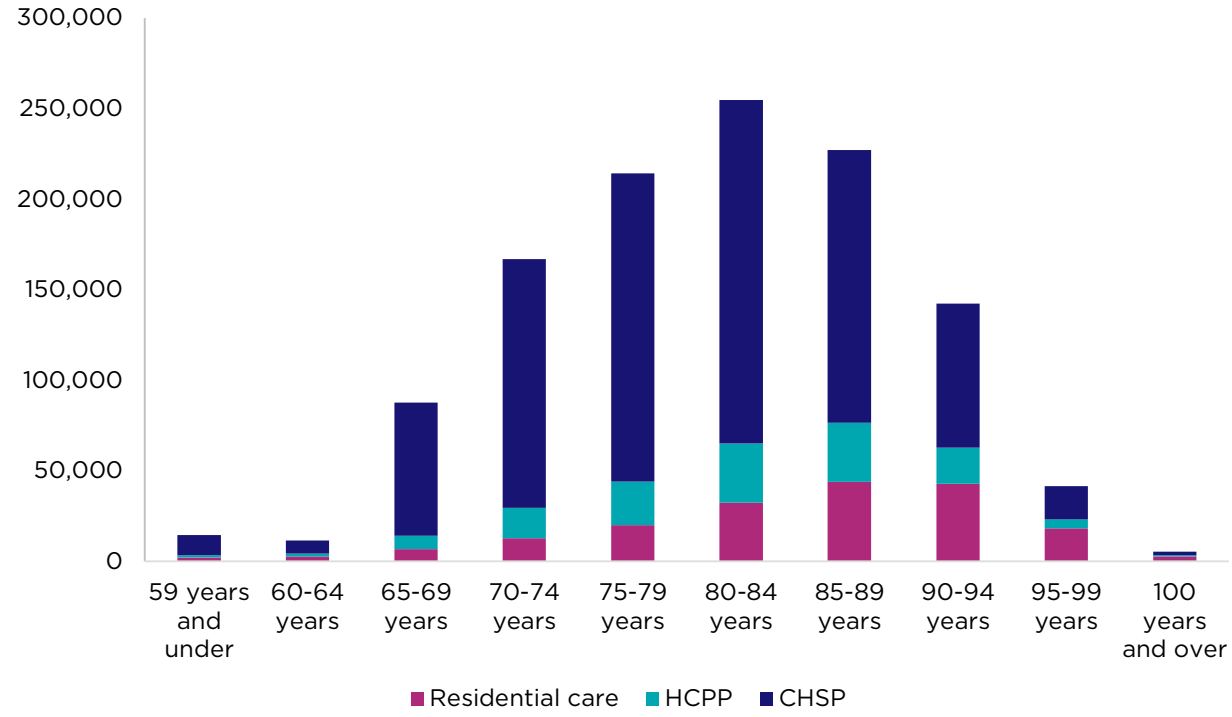
[10] Productivity Commission, Report on Government Services: Section 14, Aged care services, 2021

[11] NDIA, *Report to the COAG Disability Reform Council Quarterly Report: 30 June 2018*, 2018

[12] NDIS, *Quarterly Report to Disability Ministers: 30 June 2021*, 2021

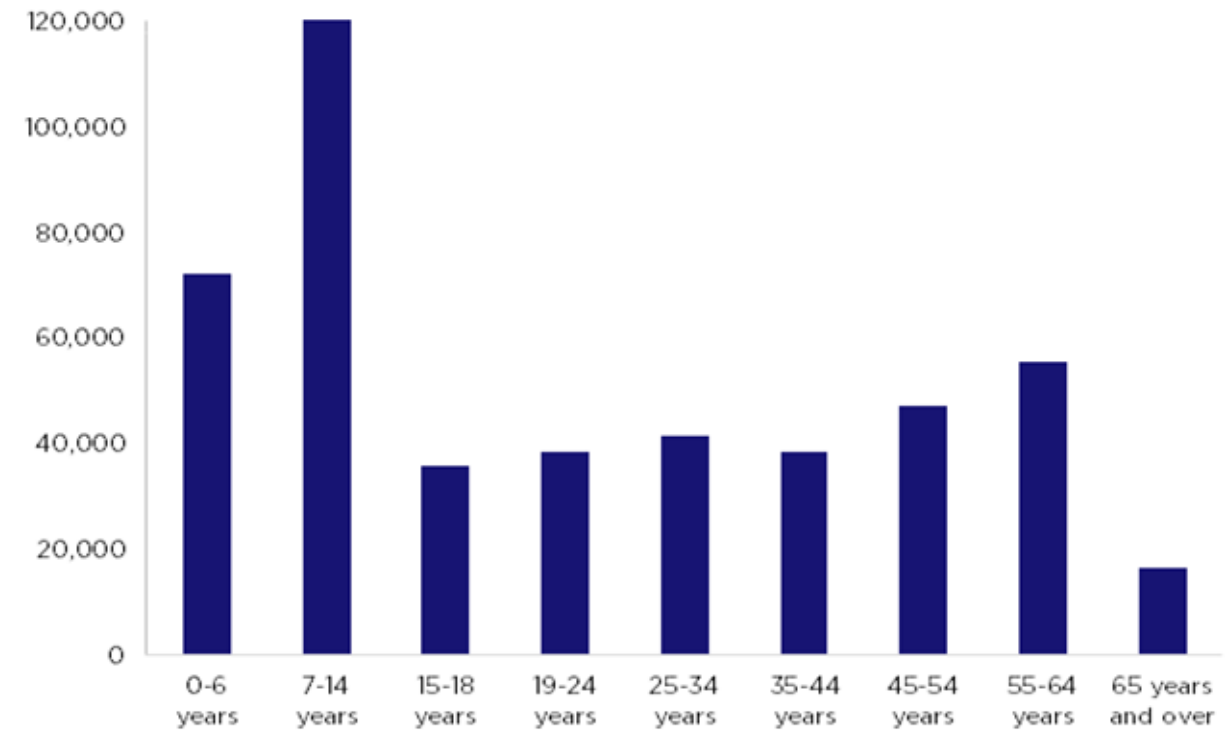
[13] Productivity Commission, Report on Government Services: Section 14, Aged care services, 2021, noting that clients can access both of these services at the same time.

Figure 6: Aged care programs, by age, June 2020



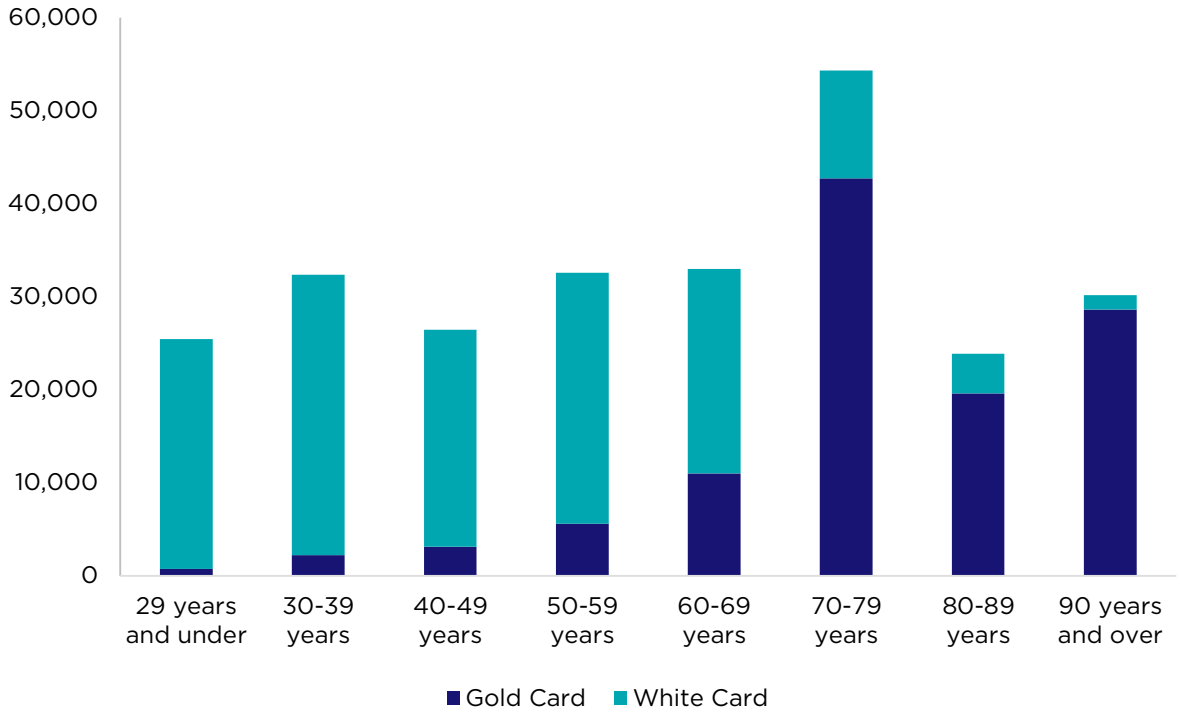
Source: AIHW GEN Aged Care data, June 2020, CHSP data refers to the 2019-20 financial year.

Figure 7: NDIS participants, by age, June 2021



Source: NDIS (2021) NDIS Quarterly Report to Disability Ministers, 30 June 2021, Table E.14.

Figure 8: DVA treatment population, by age, March 2021



Source: DVA Treatment Population Statistics, March 2021, Table 1.

2.2.2 The gender profile of care and support recipients differs across programs

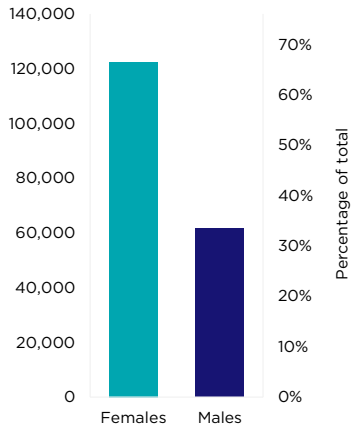
The gender profile of care recipients varies significantly between program types (Figure 9, Figure 10 and Figure 11).

Females make up two-thirds of all people in permanent residential care, while for NDIS participants and the DVA treatment population this trend is reversed.[14] Veterans and dependants holding a Gold or White Card are also referred to as the DVA treatment population.

In general, health outcomes differ between males and females, with higher life expectancy for females,[15] as well as differing incidence of health conditions, attitudes towards health and uptake of health services.[16] The increased life expectancy of females also has an influence on the composition of the veteran and dependant population including the composition of Gold Card and White Card holders, particularly in older age groups. There is a higher ratio of males to females across NDIS participants (driven in large part by the increasing incidence of young male participants entering the scheme). There are also differences in prevalence of disability between males and females, for example autism and developmental delay is considerably more common in males than females,[17] which will boost workforce demand for practitioners specialising in assessment, intervention and therapy for these conditions.

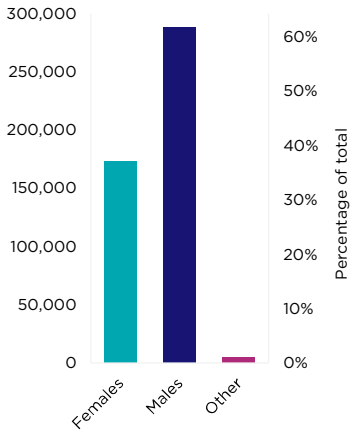
[14] DVA, Treatment population statistics: March 2021, 2021
[15] ABS, Life Tables, 2017 - 2019, 2021
[16] AIHW, Men and Women, 2021
[17] NDIA, *Young people in the NDIS: 30 June 2020*, 2020

Figure 9: Permanent aged care residents, by sex, June 2020



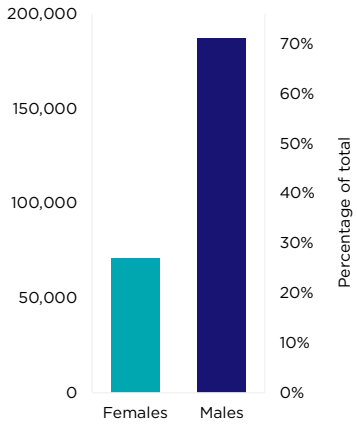
Source: AIHW GEN Aged Care data, June 2020.

Figure 10: NDIS participants, by sex, June 2021



Source: NDIS Quarterly Report to Disability Ministers, 30 June 2021, Table E.15.

Figure 11: Veteran treatment population, by sex, March 2021



Source: DVA Treatment Population Statistics, March 2021, Table 4.

2.2.3 Program use by Aboriginal and Torres Strait Islander people

As at June 2020, there were 1,850 Aboriginal and Torres Strait Islander people in permanent residential aged care, representing 1% of all permanent residents in residential aged care.[18] A further 3,400 Aboriginal and Torres Strait Islander people were accessing the HCPP.[19] In 2019-20, around 22,300 Aboriginal and Torres Strait Islander people accessed the CHSP, 12% of whom were aged under 55 years, reflecting expanded eligibility to include Aboriginal and Torres Strait Islander people aged 50 and over.[20]

There are a range of other aged care programs, including the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, which provide culturally appropriate services to support Aboriginal and Torres Strait Islander people to remain close to home and community. In June 2020, there were approximately 1,300 residential and home care places funded under this program.[21]

Aboriginal and Torres Strait Islander people, while typically having a younger age profile than the non-Indigenous population[22] have higher rates of chronic disease,[23] while there are also indications of higher rates of dementia (relative to the wider Australian population).[24] Aboriginal and Torres Strait Islander people also tend to access aged care services at younger ages.

As seen in Figure 12, relative to residential care, Aboriginal and Torres Strait Islander people aged 50 and over have a higher uptake of HCPP and CHSP at all age groups.[25]

[18] This may be an underestimate of the proportion of Aboriginal and Torres Strait Islander people in Residential Aged Care due to a significant proportion of records with missing values.

[19] AIHW, GEN Aged Care Data, People using aged care, 30 June 2020 [CURF], 2021

[20] AIHW, GEN Aged Care Data, People using aged care, 2021

[21] Royal Commission into Aged Care Quality and Safety, *Royal Commission into Aged Care Quality and Safety final report: care, dignity and respect, Final Report - Volume 2: The current system*, 2021

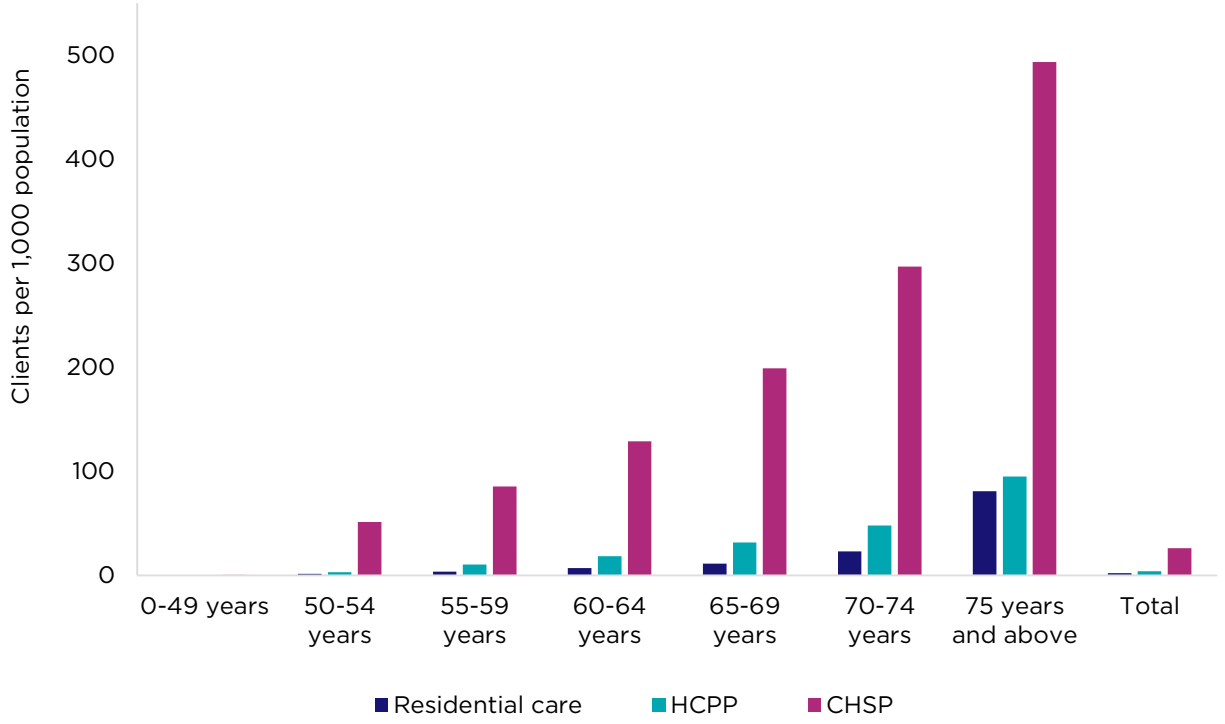
[22] ABS, Population Projections, Australia, 2017 (base) - 2066, 2018

[23] AIHW, *Aboriginal and Torres Strait Islander Health Performance Framework 2020: Summary report*, 2020

[24] AIHW, Population health impacts of dementia among Indigenous Australians, 2021

[25] AIHW, Australia's Welfare 2021: Aged care for Indigenous Australians, 2021

Figure 12: Aboriginal and Torres Strait Islander people using aged care, rate (clients per 1,000 population), by program and age group, June 2020



Source: AIHW GEN Aged Care data. Data for residential care and HCPP are for 30 June 2020, while CHSP data are for 2019-20. Data excludes clients for whom Aboriginal and Torres Strait Islander status and/or age was not stated or inadequately described. Aboriginal and Torres Strait Islander status was not stated for more than one third (36%) of home care clients at June 2020. As a result, home care data should be interpreted with caution.

The Australian Institute of Health and Welfare (AIHW) notes that Aboriginal and Torres Strait Islander people aged 65 to 75 are considerably more likely than the Australian population to use HCPP (7 times more likely), the CHSP (3 times more likely) and residential aged care (2 times more likely).[26]

These trends will continue to influence forecast participant numbers and care needs.

In June 2021, there were around 32,400 Aboriginal and Torres Strait Islander NDIS participants, representing 7% of total participants.[27] Compared with non-Indigenous NDIS participants, in 2019, Aboriginal and Torres Strait Islander NDIS participants were more likely to be younger and live in remote areas, as well as having differing incidences of disability types.[28]

Aboriginal and Torres Strait Islander people have unique support needs. While most of the Aboriginal and Torres Strait Islander population live in the capital cities or inner regional Australia, many also live in remote areas,[29] where there are specific challenges to delivering care and support services.

Ensuring Aboriginal and Torres Strait Islander people can access care and support services that are flexible, culturally safe and meet family and community needs will continue to be an important consideration into the future.

[26] AIHW, Australia's Welfare 2019: Aged care for Indigenous Australians, 2019

[27] NDIS, *Quarterly Report to Disability Ministers: 30 June 2021*, 2021

[28] NDIA, *Aboriginal and Torres Strait Islander participants: 30 June 2019*, 2019

[29] ABS, Estimates of Aboriginal and Torres Strait Islander Australians: June 2016, 2018

2.2.4 Cultural and linguistic diversity across programs

Australia has a multicultural population, comprised of people from a diverse range of cultural backgrounds and language groups. While there are many ways of estimating the cultural diversity of those using care and support services, none are perfect. This report generally uses data on those who were born in a non-English speaking country to proxy the culturally and linguistically diverse (CALD) population in Australia, noting however, that this will not capture the full range of cultural diversity in the population.

There are large number of people with CALD backgrounds accessing care and support services in Australia and demand for aged care and support services from this group is expected to continue growing strongly.

Around 1 in 5 people (aged 65 and over) living in permanent residential aged care were born in a non-English speaking country (20% or 35,000 people) (Figure 13), while 1 in 4 people accessing a HCPP were born in a non-English speaking country.[30] Related to this, and reflecting the large scale post-war migration intake in Australia, the proportion of those born in a non-English speaking country who were aged 65 years and over (18%) is higher than the average for Australia (16%).[31] Between 2015 and 2020, the number of people born in a non-English speaking country grew by 3.9% annually, more than 3 times the rate of those born in Australia.[32]

Demand for HCPP appears to be particularly strong for CALD people. People who were born in a non-English speaking country are more likely to access the HCPP (compared with permanent residential care). Of the 74,000 people (aged 65 and over and born in a non-English speaking country) accessing either residential care or a HCPP in June 2020, 52% were accessing a HCPP, well above the comparable average of 44% (for all HCPP and permanent residential care clients).[33]

In June 2021, there were around 44,100 CALD NDIS participants, representing 9.5% of all NDIS participants (Figure 14).[34] Analysis undertaken in 2019 indicates that the distribution of the CALD NDIS participant population also differs from the general population. For example, compared with all NDIS participants, CALD participants are more likely to be older, less likely to access the NDIS for autism or intellectual disability supports, and more likely to live in a major city.[35]

It is important that care and support services are accessible for all Australians, including delivery of culturally appropriate services to a diverse range of CALD care and support recipients (Part 7.3.2).

[30] AIHW, GEN Aged Care Data, People using aged care, 30 June 2020 [CURF], 2021

[31] ABS, Estimated resident population, Country of birth, Age and sex - as at 30 June 1996 to 2020, 2020

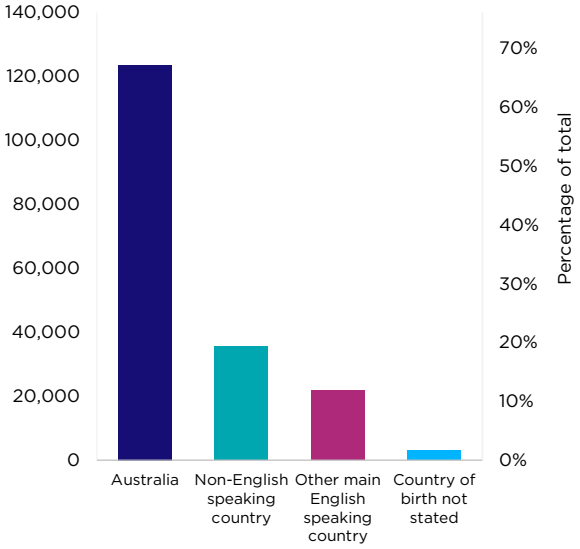
[32] ABS, National, state and territory population: Dec 2020, 2020

[33] AIHW, GEN Aged Care Data, People using aged care, 30 June 2020 [CURF], 2021. The CALD definition used by the NDIS includes those born in a non-main English speaking country as well as those where the primary language spoken at home is not English, which is different to the CALD definition used for aged care data in this section (which refers to those born in a non-main English speaking country).

[34] NDIA, *Cultural and Linguistic Diversity Strategy 2018*, 2018

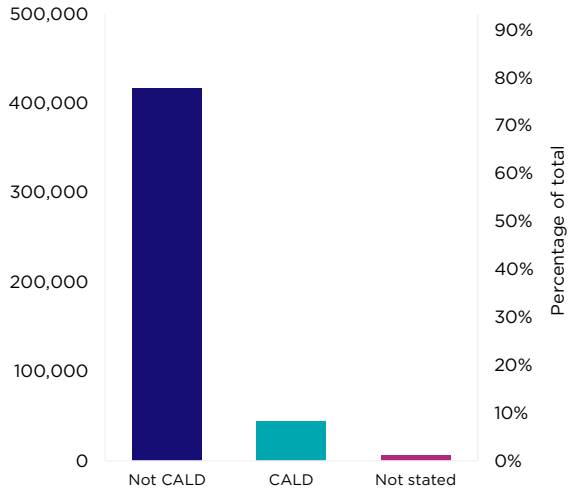
[35] NDIA, *Culturally and Linguistically Diverse participants: 30 June 2019*, 2019

Figure 13: Permanent residential aged care, by country of birth, June 2020



Source: AIHW GEN Aged Care data, June 2020.

Figure 14: NDIS participants, by CALD status, June 2021



Source: NDIS Quarterly Report to Disability Ministers, 30 June 2021, Table E.9.

2.2.5 Regional distribution

Providing equitable access to care and support services across Australian can be challenging.

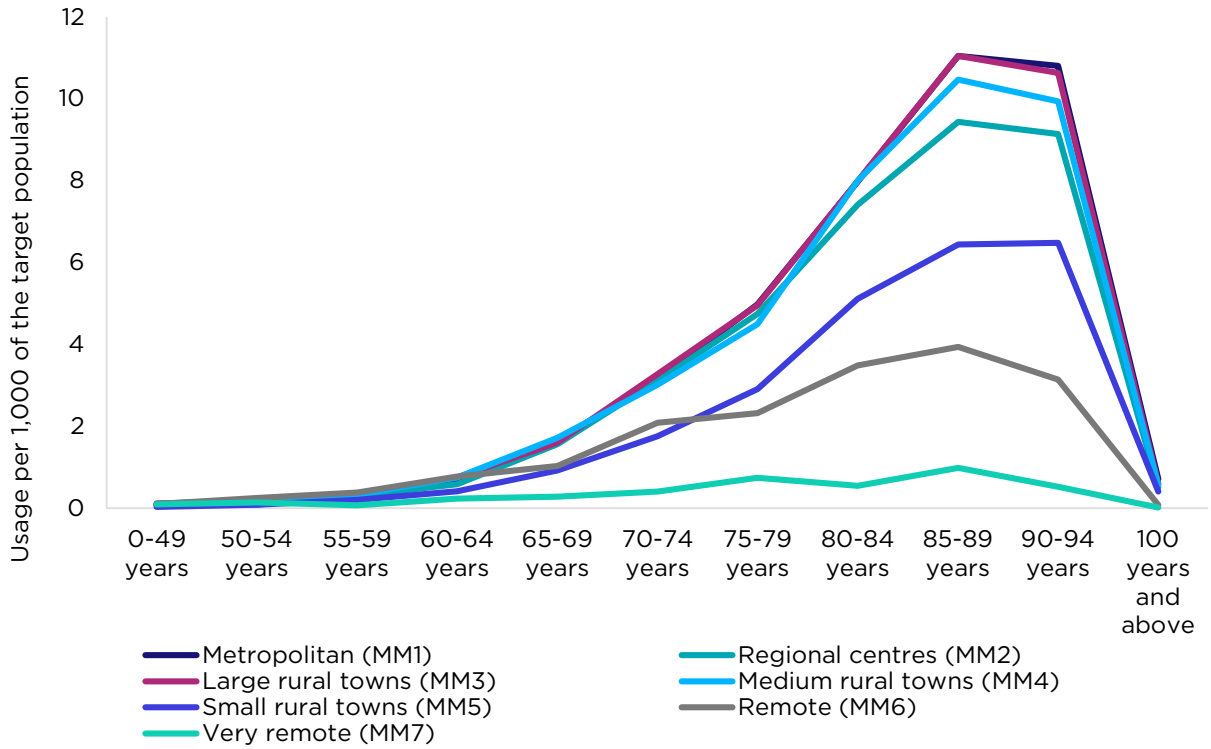
The demographic and health profile of Australians varies across metropolitan, regional and remote areas. For example, over the decade to 2020, the non-metropolitan population has been growing more slowly[36] and has an older age profile compared with metropolitan regions.[37] Life expectancy is generally higher in metropolitan regions compared with remote regions[38] and there is a higher incidence of some chronic health conditions outside of the capital cities.[39]

Throughout the Study, stakeholders consistently raised the issue of thin markets and the challenges to service provision in rural and remote areas. Stakeholders cited a shortage of care and support providers and services in these areas, with a particular shortage of allied health and specialised services. Use of technology, such as the recent expansion in the availability of telehealth services, has the potential to improve access to care and support services in regional and remote Australia. However, the ability to access reliable internet and digital services is limited in some regions, which impacts upon their ability to realise these potential benefits. Regional distribution and the workforce challenges facing rural and remote areas are discussed further in Part 8.1.4.

In general, usage of permanent residential care tends to be higher in metropolitan areas and decreases as remoteness increases. High rates of usage for HCPP occur particularly in large rural towns, but also in metropolitan areas, regional centres and medium rural towns, compared with much lower usage rates in small rural towns and remote and very remote communities. This reflects a range of factors including the types of services available in the local area and the propensity of people to move to access services. For example, people may move to a more populated area to access residential aged care if it is not available within a reasonable distance from their home.

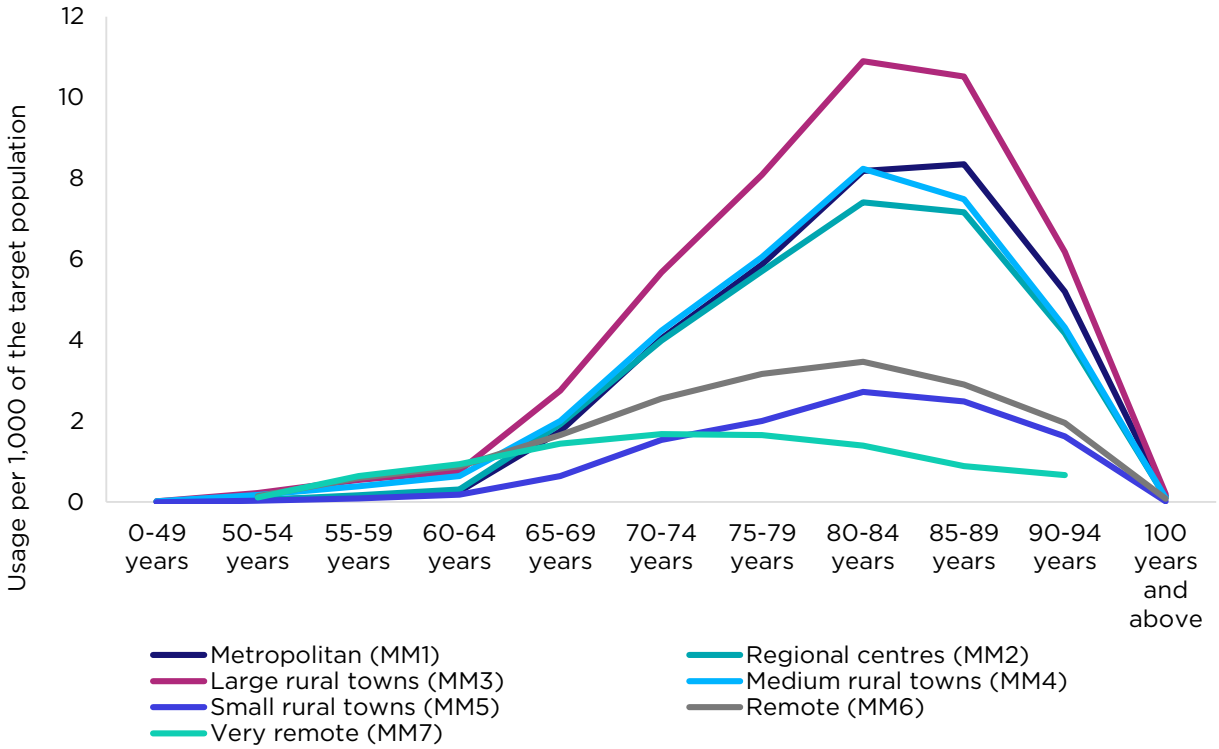
[36] ABS, Regional population: 2019-20 financial year, 2021
[37] ABS, Regional population by age and sex: 2019, 2020
[38] ABS, Life Tables, 2017 - 2019, 2021
[39] AIHW, Australia's Health 2020: Rural and remote health, 2020

Figure 15: Usage rate of residential aged care per 1,000 of the target population by age and remoteness, 30 June 2020



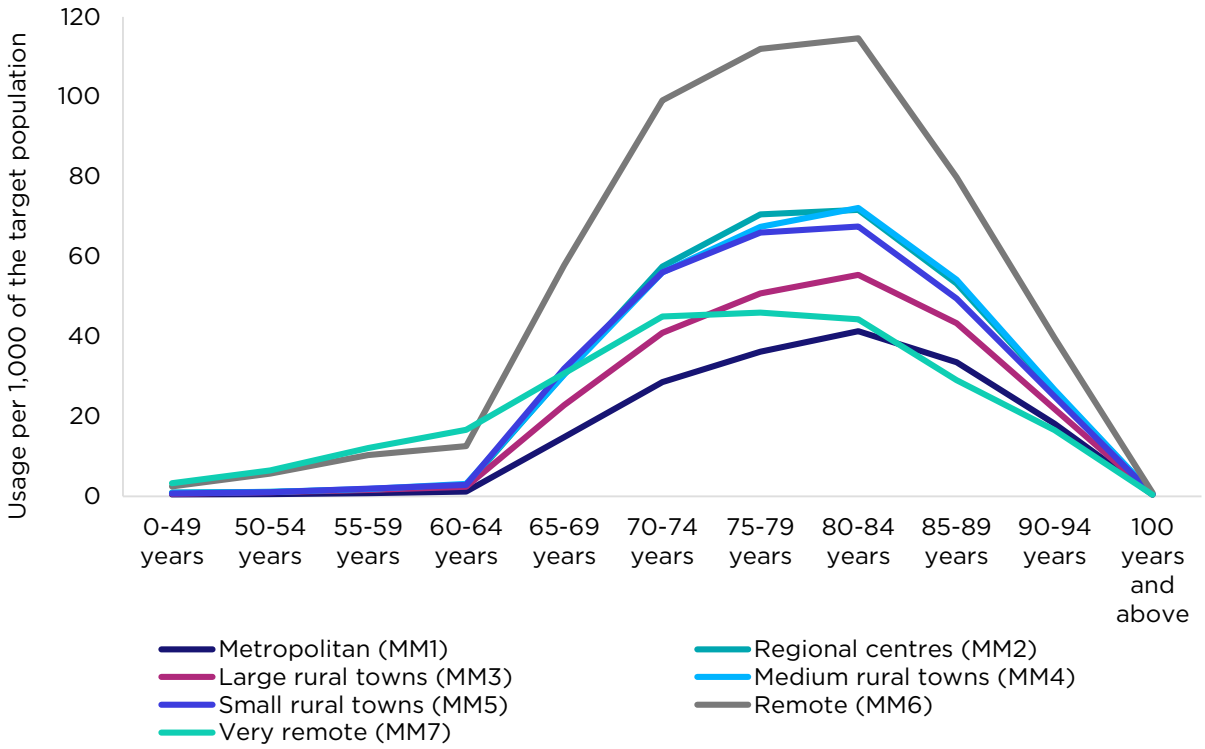
Source: AIHW Gen Aged care, June 2020. Remoteness structure used is the Modified Monash Model.

Figure 16: Usage rate of HCPP per 1,000 of the target population by age and remoteness, 30 June 2020



Source: AIHW Gen Aged care, June 2020. Remoteness structure used is the Modified Monash Model.

Figure 17: Usage rate of CHSP per 1,000 of the target population by age and remoteness, 2019-20



Source: AIHW Gen Aged care, June 2020. Remoteness structure used is the Modified Monash Model.

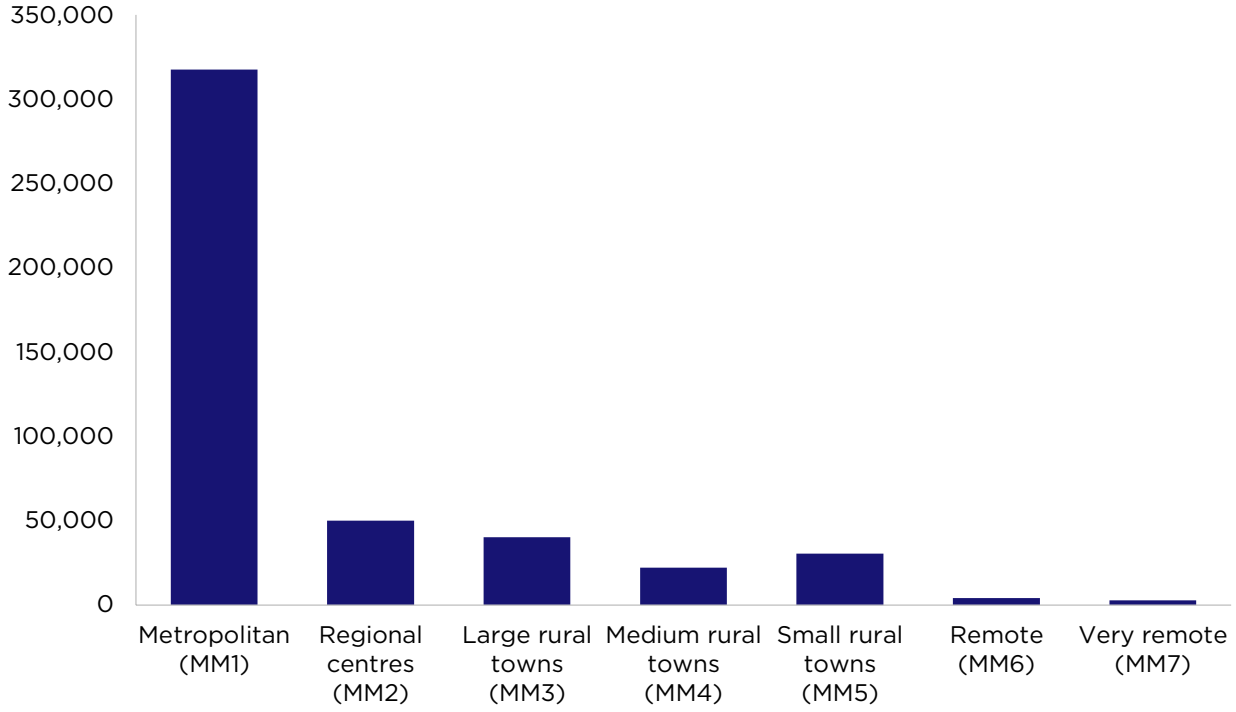
While the overall number of CHSP recipients is smaller in rural and remote regions (322,600 in MM3–7) compared with more populous regions (619,200 in MM1–2), the program is far more extensively used in remote and very remote Australia compared with other aged care programs. As shown in Figure 17, reliance on CHSP (recipients per 1,000 population) is the highest in either remote or very remote areas across every age group.[40]

There were also less than 100 people accessing respite care programs in remote and very remote areas representing around 1% of the total for respite care as at 30June 2020.[41]

As shown in Figure 18, around 32% of NDIS participants (or 149,100 people) are located outside of the major cities.[42] This is slightly above the proportion of the Australian population living outside the major cities (28%).[43] Underlying this, NDIS analysis undertaken in 2020 indicates that the prevalence of NDIS participants is highest in regional areas with a population of greater than 5,000 people (MM 2, 3 and 4 – 120 to 140% of the national average) and lowest in remote and very remote areas (MM 6 and 7 – 70% of the national average).[44] There are also differences in the incidence of primary disability types by region type. For example, the proportion of participants with acquired brain injury and other physical disabilities are much higher in the very remote areas compared with other areas, while there is a higher proportion of people with a psychosocial disability in major cities.[45]

[40] ABS, Regional population: 2019-20 financial year, 2021
[41] AIHW, GEN Aged Care Data, People using aged care, 2021
[42] NDIS, *Quarterly Report to Disability Ministers: 30 June 2021*, 2021
[43] ABS, Regional population: 2019-20 financial year, 2021
[44] NDIA, *Participants across remoteness classifications: 30 June 2020*, 2020
[45] NDIA, *Participants across remoteness classifications: 30 June 2020*, 2020

Figure 18: NDIS participants, by remoteness, June 2021



Source: NDIS Quarterly Report to Disability Ministers, 30 June 2021, Table E.11. Remoteness structure used is the Modified Monash Model.

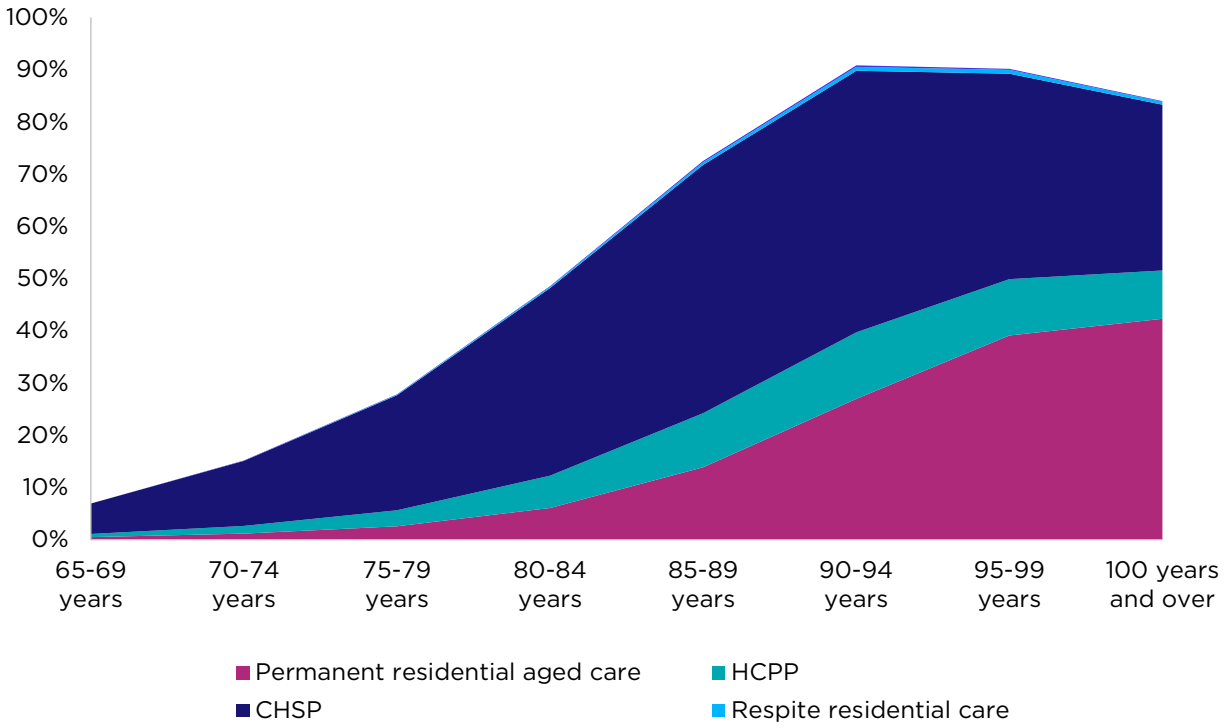
2.3 The demographic context

Demographics are the key driver of demand for care and support services. As the propensity to access various care and support services through the aged care, NDIS and veterans' programs is observably dependent on age, the future age structure of the population is a key driver of future demand. More specifically, the type of service accessed by different cohorts of the population also tends to differ by age, with important implications for future workforce requirements.

2.3.1 The share of the population accessing aged care services increases with age

For aged care, the likelihood of accessing aged care services increases for each age group. As seen in Figure 19, while less than 10% of the population aged 65 to 69 accesses aged care services, this increases to over 90% for the population aged 90 and over (noting that there are very few people in the 100 and over age group and this data should be treated with caution). Almost 2 in 5 (39%) people aged 95–99 years accessed permanent residential aged care services in the year to 30 June 2020.

Figure 19: Share of population accessing aged care services, by age group, June 2020



Source: NSC analysis, AIHW GEN Aged Care Data (June 2020), ABS National, state and territory population (June 2020). Data should be treated with caution, particularly for those in the oldest age groups. Some people may be counted in multiple programs where they have received services from one or more programs during the financial year.

2.3.1.1 The type of care accessed also varies by age

While the CHSP has the largest volume of recipients at almost every age cohort, the highest *rate* of usage of the CHSP occurs in the 75 to 84 age group (around 20% to 23% of those using CHSP are in these age groups). For HCPP the highest rate of usage occurs in the 80 to 89 age group (around 23%), while for permanent residential care highest rates occur in the 85 to 94 age group (around 23% to 24%). This indicates that CHSP has the youngest user age profile, followed by HCPP and then permanent residential aged care.[46]

A substantial and growing proportion of aged care recipients, including people living in residential aged care, have a dementia diagnosis which further increases the complexity of care and support

[46] AIHW, GEN Aged Care Data, People using aged care, 2021

needs into the future. As noted in *Dementia in Australia, 2021*, it is estimated that between 386,200 and 472,000 Australians are currently living with dementia, with 1 in 12 Australians aged 65 and over having dementia (increasing to 2 in 5 Australians aged 90 years and over).[47] This has implications for the skills needs of the care and support workforce.

2.3.2 The share of the population who are NDIS participants is more complex

The proportion of the population registered as NDIS participants differs significantly across age groups, with those of younger age more likely to be NDIS participants. This reflects, at least in part, the National Disability Insurance Agency's (NDIA's) early intervention approach for children aged 0-6 years.

In June 2021, there were around 466,600 NDIS participants, 192,900 (or 41%) of whom were aged 0-14 years.

NDIS participation rates (the number of NDIS participants as a proportion of the total population) currently peaks in the 7-14 years age group (4.7%), followed by the 0-6 years age group (3.4%) and the 15-18 years age group (3.0%). The lowest proportion was recorded for those aged 25-44 years (1.1%).[48]

The most common primary disability group for NDIS participants is autism (32% of NDIS participants), followed by intellectual disability (20%) and psychosocial disability (10%).[49] Looking at trends by age group, autism is more prevalent in the younger age groups, while the incidence of psychosocial disability is much greater in the 25-64 age group (Figure 20).[50]

As outlined in Part 2.2.2, a higher proportion of NDIS participants are males (62%). NDIA analysis indicates this is due to the higher number of children entering the scheme with autism and development delay, which are more prevalent in males than females.[51]

There is a small proportion of participants over the age of 65 years. NDIS participants who turn 65 can choose to remain in the NDIS or switch to aged care. However, once NDIS participants 65 years and over enter aged care (either care or support in a residential or home setting), they are unable to access the NDIS.

[47] AIHW, Dementia in Australia 2021: Summary Report, 2021

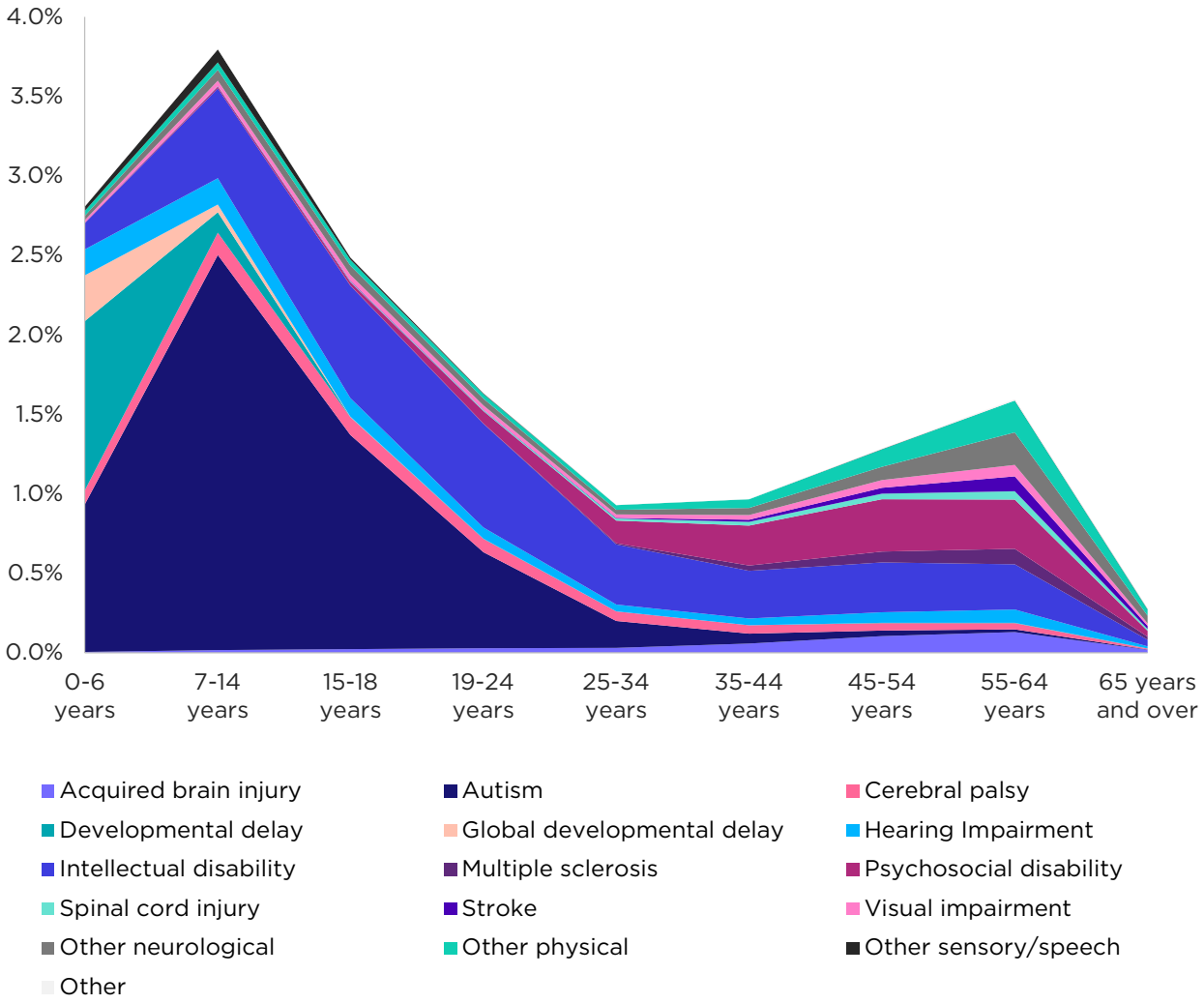
[48] NDIS, *Quarterly Report to Disability Ministers: 30 June 2021*, 2021

[49] NDIS, *Quarterly Report to Disability Ministers: 30 June 2021*, 2021

[50] NDIS, Participant data downloads: Participant numbers and average plan budgets, 2001

[51] NDIA, *Young people in the NDIS: 30 June 2020*, 2020

Figure 20: NDIS participants by primary disability, share of population (%), by age group, June 2020



Source: NDIS Participant numbers and plan budgets data (March 2020 and June 2020), 2020; ABS National, state and territory population (June 2020).

2.3.3 The share of the population who are Gold or White Card holders

Eligible DVA veterans and dependants with a Gold Card are covered for the cost of all required medical treatment. White Cards cover the cost of treatment for accepted service-related injuries or conditions and all mental health conditions. DVA veterans and dependants holding a Gold or White Card are also referred to as the DVA treatment population.

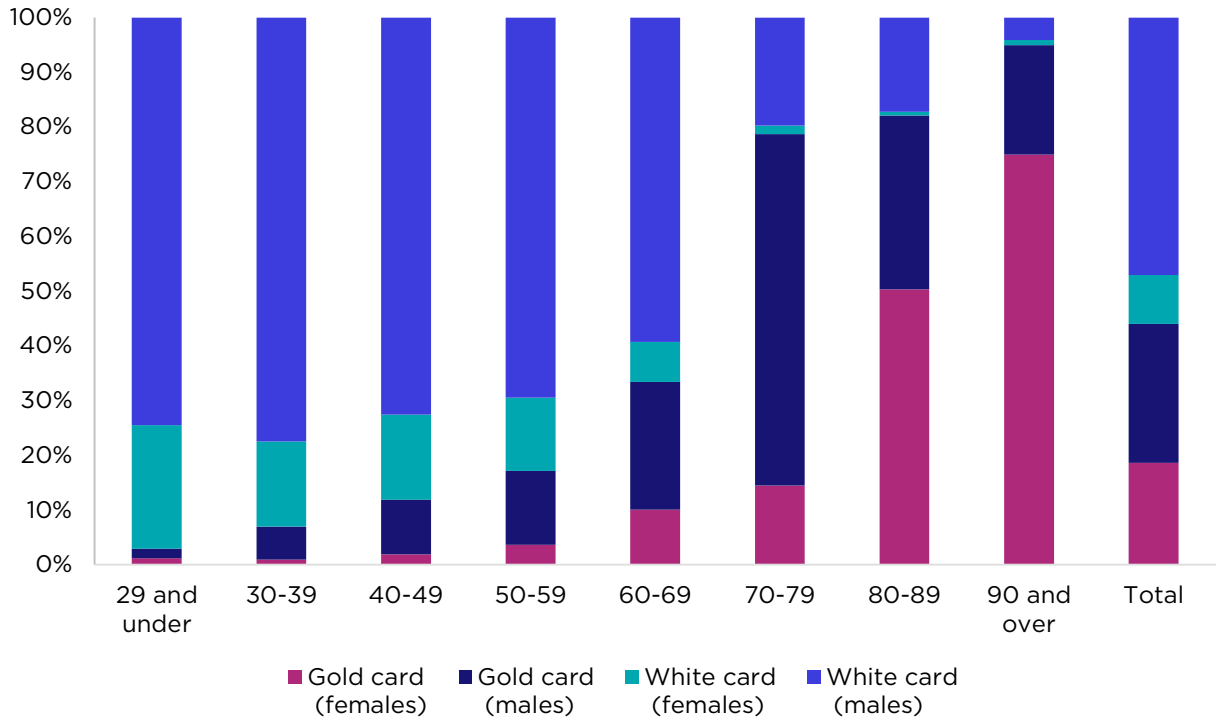
In total there were around 258,000 people in the DVA treatment population as at March 2021, comprised of 44% (or 114,000) who are Gold Card holders and 56% (or 144,000) who are White Card holders.[52]

The DVA treatment population accounts for around 1% of the total population or 3% of the total Australian population aged 80-89 years. At the oldest ages – 90 years and over – the DVA treatment population accounts for around 14% of the population with the majority of people in this age group being female Gold Card holders (Figure 21).[53]

[52] DVA, Treatment population statistics: March 2021, 2021

[53] DVA, Treatment population statistics: March 2021, 2021

Figure 21: Share of the DVA treatment population with a Gold or White Card, by age and sex, March 2021



Source: NSC analysis, DVA Treatment Population Statistics, March 2021, Table 4; ABS National, state and territory population (2020).

These trends are driven by the age of veterans (and the age of their dependants) at the time of active service. Accordingly, their age profile is closely linked to the likelihood of holding a Gold or White Card. The average age of a Gold Card holder is 77 years, compared with 48 years for a White Card holder.[54]

As shown in Figure 21, younger males are most likely to hold a White Card, while older males (particularly in the 70 years and over age group) are more likely to hold a Gold Card. Female Gold Card holders are highly represented in the 80 years and over age group,[55] largely reflecting their war widow status on the death of their veteran spouse.

[54] DVA, Treatment population statistics: March 2021, 2021

[55] DVA, Treatment population statistics: March 2021, 2021

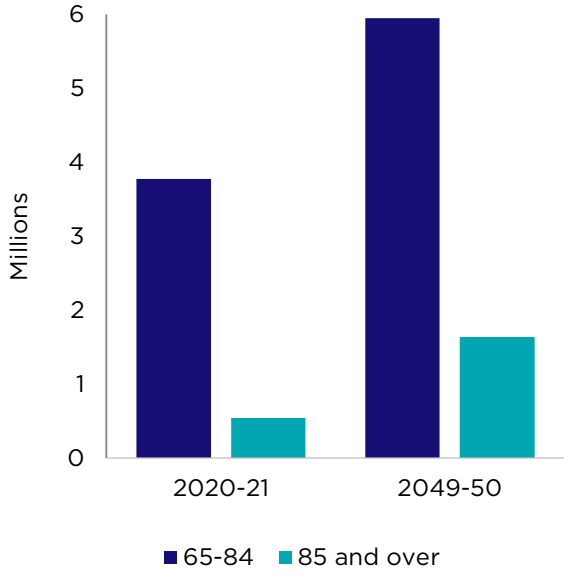
2.4 Drivers of future demand

2.4.1 An ageing population will drive demand for aged care services

The most recent population projections produced by the Centre for Population (Commonwealth Treasury) for the 2021 Intergenerational Report (IGR) predicts that by 2049-50 over 1 in 5 (21%) of the population will be aged 65 years and over, with 1 in 20 (5%) of the population aged 85 years and over (Figure 22 and Figure 23). Given the propensity to access aged care and support services increases significantly at the older ages, particularly for residential aged care, a large and growing workforce will be required to support these cohorts of older Australians.

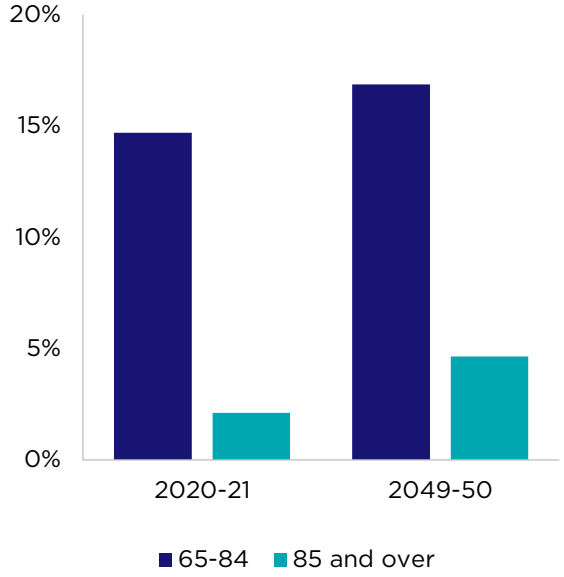
The impact of Australia's ageing population on the demand for aged care and support services is significant. If the propensity to access residential aged care services were to remain unchanged from current levels, a significant number of *additional* residential places would be needed by 2050 to meet demand, together with the accompanying care and support workforce. Even if the propensity to access residential aged care services were to be significantly reduced – through, for example, an increase in the utilisation of in-home care and support services – the number of residential aged care places will still need to increase significantly given the ageing population.

Figure 22: Older Australians (no.), 2020-21 and 2049-50



Source: Commonwealth Treasury (2021).

Figure 23: Older Australians (%), 2020-21 and 2049-50



Source: Commonwealth Treasury (2021).

Australia is not alone in facing an ageing population. Larger cohorts of older people will drive an increase in demand for aged care and support services across almost all countries around the globe. At the same time, the share of the working age population will decrease for many regions, resulting in an increasing old-age dependency ratio (measured as the ratio of people aged 65 years and over relative to the population aged 15-64 years).

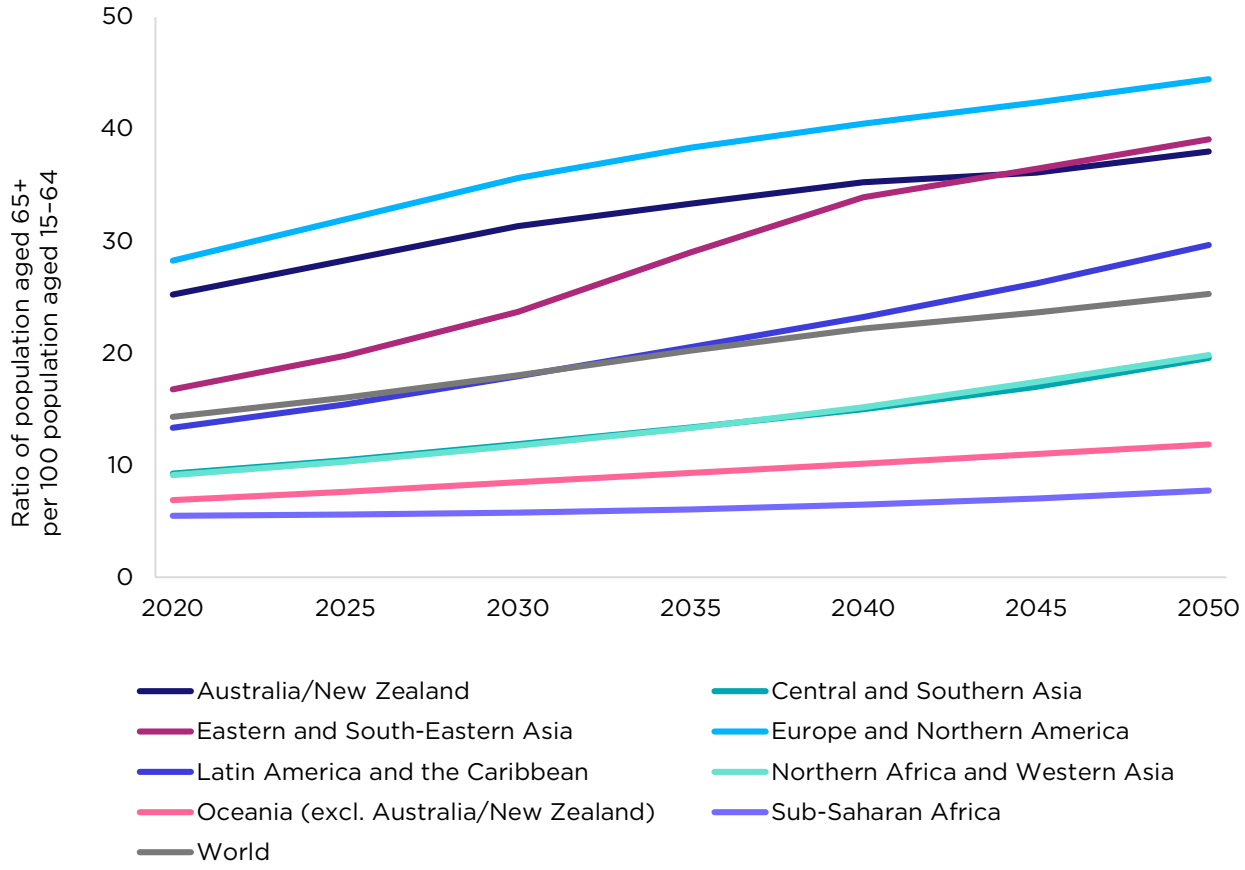
For example, the United Nations projects that the old-age dependency ratio for the world as a whole will increase from around 15 people aged 65 years and older for every 100 people of working age in 2020 to 25 people aged 65 years and older for every 100 people of working age in 2050 (Figure 24). The ratio of older people for the regions of Europe and Northern America, Eastern and South-Eastern Asia, and Australia/New Zealand are significantly higher, and increase at a relatively faster rate.[56]

In the absence of significant technological advancements, the challenge of diverting a larger proportion of the working age population – either through formal workforce or informal care arrangements – to the provision of relatively labour-intensive care and support services for the

[56] United Nations, Department of Economic and Social Affairs, World Population Prospects 2019, 2021

growing older population will be a challenge shared by many Organisation for Economic Co-operation and Development (OECD) nations.

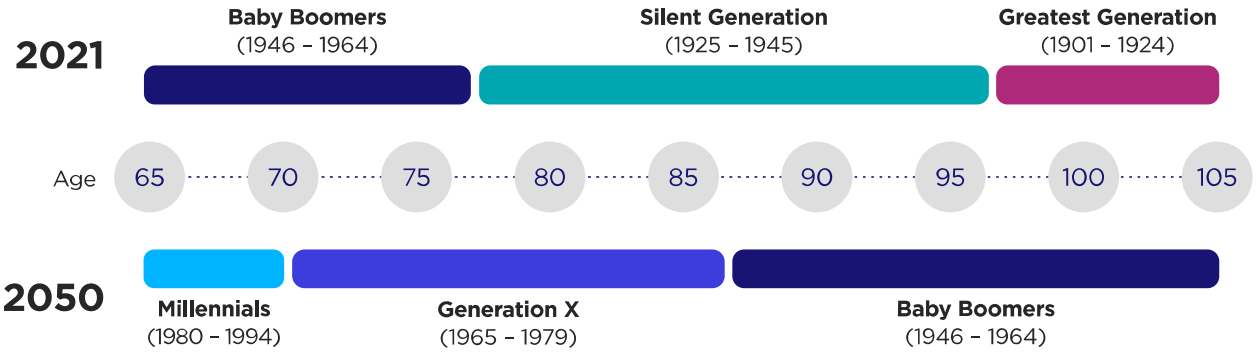
Figure 24: Old-age dependency ratio, regions of the world, 2020 to 2050



Source: United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019, Medium fertility variant, 2020–2100, Online Edition.

By 2050, the oldest Millennials will be eligible for aged care and support services in Australia (Figure 25). As new cohorts become eligible for aged care and support services, the types of services, and their method of delivery will necessarily evolve over time. In response, the skills of the workforce will also need to change.

Figure 25: Accessing aged care services, a generational perspective



Source: NSC analysis, ABS Changing female employment over time, 2021.

2.4.2 The number of participants in the NDIS is likely to grow

The demand for disability care and support in the future is uncertain, although the overall number of NDIS participants is expected to continue to grow. The number of NDIS participants has grown by almost 300,000 people over the last 3 years, to around 466,600 scheme participants as at 30 June 2021.[57] The number of future participants is expected to continue to increase, with higher than anticipated entrants of children and lower than expected exit rates from the scheme (including for those aged 65 years and over).

2.4.3 The veteran population, and their needs, will also change over time

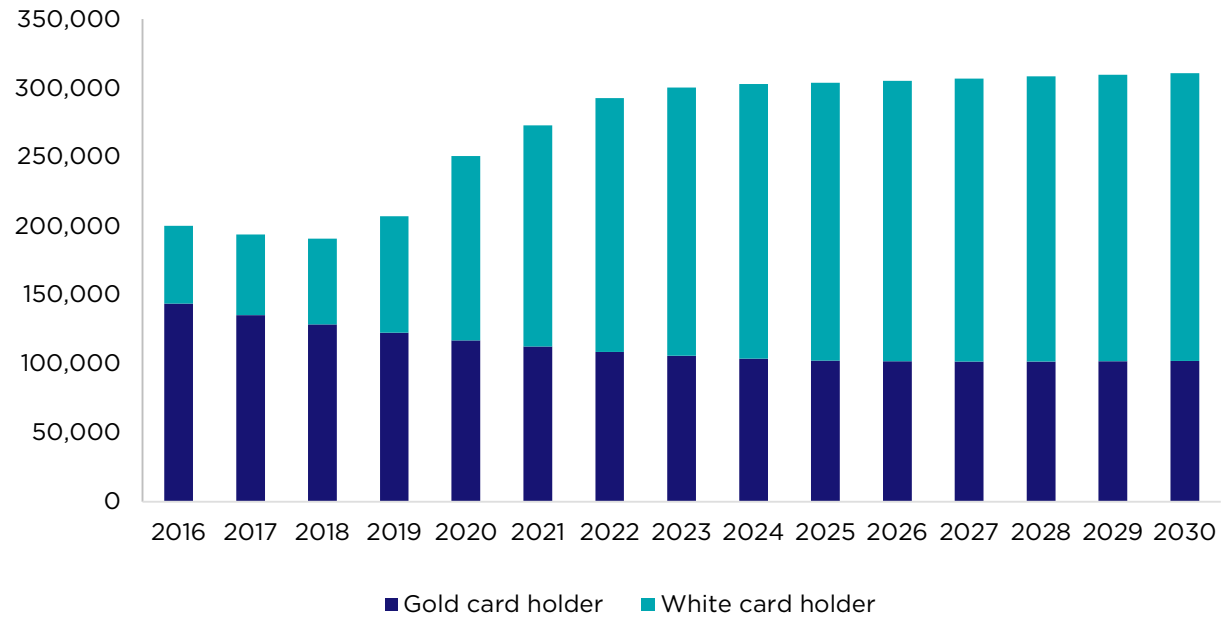
Veterans and/or their dependants must have a Gold or White Card to be eligible for the DVA programs listed previously in Part 2.1.3. The changing composition of Gold and White Card holders (the DVA treatment population) will mean the demand for services will also change. Currently, the DVA treatment population accounts for 1% of the total population, but this increases for the much older age groups with 5% of the population aged 80 years and over holding a gold or white card.[58]

Overall, the total number of DVA card holders (including both veterans and eligible dependants) is projected to continue to increase over the forecast period to stand at 310,900 in 2030.[59]

- Within that, the number of Gold Card holders has been trending downwards over recent years (Figure 26) and is expected to continue to decline (until 2027) to account for 33% of card holders in 2030 (down from 44% in March 2021). On the other hand, the number of White Card holders has been increasing and is anticipated to continue to increase over the forecast period (until 2030) to account for around two-thirds of card holders.[60]

The projected trends in White and Gold Card holders suggest that the services demanded by the treatment population (DVA Gold and White Card holders) will somewhat reorient towards the treatment of service-related injuries and conditions including those related to mental health.

Figure 26: DVA treatment population, by card type, actual (2016 to 2020), projected from 2021 onwards



Source: DVA Treatment Population Statistics, March 2021, Table 9.

[57] NDIS, *Quarterly Report to Disability Ministers: 30 June 2021*, 2021

[58] ABS, National, state and territory population: Dec 2020, 2020; DVA, Treatment population statistics: March 2021, 2021

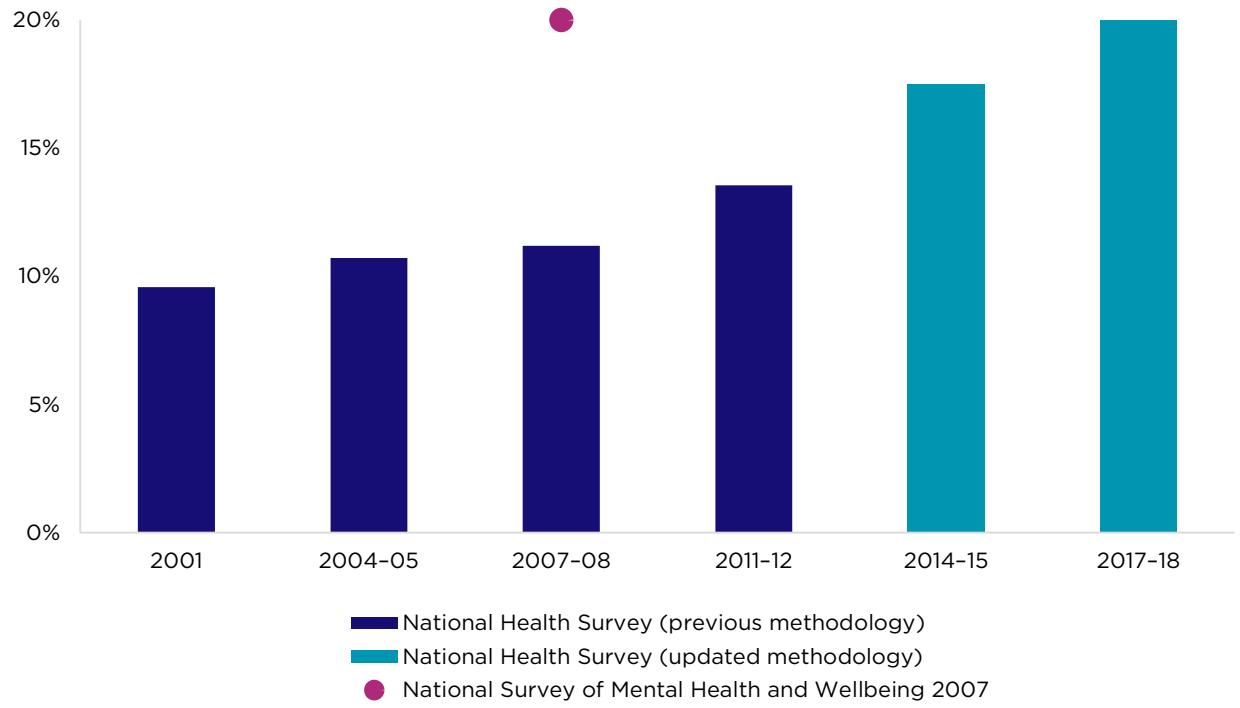
[59] DVA, Treatment population statistics: March 2021, 2021

[60] DVA, Treatment population statistics: March 2021, 2021

2.4.4 Mental health

The total Australian population with a mental health illness is difficult to identify as the term 'mental illness' and 'mental disorder' are used to describe a broad range of mental health and behavioural disorders, varying in severity and duration. In addition, data on mental illness is collected through infrequent surveys that rely on self-reported observations. The National Health Survey 2017-18 estimates that around 1 in 5 Australians had a mental health or behavioural condition, and that this has been increasing over time (Figure 27).

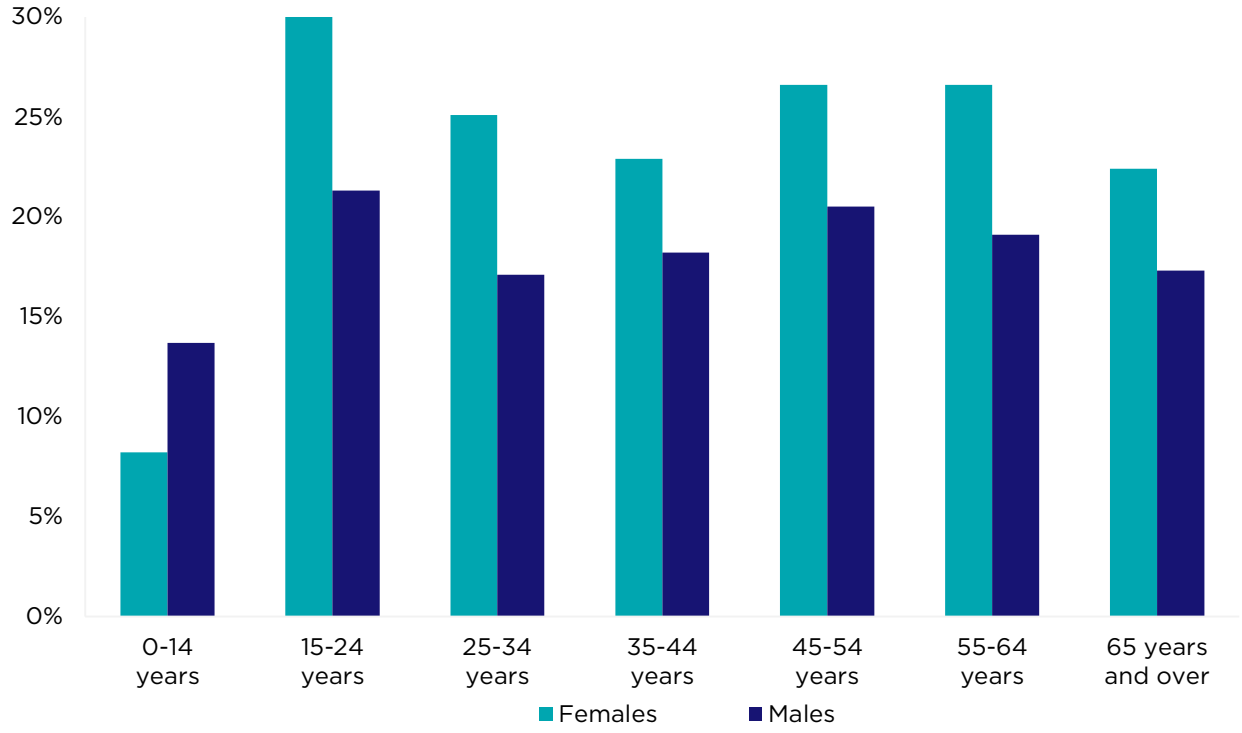
Figure 27: Share of the population with a mental health illness/disorder over time



Source: ABS National Survey of Mental Health and Wellbeing 2007; ABS National Health Survey: first results, 2017-18. National Survey of Mental Health and Wellbeing 2007 data includes any 12-month mental disorder (16-85 years). National Health Survey data includes any mental health or behavioural conditions (total population). Data for 2014-15 and 2017-18 are not comparable to earlier years as information on mental health conditions was obtained through different collection modules. The National Health Survey was conducted on a calendar year basis in 2001.

The 2007 National Survey of Mental Health and Wellbeing data found a higher proportion of males had experienced a mental health disorder in their lifetime (48% compared with 43% for females). However, a higher proportion of females reported symptoms in the 12 months prior to the survey. Consistent over the 2 surveys, is the higher share of people aged 16–25 reporting suffering from a mental health or behavioural disorder relative to older age groups. Further, a higher proportion of females reported a long-term mental health or behavioural condition than males for most age groups, with the exception being the 0 to 14 age group (Figure 28).

Figure 28: Share of population with long-term mental or behavioural disorder by age and sex, 2017-18



Source: ABS National Health Survey: first results, 2017-18.

Further, it is also difficult to determine the demand for mental health services relating to mental wellbeing, particularly in the areas of prevention and early intervention, however, stakeholder feedback indicates demand is continuing to grow and may be exacerbated by the impacts of COVID-19 and related restrictions.

2.5 Influencers of demand

In addition to the demographic drivers of demand highlighted previously, a range of other influences are at play in Australia's care and support landscape with potential to influence demand now and into future. These include the recently completed Royal Commission into Aged Care Quality and Safety (Aged Care Royal Commission) and the current Royal Commissions into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission) and Defence and Veteran Suicide (Defence and Veteran Suicide Royal Commission).

2.5.1 Royal Commissions will continue to influence the care and support landscape

The Australian Government's responses to Royal Commission recommendations have the potential to shape demand settings for care and support services now and into the future. For this report, the Study has considered recommendations which have been agreed by the Australian Government.

For example, in February 2021 the Aged Care Royal Commission made 148 wide ranging recommendations to improve Australia's aged care system. The Australian Government accepted the recommendation to introduce minimum staffing levels, including that residential care time be increased to at least 200 minutes a day per resident, with at least 40 minutes of that time provided by a registered nurse.[61] This recommendation has been built into the Study's baseline assumptions, along with other accepted recommendations, of the demand side model. The effect on demand and supply of a further increase to the minimum care minutes in line with the Royal Commission recommendation is modelled as a sensitivity to the baseline in Part 10.7.

A range of other recommendations have been accepted in-principle by the Australian Government, with redesign of aspects of the aged care system currently being considered. While these do not form part of the Study's model it is noted that some may have an impact on demand if they change eligibility or access to services.

The Disability Royal Commission's terms of reference include 'recommendations about policy, legislative, administrative or structural reforms' to support the independence of people with disability[62] while the Defence and Veteran Suicide Royal Commission's is to inquire into '…the availability, timeliness and quality of health, wellbeing and support services, and the role of non-government organisations in providing those services…'.[63]

Given the broad remit of these Royal Commissions, their recommendations could influence future demand for disability and veteran care and support, and workforce supply settings, should there be resulting changes to programs, systems and legislative frameworks.

[61] Royal Commission into Aged Care Quality and Safety, *Royal Commission into Aged Care Quality and Safety final report: care, dignity and respect*, 2021

[62] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Our Terms of Reference, 2019

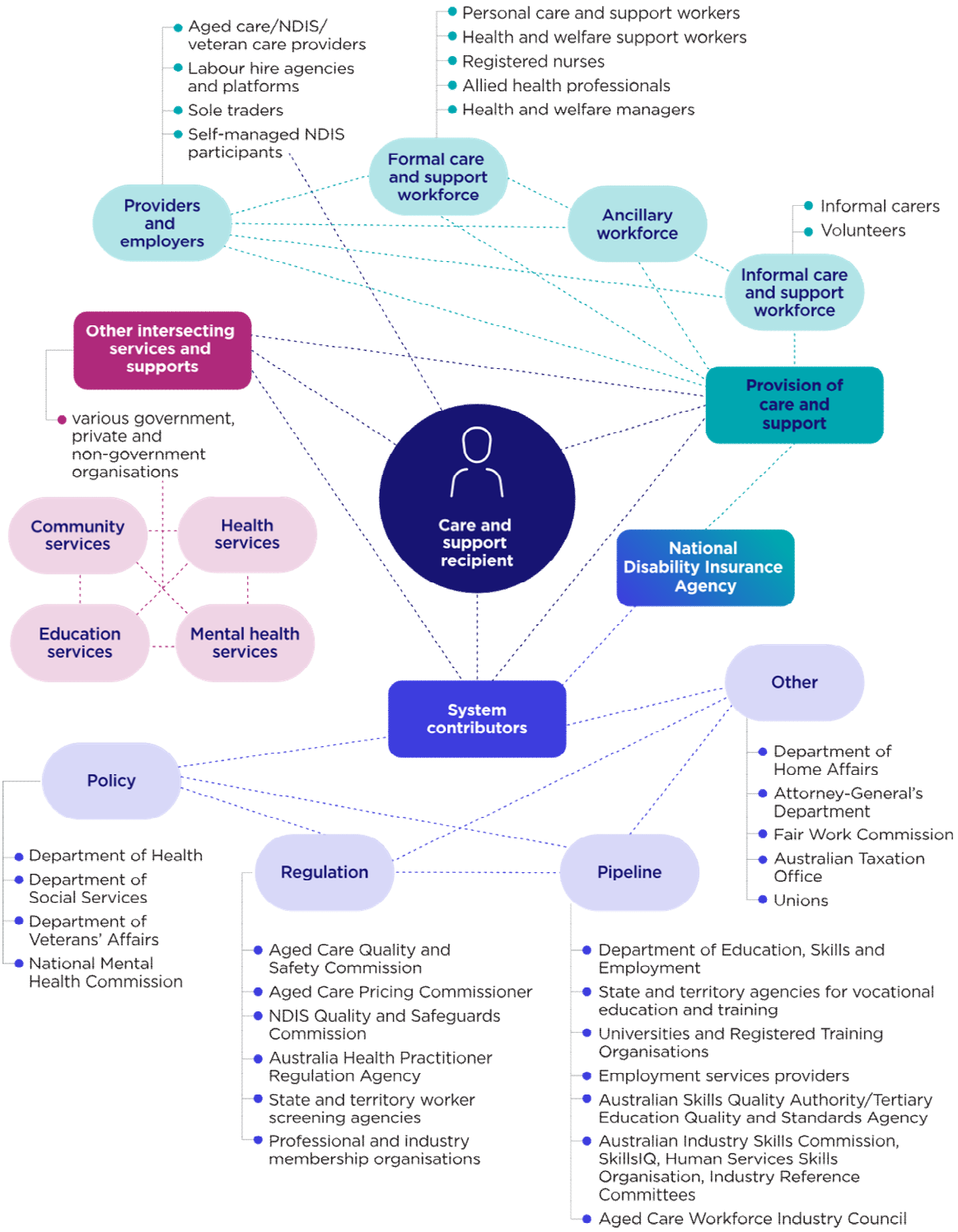
[63] Royal Commission into Defence and Veteran Suicide, Terms of reference, 2021

2.6 Contributors to care and support

The demand for care and support is met by a complex system. Many organisations (government and non-government), businesses and people contribute to the provision of care and support, across a wide range of roles and functions in a complex environment (Figure 29).

Care and support are also delivered alongside other services such as primary health, community health, mental health, community and social services. These services traverse complicated jurisdictional boundaries, as well as intra and intergovernmental agreements.

Figure 29: Contributors to the care and support system



Source: NSC analysis.

2.6.1 System contributors

At the national level, policy leadership for the care and support environment is dispersed across several Australian Government departments including the Department of Health (aged care and mental health), Department of Social Services (DSS) (disability) and DVA (veterans). The National Mental Health Commission provides independent policy advice on ways to improve Australia's mental health and suicide prevention system, while the NDIA is the administrator of the NDIS.

Additionally, there are multiple regulatory bodies, such as the Aged Care Quality and Safety Commission, Aged Care Pricing Commissioner, and NDIS Quality and Safeguards Commission. The Australian Health Practitioner Regulation Agency (AHPRA) also has a direct role in the registration for many, but not all, occupations operating as part of the care and support workforce. Respective states and territories process worker screening checks, such as those introduced by the Australian Government for NDIS workers. There are also several organisations which play a role in oversight of occupations in the care and support workforce, including the National Alliance of Self Regulating Health Professions (an independent body that works to maintain a framework of standards for self-regulating health professions), as well as professional associations such as Speech Pathology Australia, Audiology Australia, the Australian Association of Social Workers and the Australian Community Workers Association who offer membership or accreditation to suitably qualified practitioners.

From a workforce pipeline perspective, DESE oversees the education and training systems which provide the skilling pipeline for the workforce and employment programs which assist Australians to find jobs, including in the care and support workforce. Universities, registered training organisations and employment providers contribute to providing pathways into the care and support workforce. Tertiary Education Quality and Standards Agency (TEQSA) and Australian Skills Quality Authority (ASQA) also have a role in the regulation of education and training providers. There are also organisations which support the Australian Industry Skills Committee to develop national training package products for care and support qualifications, including the Skills Service Organisation (SkillsIQ) and Industry Reference Committees.

While not exhaustive, other care and support system contributors include the:

- Human Services Skills Organisation (HSSO) and Aged Care Workforce Industry Council (ACWIC) with their respective roles in job design of care and support roles and career paths, as well as ACWIC's broader leadership role in implementing the Aged Care Workforce Strategy.
- Department of Home Affairs with its role in facilitating supply to the care and support workforce through its migration programs.
- Attorney-General's Department, Fair Work Commission (FWC), ATO, employers and unions in the context of their respective roles in shaping the industrial relations and worker entitlements settings relevant to the care and support workforce.

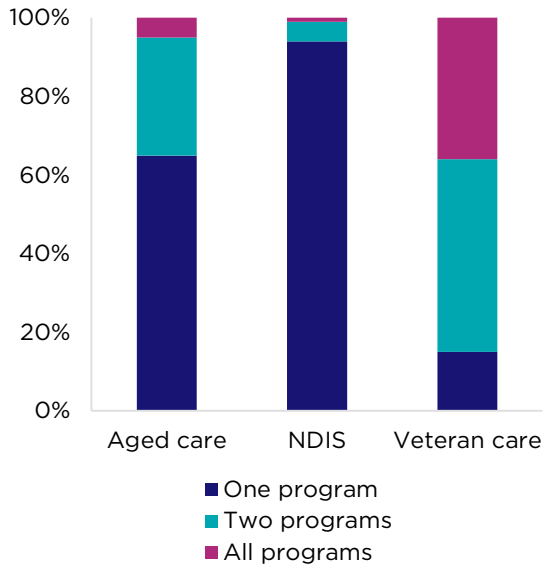
2.7 Providers of care and support

Over 13,000 providers operate across the care and support landscape (Figure 30 and Figure 31). There are many types of providers who may operate within one or more of aged, disability and veteran care and support – from small to large and not-for-profit to for-profit providers. The bulk of care and support providers operate exclusively within the NDIS, around 11,000 providers. Around one-third of aged care providers operate across disability and/or veteran care and support, while 85% of veteran providers operate across aged care and/or NDIS.[64]

As noted previously in (Part 2.1.5), around:

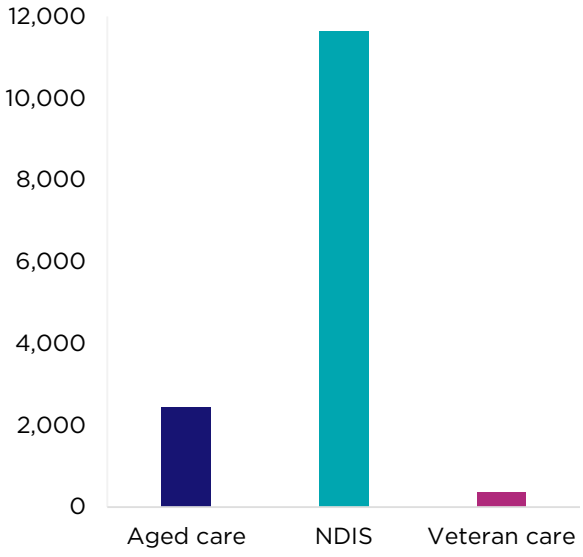
- 31% of aged care providers delivered NDIS services
- 11% of aged care providers delivered veteran services
- 6% of NDIS providers delivered aged care services
- 1% of NDIS providers delivered veteran services
- 78% of veteran providers delivered aged care services
- 50% of veteran providers delivered NDIS services.[65]

Figure 30: Share of care and support providers across programs, June 2020



Source: NDIS National Workforce Plan: 2021-2025, Australian Government Department of Social Services, 2021.

Figure 31: Number of care and support providers across programs, June 2020



Source: NDIS National Workforce Plan: 2021-2025, Australian Government Department of Social Services, 2021.

2.7.1 Sole traders and labour hire in the care and support workforce

While most care and support workers are employed as staff by providers, some workers are sourced through employment agencies or employed as independent contractors. Employment agencies are traditionally used to fill temporary gaps when permanent or casual staff are on leave, or when there is an unexpected vacancy, supplementing a provider's regular workforce. Sole

[64] DSS, *NDIS National Workforce Plan: 2021 - 2025*, 2021 Provider information across programs is not collected on a consistent basis, so may not be directly comparable. Provider status of Allied health professionals varies across programs and the majority are not engaged directly as providers in the care and support programs in scope for this Study.

[65] Department of Health, *Service Delivery Across Social Policy Programs, unpublished*, 2021

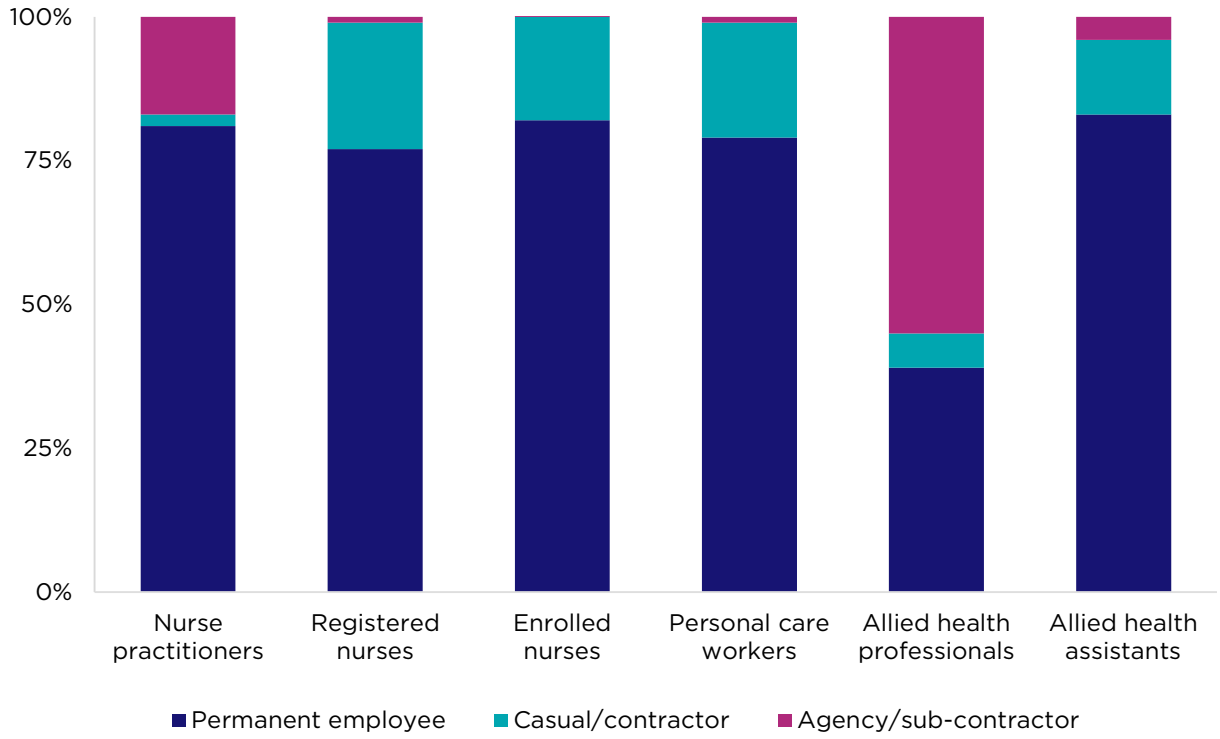
traders are typically used to obtain the skills of higher skilled workers, particularly for Allied health professionals in aged care and the NDIS.[66]

Due to limitations around how employment data is collected, it is difficult to measure the contribution of these types of employment arrangements (Part 1.6).

The 2016 ACWC found 41% of residential facilities used agency workers, with the most common reasons being short-term cover for staff absences (87%) or to address unfilled vacancies (51%). The use of agency workers by providers was most common for personal care attendant positions (27% of providers), followed by registered nurses (27%) and enrolled nurses (13%). The use of agency workers was less common in aged home care and support, with only 12% of providers using them in 2016.

In 2020, 55% of allied health professionals in residential aged care were agency workers or sub-contractors (Figure 32). Conversely, allied health assistants was the occupation with the highest share of permanent staff, with only 13% employed as casuals or contractors and 4% employed as agency workers or sub-contractors.

Figure 32: Proportion of residential aged care staff by job role and employment type, 2020

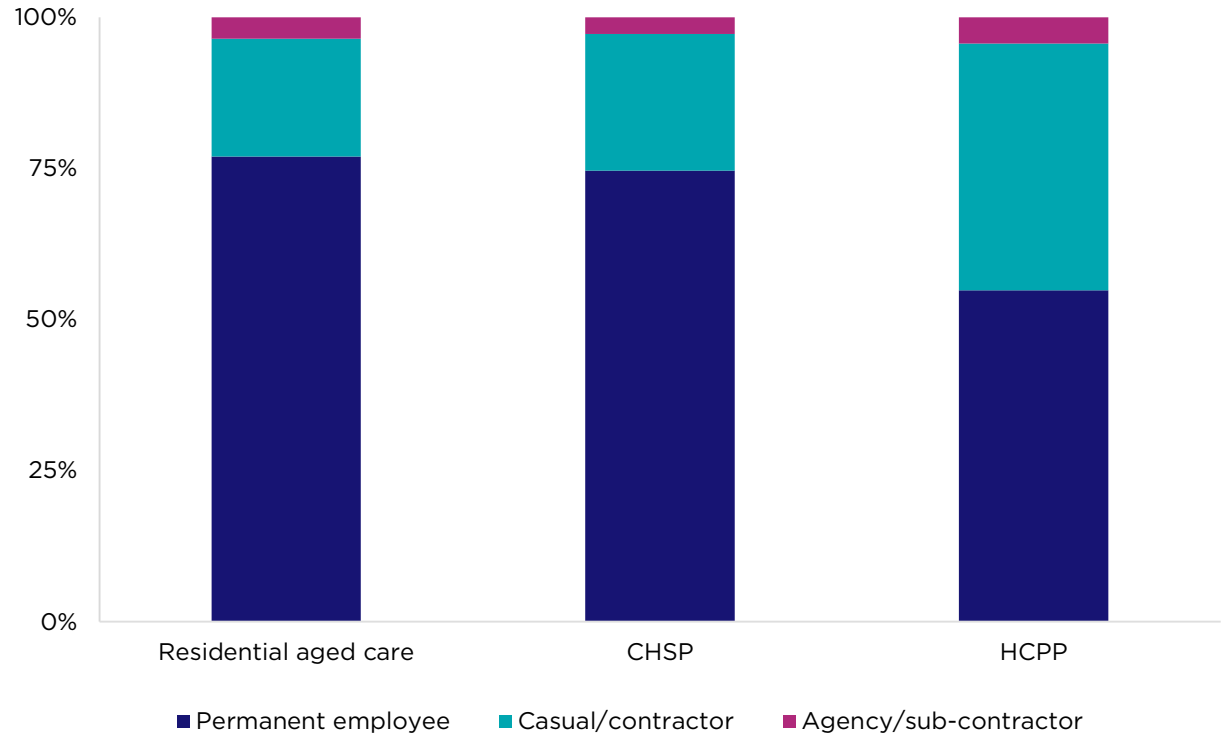


Source: 2020 Aged Care Workforce Census. Note that occupations in the ACWC do not necessarily align with ANZSCO occupation titles/definitions.

Across aged care programs, HCPP had the highest share of agency and sub-contractor employment (4.4%) followed by residential care (3.5%) and CHSP (2.7%) (Figure 33). HCPP also had the highest share of casual and contractor employment, accounting for 41% of the program's workforce.

[66] Department of Health, National Aged Care Workforce Census 2020, 2021

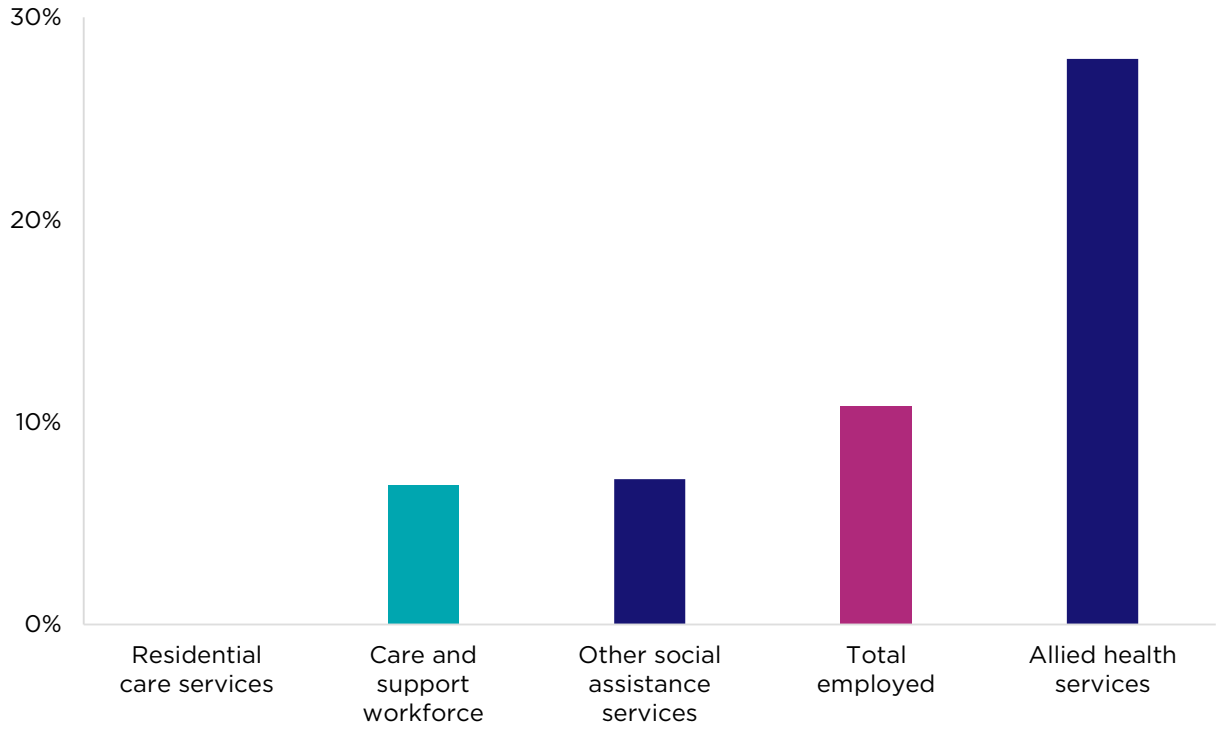
Figure 33: Proportion of workforce by employment type and aged care program, 2020



Source: 2020 Aged Care Workforce Census.

Self-employed workers, including sole traders, are less common in aged care but play a substantial role in the NDIS. Only 6.5% of residential and 4.5% of in-home age care providers reported using self-employed workers in 2016. The vast majority of self-employed workers in aged care were Allied health professionals, with 75% of providers saying the reason for using sole traders was to 'obtain specialist skills'. This aligns with recent ABS labour force statistics, where 26% of Allied health professionals were reported as being owner managers with no employees, more than double the Australian average of 11% (Figure 34). Sole traders are more common in the NDIS, representing 37% of all active providers in 2019. This may reflect the different operating model of the NDIS, where the type, frequency and quantity of service is driven by the consumer.

Figure 34: Share of care and support owner-managers with no employees, by industry, 2021



Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Care and support workforce includes 15 care and support ANZSCO occupations. *Other social assistance services* is a 3-digit industry which consists of businesses engaged in the provision of a wide variety of social support services directly to their clients (outside of accommodation services, except on a short stay basis). This includes aged care assistance services, disabilities assistance services and welfare counselling services. See Figure 2 for further detail.

Part 3
An overview of the care and support workforce

Part 3 provides a brief overview of the care and support workforce.

As noted previously, the Study estimates there are around 460,000 care and support workers (excluding mental health) in Australia who are employed across a wide range of occupations and multiple industries.

- The largest occupation group in the care and support workforce is Personal care and support workers. These workers make up over half of the entire workforce (59%) and have been growing rapidly.
- Allied health professionals are the second largest group (13%), followed by Health and welfare support workers and Registered nurses (both 12%) and Health and welfare managers (5%).

Care and support occupations are characterised by a range of different skill levels.

- Nine of the 15 care and support occupations are skill level 1 (commensurate with a bachelor degree or higher qualification) and this accounts for approximately 29% of the total care and support workforce. This skill level includes all Registered nurses, Health and welfare managers and Allied health professional occupations.
- Four occupations are skill level 2 (commensurate with an advanced diploma or diploma level qualification) or skill level 3 (commensurate with a certificate III with at least 2 years of on-the-job training, or a certificate IV level qualification) and together make up approximately 11% of the total care and support workforce.
- Personal care and support workers are skill level 4 occupations (commensurate with a certificate II or III level qualification, or at least one year of relevant experience).

The care and support workforce has grown rapidly in recent years

Growth in the care and support workforce is 3 times faster than the Australian workforce, reflecting the ongoing increase in demand for care and support, and particularly in recent years the introduction and subsequent expansion of the NDIS.

Changes in technology, business requirements, and consumer preferences and needs drive the creation of new roles and the evolution of existing ones.

- An example of the latter is how a range of behavioural and psychosocial conditions place increasing importance on competencies across dementia and mental health.

Throughout the Study a broad range of job titles have been used by stakeholders to identify the occupations within the care and support workforce, which may not align precisely with occupation titles in ANZSCO. These likely reflect the evolving models of care and support and the job roles needed to deliver it, with most, but not all, mapping to existing ANZSCO occupation titles based on their job descriptions. For those job titles which do not map well to an existing ANZSCO occupation it may indicate an emerging role.

The contribution of informal carers and volunteers is significant

While out of scope for this Study, carers and volunteers make an invaluable and important contribution to the delivery of care and support. The 2018 Survey of Disability Ageing and Carers (SDAC) estimated there were around 2.6 million carers in Australia, equating to around 1 in 9 Australians.

Deloitte Access Economics estimated the replacement value of informal care to be $77.9 billion in 2020.

While not fully representative of the entire disability sector, the National Disability Services (NDS) State of the Disability Sector annual market survey found that 58% of disability organisations used volunteers in 2020.

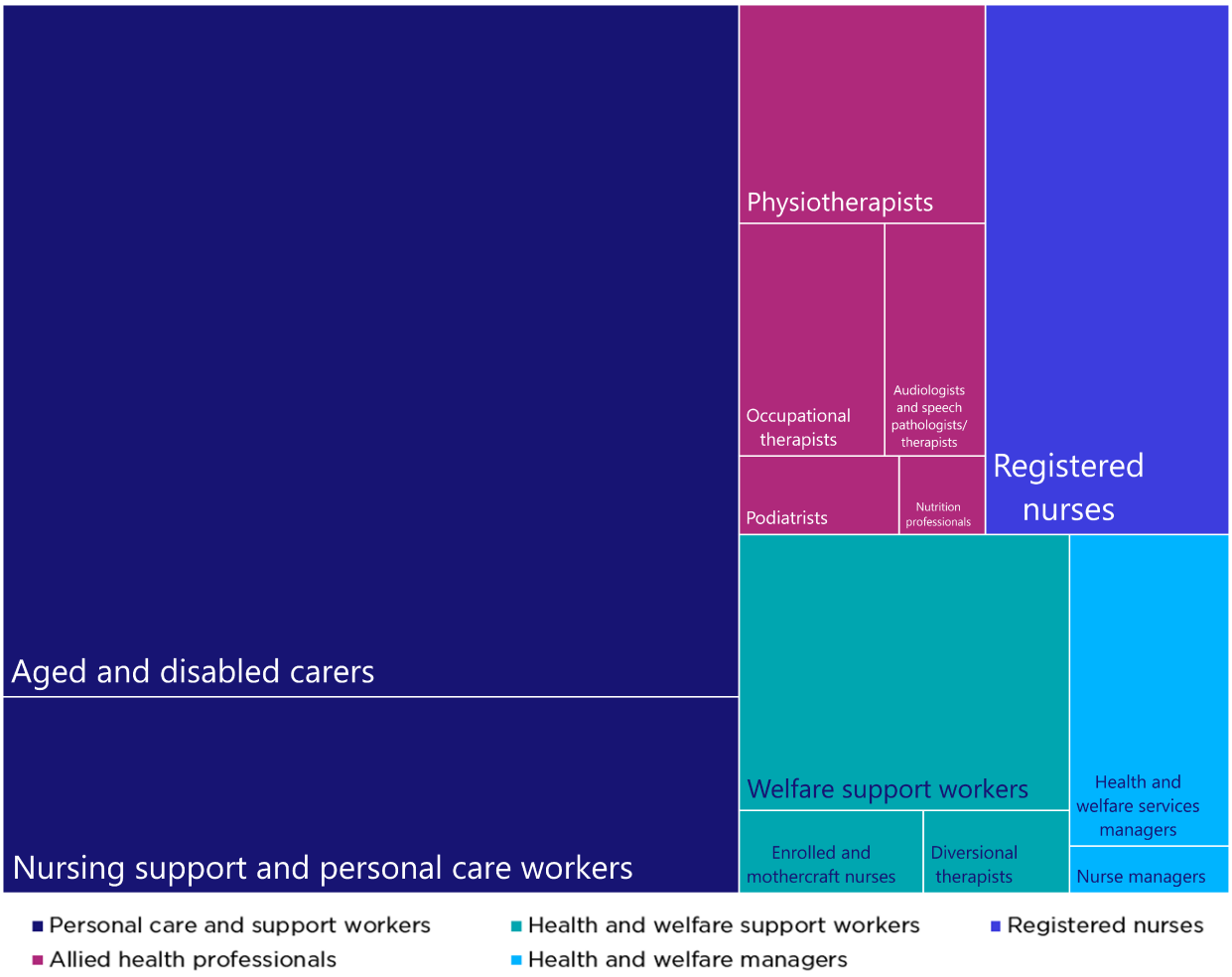
The ABS General Social Survey, while not specific to the health sector, suggests that the overall propensity to volunteer is decreasing. Between 2006 and 2019, the proportion of people who had undertaken unpaid voluntary work through an organisation in the 12 months prior had declined from 34% to 25%.

The overall impact of a declining propensity to volunteer is complex as it is interlinked with changes in participation rates and demographics, but a continuing long-term decline is a potential further pressure on demand for the care and support workforce.

3.1 An overview of the care and support workforce

The care and support workforce is diverse and comprises several occupations across a number of industries (defined in Part 1.3). For the purposes of this report, the care and support workforce has been defined using a combination of ANZSCO occupations and ANZSIC industries (Figure 35).

Figure 35: Share of care and support occupations in care and support specific industries, by occupation group (aggregate), February 2021

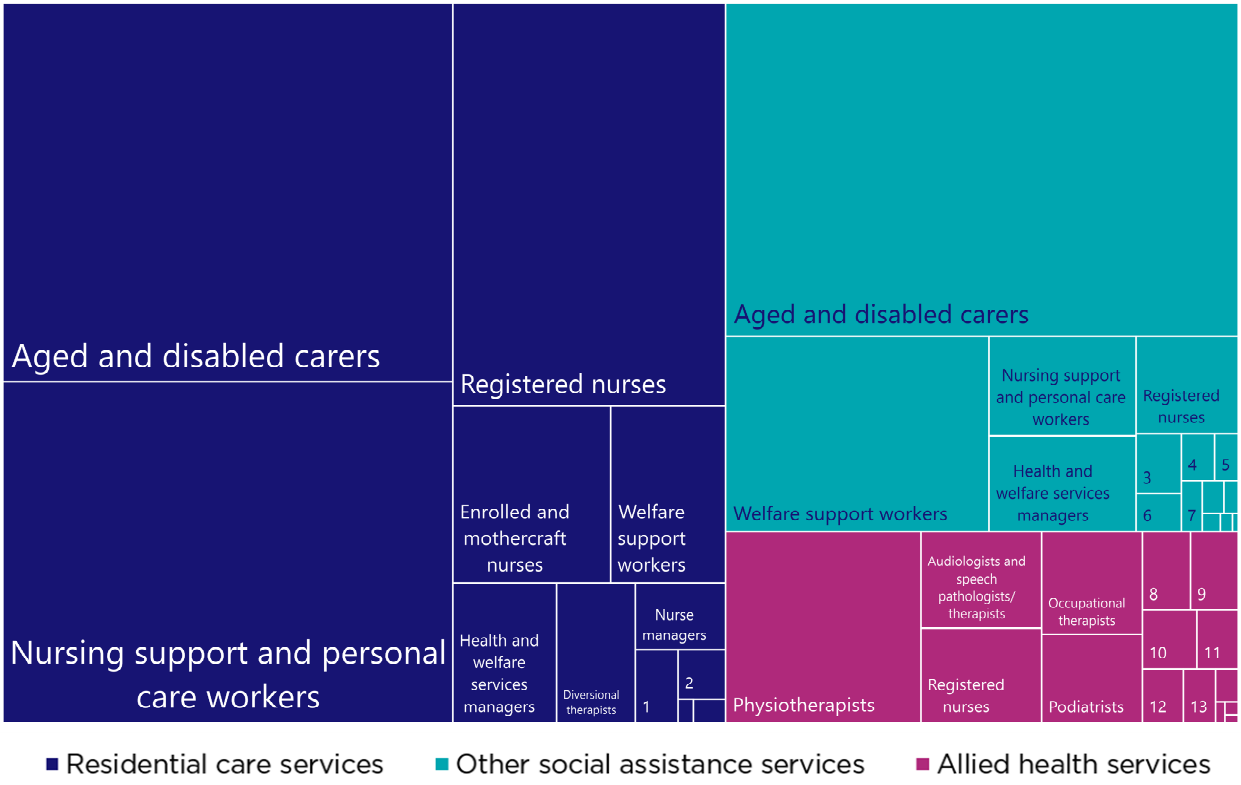


Source: ABS ANZSCO, 2013, Version 1.3; ABS Participation, Job Search and Mobility, 2021, Occupation of current main job and Industry of current main job by Reference year. Population: 15 in-scope occupations (ANZSCO 4-digit level) across 3 in-scope industries (ANZSIC 3-digit level). Data is not shown for some occupations (including *Indigenous health workers* and *Social professionals*) due to low counts.

The largest occupation group in the care and support workforce is Personal care and support workers. These workers make up over half of the entire workforce (59%) and are growing rapidly. Allied health professionals are the second largest group (13%), followed by Health and welfare support workers and Registered nurses (both 12%) and Health and welfare managers (5%).

The distribution of the 15 care and support occupations across the care and support specific industries, also shows that Personal care and support workers are the largest occupation group in all care and support specific industries except for *Allied health services* (Figure 36).

Figure 36: Share of care and support occupations in care and support specific industries (disaggregated), 2016



1 = Physiotherapists, 2 = Occupational therapists, 3 = Occupational therapists, 4 = Enrolled and mothercraft nurses, 5 = Diversional therapists, 6 = Audiologists and speech pathologists/therapists, 7 = Physiotherapists, 8 = Nursing support and personal care workers, 9 = Aged and disabled carers, 10 = Nutrition professionals, 11 = Health and welfare services managers, 12 = Welfare support workers, 13 = Enrolled and mothercraft nurses. Other care and support occupations with less than 250 workers in these industries are not denoted with a number.

Source: ABS Census of Population and Housing, 2016. Population: 15 in-scope ANZSCO 4-digit occupations. *Other social assistance services* is a 3-digit industry which consists of businesses engaged in the provision of a wide variety of social support services directly to their clients (outside of accommodation services, except on a short stay basis). This includes aged care assistance services, disabilities assistance services and welfare counselling services. See Figure 2 for further detail.

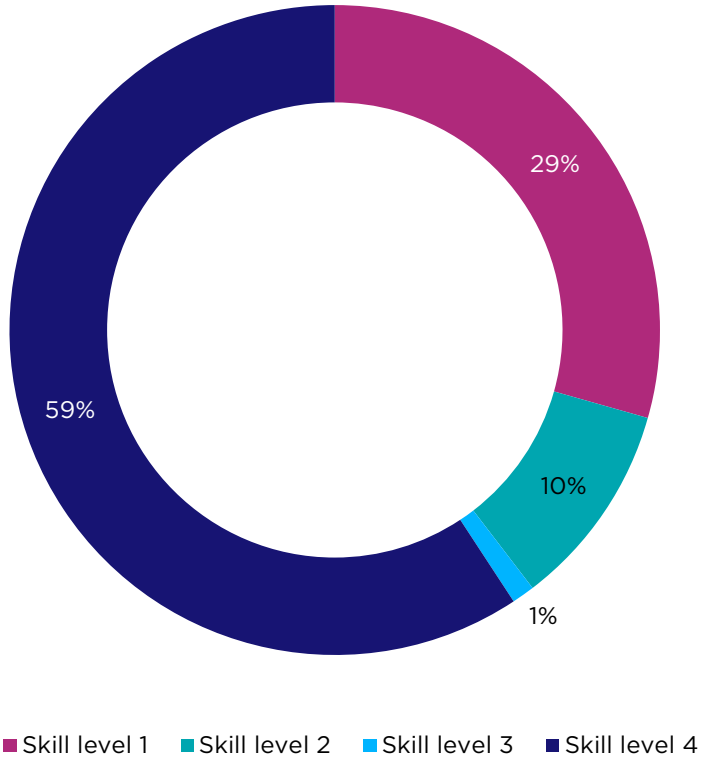
The mental health workforce is more difficult to define as there are no specific industries that mental health workers are attached to within ANZSIC. While it is possible to identify specialised mental health occupations such as *Psychiatrists*, *Psychologists*, mental health nurses and *Social workers*, other occupations are generalist and only part of the job may be focused on mental health. These occupations include *General practitioners and resident medical officers*, Allied health professionals, *Indigenous health workers* and nurses. The approach used to identify occupations in the mental health workforce is discussed further in Part 12.

3.2 A range of different occupations at different skill levels and industries

Care and support occupations are across a range of different skill levels (Figure 37 and Table 1).

- Nine of the 15 care and support occupations are skill level 1 (commensurate with a bachelor degree or higher qualification) and this accounts for approximately 29% of the total care and support workforce. This skill level includes all Registered nurses, Health and welfare managers and Allied health professional occupations.
- Four occupations are skill level 2 (commensurate with an Advanced diploma or diploma level qualification) or skill level 3 (commensurate with a certificate III with at least 2 years of on-the-job training, or a certificate IV level qualification) and together make up approximately 11% of the total care and support workforce.
- Personal care and support workers are skill level 4 occupations[67] (commensurate with a certificate II or III level qualification, or at least one year of relevant experience). Combined, the 2 occupations in this group make up the majority of employment within the care and support workforce (59%).

Figure 37: Distribution of care and support occupations by skill level, February 2021



Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Population: 15 in-scope occupations (ANZSCO 4-digit level) across 3 in-scope industries (ANZSIC 3-digit level). Proportions do not add to 100% due to rounding.

[67] ANZSCO (Version 1.3) classifies *Aged and disabled carers* as skill level 4 but notes that some roles within the occupation are skill level 3.

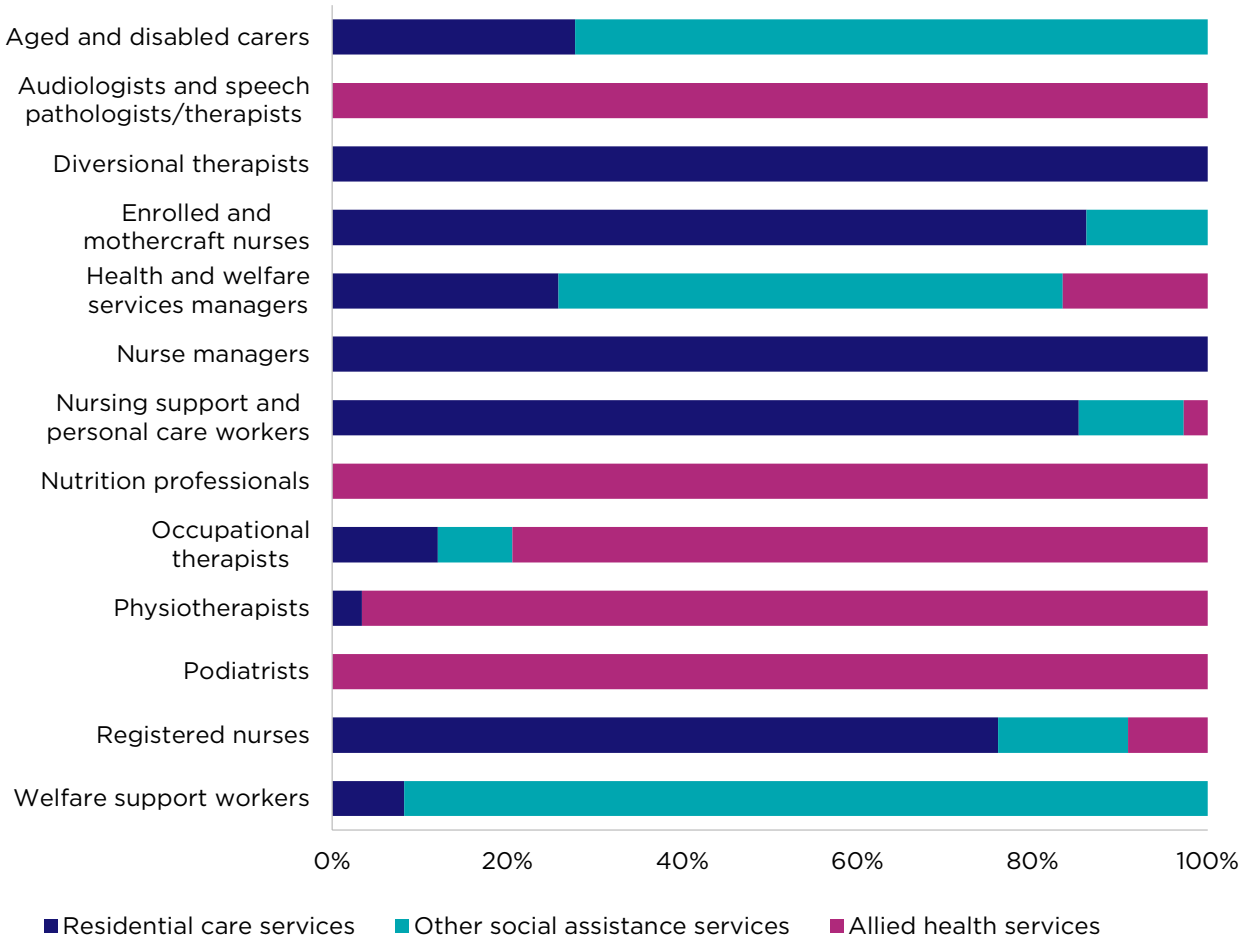
Table 1: In-scope care and support occupations by occupation group, skill level, employment size and share of employment in care and support industries, February 2021

ANZSCO code	Occupation	Skill level	Employment size	Share of employment
Personal care and support workers				
4231	Aged and disabled carers	4*	211,000	46%
4233	Nursing support and personal care workers	4	59,800	13%
Health and welfare support workers				
4117	Welfare support workers	2	37,700	8%
4114	Enrolled and mothercraft nurses	2	6,300	1%
4113	Diversional therapists	3	5,000	1%
4115	Indigenous health workers	2	N/A**	<1%
2724	Social professionals	1	N/A**	<1%
Registered nurses				
2544	Registered nurses	1	53,500	12%
Allied health professionals				
2525	Physiotherapists	1	22,300	5%
2524	Occupational therapists	1	14,000	3%
2527	Audiologists and speech pathologists/therapists	1	9,700	2%
2526	Podiatrists	1	5,200	1%
2511	Nutrition professionals	1	2,800	<1%%
Health and welfare managers				
1342	Health and welfare services managers	1	20,600	4%
2543	Nurse managers	1	3,100	<1%

Source: ANZSCO, 2013, Version 1.3; ABS Participation, Job Search and Mobility, 2021, Occupation of current main job and Industry of current main job by reference year. Population: 15 in-scope occupations (ANZSCO 4-digit level) across 3 in-scope industries (ANZSIC 3-digit level). Cells in this table have been randomly adjusted to avoid the release of confidential data. Discrepancies may occur between sums of the component items and totals. *ANZSCO (Version 1.3) classifies Aged and disabled carers as skill level 4 but notes that some roles within the occupation are skill level 3. **Data cannot be estimated due to low counts.

The care and support workforce is distributed across 3 in-scope industries. Figure 38 shows in-scope occupations are more concentrated in certain industry settings compared with others. For example, most *Aged and disabled carers* work in the *Other social assistance services* industry while the remainder work in the *Residential care services* industry. As expected, a majority of Allied health professionals work in the *Allied health services* industry.

Figure 38: Distribution of care and support occupations by in-scope industries, February 2021



Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. *Other social assistance services* is a 3-digit industry which consists of businesses engaged in the provision of a wide variety of social support services directly to their clients (outside of accommodation services, except on a short stay basis). This includes aged care assistance services, disabilities assistance services and welfare counselling services. See Figure 2 for further detail.

While much of the analysis presented in this Study refers to the care and support workforce within in-scope industries, some analysis using MADIP and ATO data encapsulates workers across all industries. Therefore, it is important to keep in mind there may be some variance between the broader trends presented in these analyses compared with the care and support industries. This is particularly important for occupations such as *Enrolled and mothercraft nurses*, *Indigenous health workers*, *Nurse managers*, *Registered nurses* and *Social professionals* where a large majority of people working in these occupations are employed in industries outside the scope of this Study.

Multi-Agency Data Integration Project (MADIP)

MADIP is a secure data asset combining information on health, education, government payments, income and taxation, employment, and population demographics (including the Census) over time. MADIP was first established in 2015 in response to a review of the Australian Government arrangements for data integration that found more focus was needed to access the substantial value inherent in public data.

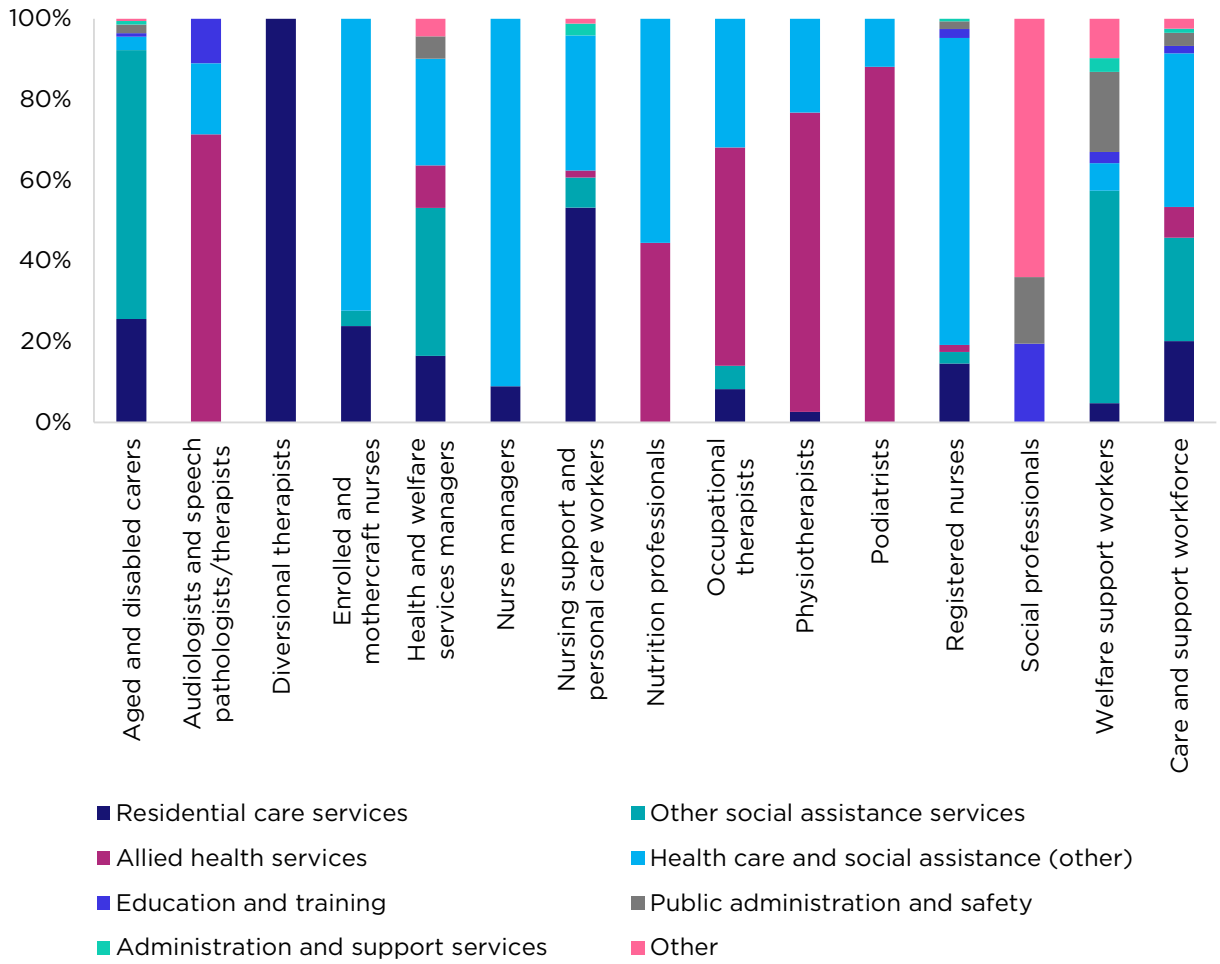
MADIP data is accessed in a secure IT environment by authorised researchers to look at patterns and trends in the Australian population and provide new insights into the development and evaluation of government policies, programs and services.

MADIP data has been used in this Study to provide more detailed data on some of the key characteristics of people working in care and support occupations, such as median wage, age and gender, and duration within an occupation.

The majority of analysis included in this Study uses Personal Income Tax (PIT) data (accessed via MADIP) for the period 2010-11 to 2018-19. The scope of the PIT data includes all persons that the ATO determined were Australian residents during this time[68] and who submitted a tax return for that financial year. As administrative by-product data, this information should be interpreted with caution, particularly noting that some records may be missing (where a PIT has not been completed), and that occupation is self-reported and auto-filled after the initial year of inputting this information.

A key limitation of the use of MADIP data in this Study is that all data is presented on an occupation-basis. That is, data is included for all industries and may limit the value of analysis for some occupations where a significant proportion of the workforce is engaged outside the in-scope care and support industries (Figure 39).

Figure 39: Distribution of care and support occupations by all industries, February 2021



Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. *Other social assistance services* is a 3-digit industry which consists of businesses engaged in the provision of a wide variety of social support services directly to their clients (outside of accommodation services, except on a short stay basis). This includes aged care assistance services, disabilities assistance services and welfare counselling services. See Figure 2 for further detail.

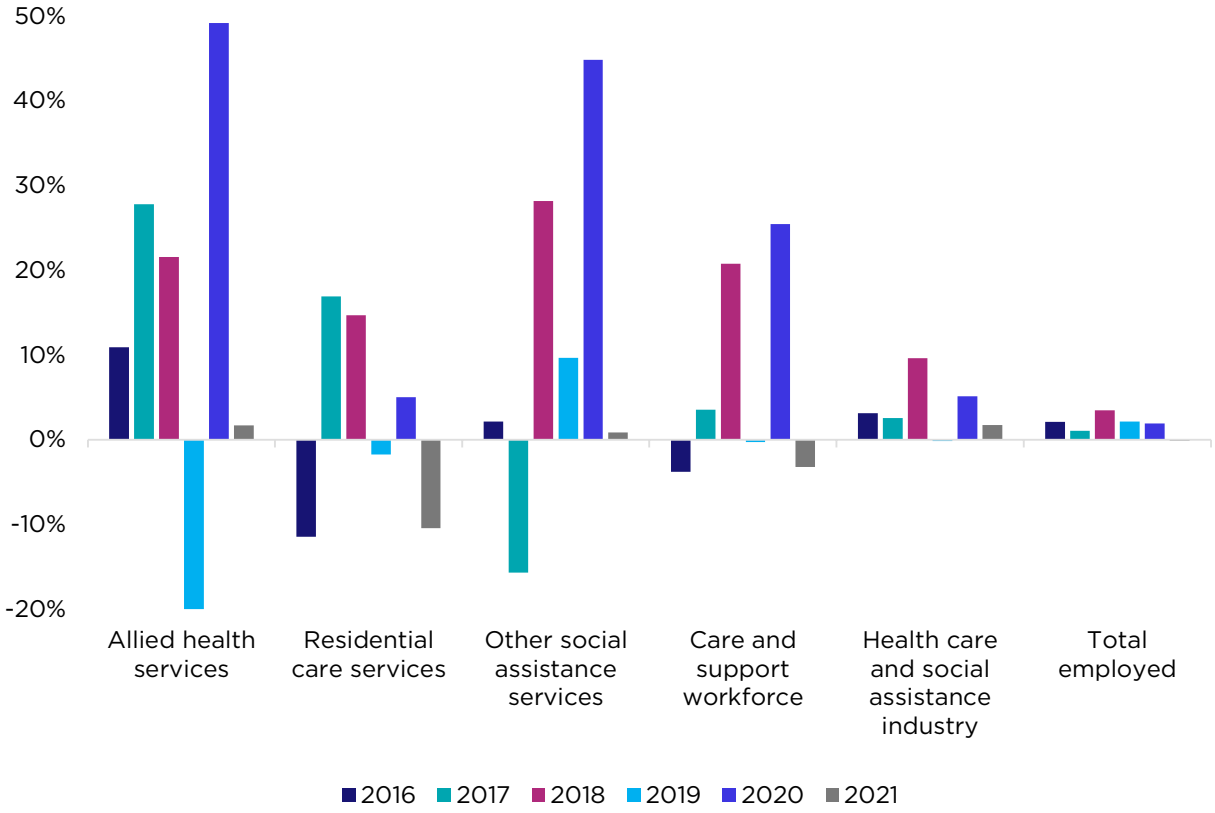
[68] Includes people who have been in Australia for more than half the financial year, had been in Australia continuously for 6 months or more and for most of that time had been working and living in the same place and overseas students enrolled in a course of study for more than 6 month's duration.

3.3 Growth in the care and support workforce

Growth in the care and support workforce is 3 times faster than the Australian workforce. This reflects the ongoing increase in demand for care and support, and particularly in recent years the introduction and subsequent expansion of the NDIS. The number of care and support workers employed in the in-scope industries – *Residential care services*, *Other social assistance services* and *Allied health services* - grew from around 314,000 to around 460,000 (or 46%) between February 2015 to February 2021. This far outpaced the total employment growth in Australia over the same period (11%), and also that across the broader *Health care and social assistance* industry (24%).

Across the in-scope industries, growth was relatively volatile on an annual basis (Figure 40), with strong annual growth recorded in some industries and for some years across the period.

Figure 40: Annual growth of care and support industries, February 2016 to February 2021

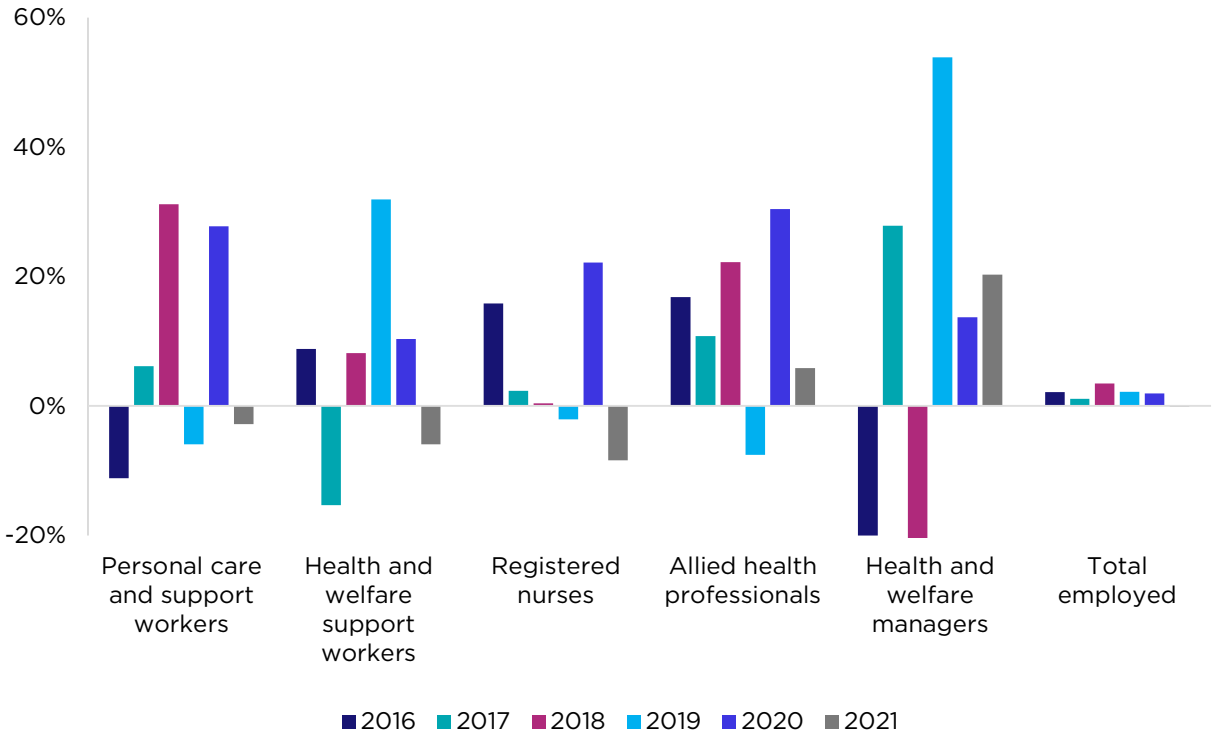


Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. *Allied health services*, *Residential care services* and *Other social assistance services* includes the 15 in-scope ANZSCO 4-digit occupations within 3 in-scope ANZSIC industries. *Other social assistance services* is a 3-digit industry which consists of businesses engaged in the provision of a wide variety of social support services directly to their clients (outside of accommodation services, except on a short stay basis). This includes aged care assistance services, disabilities assistance services and welfare counselling services. See Figure 2 for further detail.

All care and support roles are growing, but not at the same rate. Allied health professionals have grown the fastest and are now over double their 2015 size (102%). Personal care and support workers and Registered nurses have also grown rapidly (44% and 30%, respectively). Health and welfare managers and Health and welfare support workers have grown by 68% and 37% respectively, well above the average for total employed.

In actual size, Personal care and support workers has grown the most in level terms, seeing an additional 83,700 workers over 6 years. In comparison, there were only around 29,100 additional Allied health professionals over this time.

Figure 41: Annual growth of care and support workforce, by occupation group, February 2016 to February 2021



Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. *Allied health services*, *Residential care services* and *Other social assistance services* includes the 15 in-scope ANZSCO 4-digit occupations within 3 in-scope ANZSIC industries. *Other social assistance services* is a 3-digit industry which consists of businesses engaged in the provision of a wide variety of social support services directly to their clients (outside of accommodation services, except on a short stay basis). This includes aged care assistance services, disabilities assistance services and welfare counselling services. See Figure 2 for further detail.

3.4 Emerging roles across the care and support workforce

Changes in technology, business requirements, and consumer preferences and needs drive the creation of new roles and the evolution of existing ones. This can involve existing roles acquiring different skill sets that are distinct to its traditional job description or an emergence of a role that is hybridised by 2 different roles. Certain skills may also start to emerge in an occupation to respond to social, cultural, and economic challenges and opportunities.

- An example of this is how a range of behavioural and psychosocial conditions place increasing importance on competencies across dementia and mental health. The skills used by the care and support workforce are detailed in Part 6.

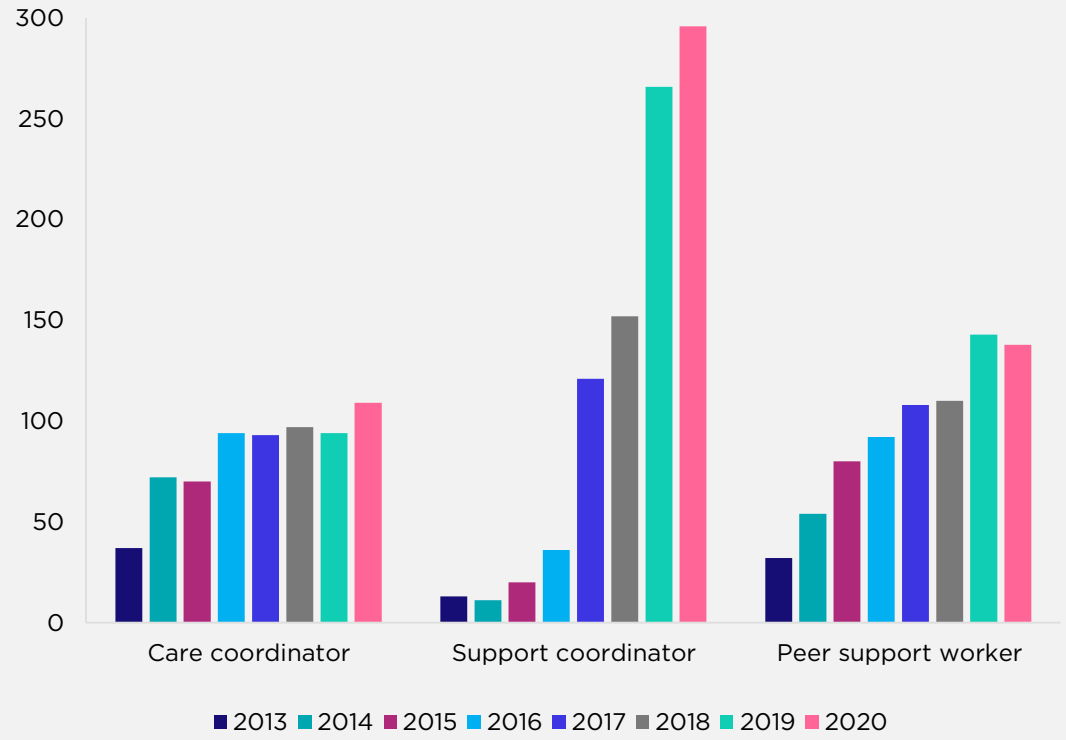
By identifying emerging skills and looking at how these skills change existing jobs, we can identify emerging or new jobs in the labour market. Emerging occupations are defined as new, frequently advertised jobs which are substantially different to occupations already defined in ANZSCO.

Throughout the Study a broad range of job titles have been used by stakeholders to identify the occupations within the care and support workforce, which may not align precisely with occupation titles in ANZSCO. Examples include peer support workers, allied health assistants, care coordinators, and support coordinators. Similarly, a range of job titles in mental health were identified, including lived experience (peer) workers, psychosocial support workers, and Indigenous mental health workers. These likely reflect the evolving models of care and support and the job roles needed to deliver it, with most, but not all, mapping to existing ANZSCO occupation titles based on their job descriptions. For those job titles which do not map well to an existing ANZSCO occupation it may indicate an emerging role.

New roles in the care and support workforce are potentially emerging: care coordinators, support coordinators and peer support workers

The number of job advertisements for care coordinators has almost tripled since 2013 and support coordinators has grown by almost 2200% (off a low base) over the same period (Figure 42). More importantly, the role of support coordinators grew by over 236% between 2016 and 2017, which can be attributed to the NDIS national roll-out and has continued to grow year on year. In mental health, the role peer support workers (sometimes referred to as lived experience workers) has emerged and grown over time. In 2020 there were over 4 times as many online job advertisements for this role compared with 2013. Given the nature of these roles it is likely these are more than just emerging job titles and may be emerging occupations as their job descriptions and skills profiles are unique to other occupations in ANZSCO.

Figure 42: Number of online job advertisements for care coordinators, support coordinators, and peer support workers between 2013 and 2020



Source: NSC analysis, Burning Glass Technologies.

Based on descriptions from online job advertisements, care coordinators may work across hospital, residential and community settings for aged and disability care. Support coordinators primarily work in residential and community settings for disability care. As defined by the NDIS, support coordinators assist NDIS participants to connect with providers in accordance with their funding arrangements and care plans. The key difference between care and support coordinators and other Health and welfare support workers is that they play a critical role in planning care for clients and managing relationships with care providers. Further to this, they may require extensive knowledge of private and public insurance schemes to ensure the provision of care is adequately funded.

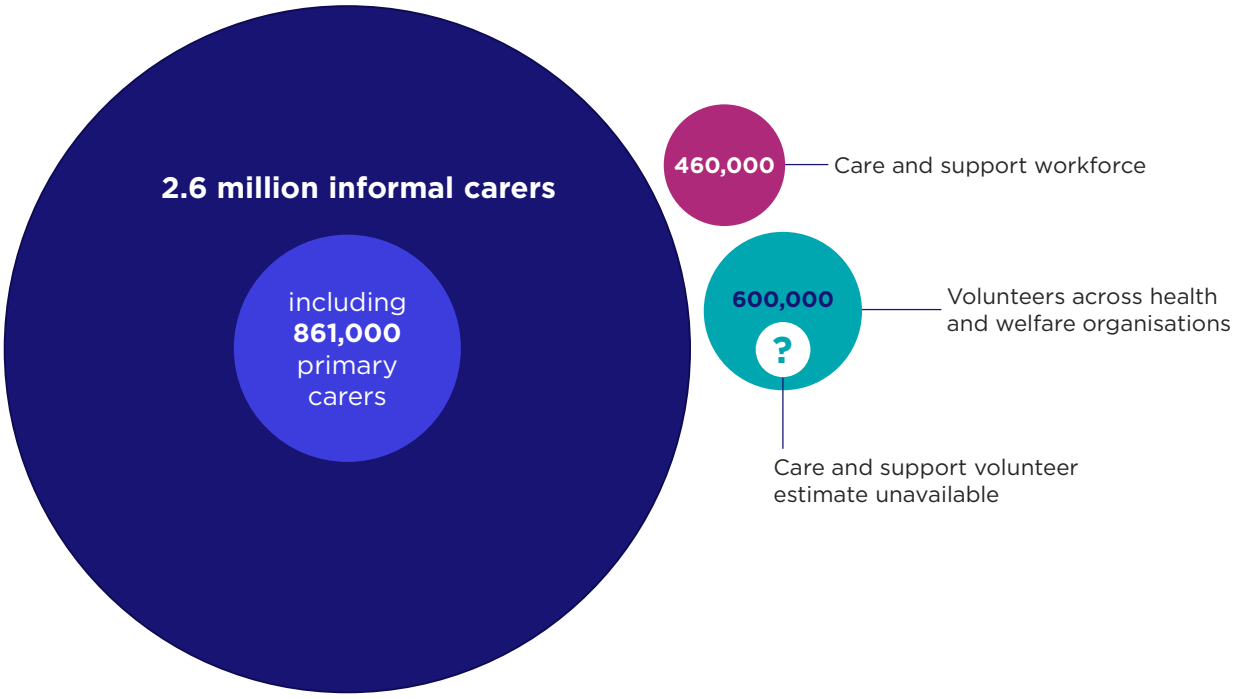
Emerging occupations in the care and support workforce has implications for individuals accessing up to date training to meet job expectations and regulatory requirements, for training providers to deliver the necessary skills for the workforce, and for employers to undertake effective workforce planning.

3.5 The ancillary and informal care and support workforce

Carers and volunteers make an invaluable and important contribution to the delivery of care and support (Figure 43). While outside the direct scope of this Study, it is acknowledged that a significant amount of care and support is provided by an informal workforce.

Complementary to the formal care and support workforce is the ancillary workforce and its role in facilitating delivery of care and support services, such as cooking, cleaning, transport and business administration.

Figure 43: Relative size of the informal care and support workforce



Source: ABS SDAC, 2018; ABS Longitudinal Labour Force Survey, 2021; ABS General Social Survey, 2020.

Informal carers are those that provide unpaid assistance to a family member or friend who are frail, aged, or have a mental illness, disability, chronic condition, terminal illness or other health condition. This might include support with daily activities, physical and personal care, personal mobility, transport or communication.

The 2018 SDAC estimated there were around 2.6 million carers in Australia, equating to almost 1 in 10 Australians. Of these, around a third (861,600) are primary carers (the person providing the main source of assistance and support to an individual requiring care). Primary carers are more likely to be female (72%), older (an average of 54 years), have disability or activity limitation themselves (37% compared with 15% of non-carers) and a lower income.[69]

Deloitte Access Economics estimated the annual replacement value of informal care to be $77.9 billion in 2020. Their analysis also indicates that the propensity to care has been declining over the last 20 years.[70] This demonstrates the critical foundation informal carers provide to care and support and highlights that reductions in the propensity of informal care has the potential for additional workforce demand pressures.

It is difficult to estimate the number of volunteers who contribute their time to care and support organisations. In 2020, around 606,700 people volunteered through a health or welfare related

[69] ABS, Disability, Ageing and Carers, Australia: Summary of Findings, 2018

[70] Deloitte Access Economics, *The value of informal care in 2020*, 2020

organisation in the previous 12 months,[71] noting that this would be a considerable overestimate as it includes a wide range of out-of-scope industry sectors. The 2016 NACWCS estimated there were around 23,500 volunteers in residential aged care and a further 44,900 in home care.[72] The 2020 ACWC[73] shows that the number of volunteers working across all aged care programs has declined, likely due to the COVID-19 pandemic, with only 11,980 volunteers providing support at residential aged care facilities – almost half the number compared with 2016. HCPP and CHSP providers also report a decline in the number of volunteers due to the COVID-19 pandemic although the extent of decline has been smaller. While not fully representative of the entire disability sector, the National Disability Services (NDS) State of the Disability Sector annual market survey found that 58% of disability organisations used volunteers in 2020.[74]

Volunteers contribute through augmentation of the paid care and support workforce. A small proportion of businesses may also use volunteers to assist in mitigating skill shortages. In the aged care sector in 2016, of those aged care providers affected by skill shortages, a small proportion reported using volunteers as a response (5.9% in residential aged care and 9.5% in home care and support settings).[75]

The ABS General Social Survey, while not specific to the health sector, suggests that the overall propensity to volunteer is decreasing. Between 2006 and 2019, the proportion of people who had undertaken unpaid voluntary work through an organisation in the 12 months prior had declined from 34% to 25%.[76] The overall impact of a declining propensity to volunteer is complex as it is interlinked with changes in participation rates and demographics, but a continuing long-term decline is a potential further pressure on demand for the care and support workforce.

[71] ABS, General Social Survey, Summary Results, Australia, 2020, 2021

[72] Kostas Mavromaras, et al., *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce*, 2017

[73] Department of Health, National Aged Care Workforce Census 2020, 2021

[74] NDS, *State of the Disability Sector Report 2020*, 2020

[75] Mavromaras, et al., *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce*, 2017

[76] ABS, General Social Survey, Summary Results, Australia, 2020, 2021

Part 4
Demographic characteristics of the care and support workforce

Part 4 outlines the broad demographic characteristics of the care and support workforce. While there are differences between occupations, in general the care and support workforce is much more likely to be female, more likely to be a recent migrant and slightly older than the broader Australian workforce.

That said, and of interest over recent years has been the increase in males (noting this is off a relatively low base), and younger people in the care and support workforce. This has occurred against the backdrop of rapid growth in the workforce.

While not wanting to overplay these recent trends, as they may not be sustained and given the majority of the care and support workforce are female and older than the Australian average, they nonetheless suggest that the labour market may have been dynamic in finding a new supply of workers for the sector during a recent period of rapid growth.

The care and support workforce is predominantly female

The care and support and mental health workforces have a higher share of female workers than the broader Australian workforce, with women accounting for around 79% of the care and support workforce, and 82% of the mental health workforce in February 2021.

The high proportion of female workers in the care and support workforce is a consistent theme across all OECD countries. In fact, compared with the OECD average, females comprise a marginally lower proportion of the care and support workforce in Australia.

The proportion of female Personal care and support workers (77%) is relatively lower than for most other care and support occupations, with the number of men employed as Personal care and support workers increasing by 67% from February 2015 to February 2021 and outpacing the 40% growth for women.

- As most of the increase in male participation has occurred in the last few years, detailed data are not yet available to determine drivers for this change. The timing would, however, tend to suggest the roll-out of the NDIS may have had an impact.

Relative to females, males are more likely to be employed in a lower skill care and support role.

- Around 64% of male care and support workers were in a job with a skill level classification of 3 or 4 in February 2021, compared with 59% of females in the workforce. (Again, however, it is important to note that men currently account for a fraction of the care and support workforce.)

And has a greater share of recent migrants, and is culturally and linguistically diverse

The care and support workforce is culturally and linguistically diverse with around 40% of workers (or 183,000) born overseas – higher than the share across the overall Australian workforce (32%). This proportion has steadily increased over the last 15 years.

- Many care and support workers who were born overseas have been in Australia for at least a decade.

- In February 2021, there were around 54,000 recent migrants – defined in the Study as overseas-born people who arrived in Australia within 10 years from the time of survey – accounting for around 12% of the care and support workforce. In comparison, there were around 126,000 non-recent migrants (or 28%) and 277,000 (or 60%) care and support workers born in Australia.

Other OECD countries are also heavily reliant on workers who are born overseas. While noting the considerable variation across countries, OECD analysis suggests that Australia has a relatively high share of foreign-born workers (29%) compared with the OECD average (23%) for the long-term care workforce.

Recent migrants in the care and support workforce tend to be much younger than their counterparts – contributing to the decline in average age of the workforce in recent years. Care and support workers born overseas are also more likely to be male compared with their Australian-born counterparts.

The OECD highlights that the recruitment of overseas-born workers in a number of member countries is commonly drawn from people that have arrived through 'non-economic' visa channels. That is also the case in Australia.

The care and support workforce is slightly older than the broader Australian workforce

The care and support and mental health workforces have historically been relatively older than the overall Australian workforce, with an average age around 43 years over February 2015 to February 2021. This is slightly older than the average age for workers in the *Health care and social assistance* industry (42 years) or for all employed Australians (40 years) over the same period.

- The older age profile of the care and support workforce in Australia is consistent with international trends. In 2016, the median age of long-term care workers in the OECD (45 years) was around 1.5 years above the median OECD workforce age.

That said, the average age for the care and support workforce has gradually declined over time, falling from around 44 years in February 2015 to around 42 years by February 2021. This decline in average age corresponds with a rise in the number of younger people entering care and support occupations over the same period.

The distribution of the care and support workforce by skill level differs across the age groups. While younger workers (aged 15-24 years) are most likely to be engaged in the care and support workforce within skill level 4 occupations, those aged 25–44 years are relatively more likely to be working in skill level 1 and 2 occupations.

Regional shares have remained broadly stable over recent years

The regional share of the care and support workforce has remained relatively stable over the last decade with around 39% of the workforce employed in regional areas (i.e. all areas outside of capital cities) in 2021. In contrast, the regional share of total employment has declined over the same period, apart from a recent COVID-19 related lift.

- However, the share of workers employed outside capital cities in other *Health care and social assistance* industries (that is, those outside the care and support sector) is much higher than that in the care and support sector.
- This aligns with the views of stakeholders, who cited greater difficulties in recruiting for care and support workers in regional areas compared with other health workers.

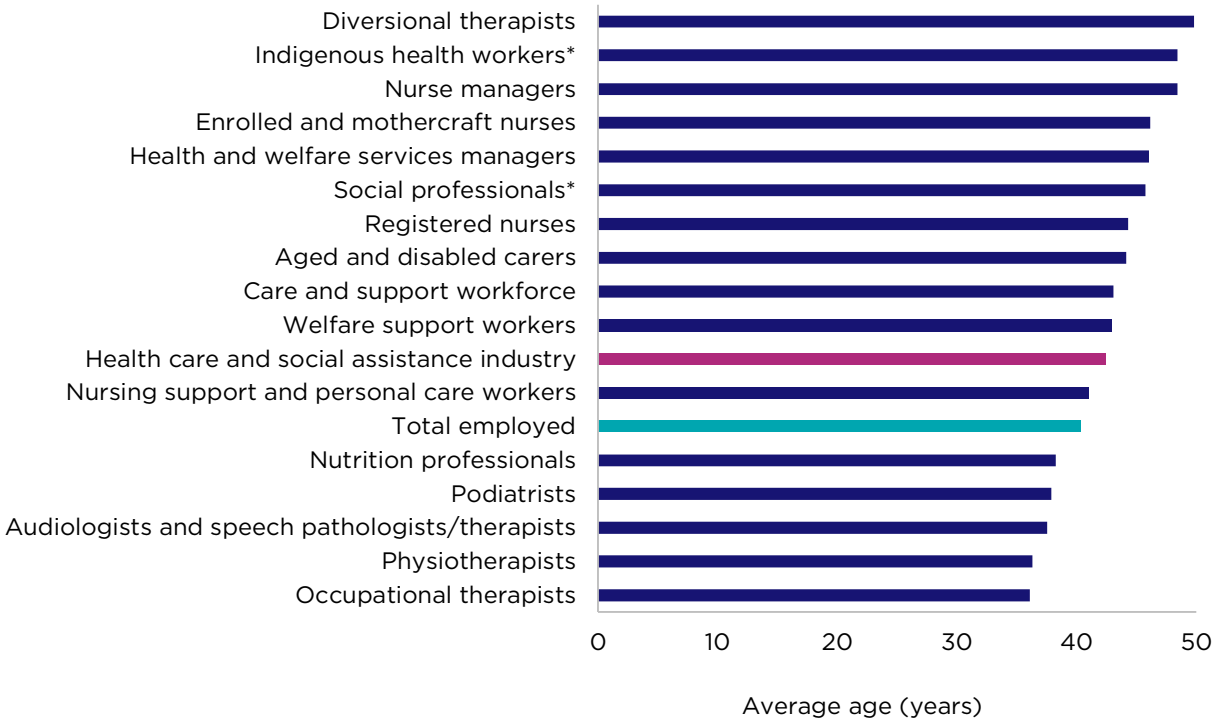
4.1 The care and support workforce is relatively older, but the age profile is changing

The care and support and mental health workforces have historically been relatively older than the overall Australian workforce, with an average age around 43 years between February 2015 to February 2021 (Figure 44). This is slightly older than the average age for workers in the *Health care and social assistance* industry (42 years) or for all employed Australians (40 years) over the same period.[77]

Between February 2015 and February 2021, female care and support workers were, on average, aged around 44 years, compared with around 40 years for males.[78] This is partly attributed to the high concentration of older females in most care and support roles, particularly *Diversional therapists, Health and welfare services managers*, *Registered nurses*, and *Aged and disabled carers*. Allied health roles, in contrast, tend to attract younger workers – suggesting there is likely to be a steady workforce supply for these occupations over the next few decades.

The older age profile of the care and support workforce in Australia is consistent with international trends. In 2016, the median age of long-term care[79] workers in the OECD (45 years) was above the median OECD workforce age (by around 1.5 years). While the OECD notes that the long-term care workforce is ageing, between 2011 and 2016 the median age remained relatively stable across most OECD countries.[80]

Figure 44: Average age of care and support workforce, care and support industries, average February 2015 to February 2021



Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Average age is calculated as the average weighted mean age of occupations between February 2015 and February 2021. * The average age for

[77] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

[78] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

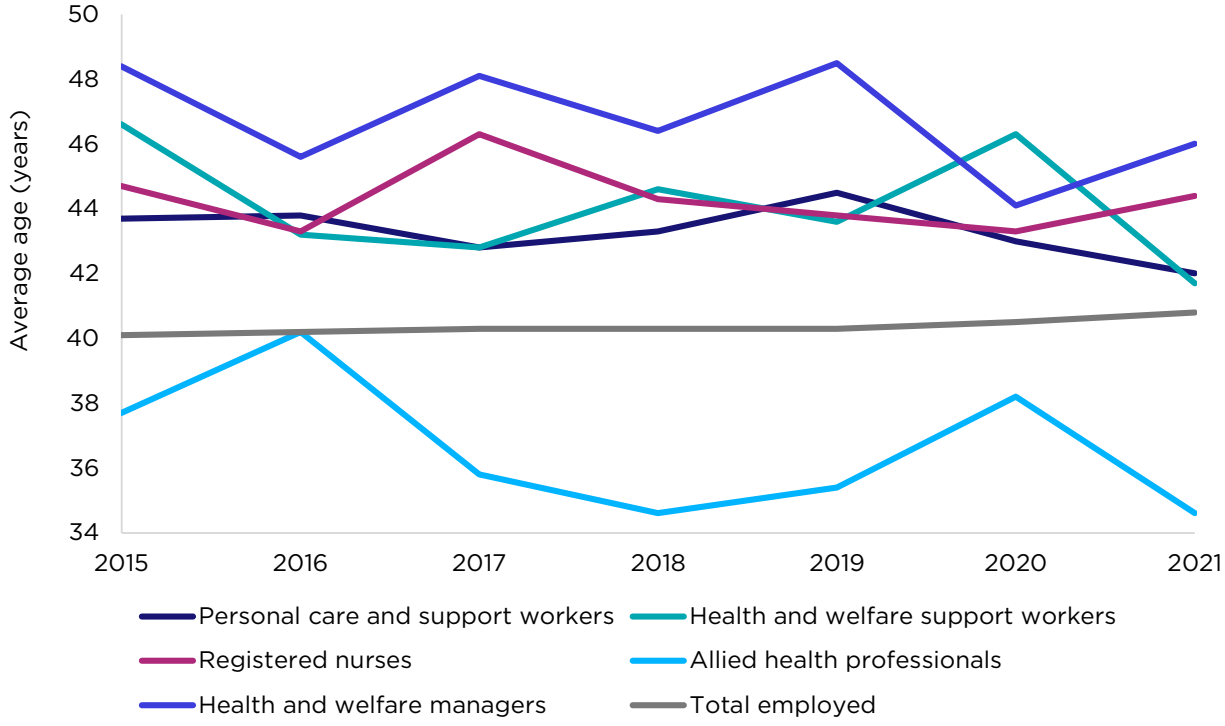
[79] Long-term care, as defined by the OECD, consists of a range of medical, personal care and assistance services that are provided with the primary goal of alleviating pain and reducing or managing the deterioration in health for people with a degree of long-term dependency, assisting them with their personal care and living independently. Long-term care workers are defined as those who provide care to long-term care recipients at home or in long-term care institutions (other than hospitals). Formal long-term workers comprise 2 main professional categories: nurses and personal care workers. While there is broad alignment, the definition used by the OECD is not consistent with those used in this Study.

[80] OECD, *Who Cares? Attracting and retaining care workers for the elderly*, 2020

Social professionals and *Indigenous health workers* is for people in all industries. Age for *Indigenous health workers* is the average weighted mean age for 2016, 2017, 2019 and 2020 only (availability of reliable data).

The average age of the Australian care and support workforce has gradually declined over time, falling from around 44 years in February 2015 to around 42 years by February 2021 (Figure 45). This trend is most pronounced among Health and welfare support workers, as well as Allied health professionals.[81]

Figure 45: Average age of the care and support workforce, by occupation group, in-scope industries, February 2015 to February 2021

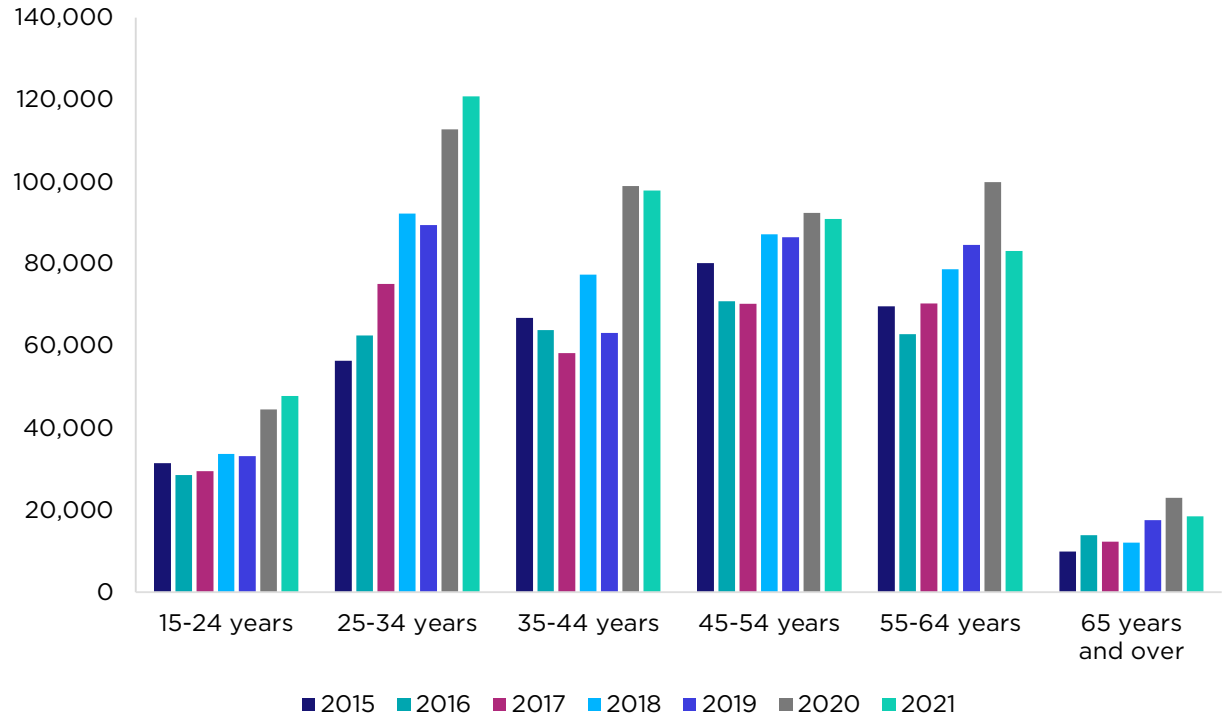


Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder.

The decline in average age corresponds with a rise in the number of younger people entering care and support occupations over the same period (Figure 46). Around 111,000 workers aged 15–44 years joined the care and support workforce between February 2015 and February 2021, compared with nearly 33,000 people aged 45 years and over.[82]

[81] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021
[82] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

Figure 46: Age distribution of the care and support workforce, in-scope industries, February 2015 to February 2021



Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder.

Despite the recent decline in average age, around 102,000 care and support workers were aged 55 years and over at February 2021, with many workers likely to retire over the next decade.

Detailed analysis of care and support occupations across all industries, contained in the data appendix to this Part, also shows the increase in the number of younger people entering many of these occupations in recent years, including *Aged and disabled carers*, *Enrolled and mothercraft nurses*, *Registered nurses (Aged Care)* and *Welfare support workers* (Figure 65 to Figure 86).

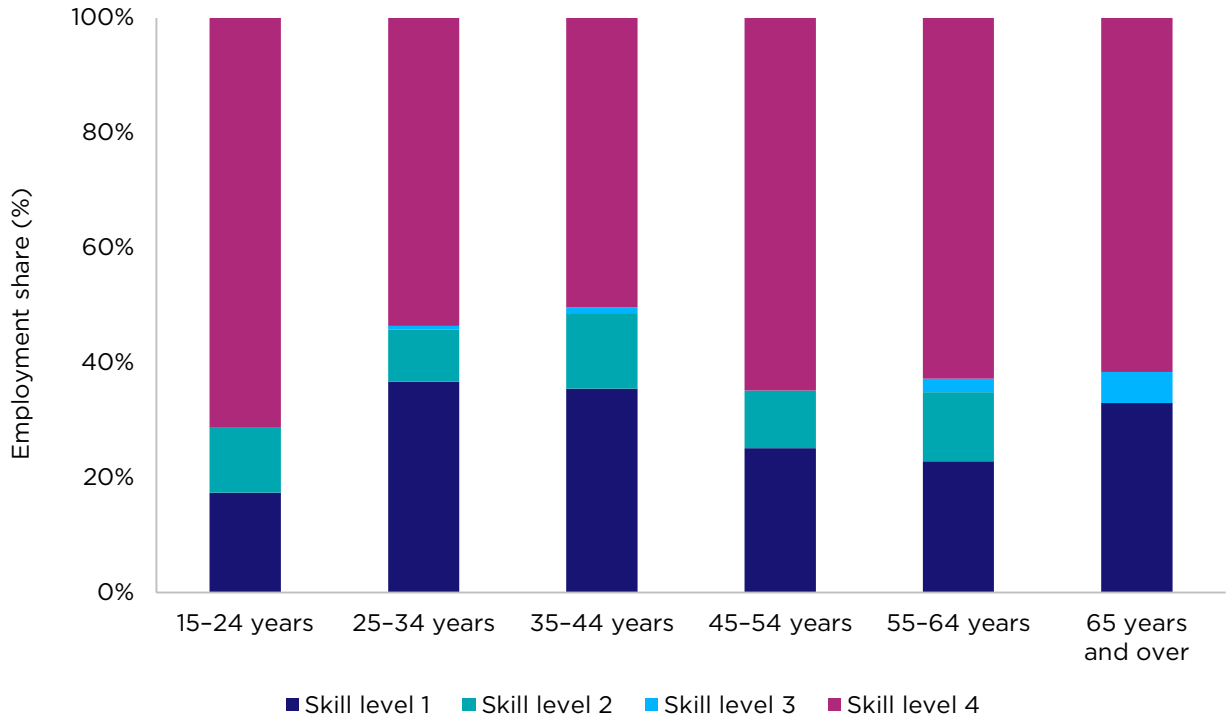
- In contrast to the data presented above, it is important to note that this analysis does not include an industry lens and therefore includes *all* people working in the specified occupations.

Despite this recent increase in younger people entering the workforce, the age structure of most occupations within the care and support workforce continues to be skewed towards the older age groups, particularly when compared with the total workforce. Exceptions to this are the Allied health professionals occupation group which has a much younger age structure, while *Welfare support workers* and *Social professionals* have a more evenly distributed age structure.

4.2 Higher representation of young and mature age workers in lower skill care and support roles

The distribution of the care and support workforce by skill level differs across the age groups (Figure 47). While younger workers (aged 15-24 years) are most likely to be engaged in the care and support workforce within skill level 4 occupations, those aged 25–44 years are more likely to be working in skill level 1 and 2 occupations, such as *Registered nurses* (although the majority are still engaged in skill level 4 occupations). The proportion working in skill level 4 occupations increases again for those aged 45 years and over, with around two-thirds of the workforce in the older age groups engaged in skill level 4 occupations.

Figure 47: Distribution of the care and support workforce by skill level and age, in-scope industries, February 2021

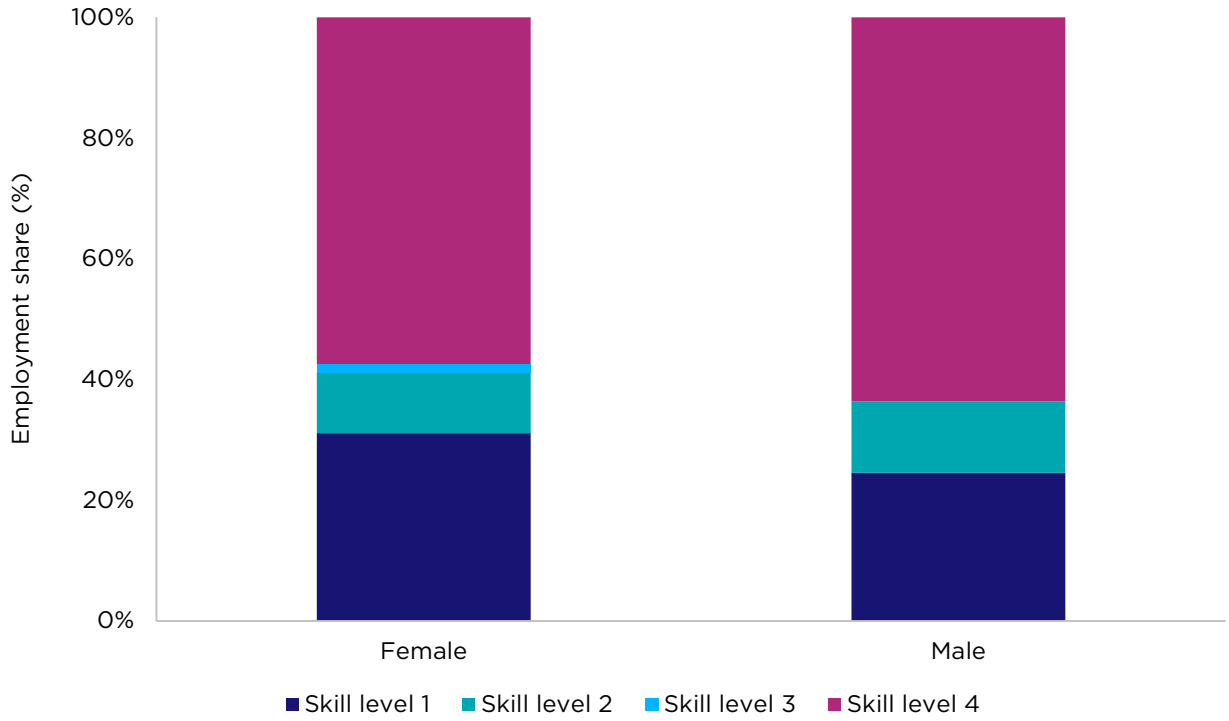


Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder.

Men are also more likely to be employed in a lower skill level care and support role. Around 64% of male care and support workers were in a job with a skill level classification of 3 or 4 in February 2021, compared with 59% of females in the workforce (Figure 48).[83] However, it is important to note that men currently account for a fraction of the care and support workforce.

[83] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

Figure 48: Distribution of the care and support workforce by skill level and gender, in-scope industries, February 2021



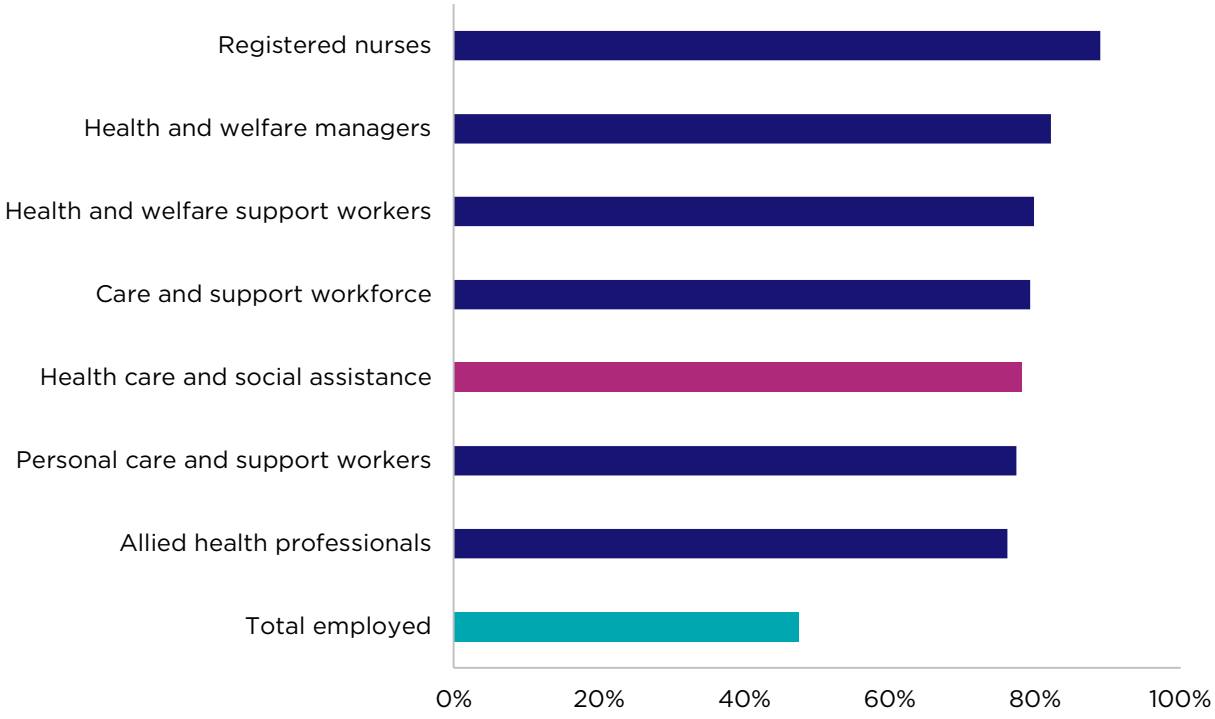
Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder.

4.3 Gender imbalance with a higher share of female workers

The care and support and mental health workforces have a higher share of female workers than the broader Australian workforce (Figure 49), with women accounting for around 79% of the care and support workforce, and 82% of the mental health workforce in February 2021.

The share of females in the care and support workforce has fallen slightly in recent years (from 82% in February 2015) and increased for the mental health workforce (from 77%). The concentration of female workers is highest among Registered nurses (89%) and lowest among Allied health professionals (76%) – although this is still much higher than for total employed (48%).[84]

Figure 49: Proportion of women in the care and support workforce, in-scope industries, February 2021

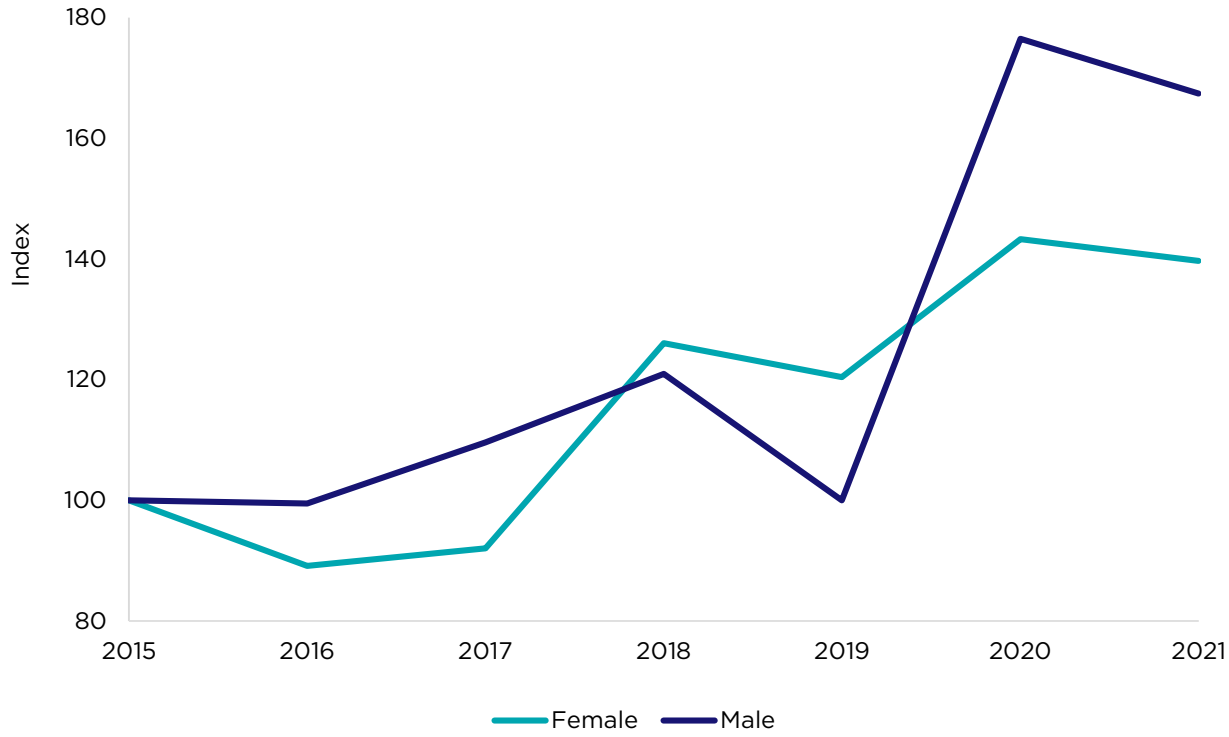


Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder.

The proportion of female Personal care and support workers (77%) is relatively lower than for most other care and support occupations. This may be attributed, in part, to the increase in male Personal care and support workers in recent years. Between February 2015 and February 2021, the number of men employed as Personal care and support workers increased by 67%, outpacing the 40% growth for women – albeit from a much lower base for men (who account for around 22% of Personal care and support workers).[85] As most of the increase in male participation has occurred in the last few years (Figure 50), and there is a lag in available granular data, the Study was unable to determine drivers for this change. The timing, however, tends to suggest the roll-out of the NDIS may have had an impact.

[84] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021
[85] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

Figure 50: Personal care and support workers employment index, by gender, in-scope industries, (100=February 2015)



Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder

The high proportion of female workers in the care and support workforce is a consistent theme across all OECD countries. OECD analysis of data from 2016 found that women account for around 90% of the long-term care workforce in OECD countries. Compared with the OECD average, females comprise a marginally lower proportion of the care and support workforce in Australia.[86]

[86] OECD, *Who Cares? Attracting and retaining care workers for the elderly*, 2020

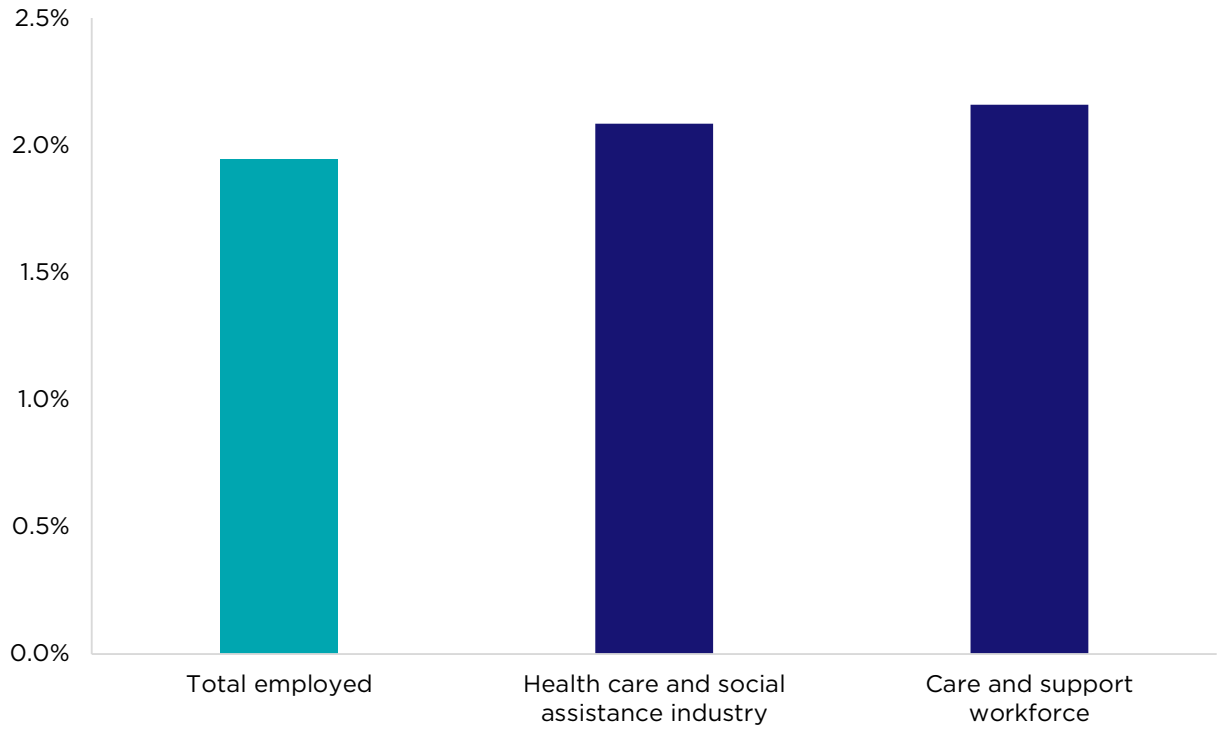
4.4 Aboriginal and Torres Strait Islander people

There is a slightly higher representation of Aboriginal and Torres Strait Islander workers in the care and support workforce than in other industries. As shown in Figure 51, in 2018-19 around 2.2% (just over 8,000) of the care and support workforce identified as Aboriginal and Torres Strait Islander, compared with around 2.1% (35,000) in the *Health care and social assistance* industry, around 1.9% (246,000) for total employed and around 1.4% (nearly 7,000) in the mental health workforce.[87]

Over half of the Aboriginal and Torres Strait Islander care and support workforce are employed as Personal care and support workers in the *Other social assistance services* industry. The majority of those in the mental health workforce are employed in non-medical occupations or as *Registered nurses*.[88]

In 2018-19, around 71% of Aboriginal and Torres Strait Islander care and support workers were female, compared with 76% of Aboriginal and Torres Strait Islander mental health workers.[89]

Figure 51: Proportion of Aboriginal and Torres Strait Islander workforce, 2018-19



Source: National Aboriginal and Torres Strait Islander Health Survey, 2018-19, and Qualifications and Work, 2018-19 in TableBuilder. Care and support workforce includes the 15 occupations within the 3 in-scope industries.

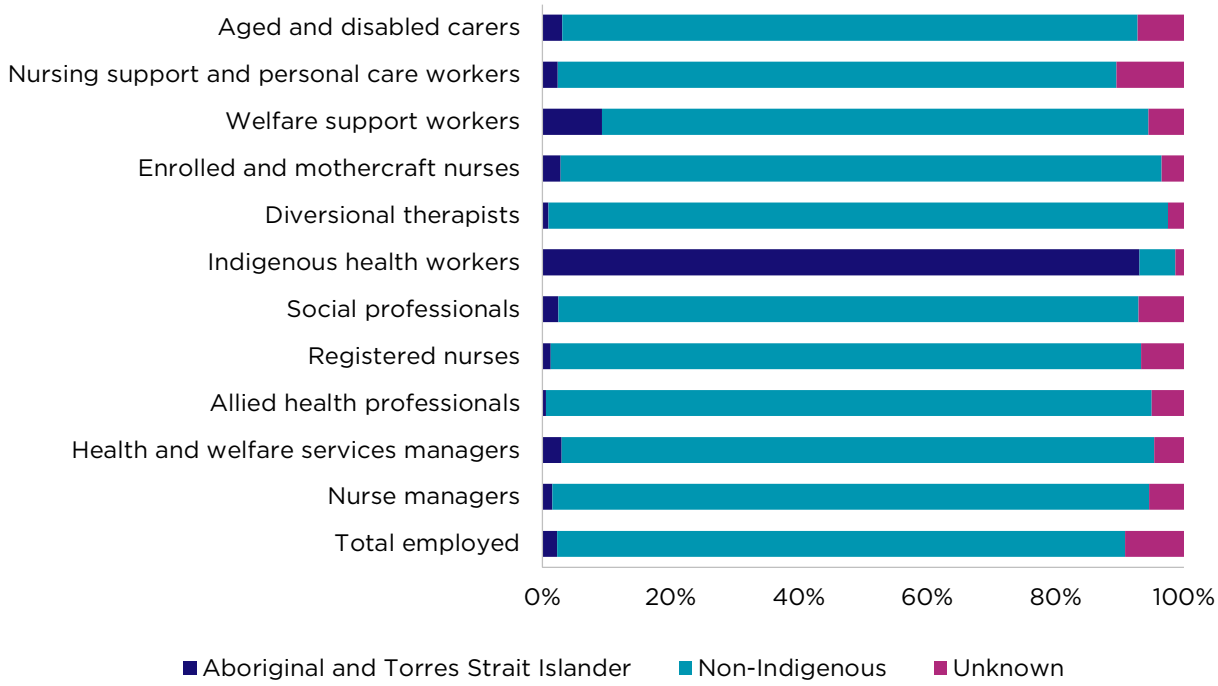
More detailed occupation analysis using MADIP shows the distribution of the Aboriginal and Torres Strait Islander workforce across the relevant care and support occupations (Figure 52). In 2018-19, approximately 2% of the total workforce were Aboriginal and Torres Strait Islander people. For the majority of care and support occupations, Aboriginal and Torres Strait Islander people comprised between 0.6% (Allied health professionals) to 9.3% (*Welfare support workers*), except for *Indigenous health workers* where they made up approximately 93.1% of the occupation in 2018-19.

[87] ABS, National Aboriginal and Torres Strait Islander Health Survey, 2018-19 financial year, 2019; ABS, Qualifications and work, 2018-19 [Tablebuilder], 2020

[88] ABS, National Aboriginal and Torres Strait Islander Health Survey, 2018-19 financial year, 2019

[89] ABS, National Aboriginal and Torres Strait Islander Health Survey, 2018-19 financial year, 2019

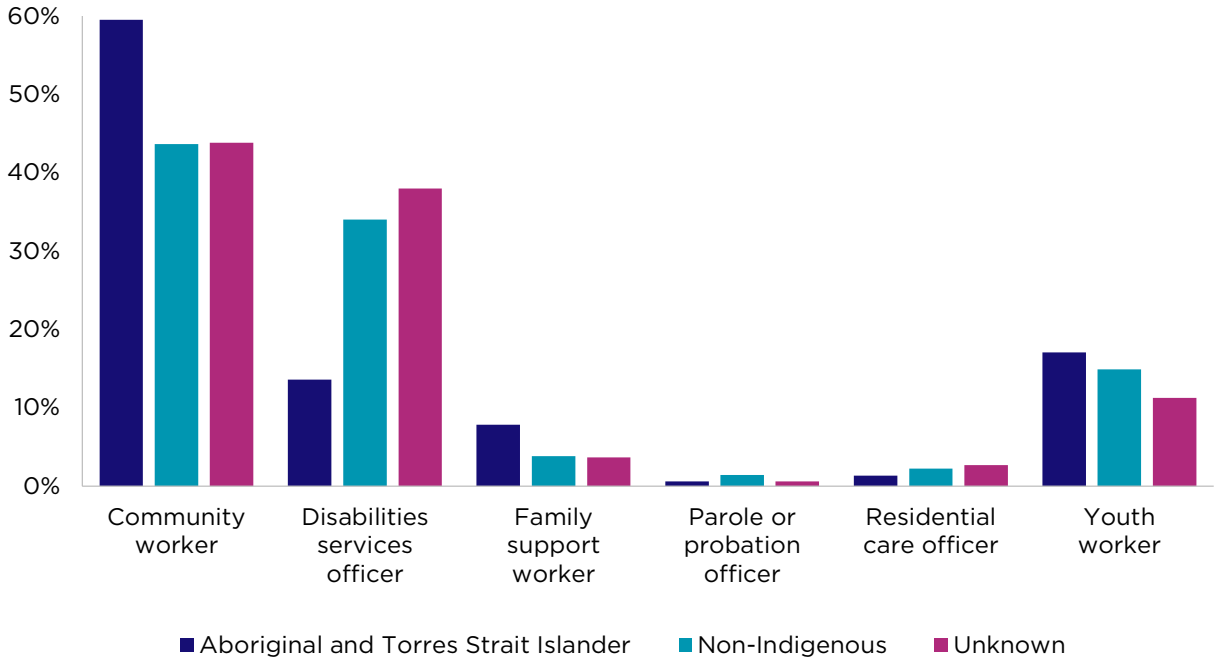
Figure 52: Care and support workforce, by occupation (all industries), share (%) by Indigenous status, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Care and support workforce includes the 15 occupations within the 3 in-scope industries.

Almost 1 in 10 (9.3%) of people working as *Welfare support workers* were Aboriginal or Torres Strait Islander in 2018-19, notably higher than the share of the total workforce (Figure 53). The majority (60%) of Aboriginal and Torres Strait Islander people working in the *Welfare support workers* occupation were employed as *Community workers*, while a further 17% were working as *Youth workers* and 14% as *Disability services officers*.

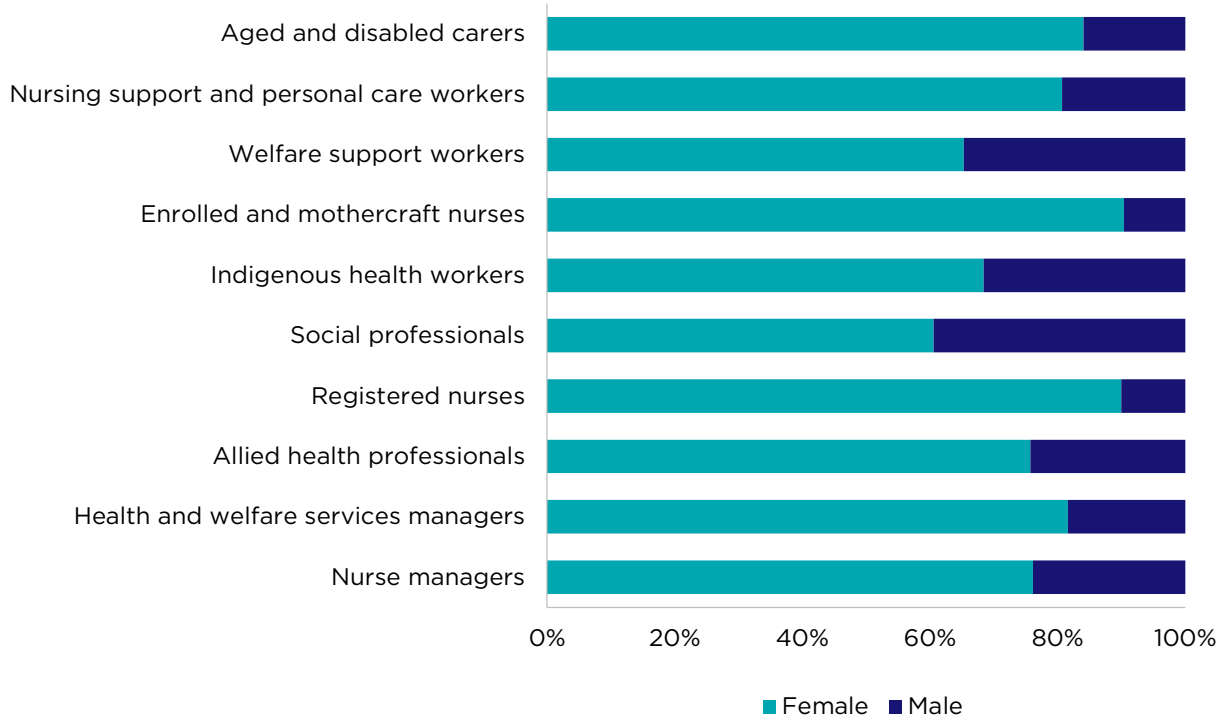
Figure 53: *Welfare support workers* - detailed occupations (all industries), share of *Welfare support workers* occupation (%), by Indigenous status, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

As with the total care and support workforce, the majority of Aboriginal and Torres Strait Islander people working in care and support occupations are female (Figure 54). Around 9 in 10 *Registered nurses* who identify as Aboriginal or Torres Strait Islander are female, compared with 68% of *Indigenous health workers* and 65% of *Welfare support workers*.

Figure 54: Care and support occupations (all industries), Indigenous, by gender (%), 2018-19



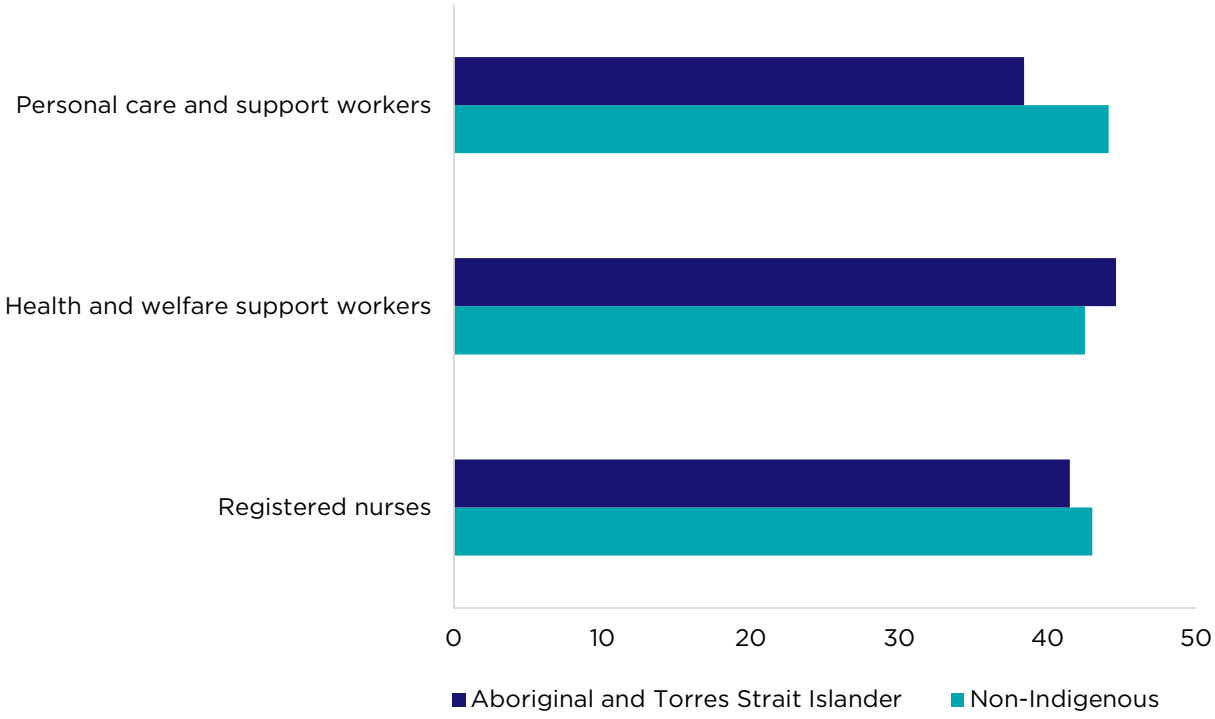
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Aboriginal and Torres Strait Islander care and support workers and mental health workers tend to be slightly younger than the average for these workforces (Figure 55).

In 2018-19, the average age of those employed in the care and support and mental health workforces who identified as Aboriginal and Torres Strait Islander were around 41 years and 42 years respectively, compared with an overall average of 43 years for workers in these workforces. There is some variance in age across occupations, with Aboriginal or Torres Strait Islander Personal care and support workers typically much younger than the overall average – around 38 years in 2018-19, compared with 44 years for all Personal care and support workers employed in care and support industries.[90]

[90] ABS, National Aboriginal and Torres Strait Islander Health Survey, 2018-19 financial year, 2019

Figure 55: Average age of care and support workers by Indigenous status, in-scope industries, 2018-19



Source: ABS *National Aboriginal and Torres Strait Islander Health Survey, 2018-19.*

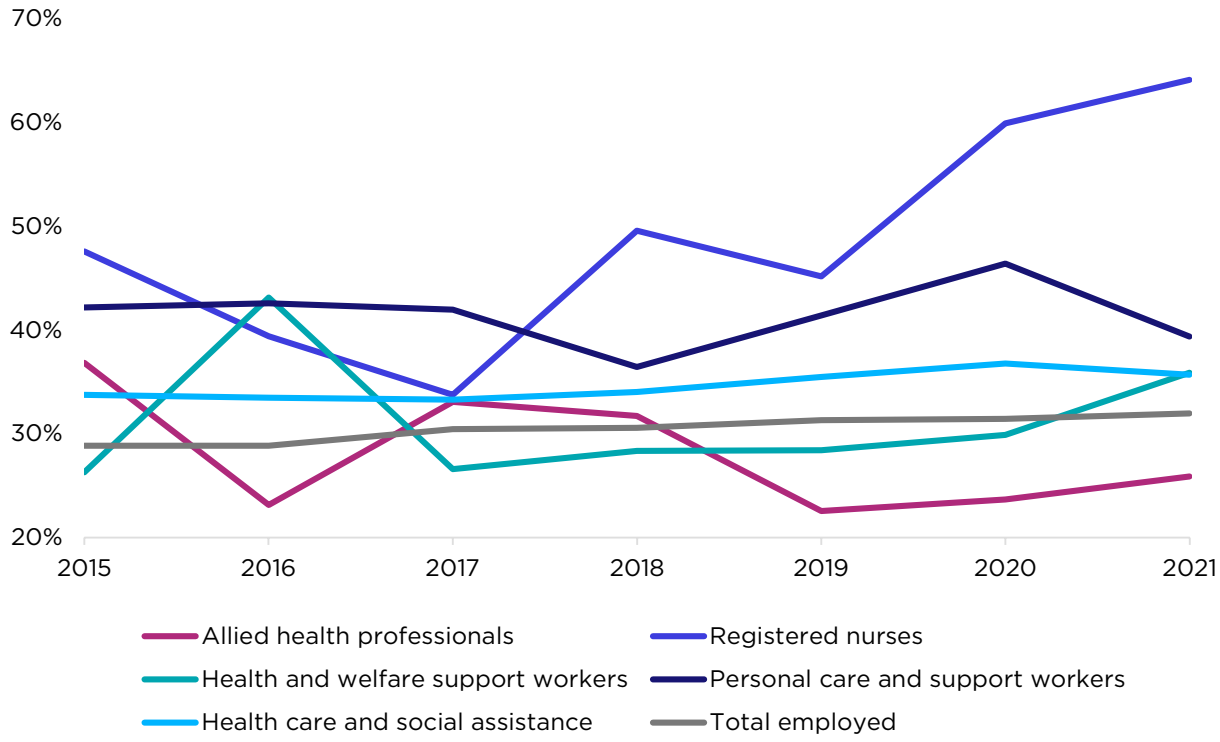
4.5 Culturally and linguistically diverse people

4.5.1 People born overseas

The care and support workforce is culturally and linguistically diverse with around 40% of workers (or 183,000) born overseas (Figure 56) – higher than the share across the overall Australian workforce (32%). This proportion has steadily increased over the last 15 years.[91]

In more recent years, there has been a marked increase in Registered nurses employed in care and support industries who are born overseas. In February 2021, nearly two-thirds of all Registered nurses working in the care and support sector were born overseas. In contrast, only a quarter of Allied health professionals were born overseas.[92]

Figure 56: Proportion of care and support workers born overseas, by occupation group, in-scope industries, 2015 to 2021



Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder.

The mental health workforce also has a relatively higher proportion of workers who were born overseas (around 40% in February 2021). However, similar to the care and support workforce, there is variance across occupations, with around 45% of Medical mental health workers born overseas compared with 25% of Non-medical mental health workers.[93]

The cultural diversity of care and support workers varies considerably across occupations.

A detailed analysis of care and support occupations across all industries, and contained in the data appendix to this Part, shows that the proportion of workers born overseas in 2018-19 ranged from a high of 62% of *Social professionals* (Figure 93) – which includes jobs that require a high degree of linguistic competency, such as translators – to a low of 2% of *Indigenous health workers* (Figure 91).

The share of overseas-born workers among *Nursing support and personal care workers* (40%) (Figure 88), *Registered nurses* (34%) (Figure 94), and *Aged and disabled carers* (37%) (Figure 87)

[91] ABS, Longitudinal Labour Force, Australia [Microdata], 2021

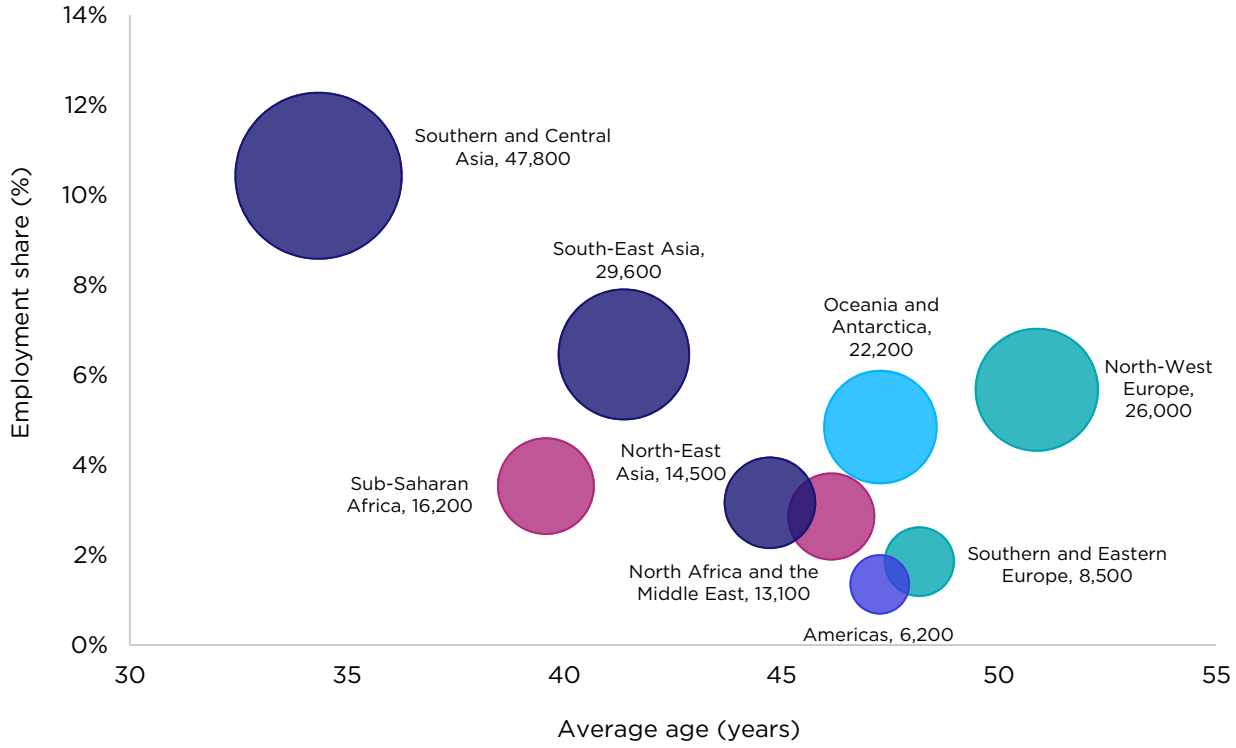
[92] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

[93] ABS, Longitudinal Labour Force, Australia [Microdata], 2021

was also relatively higher than for Allied health professionals (21%) (Figure 97) or *Welfare support workers* (26%) (Figure 92) across all industries.

As shown in Figure 57, around a quarter of the care and support workforce were born in the Asia-Pacific region, with the largest cohort from Southern and Central Asia. Care and support workers born in this region are typically much younger than other overseas-born workers with an average age of 34 years, compared with 51 years for workers from North-West Europe. This reflects, at least in part, their year of arrival into Australia.[94]

Figure 57: Care and support workforce born overseas, in-scope industries, by region of birth, age and employment, February 2021



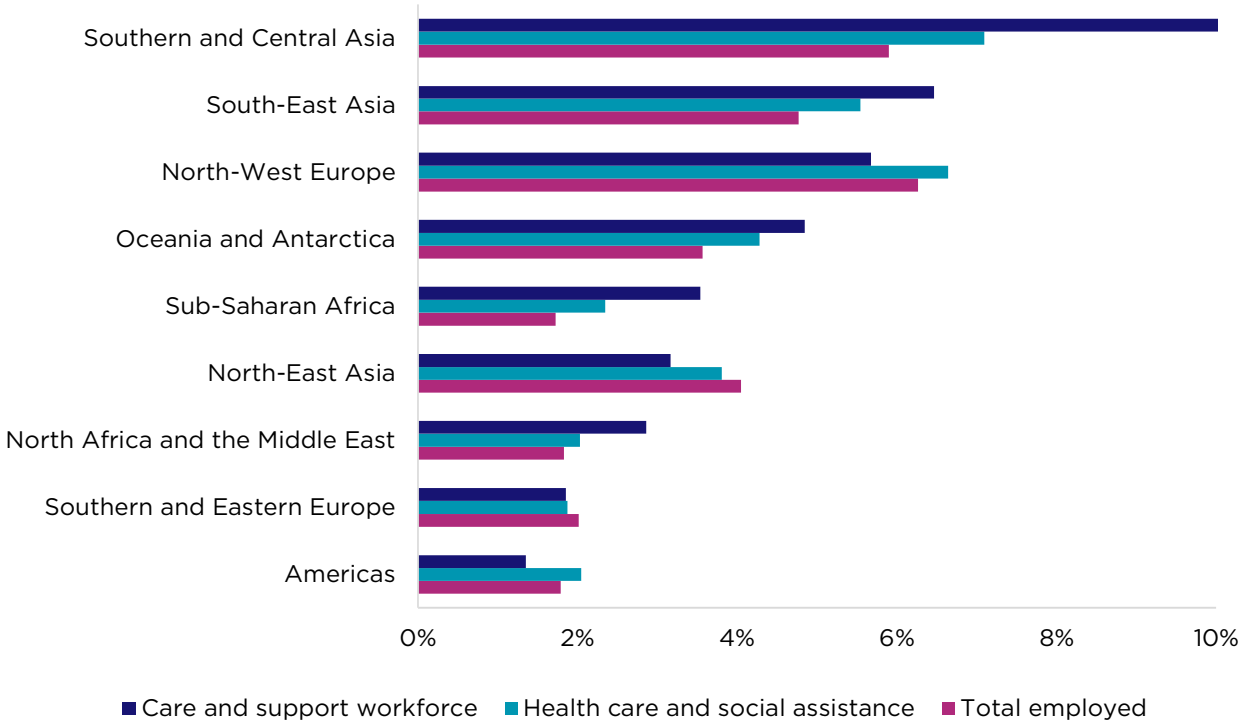
Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Age is calculated as the average weighted mean age of care and support workers by region between February 2015 and February 2021. Oceania excludes workers who were born in Australia. Bubble size represents number of people employed.

A relatively higher proportion of people born in Asian and African countries are employed in the care and support workforce (Figure 58). For example, in February 2021, around 10% of care and support workers were born in Southern and Central Asia, compared with 6% of total employed.[95]

[94] ABS, Longitudinal Labour Force, Australia [Microdata], 2021

[95] ABS, Longitudinal Labour Force, Australia [Microdata], 2021

Figure 58: Proportion of workforce born overseas by region, comparison by industry, February 2021



Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder. Care and support workforce includes the 15 occupations within the 3 in-scope industries.

A detailed analysis of MADIP 2018-19 personal tax and demographics data of care and support occupations across all industries showed that, among those born overseas, the 6 most common countries of birth were the United Kingdom (39,900), India (32,800), the Philippines (30,300), New Zealand (21,400), Nepal (12,100) and China (excluding SARs and Taiwan)[96] (11,200). (See Figure 98 to Figure 103 contained in the data appendix to this Part.)

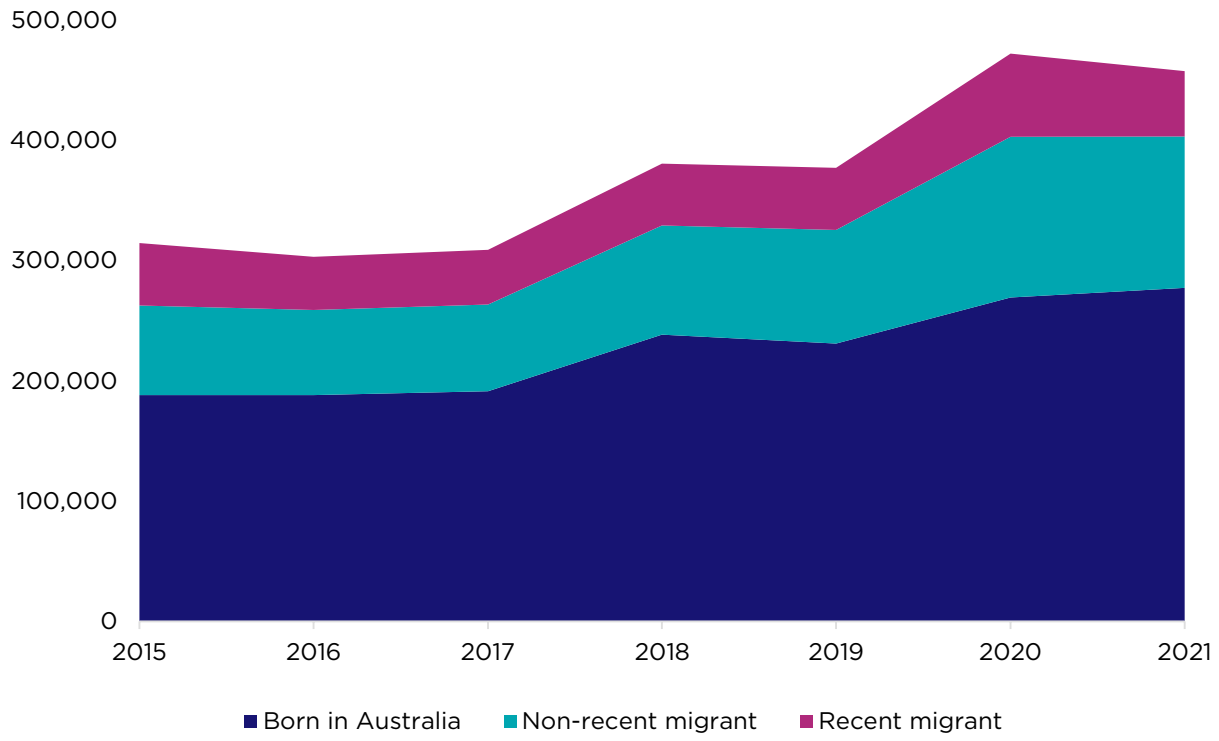
Over three-quarters of care and support workers in Australia who were born in these countries are female – in line with the overall trend in the care and support workforce. However, the proportions of males working in care and support occupations from India (24%) (Figure 99), Nepal (21%) (Figure 100) and the Philippines (20%) (Figure 102) are higher compared with people from other countries. Care and support workers from these countries are also likely to be younger than those born in New Zealand (Figure 101) or the United Kingdom (Figure 103).

[96] As defined in the ABS Standard Australian Classification of Countries, 2016, Special Administrative Regions (SARs) of China are Hong Kong and Macau.

4.6 Recent migrants

In February 2021, there were around 54,000 recent migrants – defined in the Study as overseas-born people who arrived in Australia within 10 years from the time of survey[97] – accounting for around 12% of the care and support workforce. In comparison, there were around 126,000 non-recent migrants (or 28%) and 277,000 (or 60%) care and support workers born in Australia (Figure 59).

Figure 59: Care and support workforce by migration status, in-scope industries, February 2015 to February 2021



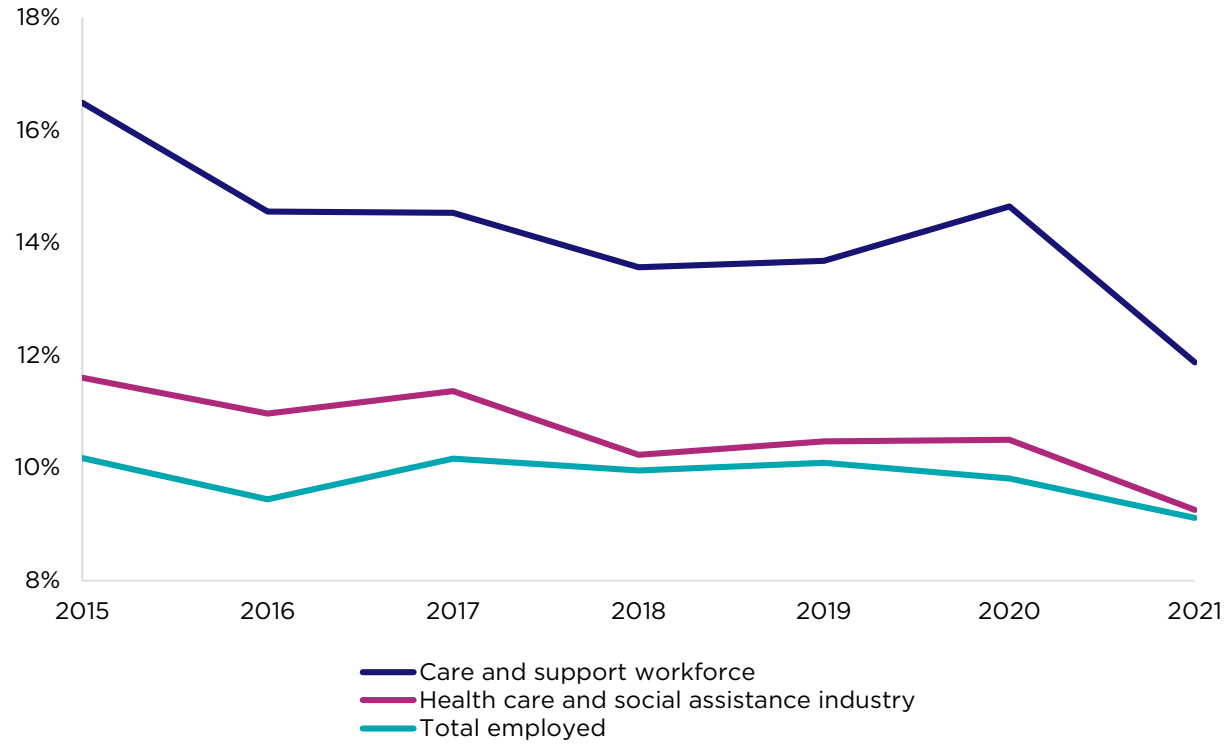
Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Recent migrants are defined as people born overseas who have arrived within the last 10 years from the time of survey.

As shown in Figure 60, recent migrants account for a higher share of the care and support workforce (12%), compared to the *Health care and social assistance* industry (9%) as well as the overall Australian workforce (9%).

The proportion of recent migrants in the care and support workforce has declined slightly from 2015 to 2020, with a sharper drop in the past year likely to be attributed to the extended international border closures amid the COVID-19 pandemic.

[97] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

Figure 60: Share of recent migrants, February 2015 to February 2021



Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Recent migrants are defined as people born overseas who have arrived within the last 10 years from the time of survey.

While the care and support sector is more reliant on recent migrants than the labour market as a whole, an analysis of new entrants[98] to care and support occupations across all industries between 2011-12 and 2018-19 shows that most new entrants to care and support occupations are domestic workers (Figure 113 to Figure 123).

As shown in the data appendix to this Part, occupations with a higher share of new entrants who were born overseas[99] include *Social professionals* (46%) (Figure 117), *Registered nurses (aged care)* (40%) (Figure 119), *Nurse managers* (34%) (Figure 120), *Aged and disabled carers* (31%) (Figure 113), and *Nursing support and personal care workers* (30%) (Figure 114).

By comparison, 17% of new entrants to allied health professions (Figure 122), and 18% of all new entrants to the Australian workforce (Figure 123) during this period were born overseas.

Recent migrants in the care and support workforce tend to be much younger than their counterparts – contributing to the decline in average age of the workforce in recent years. As shown in Figure 61, workers in this cohort tend to be around 34 years, on average, compared with 46 years for non-recent migrants and 42 years for care and support workers born in Australia. This trend is also observed in other sectors of the economy and may be attributed to the high representation of students among recent migrants and temporary residents in Australia (as discussed in Part 7.4).

Care and support workers born overseas are also more likely to be male compared with their Australian-born counterparts. In February 2021, around 30% of care and support workers who were recent migrants were male, compared with 21% of those who had arrived in Australia over a decade ago, and 18% of the workforce born in Australia.

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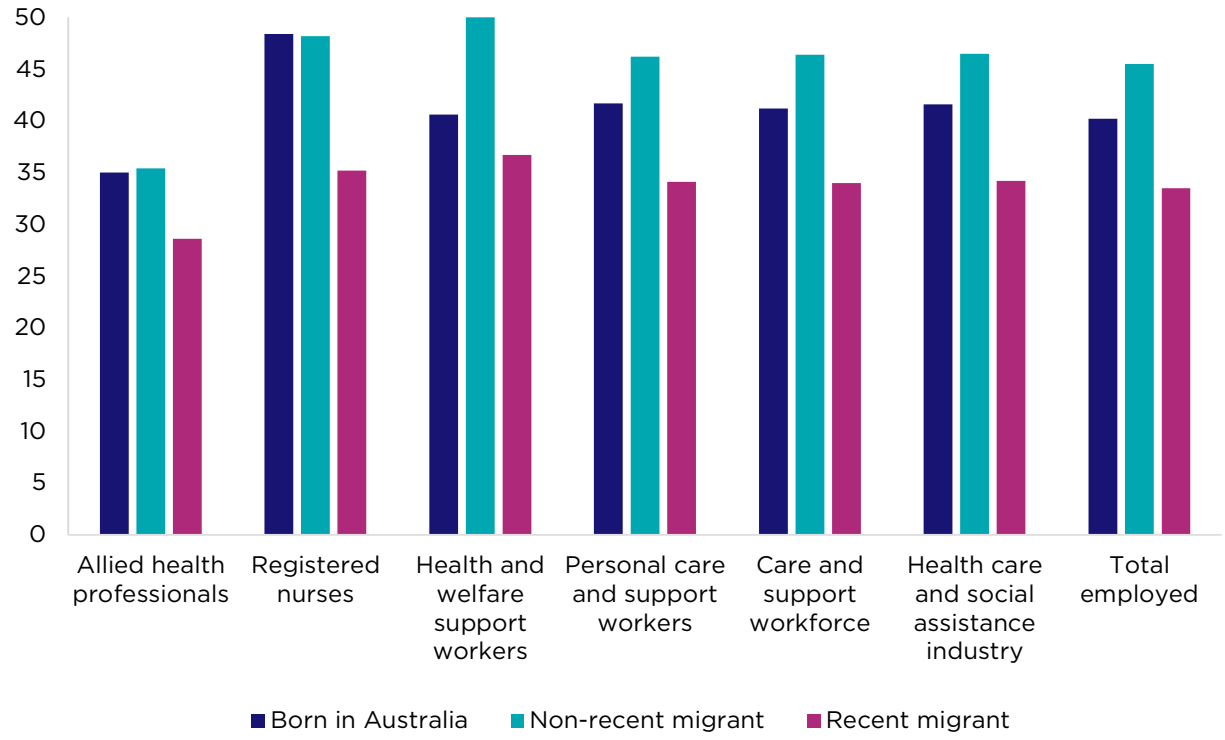
[98] New entrants are defined in this analysis as someone who enters an in-scope care and support occupation in 2011–12 or later (as 2010–11 is the first year of available data). However, new entrants to the overall Australian workforce are defined as persons who appear in the MADIP data with a non-zero wage for any occupation in 2011–12 or later.

[99] Persons born overseas are those born in any country other than Australia. Observations with a missing or non-standard country code (i.e. does not align with an ABS Standard Australian Classification of Countries code) are classified as unknown, however are more likely to be overseas-born than Australian-born.

Figure 61: Average age of workforce by occupation, all industries, migrant status, 2021



Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder. Recent migrants are defined as people born overseas who have arrived within the last 10 years from the time of survey.

Many OECD countries are also heavily reliant on workers who were born overseas. While trends in older age profiles and high female workforce shares are generally consistent across OECD countries, this is not the case for the share of overseas-born workers, where there is considerable variation. The share of foreign-born workers is the highest in Israel (71%) and Ireland (48%), compared with less than 10% in other countries including Denmark, Netherlands, Slovenia, Croatia and Finland.[100]

The OECD notes that this reflects a range of factors including migration settings, the share of residential care (with the non-home-based care setting tending to have higher rates of foreign-born workers) and the proportion of the population born overseas. The OECD also highlights that recruitment of overseas-born workers is commonly drawn from people that have arrived through 'non-economic' visa channels.[101] That is also the case in Australia.

While noting the considerable variation across countries, OECD analysis suggests that Australia has a relatively high share of foreign-born workers (29%) compared with the OECD average (23%) for the long-term care workforce.[102]

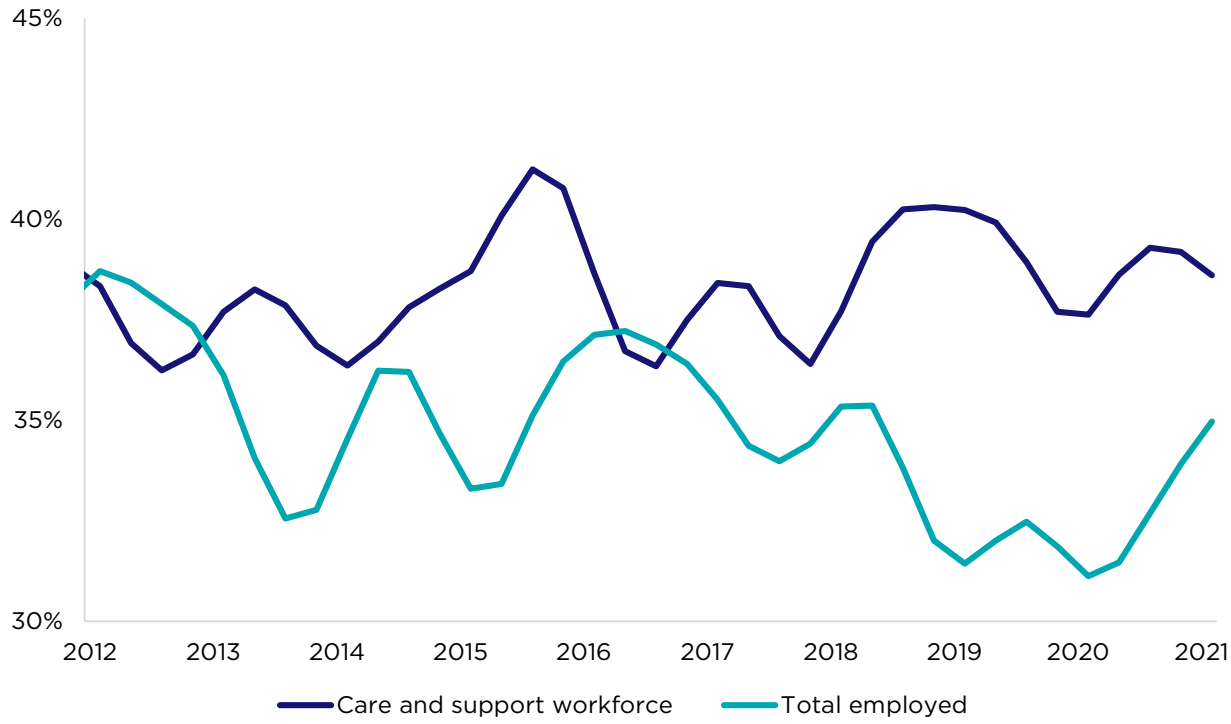
Part 10.6 models a sensitivity in relation to increased migration.

[100] OECD, *Who Cares? Attracting and retaining care workers for the elderly*, 2020
[101] OECD, *Who Cares? Attracting and retaining care workers for the elderly*, 2020
[102] OECD, *Who Cares? Attracting and retaining care workers for the elderly*, 2020

4.7 Regional distribution

The regional share of the care and support workforce has remained relatively stable over the last decade with around 39% of the workforce employed in regional areas (i.e. all areas outside of capital cities) in 2021. In contrast, the regional share of total employment has declined over the same period, apart from a recent COVID-19 related lift (Figure 62).

Figure 62: Non-capital city share of employment, in-scope industries, January 2012 to January 2021



Source: ABS Longitudinal Labour Force Survey, Deloitte Access Economics (2021).

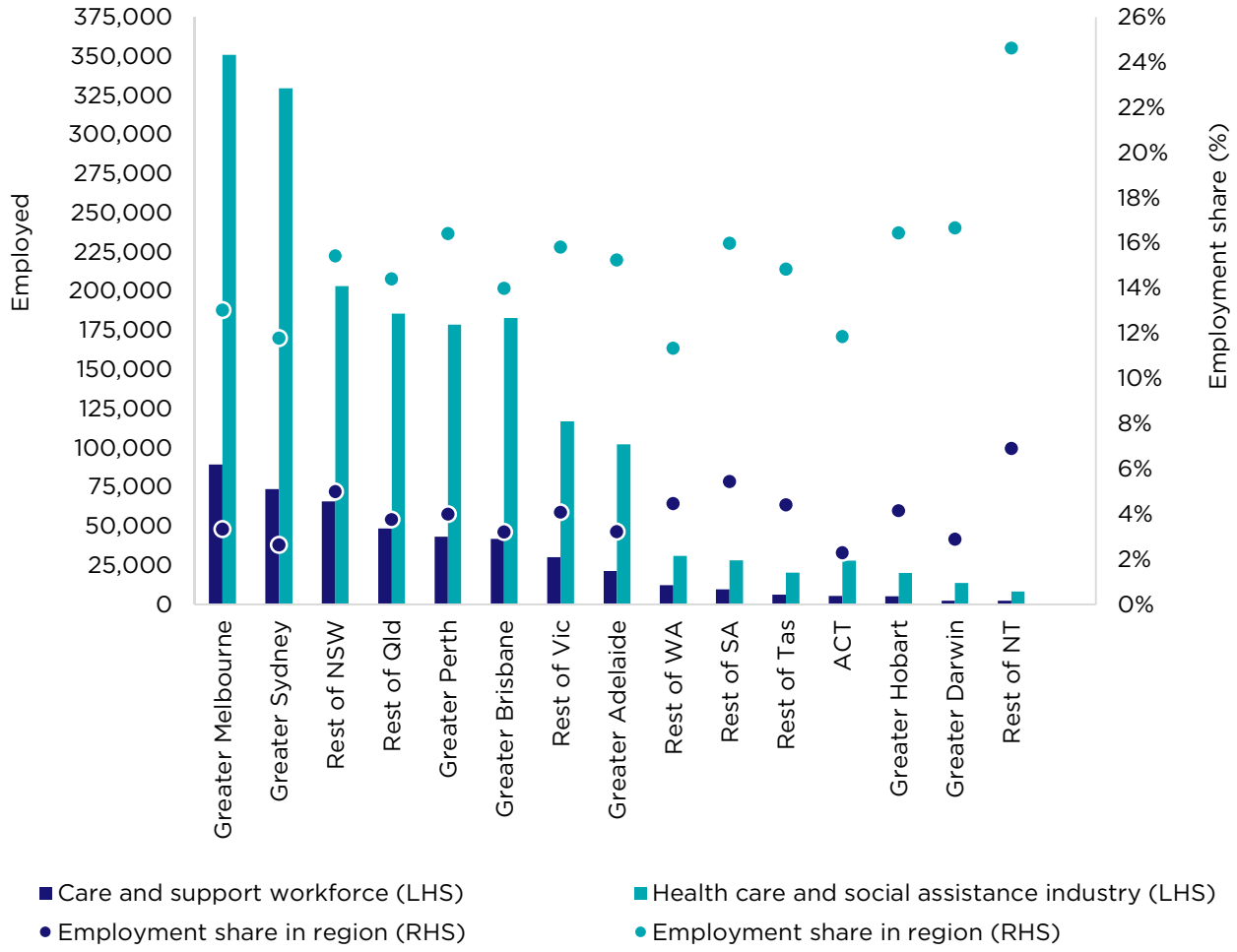
Care and support workers in the Northern Territory, South Australia and New South Wales are more likely to be employed outside capital cities than in other states and territories.

However, the share of workers employed outside capital cities in other *Health care and social assistance* industries (that is, those outside the care and support sector) is much higher than that in the care and support sector. (Figure 63).

This aligns with the views of stakeholders consulted as part of this Study, who cited greater difficulties in recruiting for care and support workers in regional areas compared with other health workers.

Some stakeholders have attributed this to the small pool of suitable candidates and the higher competition for frontline staff between care and support providers, state-run facilities, and other sectors. Stakeholders also note that attracting workers from metropolitan regions is challenging as regional living costs may be higher, housing may be difficult to obtain, and there are no financial incentives for care and support students or workers to do a regional placement (unlike for medical students) or for city workers to relocate to regional, rural or remote settings (unlike for rural doctors).

Figure 63: Distribution of workforce by capital cities and rest of state, February 2021



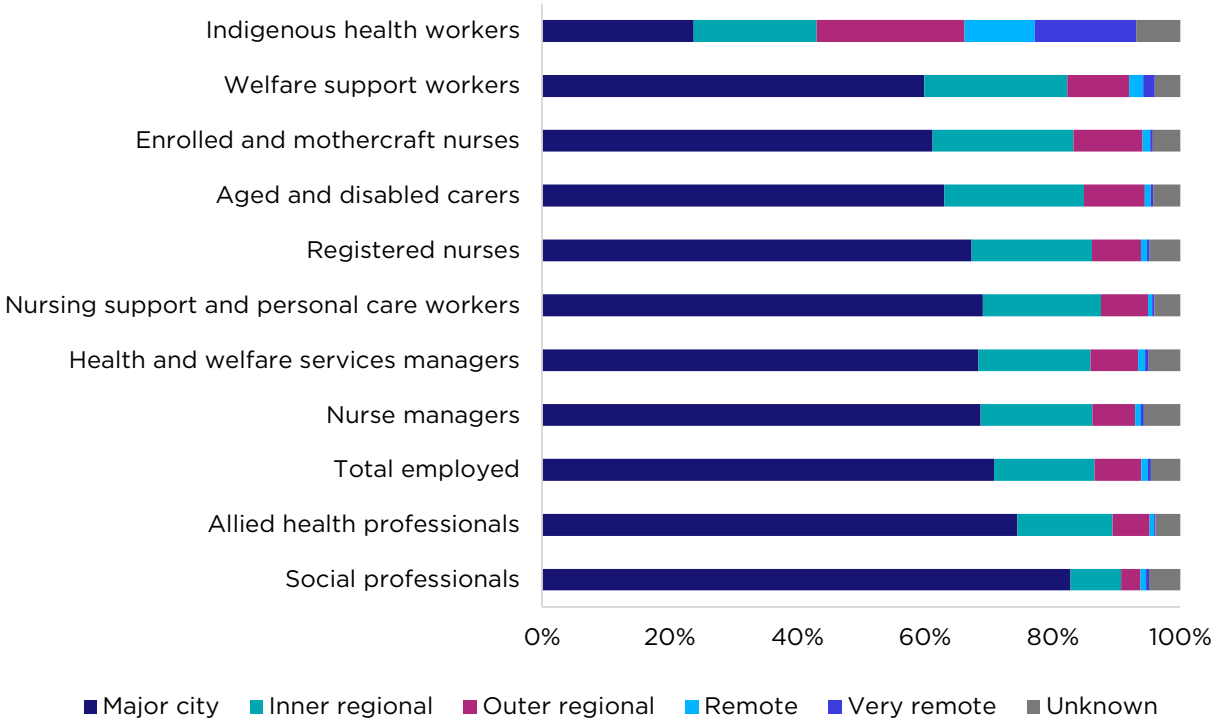
Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder.

Among care and support occupations across all industries, *Indigenous health workers* are most likely to work in a non-metropolitan region. In 2018-19, around 42% of *Indigenous health workers* worked in an inner or outer regional area, while 27% worked in a remote or very remote region.

After this, the highest share of regional employment was observed among *Welfare support workers*, *Enrolled and mothercraft nurses*, and *Aged and disabled carers*, with around a third of workers in these occupations working in a regional or remote area.

By comparison, *Social professionals* (12%) and Allied health professionals (22%) were least likely to be employed regionally – less than the share of regional employment for the overall workforce (25%) (Figure 64).

Figure 64: Care and support occupations in all industries, by remoteness, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

A more detailed analysis of the largest care and support occupations in 2018-19 showed that, while employment shares differed by state and occupation, *Welfare support workers* and *Aged and disabled carers* were the most likely to be employed in regional or remote areas across most states and territories (Figure 124 to Figure 130 contained in the data appendix to this Part).

4.8 Thin markets

Thin markets are defined as inadequate availability of services resulting in inability to meet demand. These markets most commonly occur in remote and regional areas but can also occur in metropolitan areas particularly for specialist and culturally appropriate services. This point was also reinforced by stakeholders during this Study.

Stakeholders raised the need for attraction, retention and career development strategies to address thin markets. However, several stakeholders were critical of workforce strategies that incentivise regional and remote placements, citing disruptions to the delivery of care and support when the placement ends, as well as lack of cultural awareness and language barriers. Some providers noted success in servicing thin markets with outreach services, however most raised the importance of building and retaining a local workforce and ensuring that suitable wraparound services were in place such as mentoring, supervision and access to training and professional development. Other practical workforce challenges raised for thin markets included housing availability and increased living and travel costs.

The trending occupation of allied health assistant (Part 1.6) was consistently raised in relation to remote thin markets, with some providers reporting successful operating models that incorporate allied health assistants to extend services into thin markets.

While stakeholders were positive about the potential of telehealth to extend services into thin markets, many cautioned this needed to be part of a broader strategy that includes in-person contact. Stakeholders noted that while many services are suited to digital delivery, not all services are. Further, care and support recipients may not have access to suitable infrastructure (equipment or reliable internet) to engage with telehealth. Adequate levels of digital literacy (both on the part of the care and support recipients and workforce) was also raised as a challenge.

Recognising the impact of thin markets on NDIS service delivery, the NDIS is trialling a range of flexible approaches in each state and territory. These include market facilitation initiatives to improve the connections between providers and NDIS participants, coordinated funding proposals where NDIS participants pool their plan funding to attract providers into a particular market, and direct commissioning via contracts for service delivery where other mechanisms would not achieve the required levels or service delivery.[103]

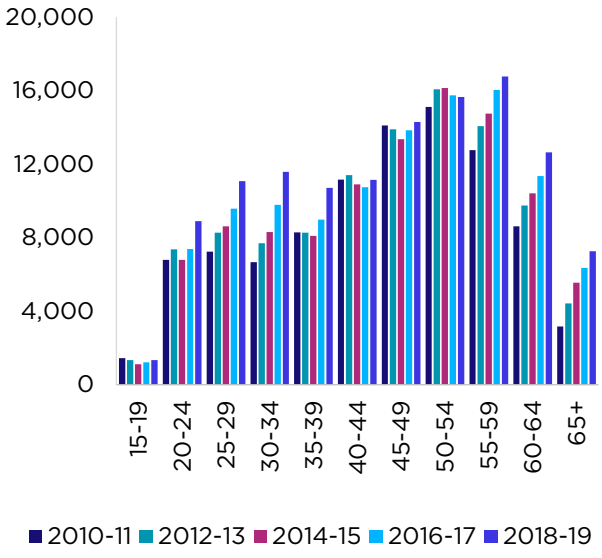
[103] NDIS, Market monitoring and intervention, 2021

4.9 Data appendix to Part 4

4.9.1 Age and gender distribution of care and support occupations - charts

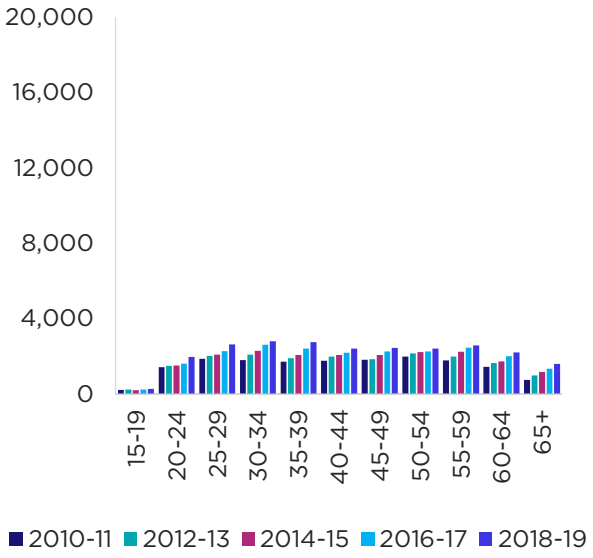
The age and gender distributions of selected care and support occupations are presented below. Some occupations have not been included due to small numbers. Note that these data include all industries, not just the Study's in-scope industries.

Figure 65: *Aged and disabled carers* (all industries), by age, female, 2010-11 to 2018-19



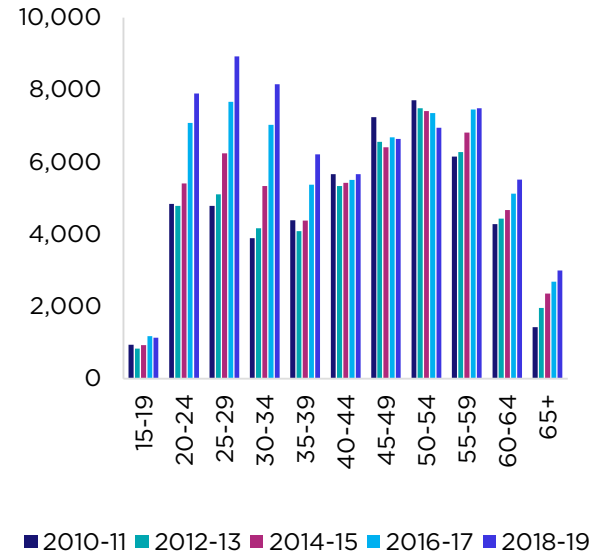
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 66: *Aged and disabled carers* (all industries), by age, males, 2010-11 to 2018-19



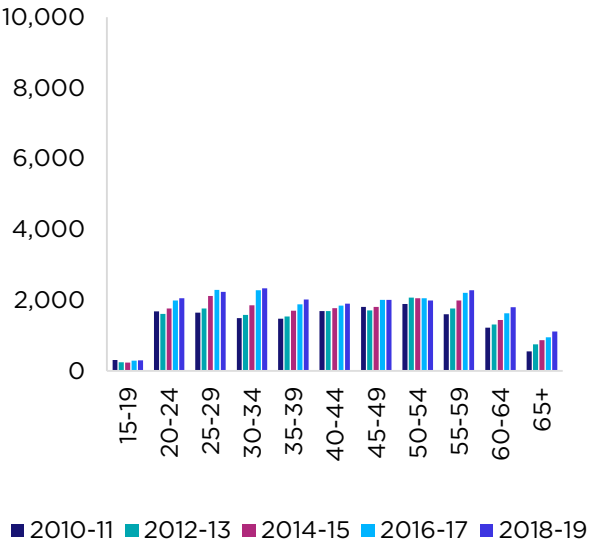
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 67: *Nursing support and personal care workers* (all industries), by age, female, 2010-11 to 2018-19



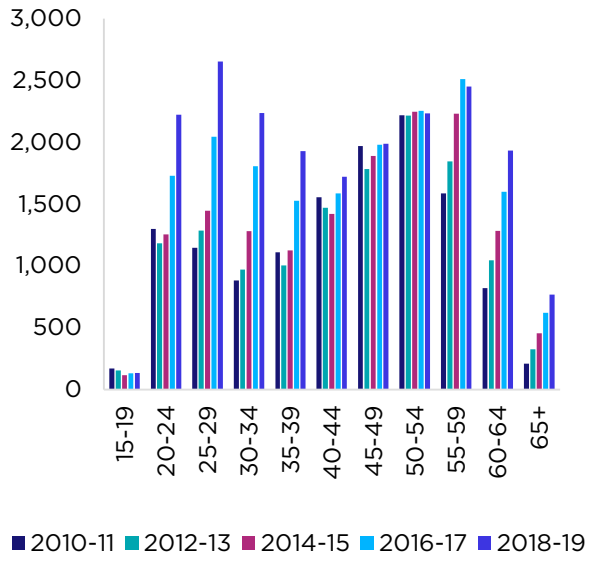
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 68: *Nursing support and personal care workers* (all industries), by age, male, 2010-11 to 2018-19



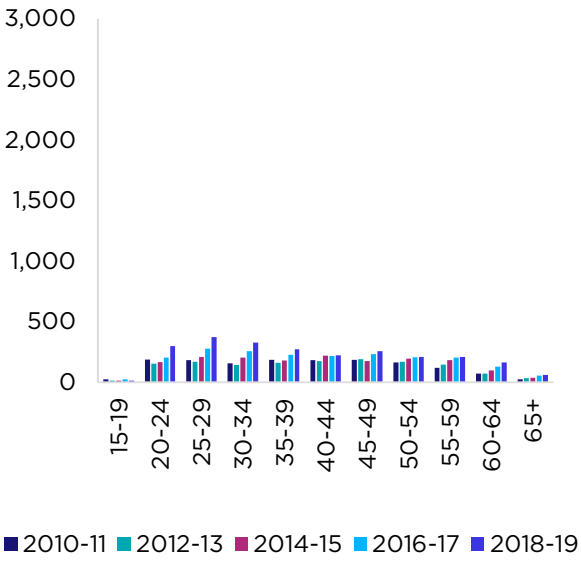
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 69: *Enrolled and mothercraft nurses* (all industries), by age, female, 2010-11 to 2018-19



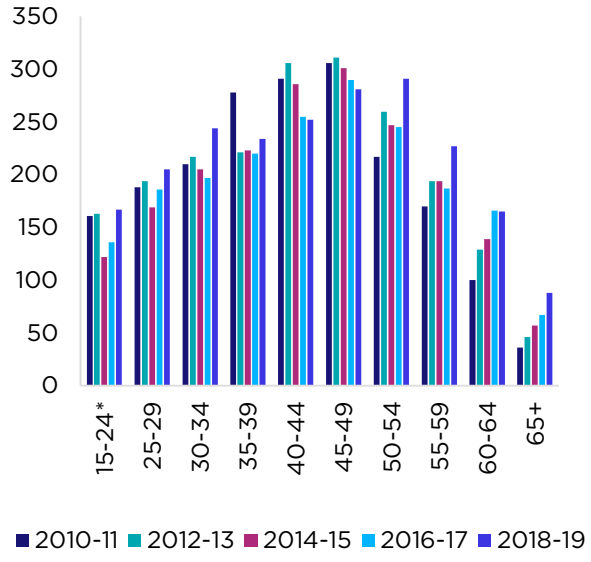
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 70: *Enrolled and mothercraft nurses* (all industries), by age, male, 2010-11 to 2018-19



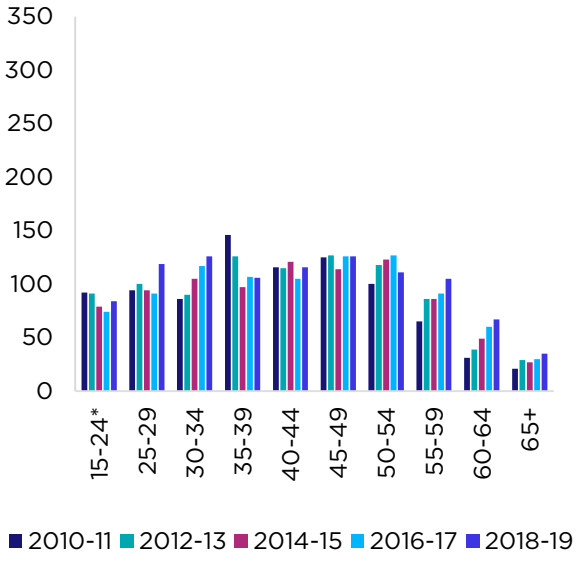
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 71: *Indigenous health workers* (all industries), by age, female, 2010-11 to 2018-19



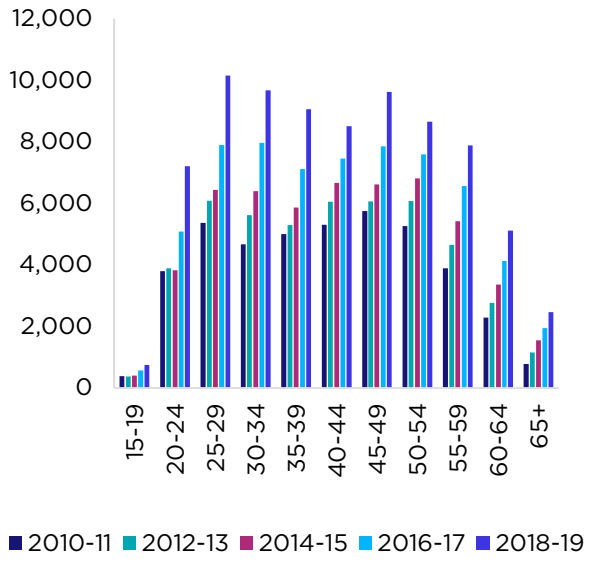
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Age groups have been combined due to small counts.

Figure 72: *Indigenous health workers* (all industries), by age, male, 2010-11 to 2018-19



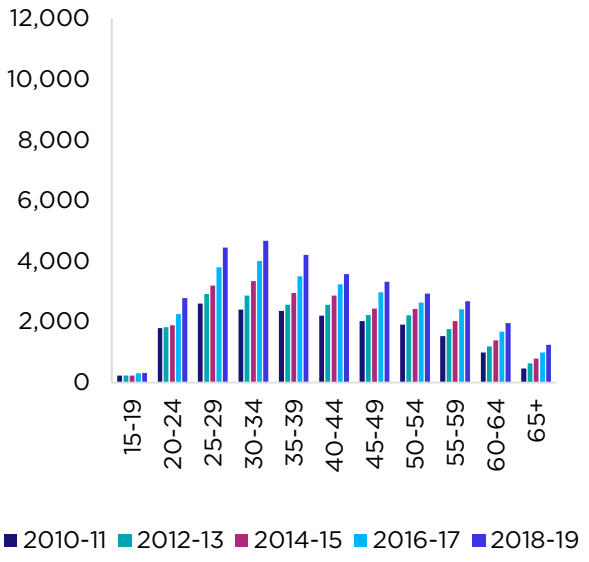
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Age groups have been combined due to small counts.

Figure 73: *Welfare support workers* (all industries), by age, female, 2010-11 to 2018-19



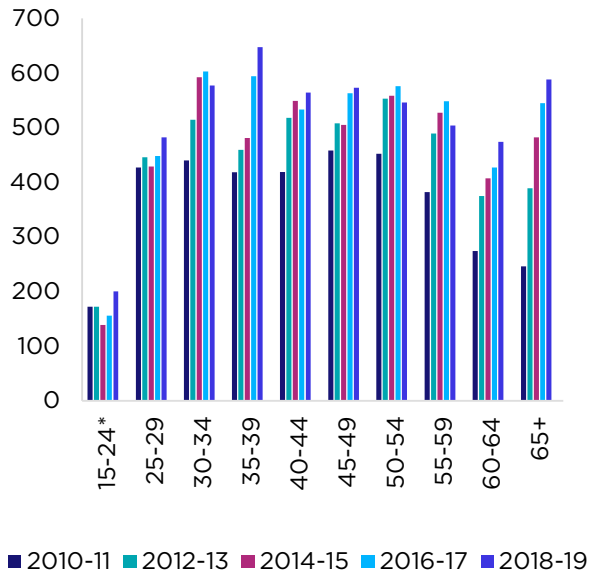
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 74: *Welfare support workers* (all industries), by age, male, 2010-11 to 2018-19



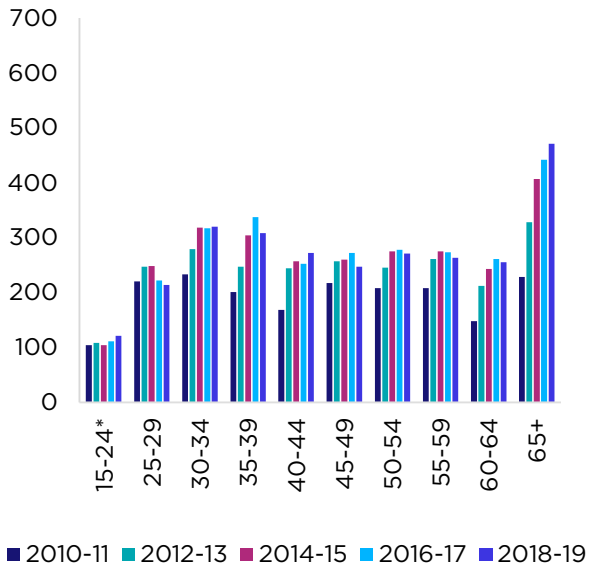
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 75: *Social professionals* (all industries), by age, female, 2010-11 to 2018-19



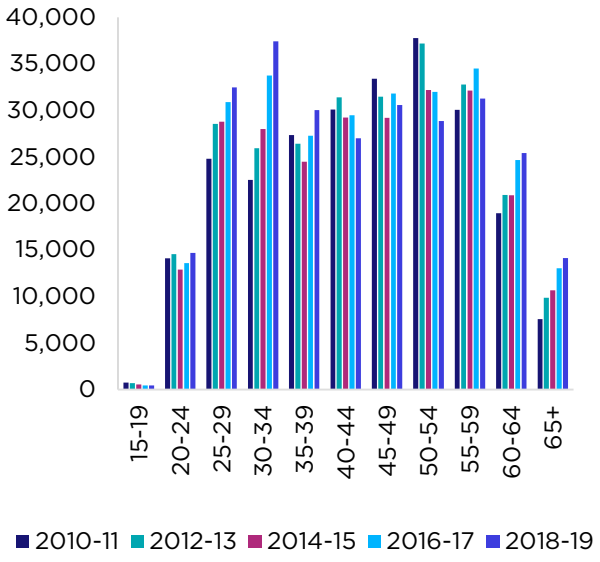
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 76: *Social professionals* (all industries), by age, male, 2010-11 to 2018-19



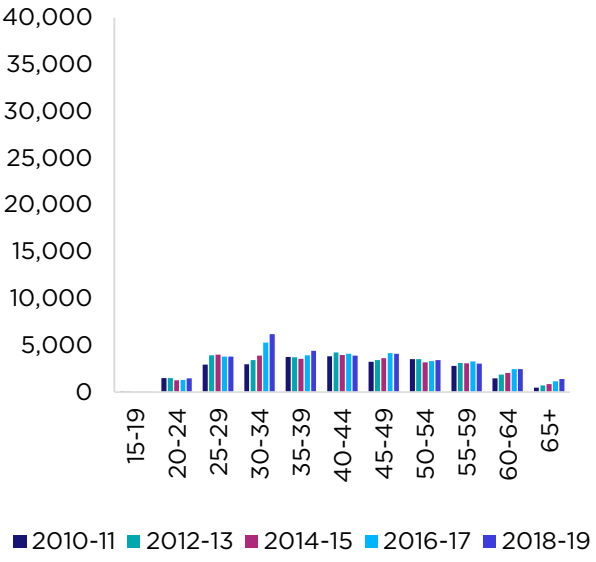
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 77: *Registered nurses* (all industries), by age, female, 2010-11 to 2018-19



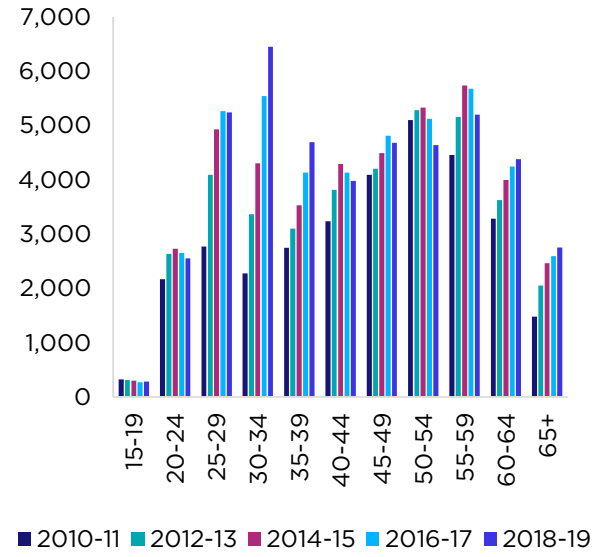
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 78: *Registered nurses* (all industries), by age, male, 2010-11 to 2018-19



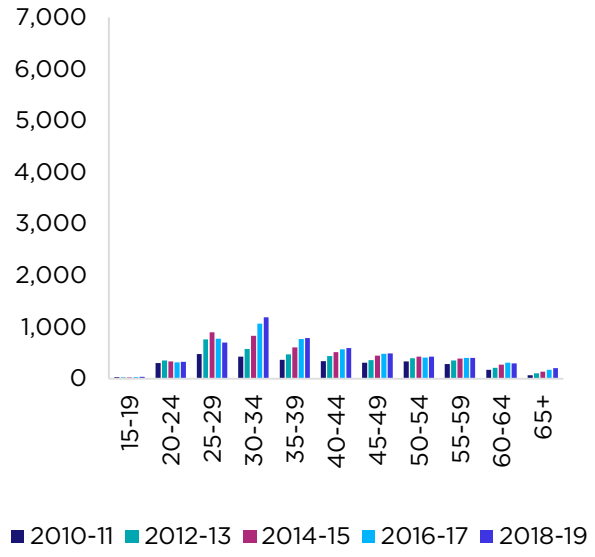
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 79: *Registered nurses (aged care)* (all industries), by age, female, 2010-11 to 2018-19



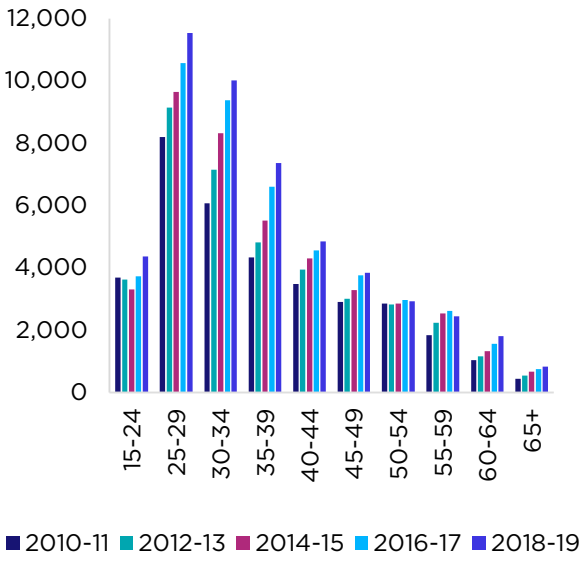
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. *Registered nurses (aged care)* is a 6-digit ANZSCO occupation.

Figure 80: *Registered nurses (aged care)* (all industries), by age, male, 2010-11 to 2018-19



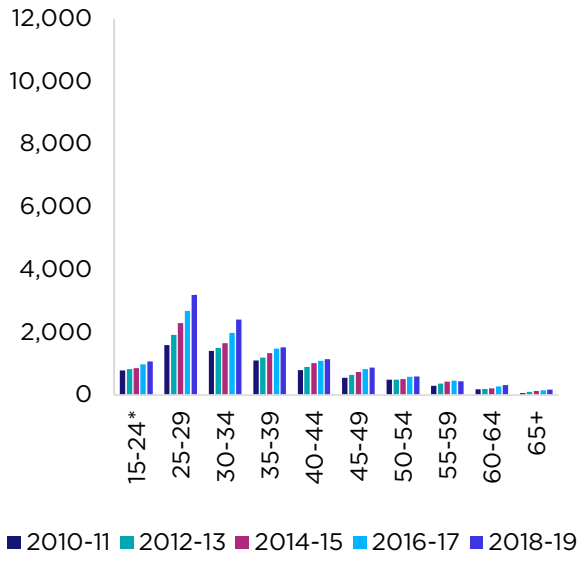
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. *Registered nurses (aged care)* is a 6-digit ANZSCO occupation.

Figure 81: Allied health professionals (all industries), by age, female, 2010-11 to 2018-19



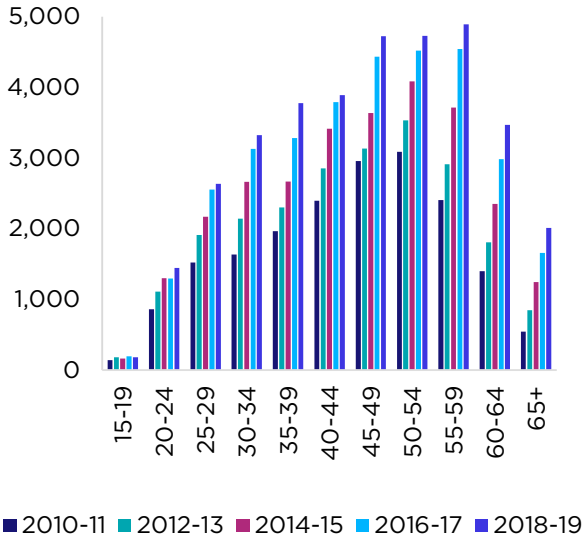
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. *Age groups have been combined due to small counts. The Allied health professionals occupation group includes *Nutrition professionals*, *Occupational therapists, Physiotherapists, Podiatrists,* and *Audiologists and speech pathologists/therapists*. These occupations have not been reported separately due to small counts.

Figure 82: Allied health professionals (all industries), by age, male, 2010-11 to 2018-19



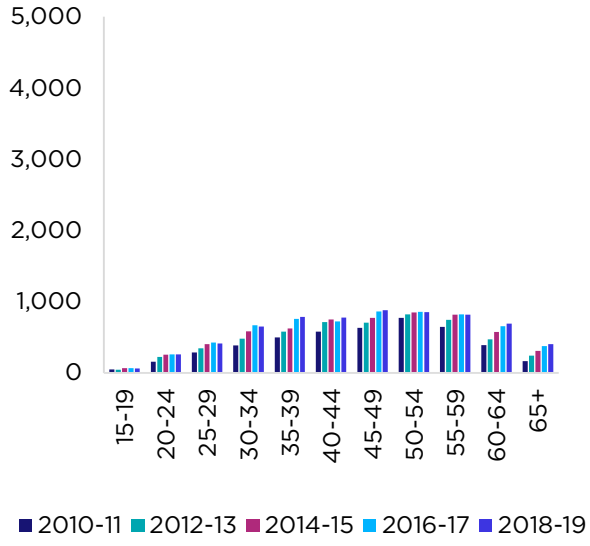
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. *Age groups have been combined due to small counts.

Figure 83: *Health and welfare services managers* (all industries), by age, female, 2010-11 to 2018-19



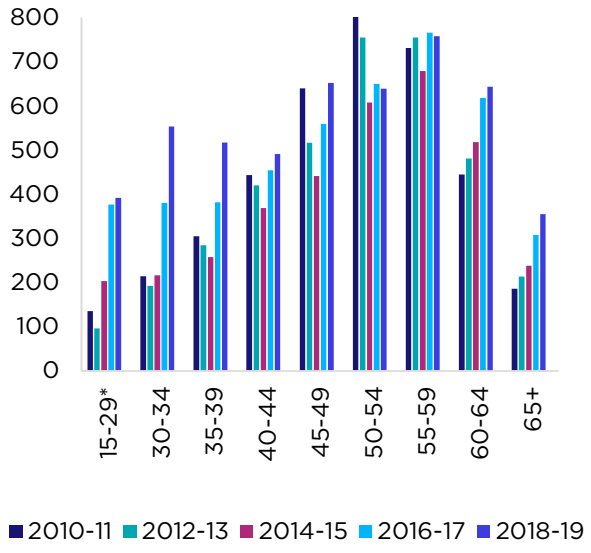
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 84: *Health and welfare services managers* (all industries), by age, male, 2010-11 to 2018-19



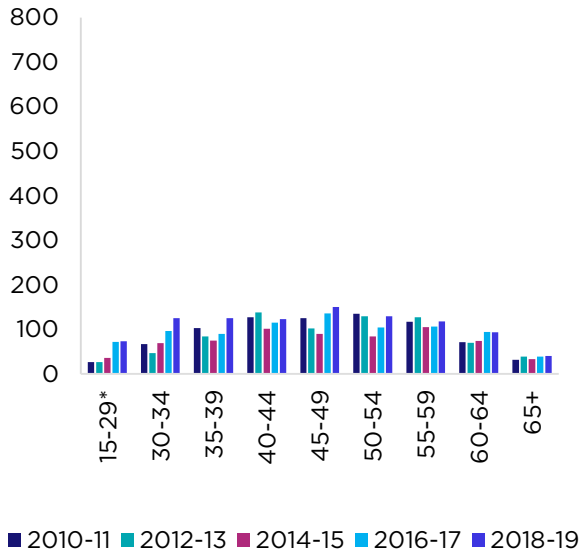
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 85: *Nurse managers* (all industries), by age, female, 2010-11 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 86: *Nurse managers* (all industries), by age, male, 2010-11 to 2018-19



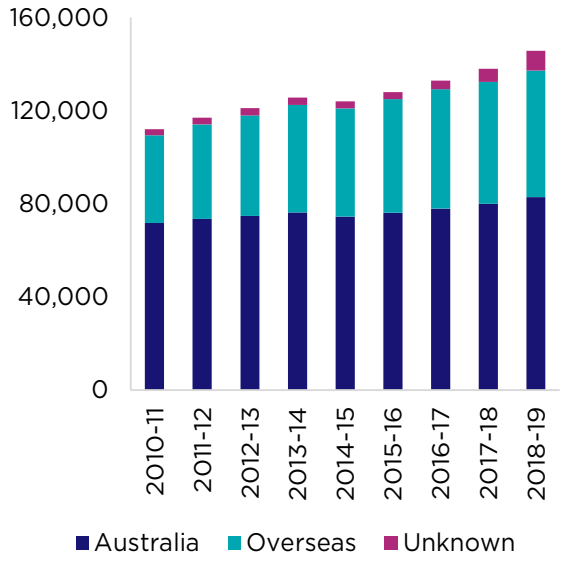
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

4.9.2 Place of birth of workers in care and support occupations - charts

The distribution of selected care and support occupations by place of birth are presented below. Some occupations have not been included due to small numbers. Persons with an unknown country of birth are most likely to have been born overseas. Note that these data include all industries, not just the Study's in-scope industries.

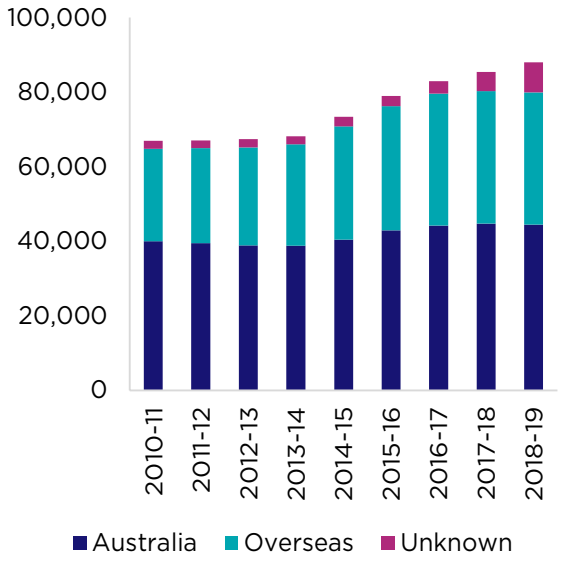
4.9.2.1 Occupation by Australian-born and overseas-born - charts

Figure 87: *Aged and disabled carers* (all industries), by place of birth, 2010-11 to 2018-19



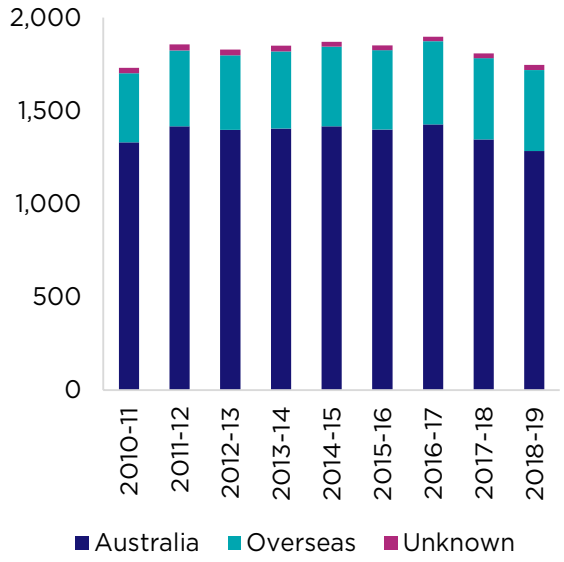
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 88: *Nursing support and personal care workers* (all industries), by place of birth, 2010-11 to 2018-19



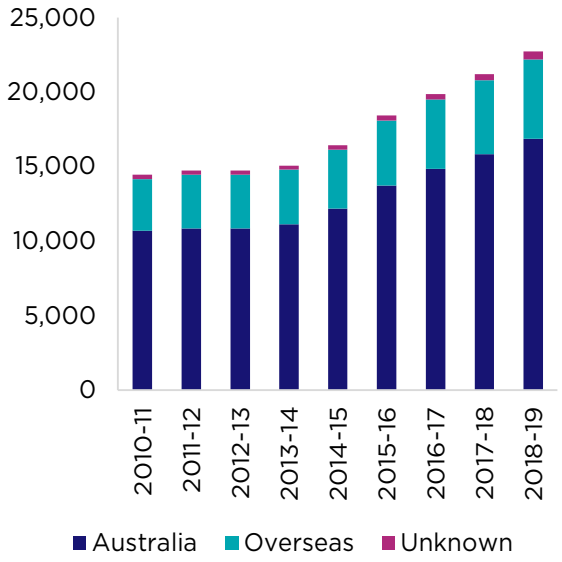
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 89: *Diversional therapists* (all industries), by place of birth, 2010-11 to 2018-19



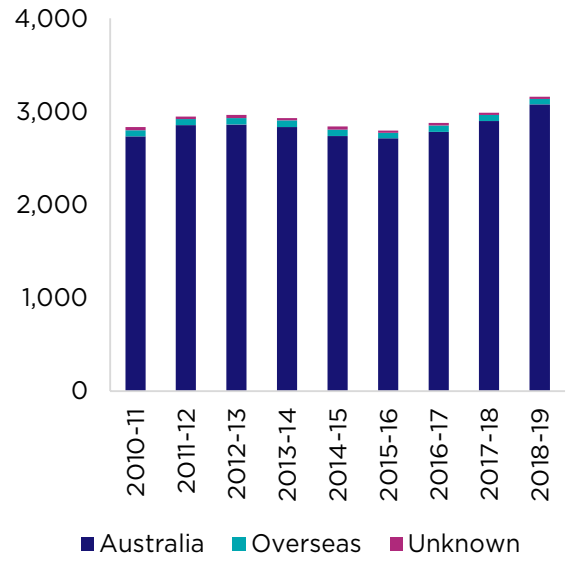
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 90: *Enrolled and mothercraft nurses* (all industries), by place of birth, 2010-11 to 2018-19



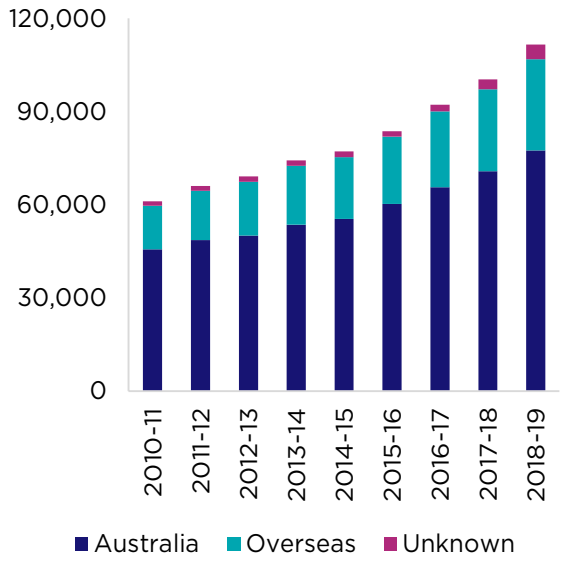
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 91: *Indigenous health workers* (all industries), by place of birth, 2010-11 to 2018-19



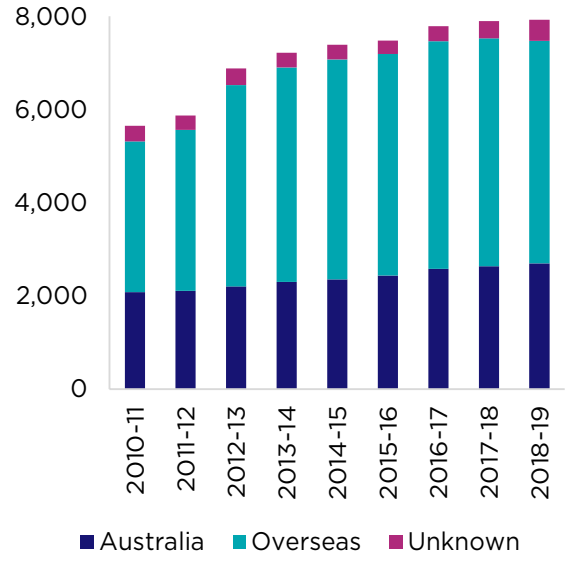
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 92: *Welfare support workers* (all industries), by place of birth, 2010-11 to 2018-19



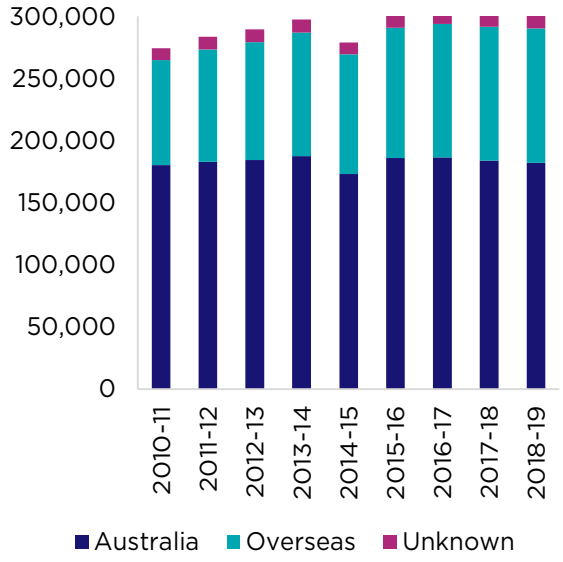
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 93: *Social professionals* (all industries), by place of birth, 2010-11 to 2018-19



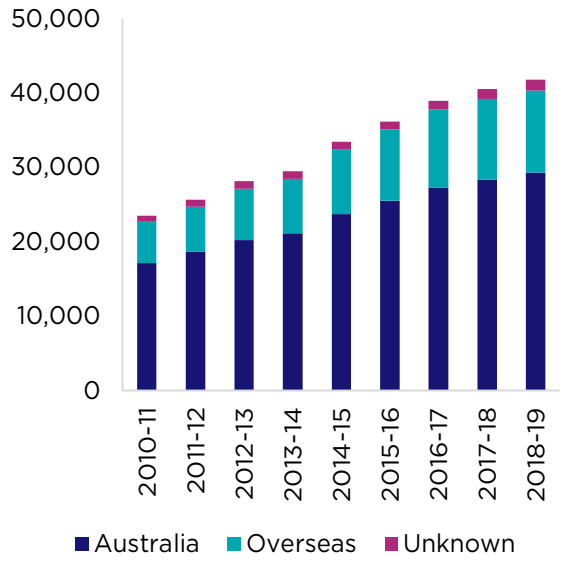
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 94: *Registered nurses* (all industries), by place of birth, 2010-11 to 2018-19



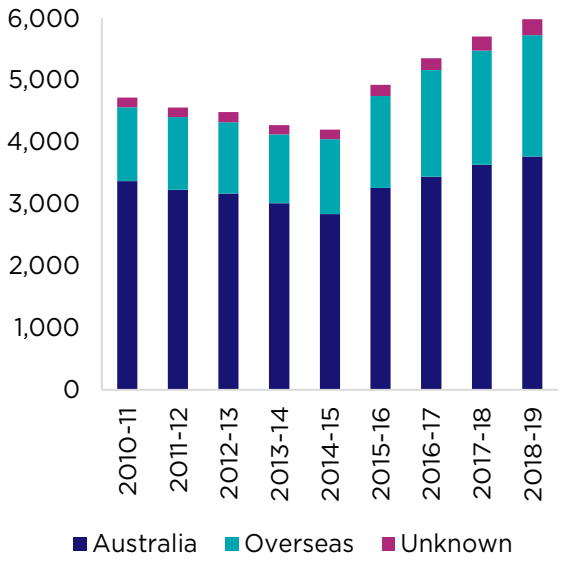
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 95: *Health and welfare services managers* (all industries), by place of birth, 2010-11 to 2018-19



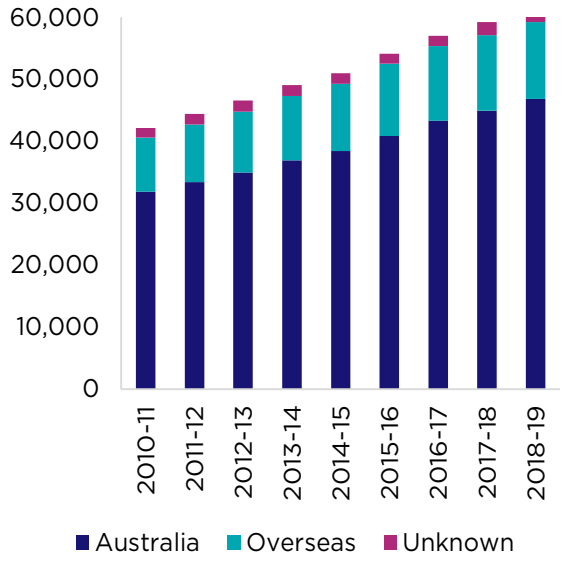
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 96: *Nurse managers* (all industries), by place of birth, 2010-11 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 97: Allied health professionals (all industries), by place of birth, 2010-11 to 2018-19

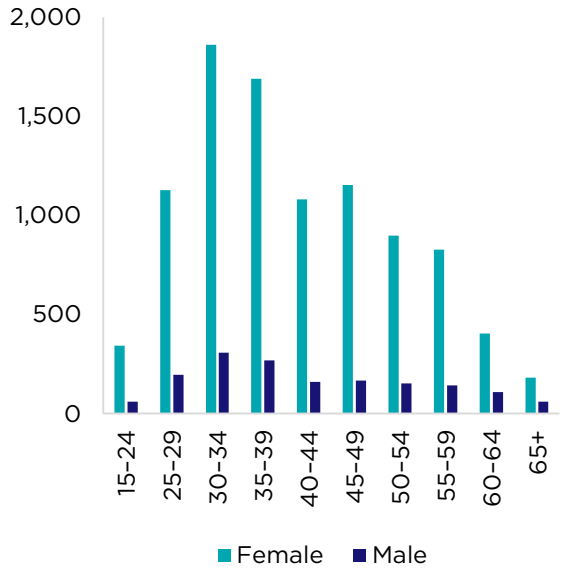


Source: NSC analysis of longitudinal linked tax data sourced via MADIP. The Allied health professionals occupation group includes *Nutrition professionals*, *Occupational therapists, Physiotherapists, Podiatrists,* and *Audiologists and speech pathologists/therapists*. These occupations have not been reported separately due to small counts.

4.9.2.2 Care and support workforce, selected country of birth by age and sex - charts

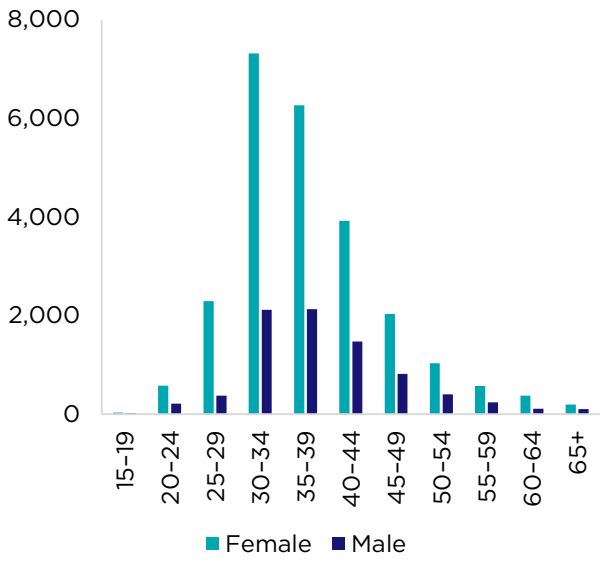
The age and gender distribution of people working in an occupation within the care and support workforce for selected countries of birth are presented below. Some age groups have been aggregated due to small counts. Data are presented in alphabetical order by country of birth. Note that these data include all people working in the care and support occupations across all industries, not just the Study's in-scope industries.

Figure 98: Care and support workers (all industries), born in China (excluding SARs and Taiwan), by age and gender, 2018-19



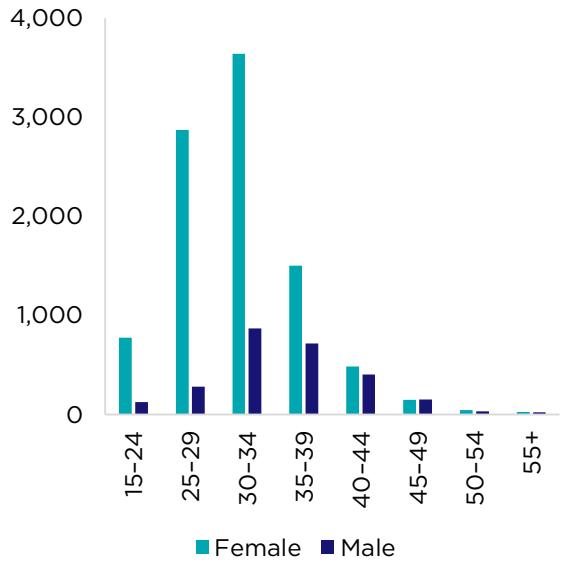
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 99: Care and support workers (all industries), born in India, by age and gender, 2018-19



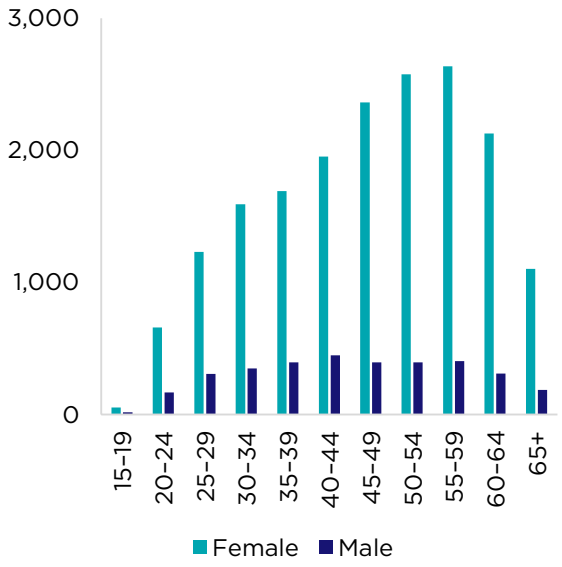
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 100: Care and support workers (all industries), born in Nepal, by age and gender, 2018-19



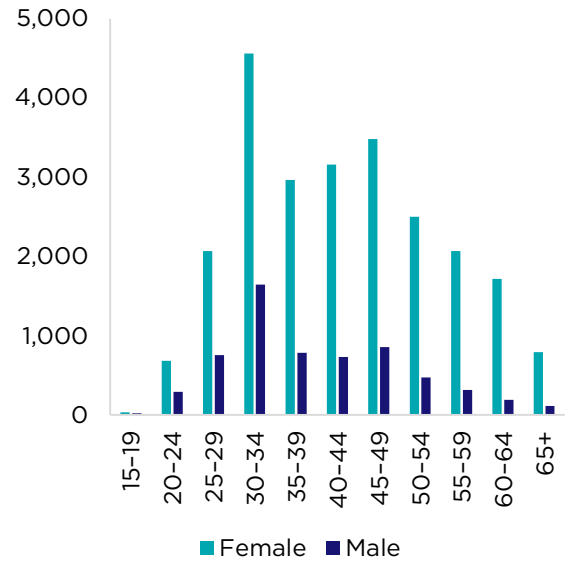
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 101: Care and support workers (all industries), born in New Zealand, by age and gender, 2018-19



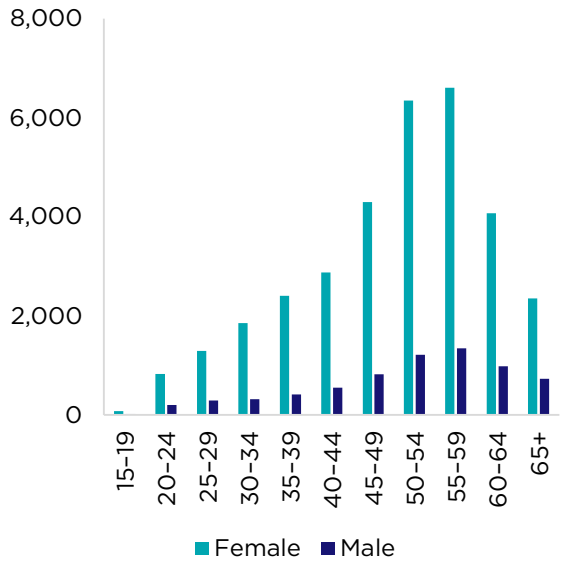
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 102: Care and support workers (all industries), born in the Philippines, by age and gender, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 103: Care and support workers (all industries), born in the United Kingdom, by age and gender, 2018-19

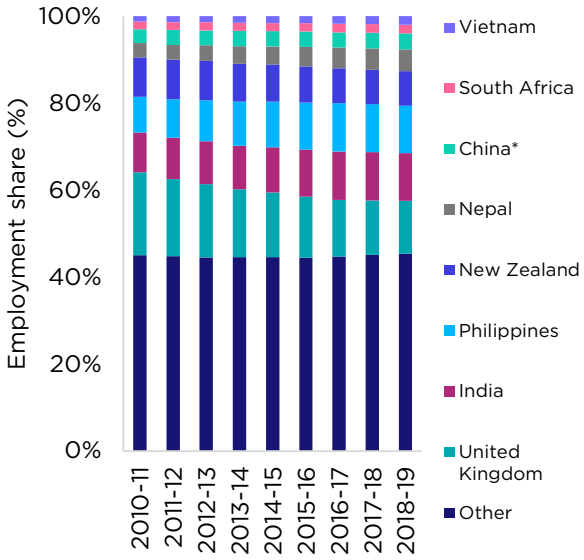


Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

4.9.2.3 Occupation, by common country of birth, 2010-11 to 2018-19 - charts

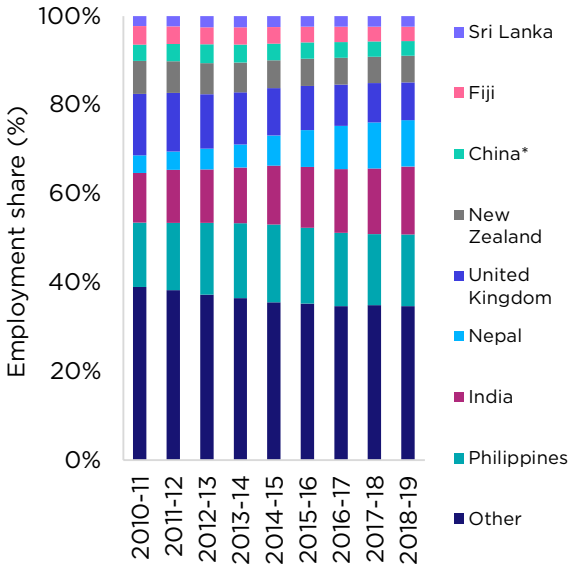
The distribution of country of birth for people who were born overseas and working in selected care and support occupations are presented below. Some occupations have not been included due to small numbers. Note that these data include all industries, not just the Study's in-scope industries.

Figure 104: *Aged and disabled carers* (all industries), country of birth, 2010-11 to 2018-19



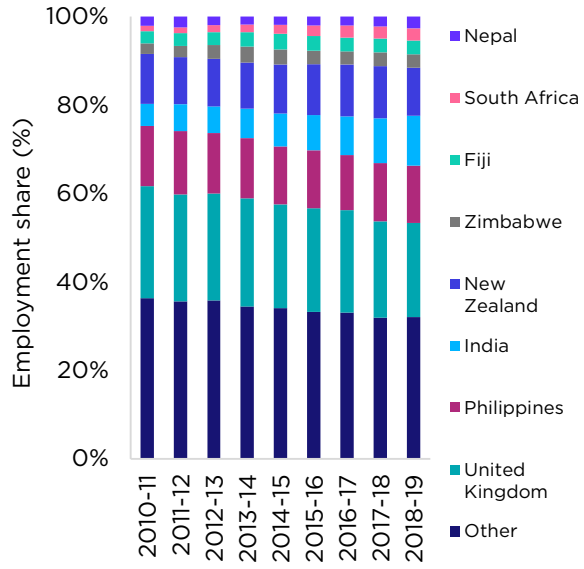
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Excludes Australia. * Excludes SARs and Taiwan.

Figure 105: *Nursing support and personal care workers* (all industries), country of birth, 2010-11 to 2018-19



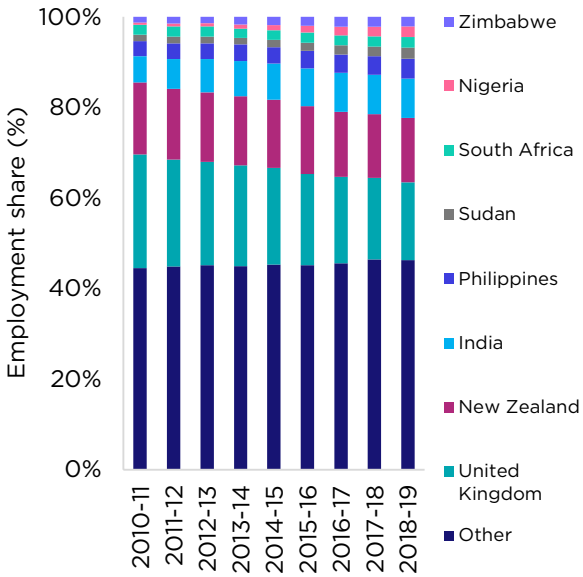
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Excludes Australia. * Excludes SARs and Taiwan.

Figure 106: *Enrolled and mothercraft nurses* (all industries), country of birth, 2010-11 to 2018-19



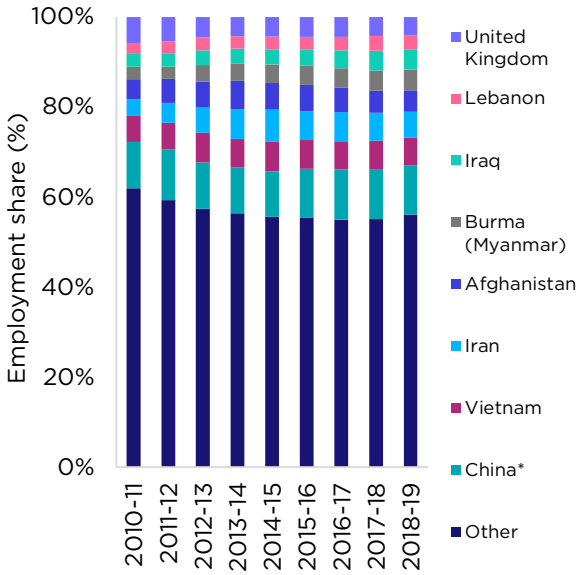
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Excludes Australia.

Figure 107: *Welfare support workers* (all industries), country of birth, 2010-11 to 2018-19



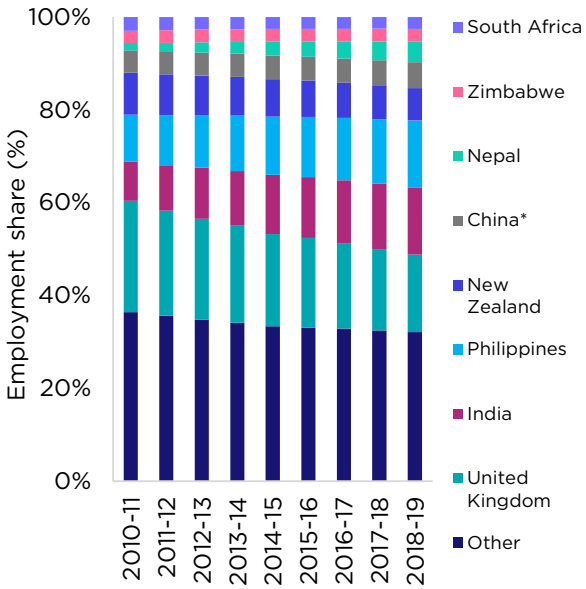
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Excludes Australia.

Figure 108: *Social professionals* (all industries), country of birth, 2010-11 to 2018-19



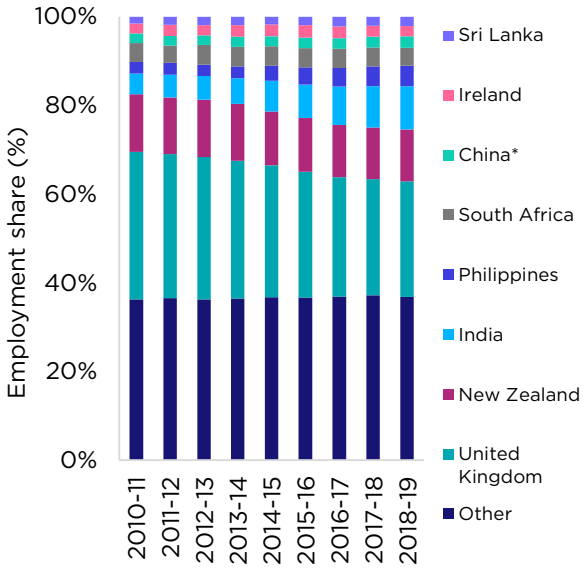
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Excludes Australia. * Excludes SARs and Taiwan.

Figure 109: *Registered nurses* (all industries), country of birth, 2010-11 to 2018-19



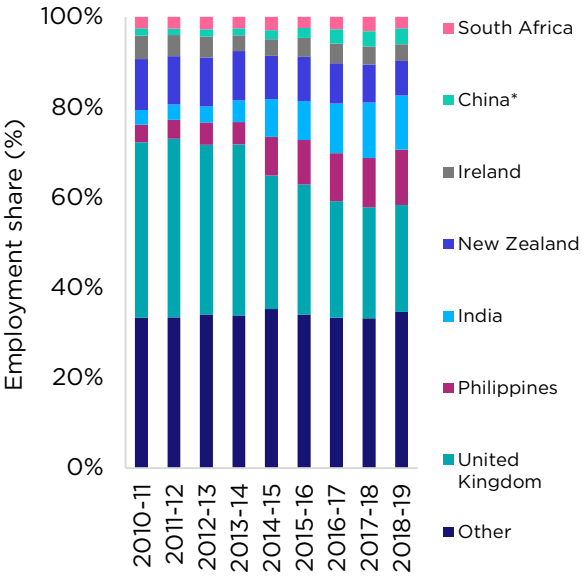
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Excludes Australia. * Excludes SARs and Taiwan.

Figure 110: *Health and welfare services managers* (all industries), country of birth (%), 2010-11 to 2018-19



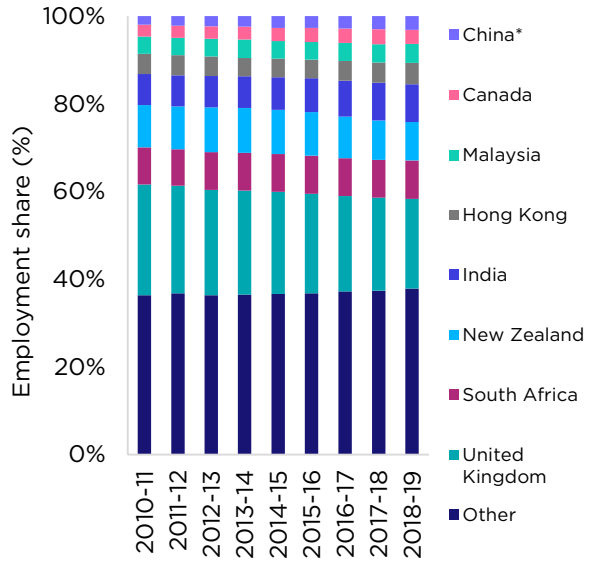
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Excludes Australia. * Excludes SARs and Taiwan.

Figure 111: *Nurse managers* (all industries), country of birth (%), 2010-11 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Excludes Australia. * Excludes SARs and Taiwan.

Figure 112: Allied health professionals (all industries), country of birth (%), 2010-11 to 2018-19



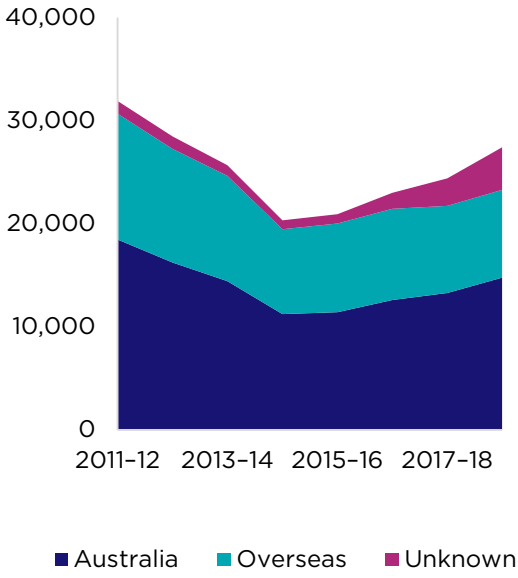
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Excludes Australia. *Excludes SARs and Taiwan. The Allied health professionals occupation group includes *Nutrition professionals*, *Occupational therapists*, *Physiotherapists*, *Podiatrists*, and *Audiologists and speech pathologists/therapists*. These occupations have not been reported separately due to small counts.

4.9.2.4 New entrants to care and support occupations, Australian-born and overseas-born - charts

A new entrant is considered to be someone who recorded an occupation who, in the previous year, had recorded a different occupation, occupation not stated, or no wage or tax return. New entrants therefore includes people moving occupations, those joining the Australian workforce for the first time (for example, a young person or new migrant), or someone re-joining the workforce.

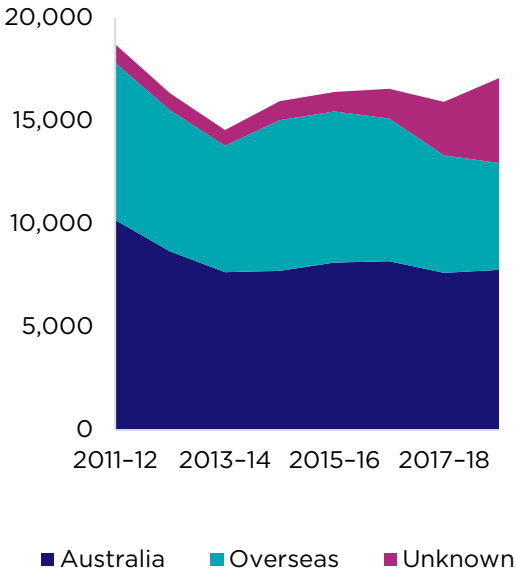
Some occupations have not been included due to small numbers. Note that these data include all industries, not just the Study's in-scope industries.

Figure 113: *Aged and disabled carers* (all industries), new entrants by place of birth, 2011-12 to 2018-19



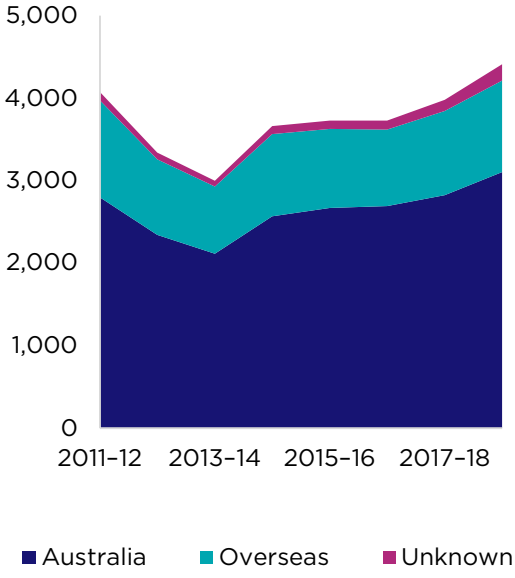
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 114*: Nursing support and personal care workers* (all industries), new entrants by place of birth, 2011-12 to 2018-19



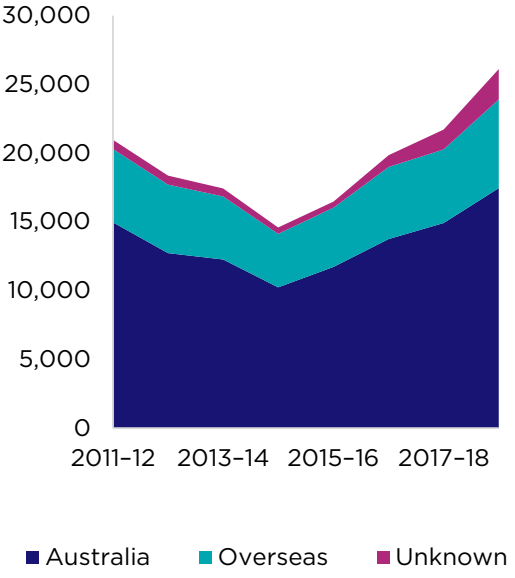
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 115: *Enrolled and mothercraft nurses* (all industries), new entrants by place of birth, 2011-12 to 2018-19



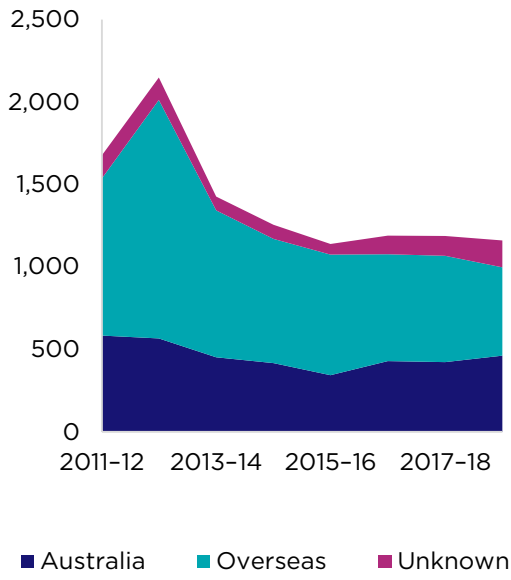
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 116: *Welfare support workers* (all industries), new entrants by place of birth, 2011-12 to 2018-19



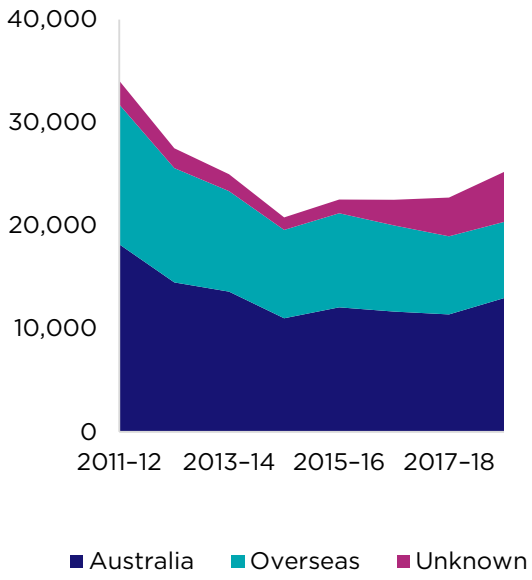
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 117: *Social professionals* (all industries), new entrants by place of birth, 2011-12 to 2018-19



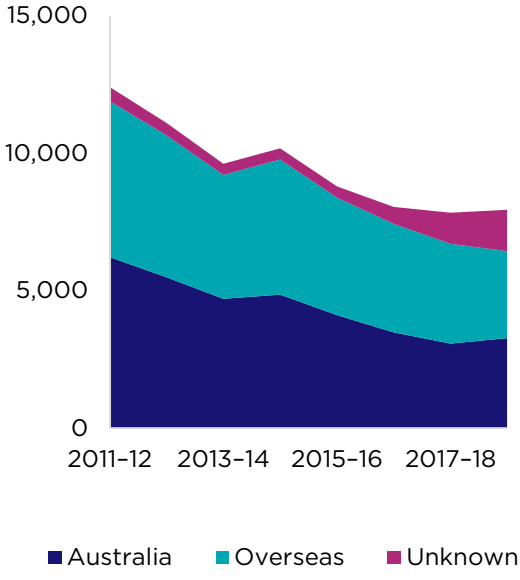
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 118: *Registered nurses* (all industries), new entrants by place of birth, 2011-12 to 2018-19



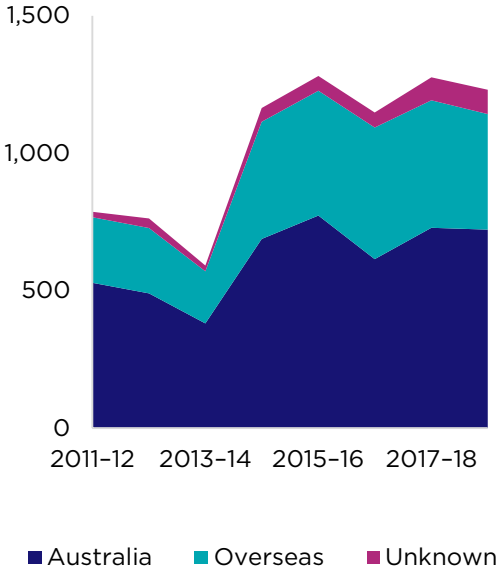
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 119: *Registered nurses (aged care)* (all industries), new entrants by place of birth, 2011-12 to 2018-19



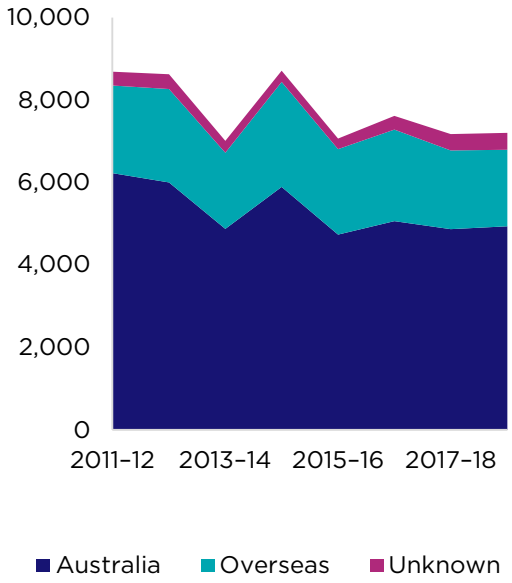
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. *Registered nurses (aged care)* is a 6-digit ANZSCO occupation.

Figure 120: *Nurse managers* (all industries), new entrants by place of birth, 2011-12 to 2018-19



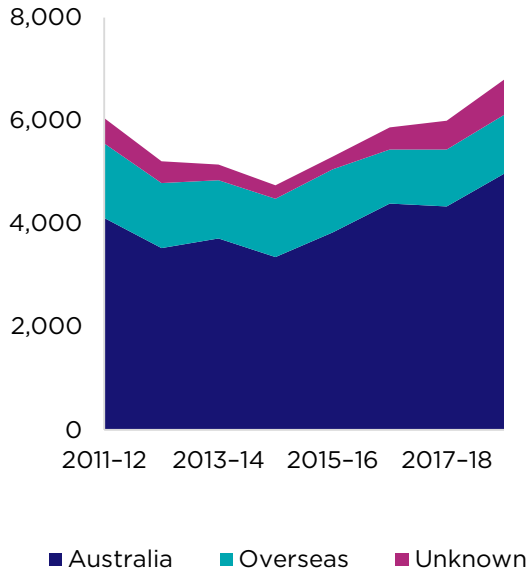
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 121: *Health and welfare services managers* (all industries), new entrants by place of birth, 2011-12 to 2018-19



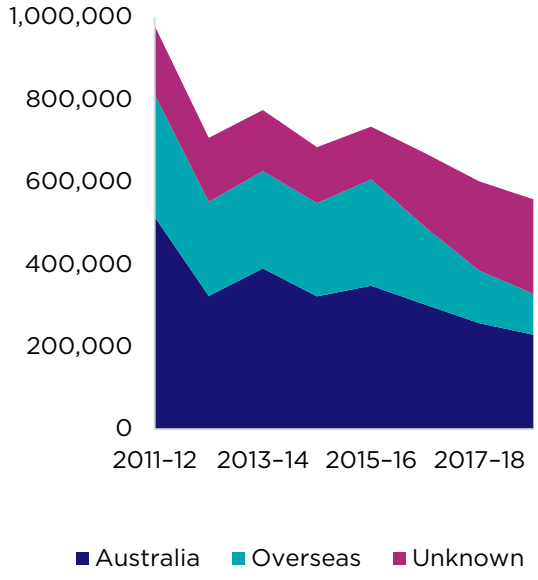
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 122: Allied health professionals (all industries), new entrants by place of birth, 2011-12 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. The Allied health professionals occupation group includes *Nutrition professionals*, *Occupational therapists*, *Physiotherapists*, *Podiatrists*, and *Audiologists and speech pathologists/therapists*. These occupations have not been reported separately due to small counts.

Figure 123: Total employed (all industries), new entrants by place of birth, 2011-12 to 2018-19

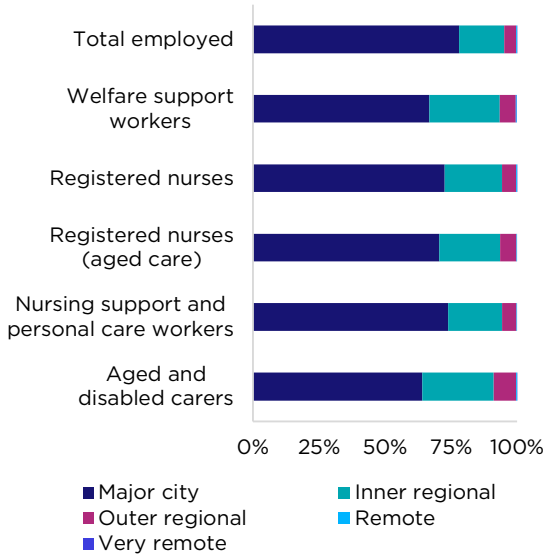


Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

4.9.3 Care and support workforce, regional distribution – charts

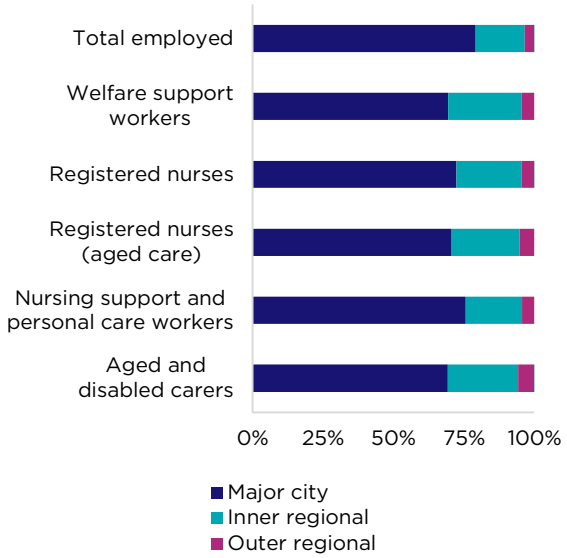
The distribution of selected care and support occupations by remoteness area by state and territory are presented below. Some occupations have not been included due to small numbers. Note that these data include all industries, not just the Study's in-scope industries. Data by remoteness is not applicable to the ACT.

Figure 124: Care and support workers (all industries), New South Wales by remoteness, 2018-19



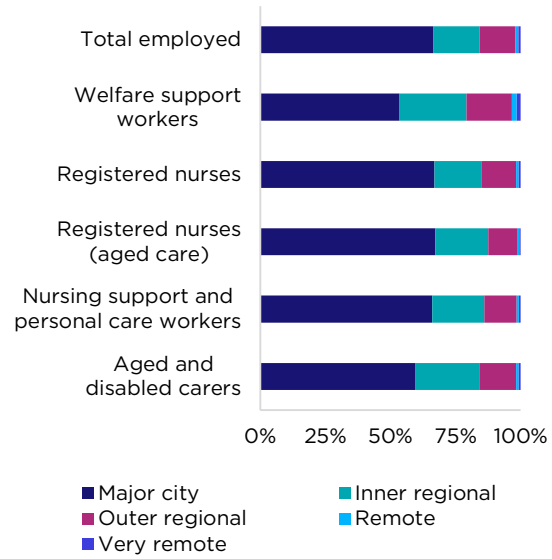
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Counts of Remote (RA3) and Very remote (RA4) were combined for *Nursing support and personal care workers* and *Registered nurses (aged care)* to comply with ABS data release rules.

Figure 125: Care and support workers (all industries), Victoria by remoteness, 2018-19



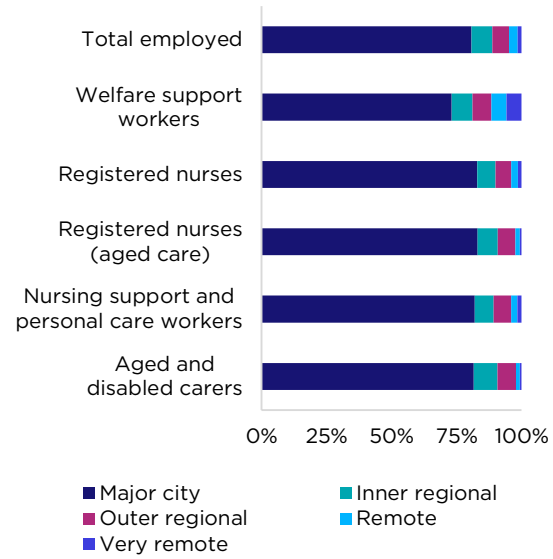
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Counts of Outer regional (RA2) and Remote (RA3) were combined for *Nursing support and personal care workers, Registered nurses (aged care)* and *Welfare support workers* to comply with ABS data release rules.

Figure 126: Care and support workers (all industries), Queensland by remoteness, 2018-19



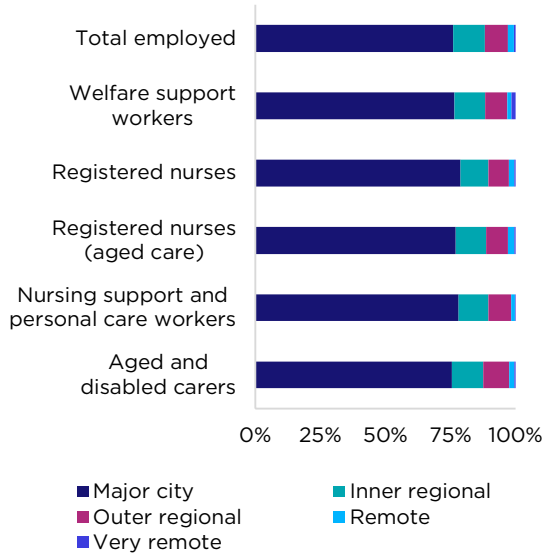
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 127: Care and support workers (all industries), Western Australia by remoteness, 2018-19



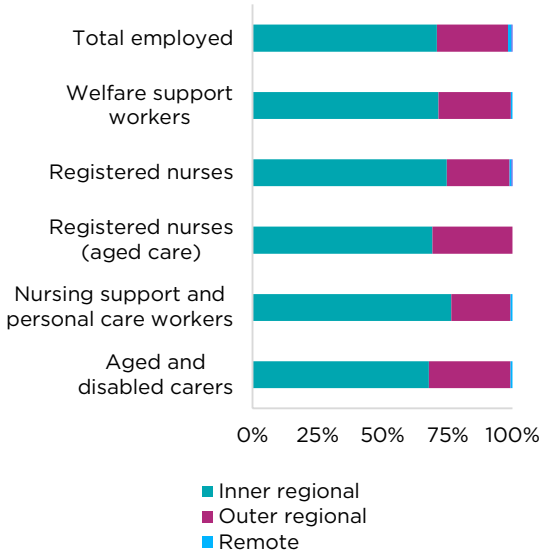
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 128: Care and support workers (all industries), South Australia by remoteness, 2018-19



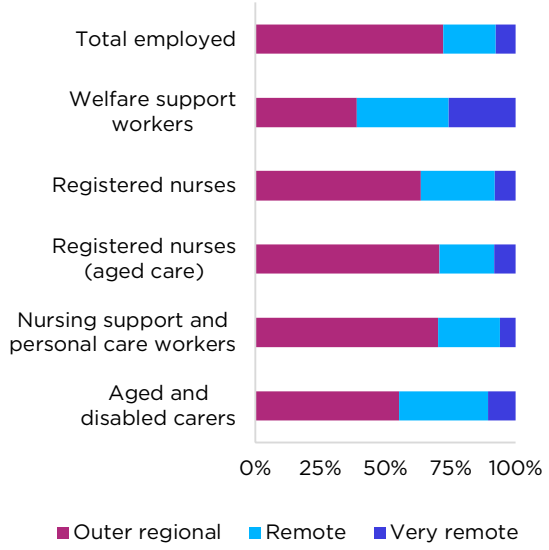
Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Figure 129: Care and support workers (all industries), Tasmania by remoteness, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Counts of Remote (RA3) and Very remote (RA4) were combined for *Aged and disabled carers, Nursing support and personal care workers* and *Welfare support workers*. Counts of Outer regional (RA2) and Remote (RA3) were also combined for *Registered nurses (aged care)* to comply with ABS data release rules.

Figure 130: Care and support workers (all industries), Northern Territory by remoteness, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP.

Part 5
Labour market characteristics of the care and support workforce

Part 5 highlights a number of labour market characteristics of the care and support workforce.

There appears to be a set of complex interactions at play that have resulted in the labour market characteristics of the care and support workforce.

While some indicators such as lower average hours worked per week and underemployment rates might suggest latent capacity within the care and support sector, the extent to which this latent capacity can be used is dependent on a range of other factors (from system settings to worker and provider preferences).

The care and support workforce tends to be more part-time and casual than the economy wide average

Around half of the care and support workforce are employed on a part-time basis, with around 240,000 people (52%) working fewer than 35 hours a week in February 2021.

- Personal care and support workers (61%) and Registered nurses (59%) are more likely to work part-time than Allied health professionals or the overall care and support workforce.

The care and support workforce are much more likely to be employed on a casual basis (defined as workers without paid leave entitlements) than other Australian workers.

- In February 2021, around 28% of the care and support workforce were casual workers, compared with 19% of the total Australian workforce, 18% of the broader *Health care and social assistance* industry, and 9% of the mental health workforce.

Stakeholder feedback provided mixed views on the propensity for parts of the care and support workforce to be engaged on a part-time and/or casual basis, with some aged care providers indicating these arrangements were 'historical' and 'long standing', while other providers across aged and disability care and support indicated these arrangements were driven by system settings. That is, the shift to person-centred care, combined with market driven approaches to care, has seen providers need to adjust their business models towards more flexible workforce rostering and scheduling to cater for recipients varied and less structured needs.

Given this greater tendency toward part-time employment, average hours worked per week is below the economy-wide average. The strong increase in demand for care and support over recent years has largely been met by an increase in the number of people working in the care and support sector; not an increase in the average number of hours worked per person.

- That said, there was a slight uptick in average weekly hours for care and support workers over the year to February 2021, which corresponds with a slight decline in the number of people employed in the care and support workforce and may reflect the impact of COVID-19 on the sector and also Australia's extended international border closure.

Lower average hours, but recruitment difficulties exist

The relatively low number of average hours worked across some occupations in the care and support workforce and reported underemployment sits in contrast with a relatively high proportion of employers experiencing difficulty when recruiting workers for care and support occupations.

This suggests that the shortage may be distributional in nature or arise from a mismatch in employers' needs and workers' preferences, rather than simply a lack of workers.

- For example, in February 2021, around 3% of the care and support workforce indicated that they would or might be willing to move interstate if offered a suitable job, while around 5% reported a willingness to move within state. This implies a relatively low propensity to relocate for work within the workforce.

Employers have also reported challenges around recruiting appropriately skilled and qualified workers. This suggests people are continuing to apply for care and support occupations, but a proportion are unsuccessful as they may not be trained to an adequate standard, lack the necessary characteristics desired by employers, or may be unwilling to move to where the jobs are.

Further, more care and support workers would prefer to remain in their current jobs than change employers or occupations to work more hours – suggesting there are opportunities to increase current workforce utilisation and improve retention in the sector.

These distributional and preferential mismatches – combined with recent structural shifts in the care and support landscape – are likely to have contributed to the higher underemployment experienced by the care and support workforce relative to the broader labour force.

Many care and support workers hold multiple jobs

Care and support workers are nearly twice as likely to have more than one job than other workers. In February 2021, around 11% of the care and support workforce (or around 50,000 people) reported holding multiple jobs, compared with around 6% of the overall workforce. Almost two-thirds of multiple job holders in the care and support workforce (or around 30,000) are Personal care and support workers.

Stakeholder views were mixed when asked about the drivers for workers employed in multiple jobs. Unions cited lack of employment security, low average hours and the need for a living wage. In contrast, providers cited employee preference for job diversity, or more commonly beneficial tax treatment when working for not-for-profit providers which could be maximised through multiple jobs.

Given differences in occupations, incomes vary across the care and support sector

There is a significant degree of variability in incomes across the care and support workforce. This variability reflects both higher average hourly rates of pay for higher skill level occupations versus lower skill level occupations – illustrative of the wage premium typically associated with higher level qualifications; but also the tendency for lower skill level occupations to have lower average hours worked per week. That is, those occupations with the lowest hourly earnings were also those occupations that tended to work the lowest number of hours per week on average.

- Four out of 5 broad occupation groups considered in this Study, and representing 95% of the care and support workforce, earned below the Australian average in May 2018. The largest occupation group, Personal care and support workers, had the lowest weekly earnings, $523 below the Australian average. Allied health professionals had the second lowest weekly earnings, $268 below the Australian average.
- Health and welfare managers was the only occupation group with weekly earnings higher than the Australian average ($754 above average).

The Study also examined earnings by age. On average and across the economy as a whole, incomes tend to increase with age, peaking at around 45-54 years (that said, this progression tends to be more pronounced for males than females). However, for Personal care and support workers, there was little to no earnings variation across age groups. Higher skill level occupations

in the care and support workforce do tend to see greater variation in earnings between age groups, with this being most pronounced for Allied health professionals.

Finally, while differences in wages earnt across the relevant programs have been identified by some stakeholders, the current data classifications do not allow for the disaggregation across industries to easily quantify these reflections. That said, based on available data, Personal care and support workers and Health and welfare support workers appear to earn marginally more per hour if they are employed in the *Social assistance services* industry (which includes in-home aged care, disability support and other industries) relative to the *Residential care services* industry (which includes residential aged care).

Greater average hours would boost the incomes of Personal care and support workers

The Study also compared the earnings of Personal care and support workers with a selection of other ANZSCO skill level 3-5 occupations outside of the *Health care and social assistance* industry.

The average hourly earnings of Personal care and support workers were higher than most comparison occupations. However, the average hours worked by Personal care and support workers were lower than most comparable occupations, including administrative roles (*Information officers*, *Accounting clerks*, *Keyboard operators*) but slightly higher than some retail, cleaning and hospitality occupations.

While the hourly earnings of Personal care workers and support workers are competitive amongst these selected comparison occupations, low hours worked mean the annual earnings of Personal care and support workers tend to be lower. With higher average hours worked, Personal care and support workers would see more competitive annual earnings.

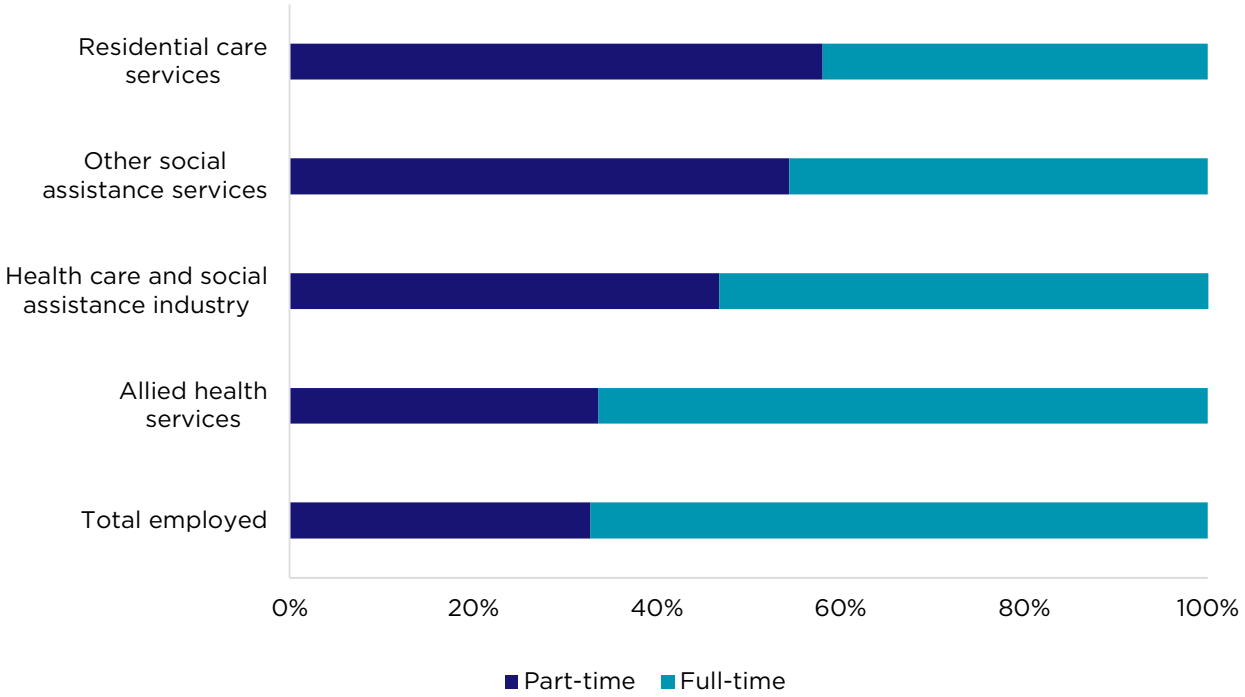
5.1 Half of the care and support workforce work part-time

Around half (52%) of the care and support workforce were employed on a part-time basis (i.e. working fewer than 35 hours a week in February 2021).[104] Many of these workers are employed in the *Residential care services* industry as well as the *Other social assistance services* industry. Workers in the *Residential care services* industry were much more likely to be employed on a permanent part-time basis than other industries (Figure 131).

The 2020 ACWC shows that 71% of workers in residential care are permanent part-time, compared with 68% of CHSP workers and 50% of home care workers, noting this only includes provider responses and not worker responses.[105]

These part-time shares are much higher than for the mental health workforce (45%), the *Health care and social assistance* industry (47%) or for the total workforce (33%), where people are more likely to be employed on a full-time basis.[106]

Figure 131: Full-time or part-time share in current main job by industry, February 2021



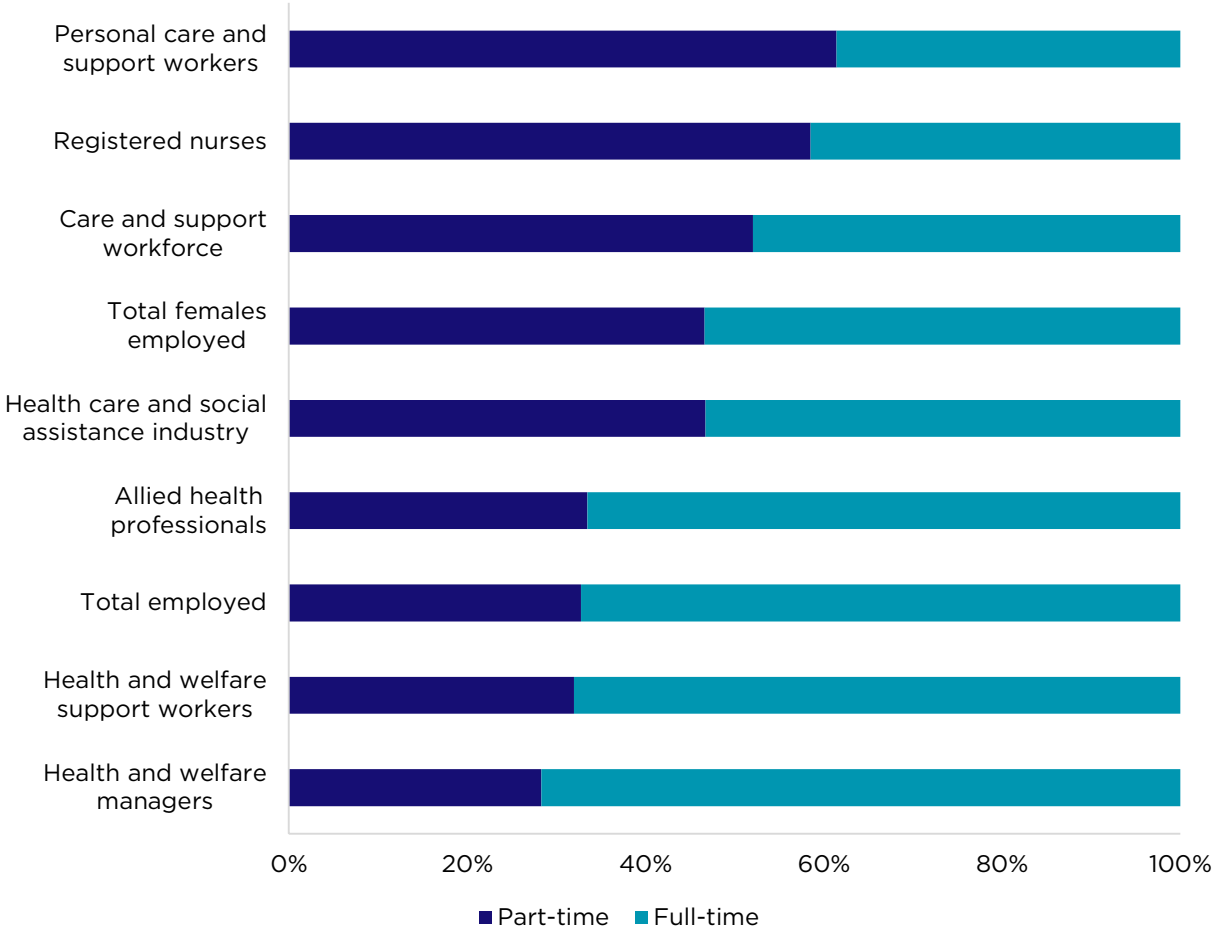
Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder. *Allied health services*, *Residential care services* and *Other social assistance services* includes the 15 in-scope ANZSCO 4-digit occupations. *Other social assistance services* is a 3-digit industry which consists of businesses engaged in the provision of a wide variety of social support services directly to their clients (outside of accommodation services, except on a short stay basis). This includes aged care assistance services, disabilities assistance services and welfare counselling services. See Figure 2 for further detail. Due to data perturbation by the ABS, discrepancies may occur between sums of the component items and totals.

Personal care and support workers (61%) and Registered nurses (59%) are more likely to work part-time than Allied health professionals or the overall care and support workforce (Figure 132). This is partly attributed to the high concentration of females in these occupations (Part 4.3) – as women are much more likely than men to work part-time in Australia. In June 2021, around 45% of employed women worked part-time, compared with around 20% of employed men.[107] The system

[104] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021
[105] Department of Health, National Aged Care Workforce Census 2020, 2021
[106] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021
[107] ABS, Labour Force, Australia, Detailed, June 2021, 2021

settings and shift to person-centred care and support in both aged care and NDIS in recent years (Part 8.3) may have also contributed to this trend.

Figure 132: Full-time or part-time share in current main job by occupation, 2021



Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder. Due to data perturbation by the ABS, discrepancies may occur between sums of the component items and totals. Data for 3 in-scope 3-digit ANZSIC industries.

Personal care and support workers are the most likely to work part-time across all age groups – even when compared with workers of similar ages in other industries.

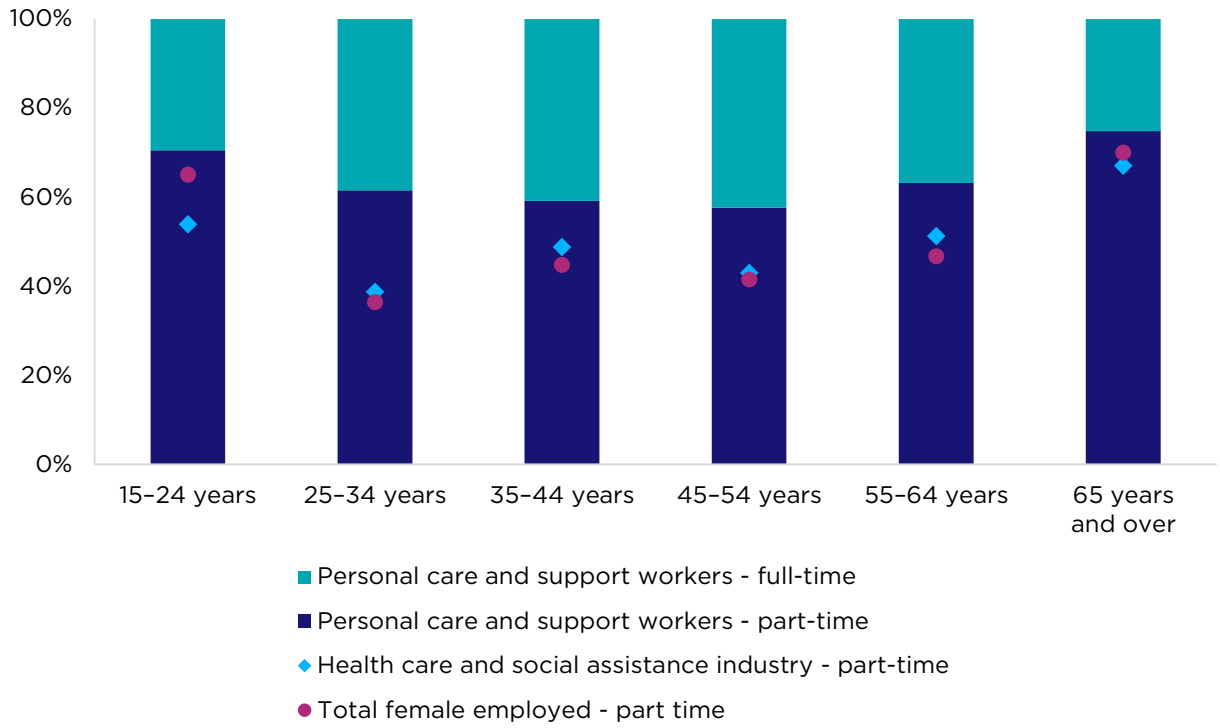
- Nearly three-quarters of young (15–24 years) or mature age (65 years and over) Personal care and support workers are employed part-time.[108] This likely reflects the preference for part-time work among young people who combine work and study, as well as older workers who are transitioning to retirement.
- Across other age groups Personal care and support workers between the ages of 25–64 are still more likely to work part-time than other workers (Figure 133). This may reflect a strong preference for part-time hours among workers, many of whom are relatively older females. Individuals with informal caring responsibilities may also be attracted to the flexible work arrangements offered in this line of work, thus contributing to the high part-time share for these occupations.

Stakeholder feedback provided mixed views on the propensity for parts of the care and support workforce to be engaged on a part-time and/or casual basis (Part 5.2), with some aged care providers indicating these arrangements were 'historical' and 'long-standing', while other

[108] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

providers across aged and disability care indicated these arrangements were driven by system settings (Part 8.3).

Figure 133: Comparison of part-time Personal care and support workers by age, 2021



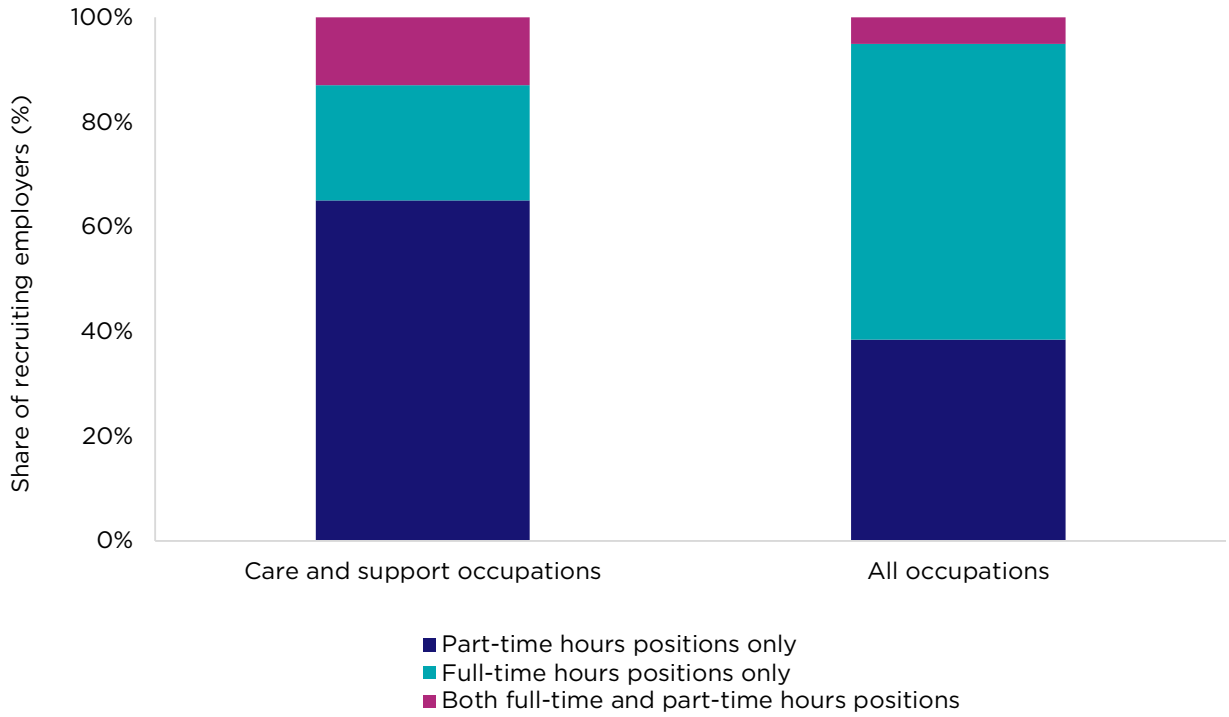
Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder. For Personal care and support workers, data is for 3 in-scope 3-digit ANZSIC industries.

Recent data from the NSC's REOS[109] (Figure 134) also shows that around two-thirds (65%) of employers recruiting for care and support occupations between 11 January 2021 to 13 August 2021 were trying to fill part-time positions only, compared with 38% for all occupations.

While the REOS sample size does not allow for the reporting of statistics by occupation groups, the data suggests that the trend towards part-time positions is more prominent in recruitment for Personal care and support workers.

[109] NSC, *Recruitment Experiences and Outlook Survey (REOS), unpublished data*, 2021

Figure 134: Recruitment for full-time and part-time care and support positions, 11 January 2021 to 13 August 2021



Source: NSC, REOS, 2021. *Note that the REOS dataset does not include all the Study's in-scope care and support occupations. REOS includes *Aged and disabled carers*, *Nursing support and personal care workers* and *Welfare support workers*, regardless of industry of employment. REOS also includes *Registered nurses*, *Enrolled and mothercraft nurses*, *Audiologists and speech pathologists/therapists*, *Physiotherapists* and *Podiatrists*, where they are employed in the *Residential care services*, *Allied health services* or *Other social assistance services* industries.

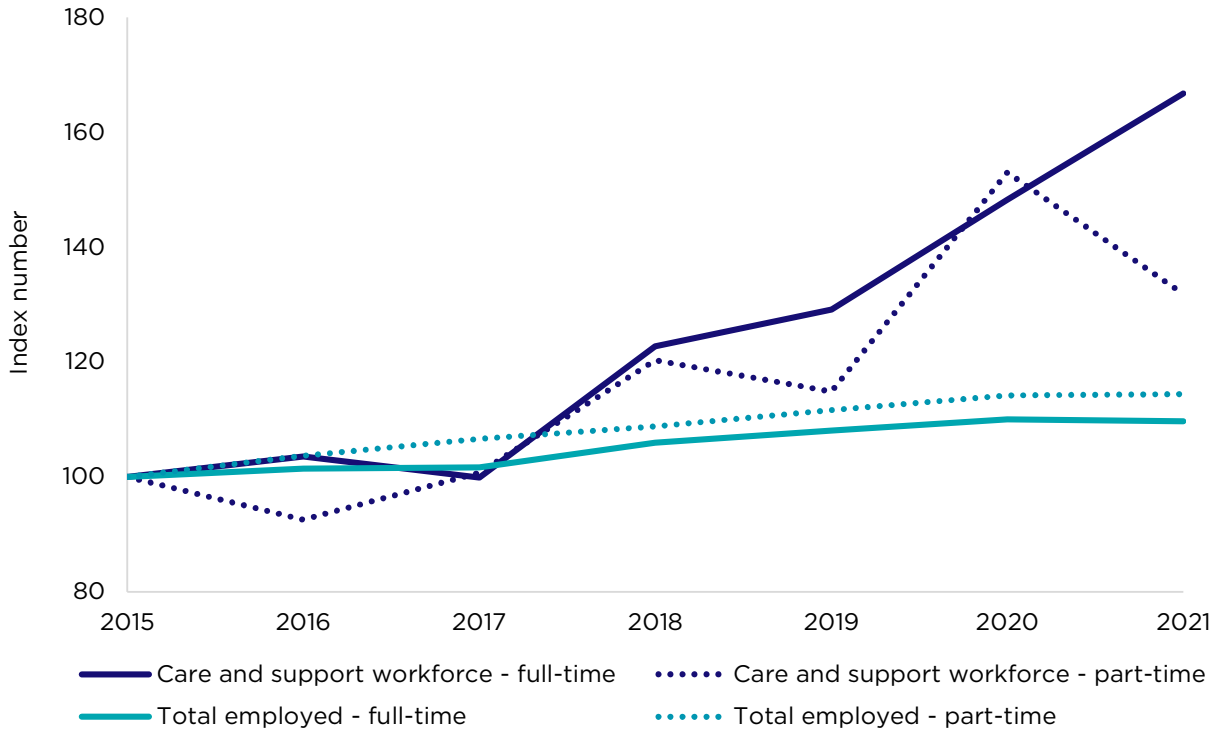
Over the 5 years to 2020 the pace of growth in part and full-time care and support jobs has been broadly similar (taking into account the volatility in the data) as shown in Figure 135. Over the past year, however, there has been more rapid growth in full-time jobs, which might more reflect the impacts of COVID-19 than the start of a new trend.[110]

In contrast, part-time employment across the overall Australian workforce has grown at a slightly faster rate than full-time employment.[111]

[110] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

[111] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

Figure 135: Full-time and part-time employment indexes (100 = February 2015)



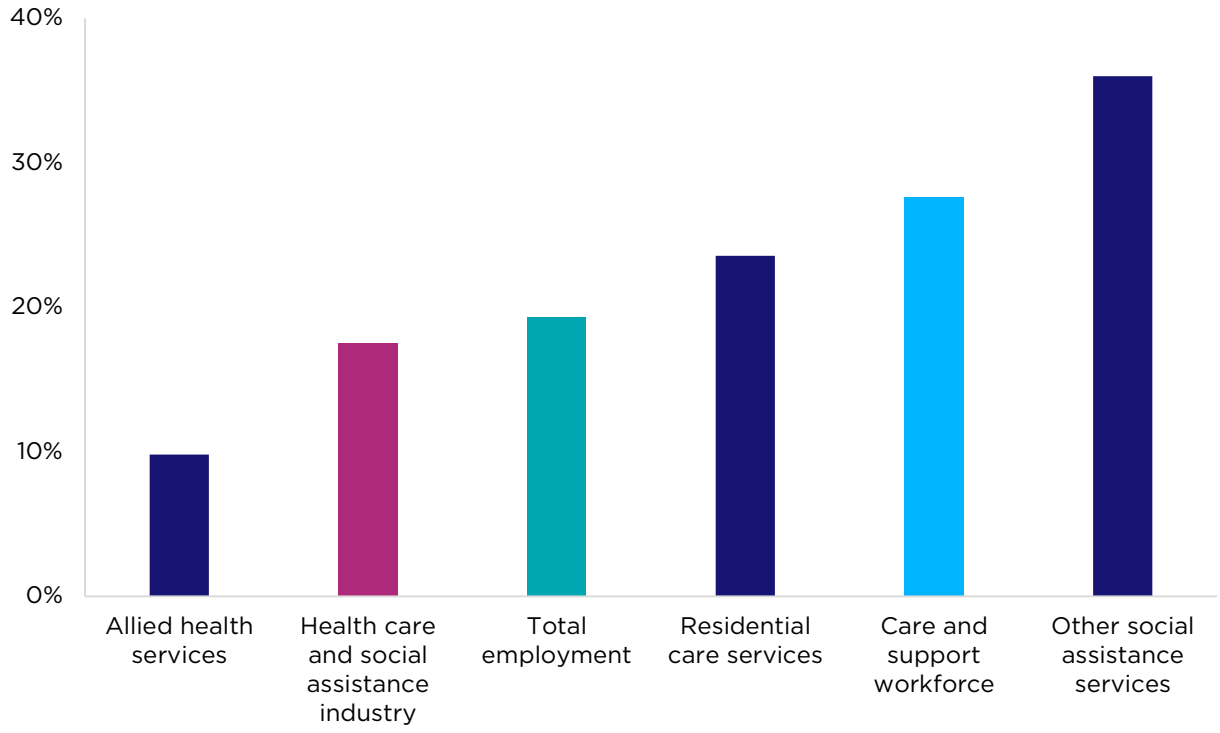
Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder.

5.2 Casualisation is relatively high

The care and support workforce are much more likely to be employed on a casual basis (defined as workers without paid leave entitlements) than other Australian workers. (Under the definitions used by the ABS, and applied by this Study, an employee is considered part-time based on the number of hours they work. Casual employment is defined with reference to paid leave entitlements. It is therefore possible for a casual employee to also be a full-time employee, and for a part-time employee to not be casual.)

In February 2021, around 28% of the care and support workforce were casual workers, compared with 19% of the total Australian workforce, 18% of the broader *Health care and social assistance* industry, and 9% of the mental health workforce (Figure 136).[112]

Figure 136: Casualisation of care and support workforce by industry, February 2021

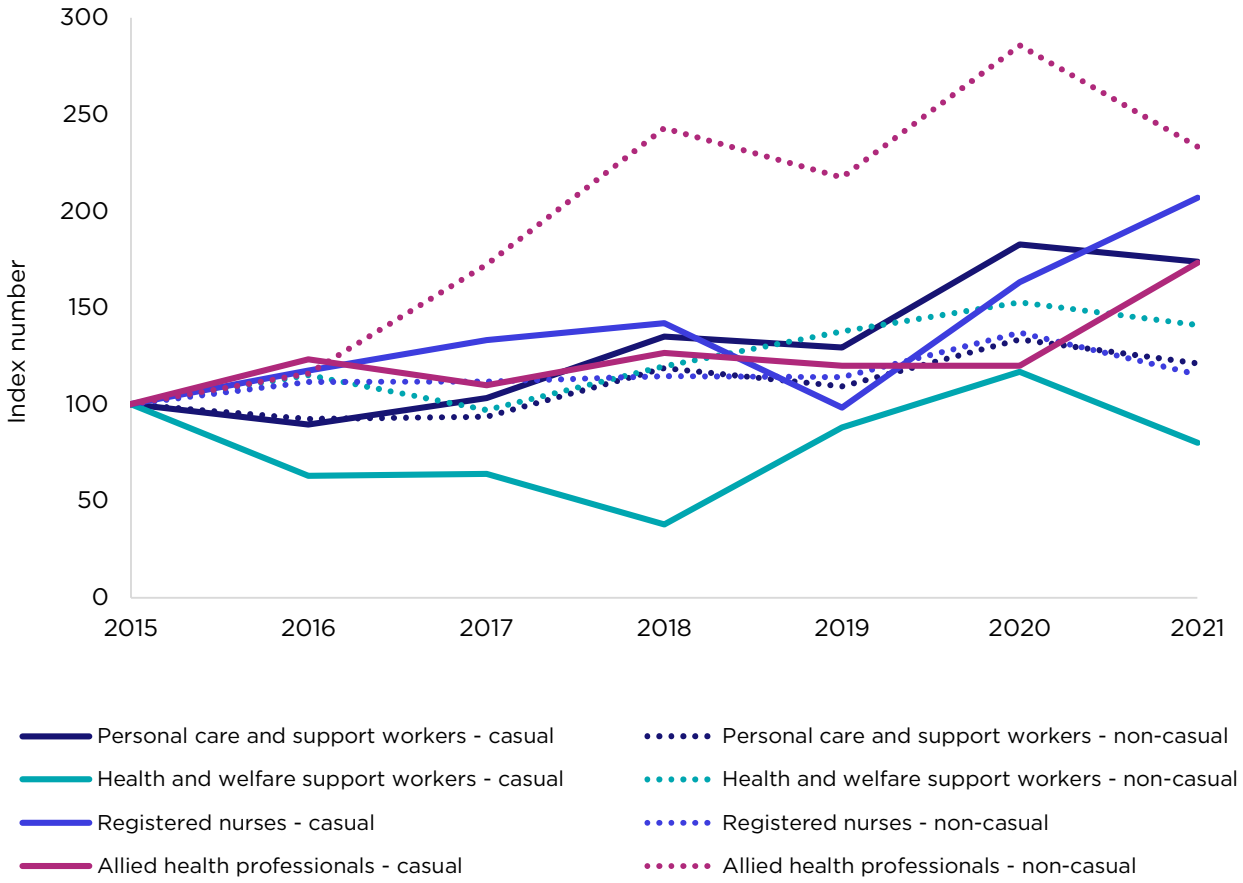


Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder. *Allied health services*, *Residential care services* and *Other social assistance services* includes the 15 in-scope ANZSCO 4-digit. *Other social assistance services* is a 3-digit industry which consists of businesses engaged in the provision of a wide variety of social support services directly to their clients (outside of accommodation services, except on a short stay basis). This includes aged care assistance services, disabilities assistance services and welfare counselling services. See Figure 2 for further detail.

Between February 2015 and February 2021, the number of care and support workers employed on a casual basis grew by around 73%, compared with 29% growth in non-casual workers. Over this period growth in casual employment for Registered nurses and Personal care and support workers outpaced growth in non-casual employment. This contrasts with the trends observed for Allied health professionals and Health and welfare support workers (Figure 137).

[112] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

Figure 137: Casual and non-casual employment indexes, by occupation group, in care and support industries (100 = February 2015)

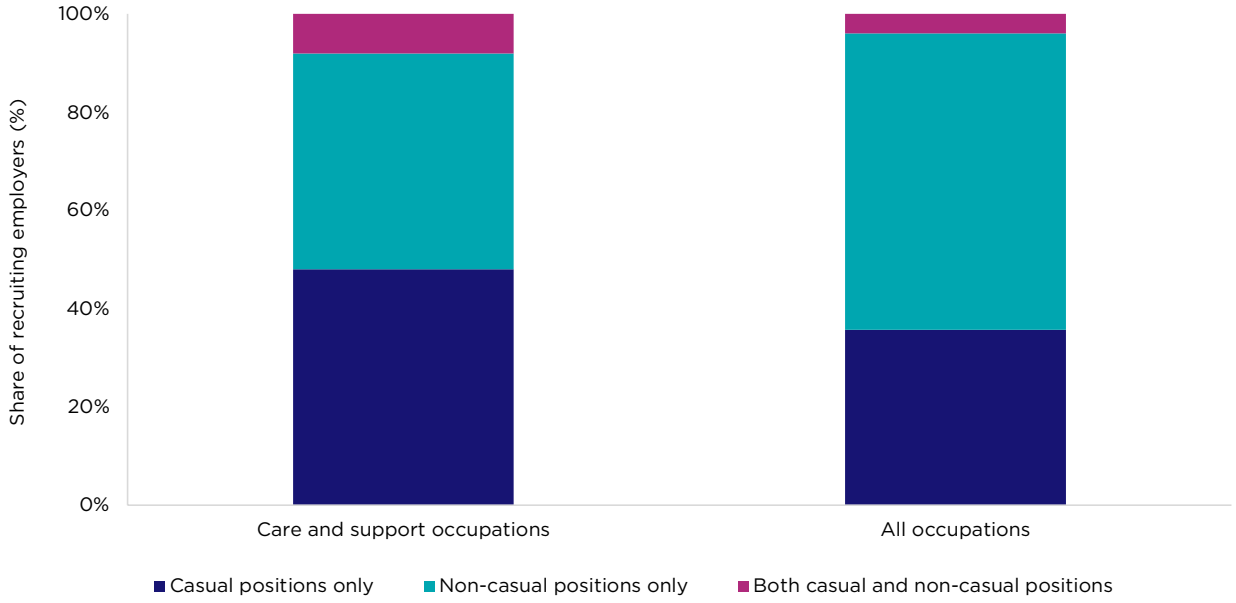


Source: ABS Participation, Job Search and Mobility, February 2015 to February 2021 in TableBuilder. Data includes 3 in-scope 3-digit ANZSIC industries.

This trend toward increased casualisation of the workforce is also reflected in recruitment activity. Around half (48%) of employers recruiting for care and support occupations between 11 January 2021 to 13 August 2021 were trying to fill *casual* positions only, compared with 36% for all occupations (Figure 138).[113]

[113] NSC, *Recruitment Experiences and Outlook Survey (REOS), unpublished data*, 2021

Figure 138: Recruitment for casual and non-casual positions, 11 January 2021 to 13 August 2021



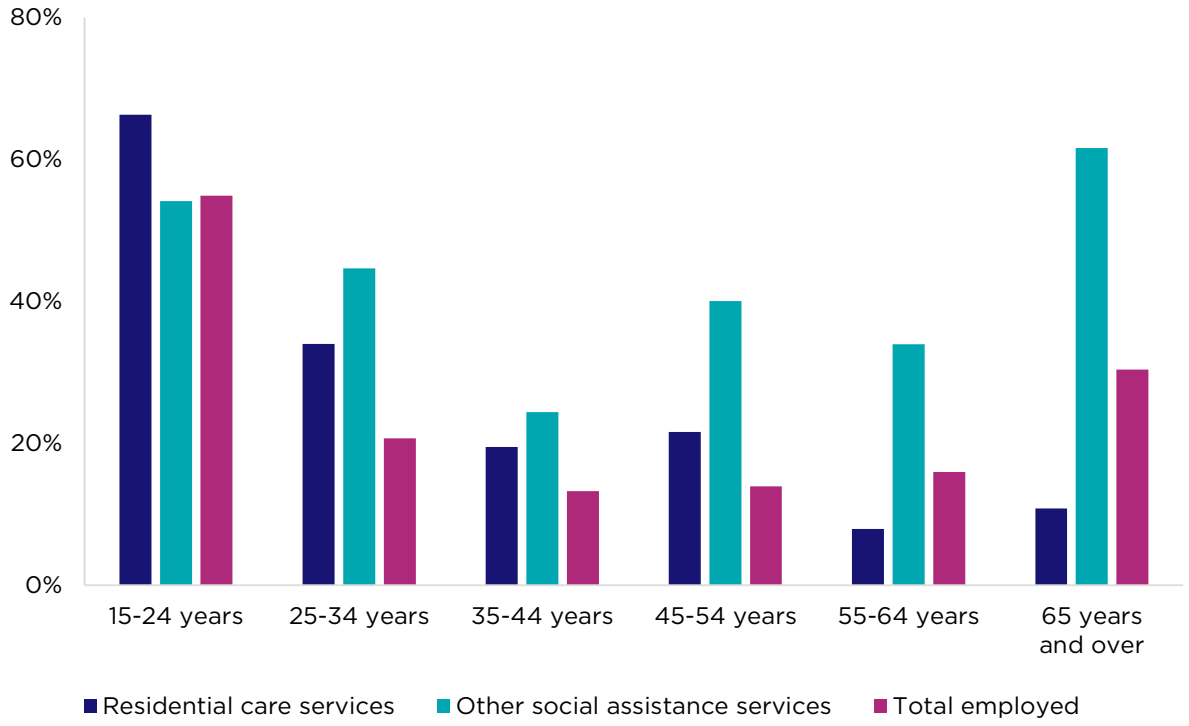
Source: NSC, REOS, 2021. *Note that the REOS dataset does not include all the Study's in-scope care and support occupations. REOS includes *Aged and disabled carers*, *Nursing support and personal care workers* and *Welfare support workers*, regardless of industry of employment. REOS also includes *Registered nurses*, *Enrolled and mothercraft nurses*, *Audiologists and speech pathologists/therapists*, *Physiotherapists* and *Podiatrists*, where they are employed in the *Residential care services*, *Allied health services* or *Other social assistance services* industries.

Providers of care and support services noted the shift to person-centred care, combined with the current market-based approach to care, has meant the need to adjust their business models towards more flexible workforce rostering and scheduling to cater for recipients varied and less structured needs (discussed in Part 8.3).

There are higher rates of casualisation among both younger and older workers in the *Other social assistance services* industry (Figure 139). This may be related to the shift to person-centred care within this industry, where the majority of in-home and disability support workers are engaged. In contrast, casual workers in the broader labour market tend to be younger workers (aged below 35 years), with casualisation rates typically lower among older cohorts.[114]

[114] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

Figure 139: Casualisation of workforce by industry and age, February 2021



Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder. *Residential care services* and *Other social assistance services* include only the 15 in-scope occupations. *Allied health services* is not included due to small numbers. *Other social assistance services* is a 3-digit industry which consists of businesses engaged in the provision of a wide variety of social support services directly to their clients (outside of accommodation services, except on a short stay basis). This includes aged care assistance services, disabilities assistance services and welfare counselling services. See Figure 2 for further detail.

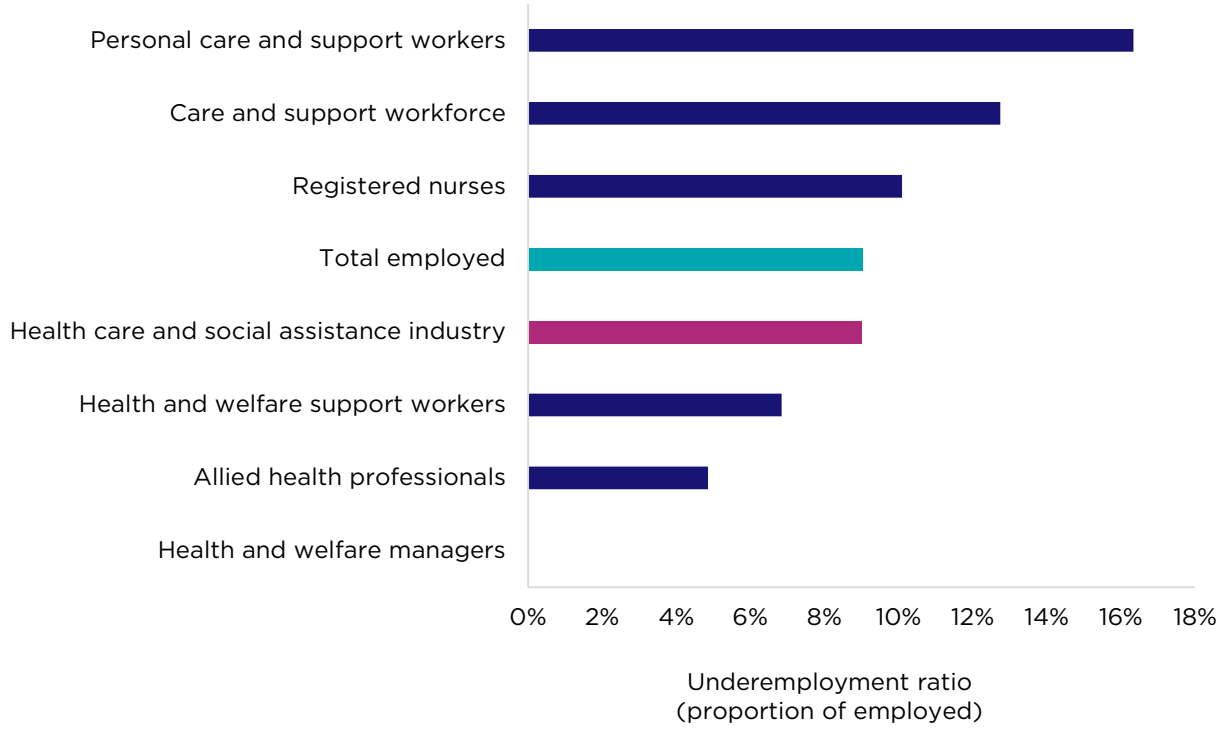
5.3 Underemployment is high but edging down

The increased demand for care and support services in recent years has been associated with a decline in underemployment, with the share of underemployed care and support workers (i.e. people who looked for and were available to work more hours) decreasing from around 16% in February 2015 to 13% in February 2021 (noting that underemployment has been relatively volatile over this period).[115]

However, there may be scope to further reduce labour underutilisation in the care and support workforce.

As shown in Figure 140, underemployment remains elevated across the care and support industries considered in this Study. This is mainly driven by high underemployment among Personal care and support workers (16%), reflecting the higher part-time incidence and lower average hours worked in these occupations.[116]

Figure 140: Underemployment ratio (proportion of employed), care and support workforce, February 2021



Source: ABS Participation, Job Search and Mobility, February 2021 in TableBuilder. Data is for 3 in-scope ANZSIC industries.

The relatively high rates of reported underemployment among the care and support workforce sits in contrast with the relatively higher rates of difficulty employers face when recruiting workers for care and support occupations.

This suggests that the shortage may be distributional in nature or arise from a mismatch in employers' needs and workers' preferences, rather than simply a lack of workers.

- For example, underemployed care and support workers may be unavailable or unwilling to work certain hours or shifts offered by employers. In February 2021, around 3% of the care and

[115] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021
[116] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

support workforce indicated that they would or might be willing to move interstate if offered a suitable job, while around 5% reported a willingness to move within state.[117]

- Employers have also reported challenges around recruiting appropriately skilled and qualified workers.[118] Between 21 September 2020 to 13 August 2021, care and support employers cited a lack of suitable applicants (45%), a lack of applicants (34%) and location (28%) as the most common recruitment issues (Figure 282).[119]

This suggests people are continuing to apply for care and support occupations, but a proportion are unsuccessful as they may not be trained to an adequate standard, lack the necessary characteristics desired by employers, or may be unwilling to move to where the jobs are. This is explored further in Part 9.1.1.3

Indeed, more care and support workers would prefer to remain in their current jobs than change employers or occupations to work more hours – suggesting there are opportunities to increase current workforce utilisation and improve retention in the sector.

- In February 2021, around 14,000 care and support workers reported that they would prefer to change employers to work more hours, compared with 40,000 workers who reported that they would prefer *not* to change. In the same period, around 13,000 care and support workers reported they would prefer to change occupations for more work hours, compared with 43,000 people who preferred *not* to change.[120]

These distributional and preferential mismatches – combined with recent structural shifts in the care and support landscape and mismatched system setting (discussed in Part 8.3) – are likely to have contributed to the higher underemployment experienced by the care and support workforce relative to the broader labour force.

[117] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

[118] NSC, submissions to this Study.

[119] NSC, *Recruitment Experiences and Outlook Survey (REOS), unpublished data*, 2021

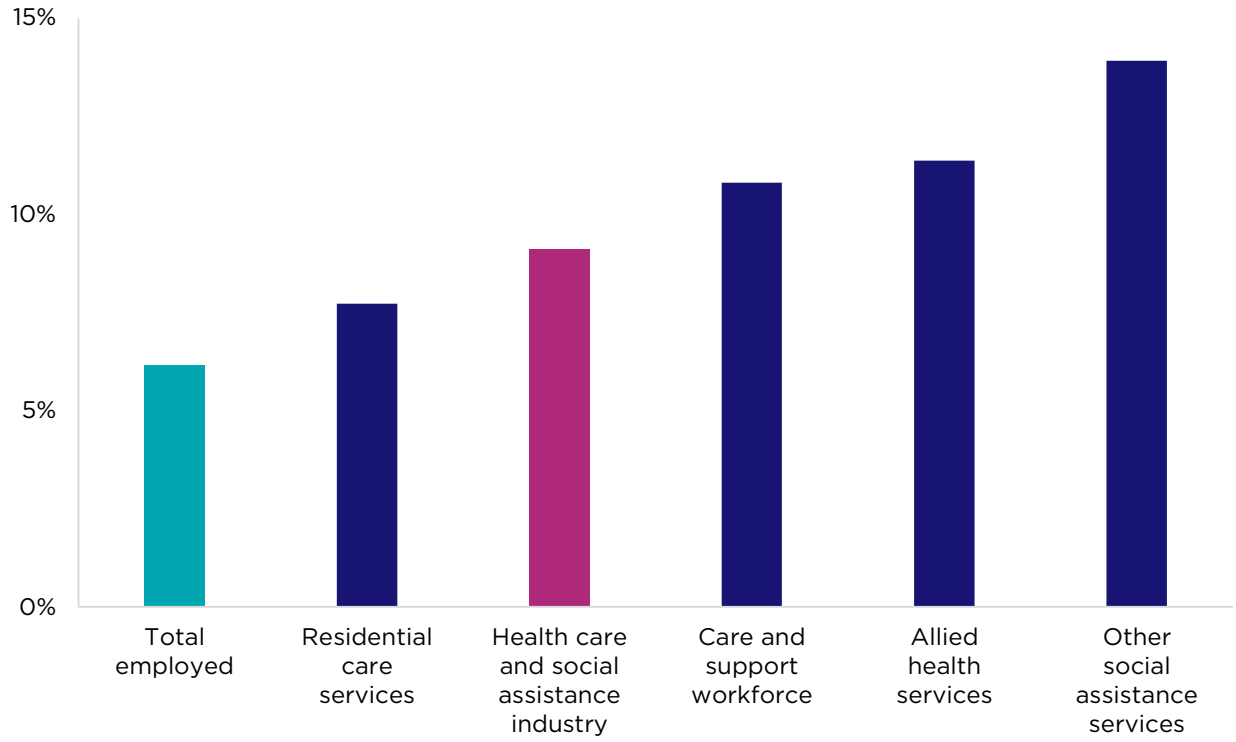
[120] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

5.4 More likely to hold multiple jobs

Care and support workers are nearly twice as likely to have more than one job than other workers. In February 2021, around 11% of the care and support workforce (or around 50,000 people) reported holding multiple jobs, compared with around 6% of the overall workforce, and around 9% of the mental health workforce or the total *Health care and social assistance* industry (Figure 141).

- Almost two-thirds of multiple job holders in the care and support workforce (or around 30,000) are Personal care and support workers.[121]

Figure 141: Share of care and support workforce with multiple jobs by industry, February 2021



Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder. Care and support industries here only include the 15 in-scope occupations. *Allied health services*, *Residential care services* and *Other social assistance services* includes the 15 in-scope ANZSCO 4-digit occupations. *Other social assistance services* is a 3-digit industry which consists of businesses engaged in the provision of a wide variety of social support services directly to their clients (outside of accommodation services, except on a short stay basis). This includes aged care assistance services, disabilities assistance services and welfare counselling services. See Figure 2 for further detail.

As shown in Figure 142, this trend is primarily driven by strong growth in the total number of care and support workers who have multiple jobs that are employed in the *Other social assistance services* industry – rising from around 8,000 workers in February 2015 to over 30,000 workers in February 2021. Many of these workers are employed as *Aged and disabled carers* and *Welfare support workers* (as shown in Part 3.2).

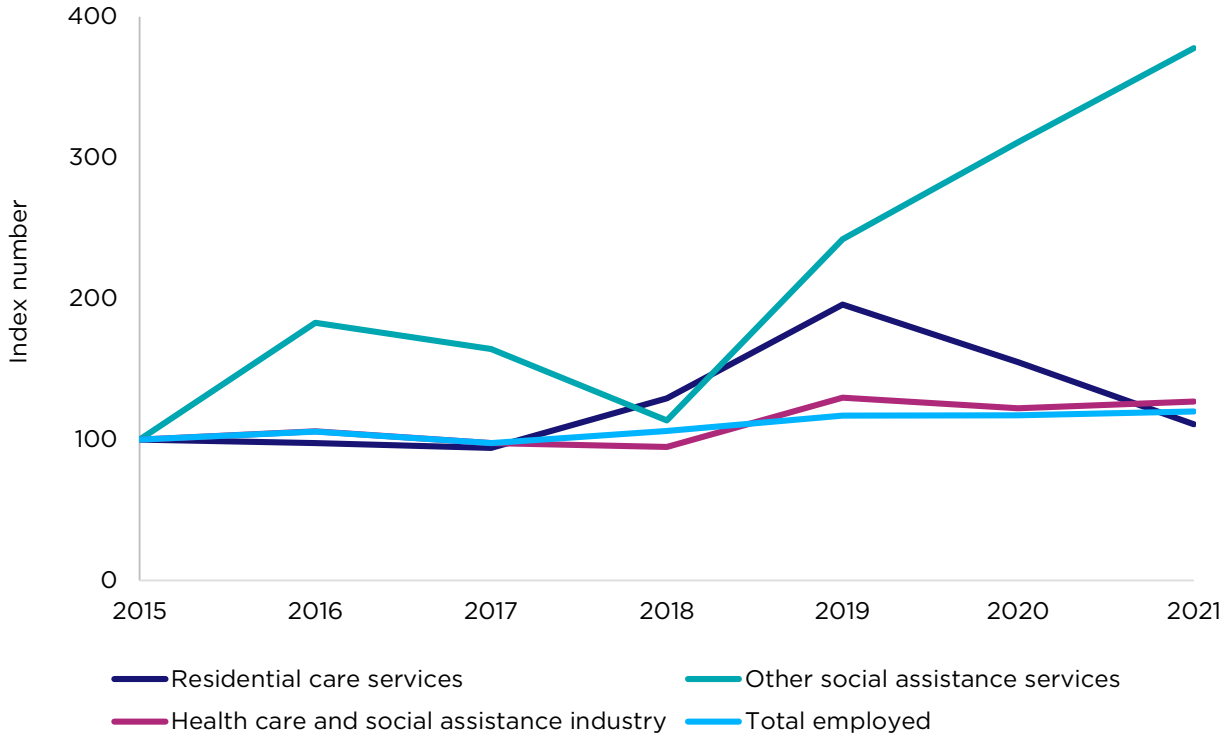
The analysis used to consider multiple jobs in this report is based on the ABS definition of multiple employers with unique Australian Business Numbers. It is noted that in the context of the care and support workforce this definition may understate the number of workers employed in multiple jobs, particularly given the use of labour hire firms (explored in Part 2.7.1).

Stakeholder views were mixed when asked about the drivers for workers employed in multiple jobs. Unions cited a lack of employment security, low average hours and the need for a living wage. In contrast, providers cited employee preference for job diversity, or more commonly

[121] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

beneficial tax treatment when working for not-for-profit providers which could be maximised through multiple jobs. This is explored further in Part 8.3.

Figure 142: Multiple job holder indexes, by industry (100 = February 2015)



Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. *Residential care services* and *Other social assistance services* includes the 15 in-scope ANZSCO 4-digit. *Other social assistance services* is a 3-digit industry which consists of businesses engaged in the provision of a wide variety of social support services directly to their clients (outside of accommodation services, except on a short stay basis). This includes aged care assistance services, disabilities assistance services and welfare counselling services. See Figure 2 for further detail.

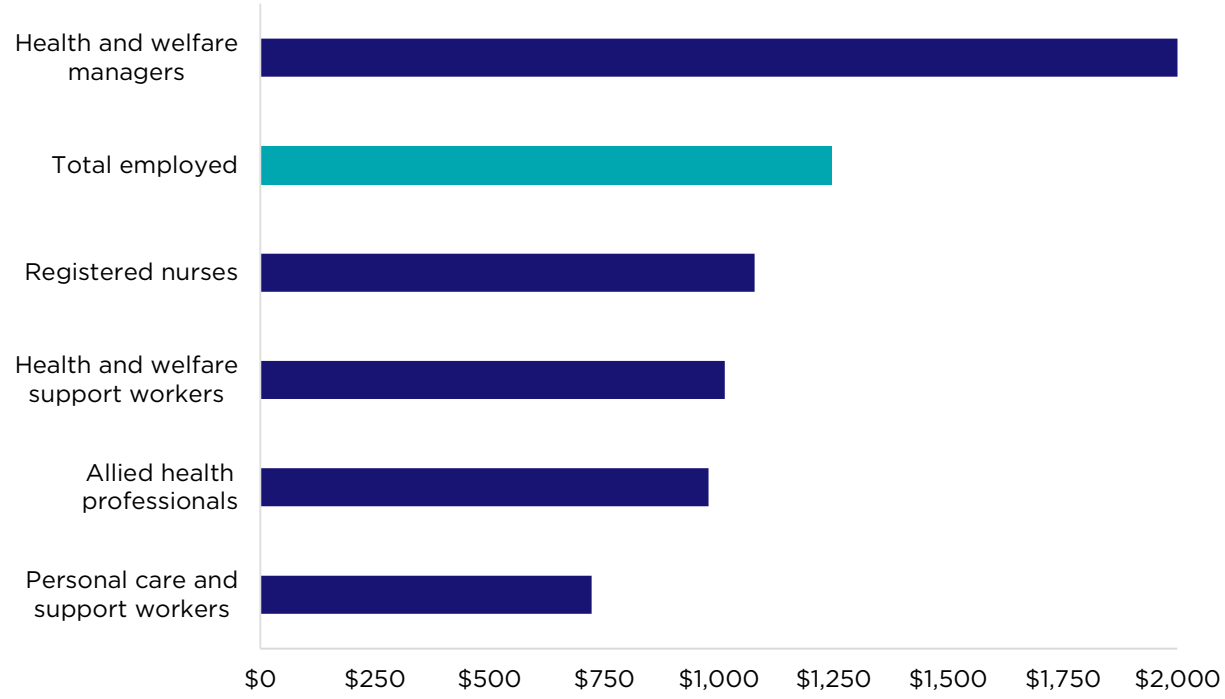
5.5 Incomes vary across the care and support workforce

There is a significant degree of variability in incomes across the care and support workforce. This variability reflects both higher average hourly rates of pay for higher skill level occupations versus lower skill level occupations, and also the tendency for lower skill level occupations to have lower average hours worked per week.

As shown in Figure 143, 4 out of the 5 occupation groups, representing 95% of the care and support workforce, earned below the Australian average in May 2018. The largest occupation group, Personal care and support workers, had the lowest weekly earnings, $523 below the Australian average. Allied health professionals had the second lowest weekly earnings, $268 below the Australian average.

Health and welfare managers was the only occupation group with weekly earnings higher than the Australian average ($754 above average).

Figure 143: Average weekly earnings by occupation group in care and support industries, May 2018



Source: ABS, Employee Earnings and Hours Microdata, May 2018 in TableBuilder. Weekly ordinary time hours paid for. In 2-digit ANZSIC care and support industries.

5.6 Average hours

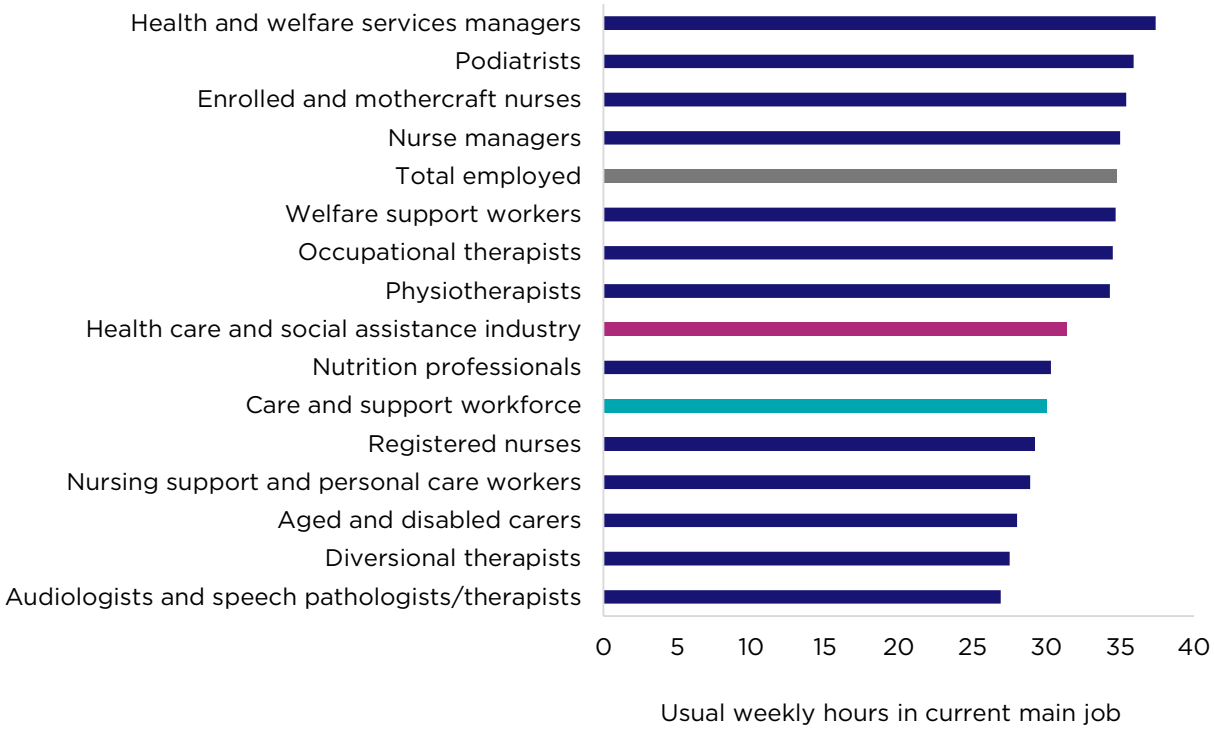
The care and support workforce tend to work fewer hours on average than workers employed in the Australian economy.

People employed in care and support occupations usually worked around 30 hours a week on average in their main job between February 2015 to February 2021 (Figure 144) – less than the average usual weekly hours worked in the mental health workforce (33 hours a week), the broader *Health care and social assistance* industry (31 hours a week) or across all occupations (35 hours a week).[122]

The number of weekly hours usually worked by the care and support workforce varies widely across occupations – ranging from a low of around 27 hours a week worked by *Aged and disabled carers* to a high of around 40 hours a week for *Health and welfare services managers*.[123] As a general observation, the higher the skill level of the occupation the higher the number of average hours worked per week.

Similarly, average hours worked by the mental health workforce varies across occupations. Between February 2015 and February 2021, the average number of hours usually worked by mental health workers ranged from a low of 31 hours a week for *Counsellors* and *Psychologists* to a high of around 38 hours a week for *General practitioners and resident medical officers*.

Figure 144: Usual weekly hours worked by care and support workforce, average, 2015 to 2021



Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Hours are calculated as the average weighted mean of usual weekly hours worked in current main job between February 2015 and February 2021. No reliable data available for *Social professionals* and *Indigenous health workers* in care and support industries.

The strong increase in demand for care over recent years (discussed earlier in Part 2) has been largely met by an increase in the number of people working in the care and support sector; not an increase in the average number of hours worked per person.

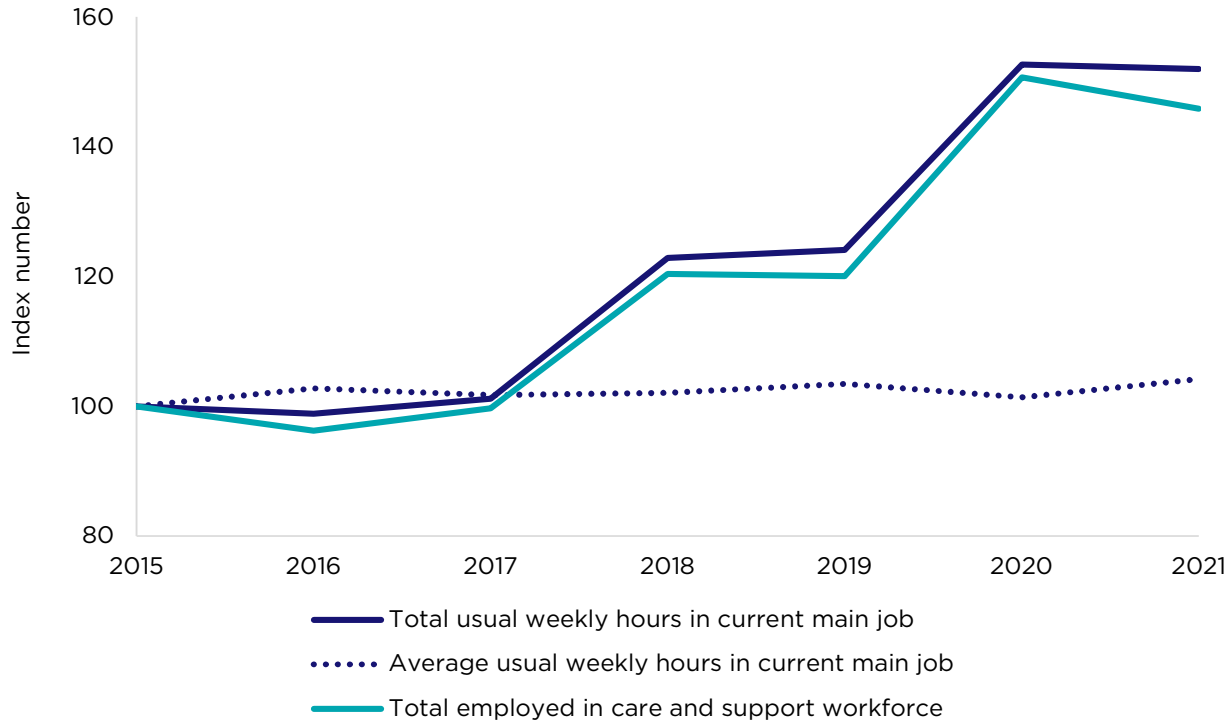
[122] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

[123] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

Total weekly hours worked by the care and support workforce (in their current main jobs) grew by around 52% between February 2015 and February 2021 (from 9.1 million to 13.8 million hours), while the total number of care and support workers grew by 46% (from 314,000 to 458,000) over the same period (Figure 145). As a result, *average* weekly hours usually worked per person has remained relatively stable, growing by just 4% between 2015 and 2021.

That said, there was a slight uptick in average weekly hours for care and support workers over the year to February 2021, which corresponds with a slight decline in the number of people employed in the care and support workforce and may reflect the impact of COVID-19 on the sector and also Australia's extended international border closure.

Figure 145: Care and support workforce, usual weekly hours and employment indexes (100 = February 2015)



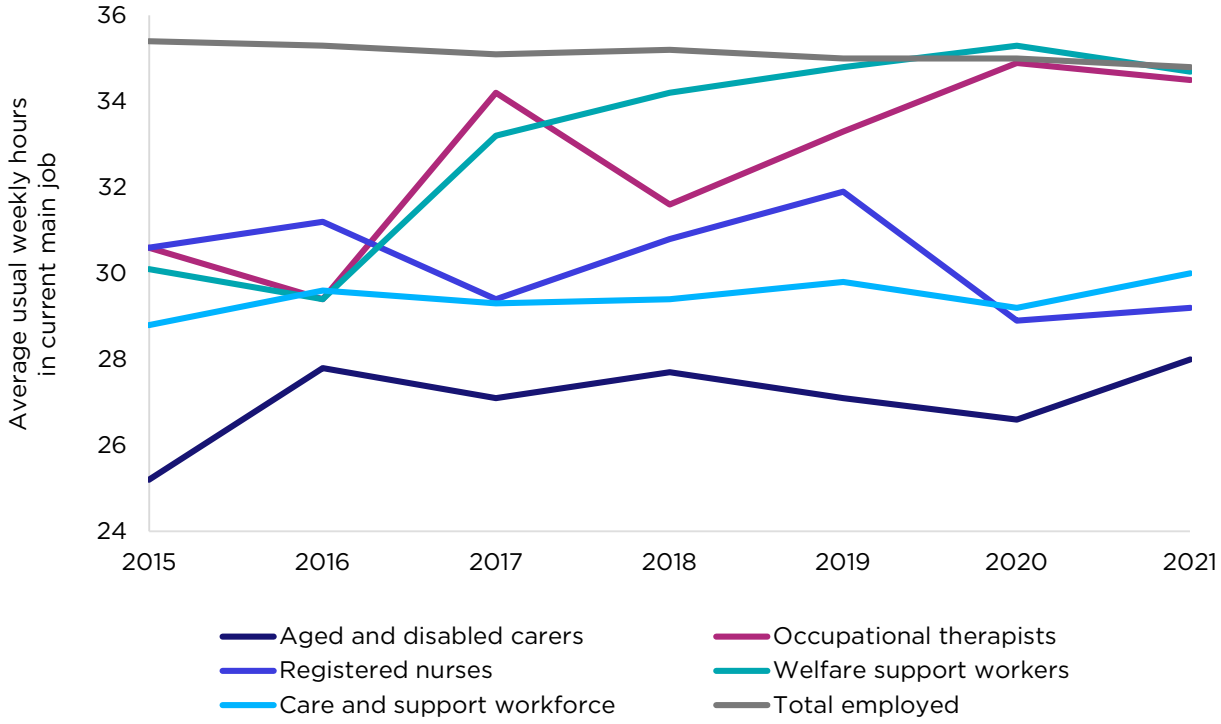
Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Data for 15 in-scope ANZSCO occupations and 3 in-scope 3-digit ANZSIC industries.

Figure 146 shows average hours worked across the various care and support occupations. As the chart shows, there has been some modest growth in average hours across 3 care and support occupations – *Welfare support workers* (15%), *Occupational therapists* (13%) and *Aged and disabled carers* (11%).[124] These increases in average hours worked have occurred against the backdrop of a relatively strong employment growth for these occupations over the same period, as well as evidence of higher demand for these services (particularly occupational therapy services) collected as part of this Study.

Part 10.5 models a sensitivity in relation to average hours.

[124] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

Figure 146: Average weekly hours worked by care and support occupations, February 2015 to February 2021



Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Data for 3 in-scope 3-digit ANZSIC industries.

5.6.1 Hours worked and hourly wages influence earnings

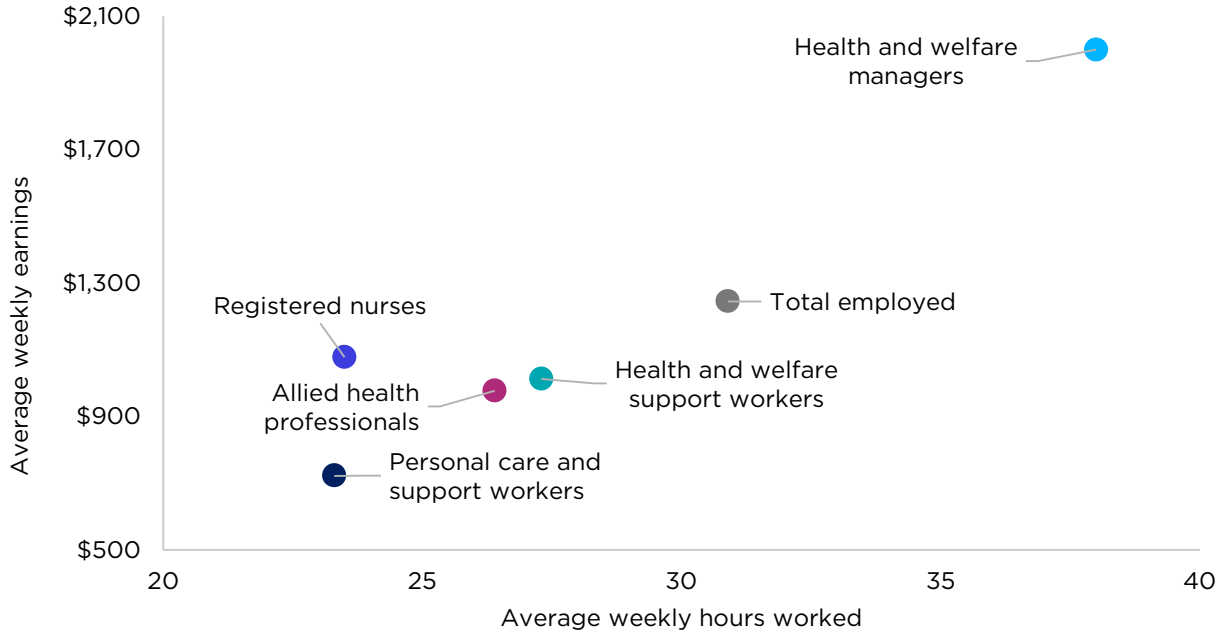
As noted, income is a function of hourly pay rates and the number of hours worked. Both average hours worked and hourly incomes across the care and support workforce vary between occupations.

Figure 147 shows average weekly earnings against weekly hours worked across a number of care and support occupations in May 2018.

Average hourly earnings of care and support workers by occupation group are shown in Figure 148.

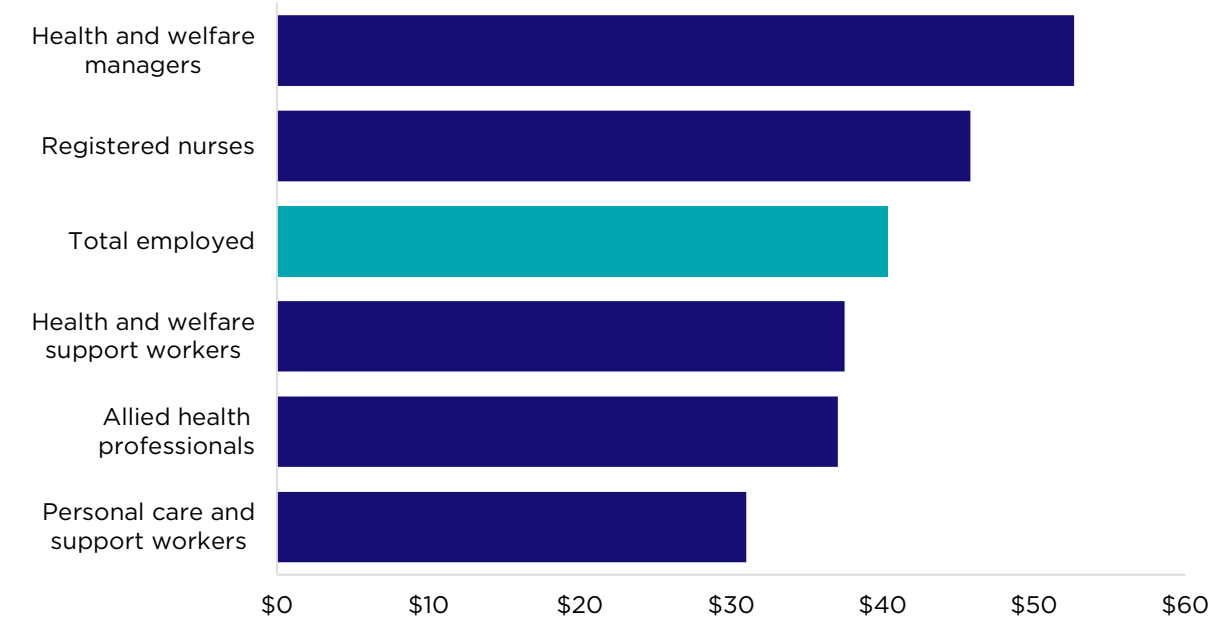
Notably, those occupations with the lowest hourly earnings were generally also those occupations that tended to work the lowest number of hours per week on average.

Figure 147: Average weekly earnings and weekly hours worked, by occupation group, in care and support industries, May 2018



Source: ABS, Employee Earnings and Hours Microdata, May 2018 in TableBuilder. Weekly ordinary time hours paid for. Specific to 2-digit ANZSIC care and support industries. Earnings and hours are collected for a sample of employees working in a sample of employing businesses (i.e. neither all jobs, nor necessarily main job).

Figure 148: Average hourly earnings, by occupation group, May 2018[125]



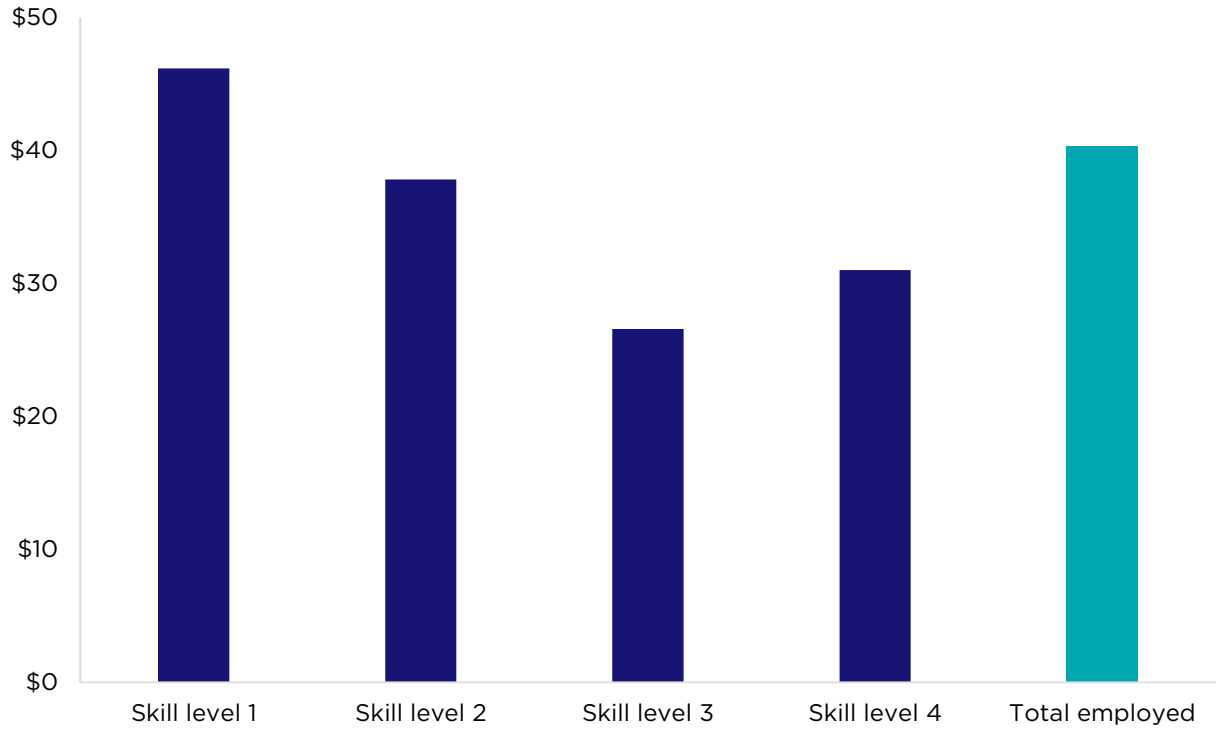
Source: ABS, Employee Earnings and Hours Microdata, May 2018 in TableBuilder. Ordinary time earnings and weekly time hours paid for. Across care and support industries (2-digit ANZSIC). Earnings and hours are collected for a sample of employees working in a sample of employing businesses (i.e. neither all jobs, nor necessarily main job).

[125] This average hourly earnings measure is created using the average ordinary earnings (which is pre-tax and includes allowances, penalty payments, regular bonuses and commissions and amounts salary sacrificed, and excludes superannuation) divided by the ordinary hours paid for. This point in time measure reflects the total hourly earnings of workers, not their minimum hourly rates.

There was also considerable variation within allied health roles. On average (across all industries), *Nutrition professionals* earned the most per hour ($51), while *Audiologists and speech pathologists/therapists* earned the least ($39). *Podiatrists*, *Physiotherapists* and *Occupational therapists* earned between $42 and $45 per hour on average.[126]

Average hourly earnings of care and support workers were highest for ANZSCO skill level 1 occupations, which include occupations that typically require a bachelor level qualification (Figure 149), and is illustrative of the wage premium typically associated with higher level qualifications. [127]

Figure 149: Average hourly earnings, by ANZSCO skill level, May 2018[128]



Source: ABS, Employee Earnings and Hours Microdata, May 2018 in TableBuilder. Ordinary time earnings and weekly time hours paid for. Skill levels are specific to the 15 care and support occupations and 2-digit industries. Earnings and hours are collected for a sample of employees working in a sample of employing businesses (i.e. neither all jobs, nor necessarily main job).

126 ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

127 Of the 15 care and support occupations, 9 are skill level 1, 3 are skill level 2, 1 is skill level 3, and 2 are skill level 4.

128 This average hourly earnings measure is created using the average ordinary earnings (which is pre-tax and includes allowances, penalty payments, regular bonuses and commissions and amounts salary sacrificed, and excludes superannuation) divided by the ordinary hours paid for. This point in time measure reflects the total hourly earnings of workers, not their minimum hourly rates.

5.7 Average hourly earnings don't differ significantly with age

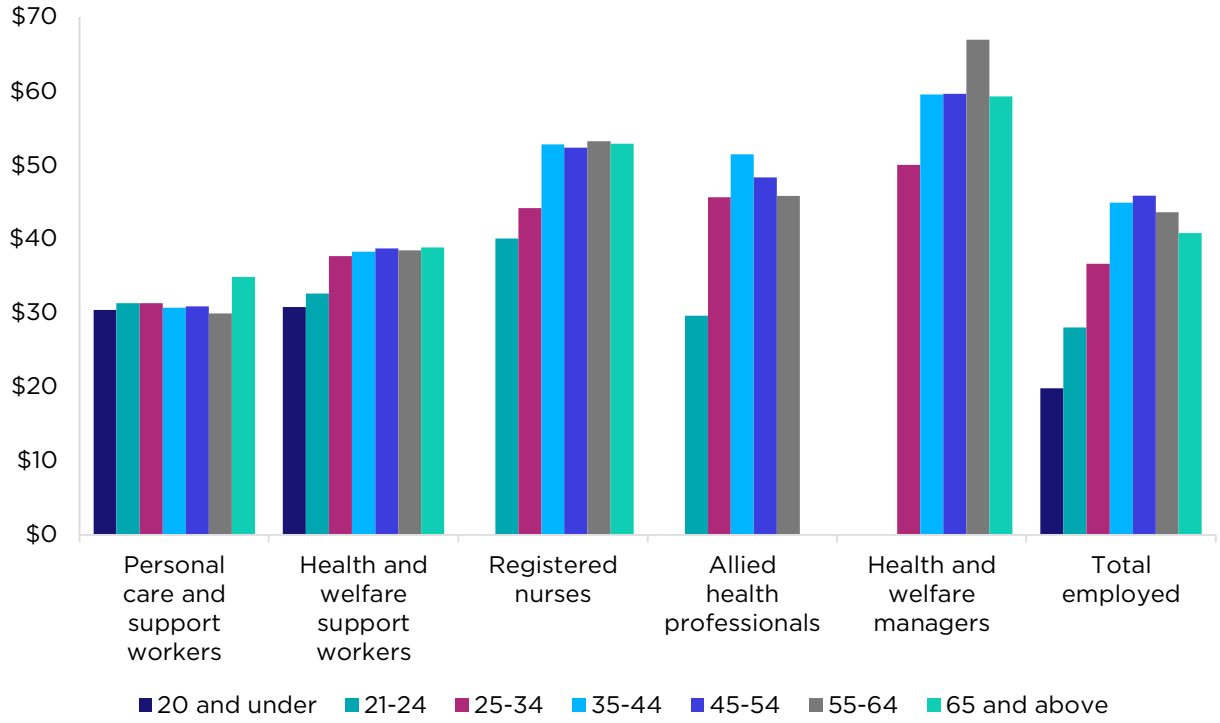
On average and across the economy as a whole, average hourly earnings tend to increase with age, peaking at around 45-54 years (Figure 150).[129] This reflects the skills and experience workers gain as they progress through their working lives.

However, for Personal care and support workers, there has been little to no earnings variation across age groups.

Higher skill level occupations in the care and support workforce do tend to see greater variation in earnings between age groups, with this being most pronounced for Allied health professionals.

In every age bracket, Health and welfare managers earned more than other roles, including the Australian average. Health and welfare managers are older than the Australian average and typically enter these positions later in their careers, bringing skills and experience from previous roles.[130]

Figure 150: Average hourly earnings, by age group and occupation (all industries), May 2018



Source: ABS, Employee Earnings and Hours Microdata, May 2018 in TableBuilder. Ordinary time earnings and weekly time hours paid for. Not specific to care and support industries. Earnings and hours are collected for a sample of employees working in a sample of employing businesses (i.e. neither all jobs, not necessarily main job). For some occupation groups, no data was recorded for younger age groups.

[129] ABS, Employee Earnings and Hours, Australia, May 2018 [Microdata], 2019

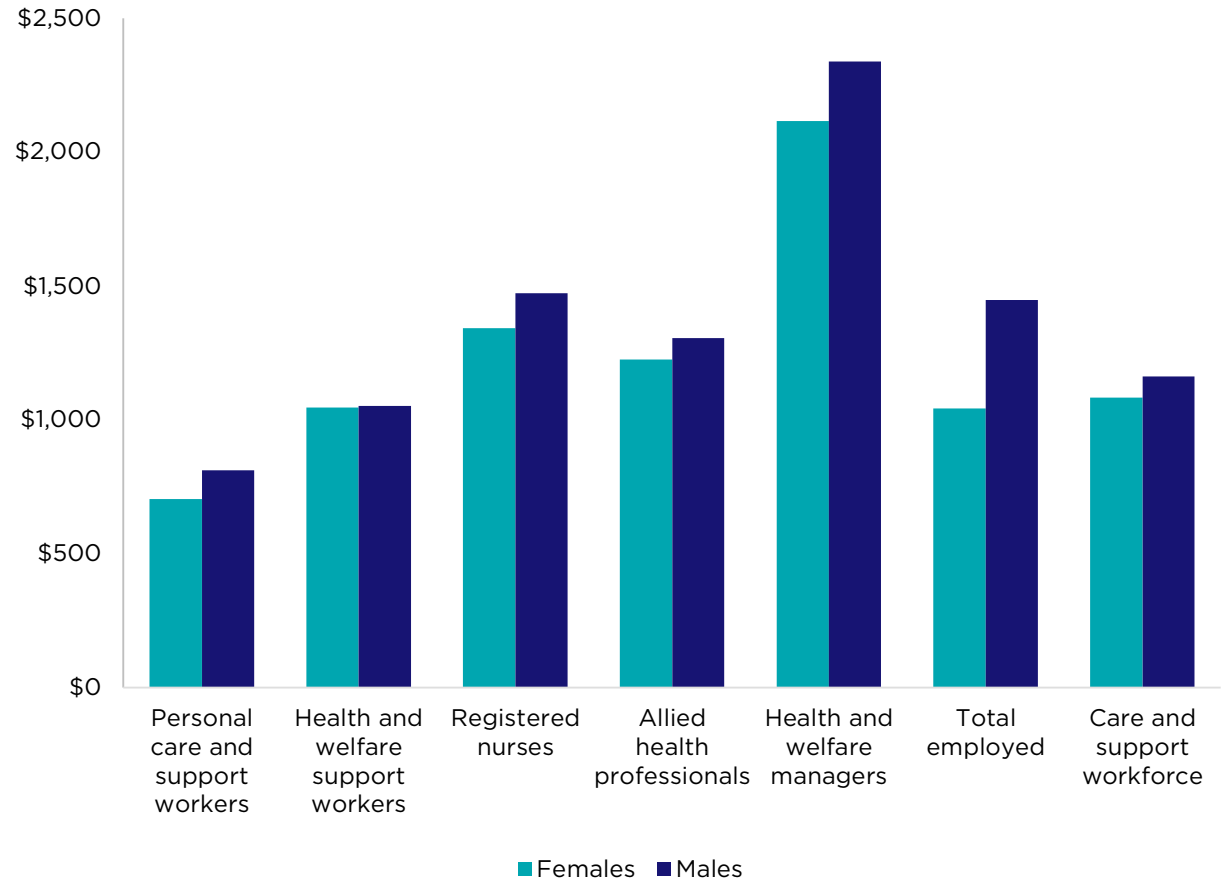
[130] ABS, Employee Earnings and Hours, Australia, May 2018 [Microdata], 2019

5.8 Male workers earn more than females in all care and support roles

Across all care and support occupation groups, the gender-pay gap ($79 per week or 7% in May 2018) was less than in the broader Australian labour market (which was $407 per week or 33% in May 2018) (Figure 151).

Health and welfare managers experienced the largest gender-gap in dollars ($222 per week or 10%) while Personal care and support workers experienced the largest percentage gap ($108 per week or 14%). The earnings gap was smallest for Health and welfare support workers, where males earned only $5 more per week, equivalent to a gap of less than 1%.

Figure 151: Average weekly income, by sex and occupation in all industries, May 2018



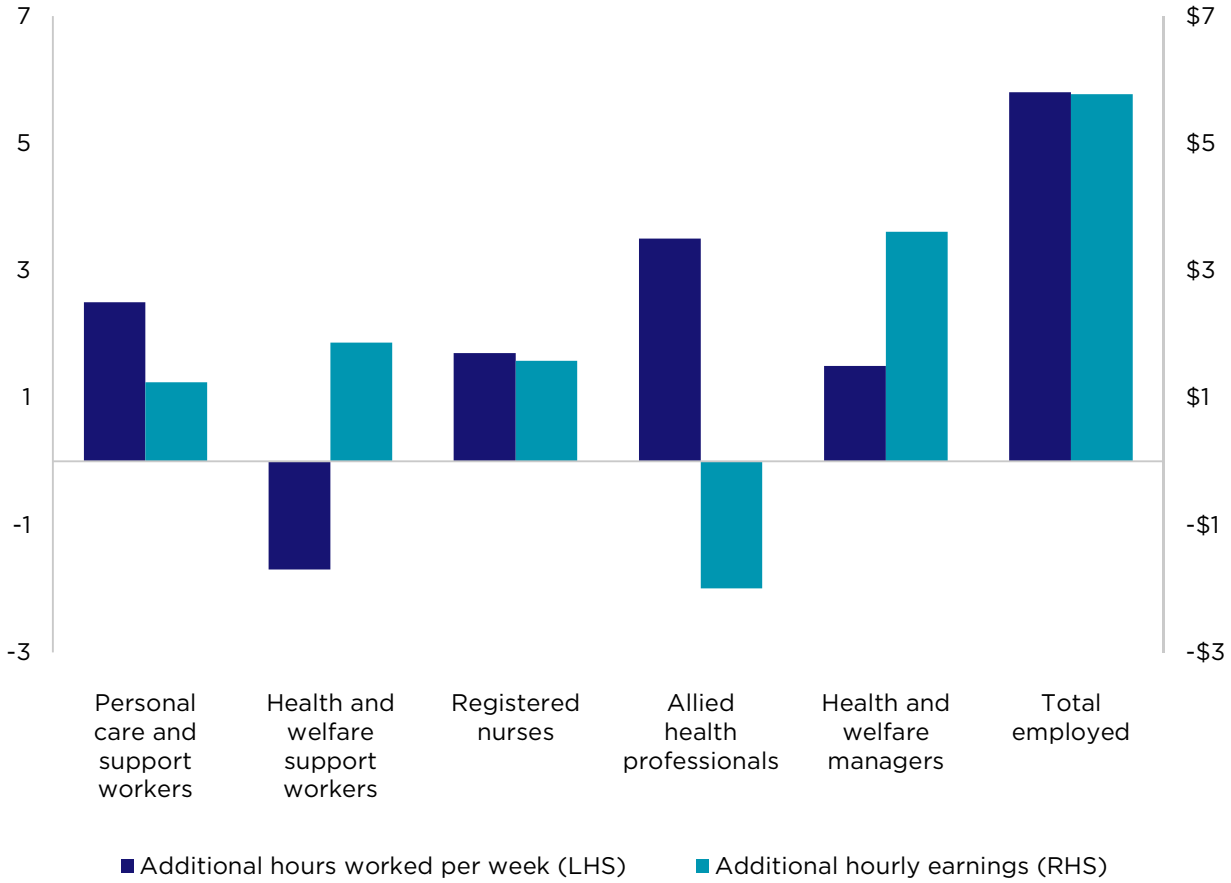
Source: ABS, Employee Earnings and Hours Microdata, May 2018. Weekly ordinary time cash earnings. Not specific to care and support industries.

In no care and support occupation group was the gap between hours worked or the hourly rate larger than the labour force average (Figure 152).

Depending on the occupation, the gender-earnings gap in May 2018 was driven by the number of hours worked, the average hourly rate or a combination of both. Across the entire labour market, male workers earned more per hour and worked more hours per week. This is also true for Health and welfare managers, Registered nurses, and Personal care and support workers.

Health and welfare support workers was the only care and support occupation group where males worked fewer hours per week than females (1.7 hours) but still earned more per hour ($2.70). Conversely, male Allied health professionals worked more hours per week (3.5 hours) but earned less per hour ($2.50).

Figure 152: Gap between male and female hourly earnings and weekly hours worked, May 2018



Source: ABS, Employee Earnings and Hours Microdata, May 2018 in TableBuilder. Ordinary time earnings and weekly time hours paid for. Not specific to care and support industries. Earnings and hours are collected for a sample of employees working in a sample of employing businesses (i.e. neither all jobs, not necessarily main job).

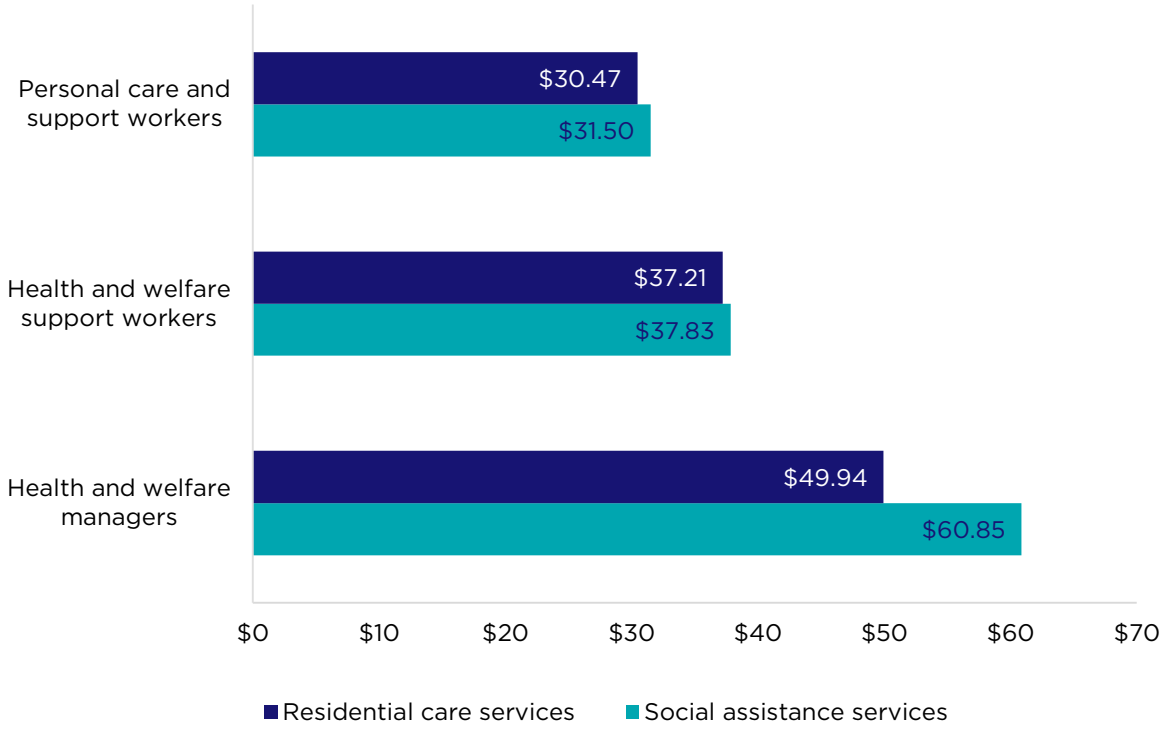
Further details on wages is outlined in the data appendix in Part 5.12.

5.9 Earnings can vary by industry

While differences in wages earnt across the relevant programs have been identified by some stakeholders, the current data classifications do not allow for the disaggregation across industries to quantify these reflections.

That said, based on available data, Personal care and support workers and Health and welfare support workers appear to earn marginally more per hour if they are employed in the *Social assistance services* industry (which includes in-home aged care, disability support and other industries) relative to the *Residential care services* industry (which includes residential aged care). As Figure 153 shows, these differences are marginal. There does appear to be a larger difference for Health and welfare managers, with those engaged in the *Social assistance services* industry likely to have higher average hourly earnings than those employed within the *Residential care services* industry.

Figure 153: Differences in hourly earnings by industry and occupation, May 2018[131]



Source: ABS, Employee Earnings and Hours Microdata, May 2018 in TableBuilder. Ordinary time earnings and weekly time hours paid for. *Residential care services* and *Social assistance services* are 2-digit ANZSIC titles. Earnings and hours are collected for a sample of employees working in a sample of employing businesses (i.e. neither all jobs, nor necessarily main job).

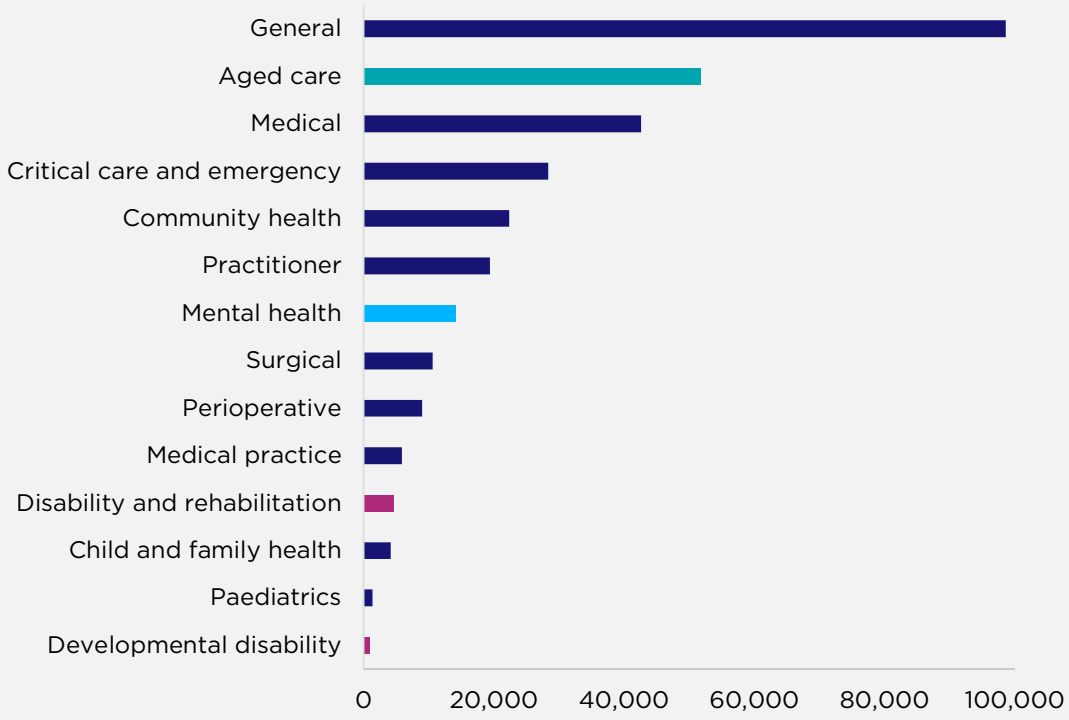
[131] This average hourly earnings measure is created using ordinary earnings (which is pre-tax and includes allowances, penalty payments, regular bonuses and commissions and amounts salary sacrificed, and excludes superannuation) divided by the ordinary hours paid for. This point in time measure reflects the total hourly earnings of workers, not their minimum hourly rates.

Benefits of more detailed disaggregation

Unlike all other care and support roles, *Registered nurses* can be disaggregated in ANZSCO by the field they work in. This means it is possible to understand and analyse the earnings of *Registered nurses* in a range of contexts.

Within ANZSCO there are 14 *Registered nurses* sub-occupations, including aged care, developmental disability, disability and rehabilitation, and mental health. While *Registered nurses* are an important and sizeable role in the care and support workforce, the majority of *Registered nurses* are employed in other industries. For example, in 2018-19, only 16.5% of all *Registered nurses* were specifically coded to aged care (Figure 154).

Figure 154: *Registered nurse* occupations by size, 2018-19

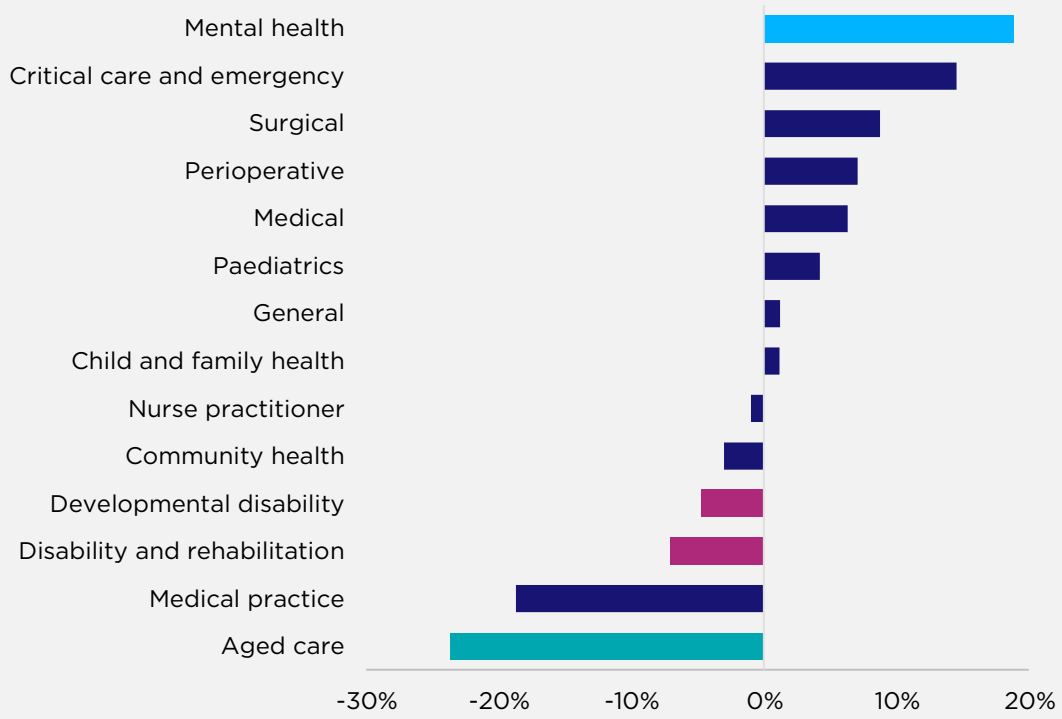


Source: ATO, Taxation statistics, Table 15: individuals, 2018-19. Wage or salary income by ANZSCO 6-digit occupation. Employed across all ANZSIC industry codes.

In the 2018-19 financial year, *Registered nurses* working in aged care and disability support earned substantially below the whole-of-occupation average (Figure 155). Comparatively, *Registered nurses* working in mental health, critical care and emergency roles earned above average. These differences in incomes may be driven by differing hourly rates, the number of hours worked each week, or the tendency to receive overtime, shift work, penalty rates and supplementary payments. This is consistent across the OECD, where nurses typically earn less on average in aged care settings than in hospitals.[132]

[132] OECD, *Who Cares? Attracting and retaining care workers for the elderly*, 2020

Figure 155: *Registered nurses* occupations, variation from whole-of-occupation average annual wage income, 2018-19



Source: ATO, Taxation statistics, Table 15: individuals, 2018-19. Wage or salary income by ANZSCO 6-digit occupation. Employed across all ANZSIC industry codes.

With this level of disaggregation across all care and support roles, specifically for Personal care and support workers, it would be possible to analyse the workforce by program and setting.

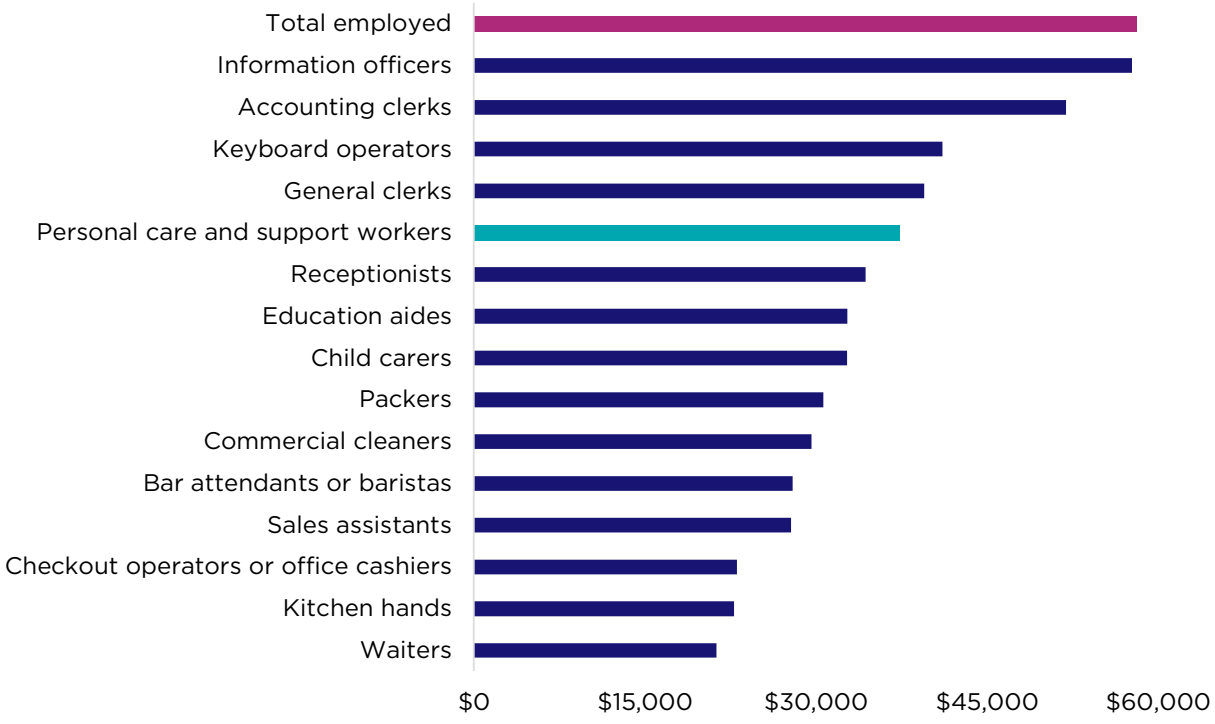
5.10 Compared with similar skill level occupations, Personal care and support workers have moderate earnings and hours

It can be useful to compare the earnings of Personal care and support workers with occupations outside of the *Health care and social assistance* industry.

The below analysis compares the earnings and hours of 14 ANZSCO occupations that have some similar characteristics to Personal care and support workers (no tertiary qualification requirements, large female workforces and common previous roles of Personal care and support workers). These 14 occupations include a mix of hospitality, retail, administration, education and cleaning roles.

Compared with these other ANZSCO skill level 3-5 occupations, Personal care and support workers have moderate annual earnings (Figure 156). *General clerks*, *Keyboard operators*, *Accounting clerks* and *Information officers* earned more on average than Personal care and support workers in 2018-19. *Child carers, Commercial cleaners*, *Sales assistants* and *Waiters* are some of the larger occupations that earned less.

Figure 156: Average annual wage or salary earning, by occupation, 2018-19

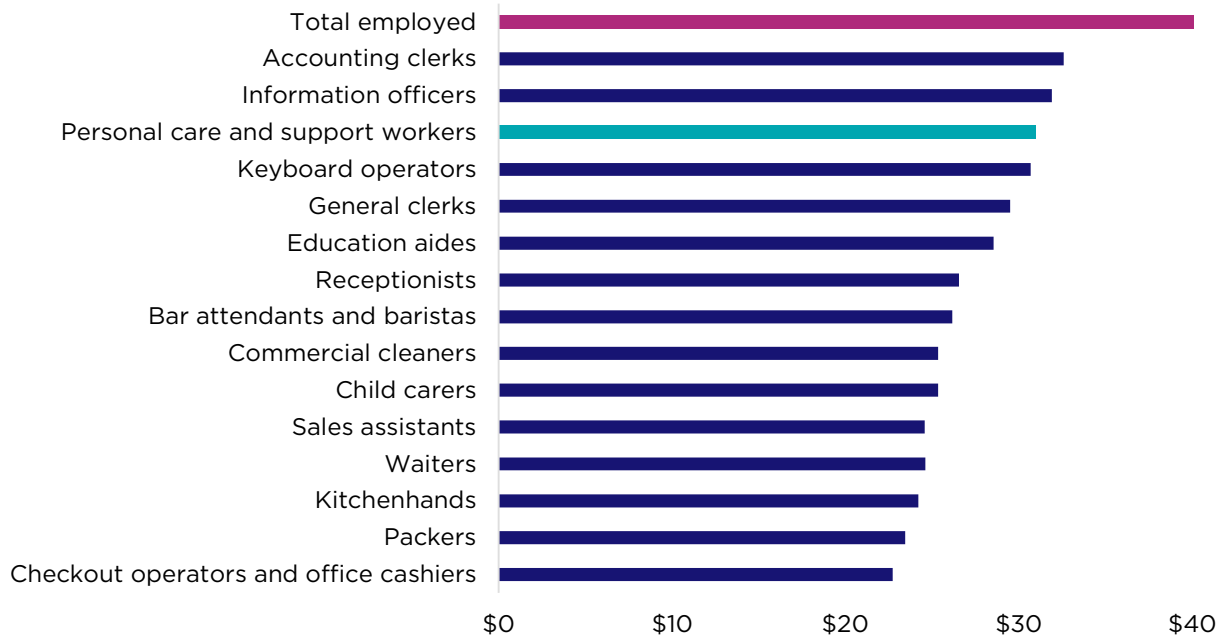


Source: ATO, Taxation statistics, Table 15: individuals, 2018-19. Wage or salary income by ANZSCO 4-digit occupation. Employed across all ANZSIC industry codes.

The average hourly earnings of Personal care and support workers are, however, higher than most comparison occupations (Figure 157). In May 2018, only *Accounting clerks* and *Information officers* earned more per hour on average than Personal care workers.

Notably, average hourly earnings of Personal care and support workers were higher than *Child carers*, *Sales assistants*, *General clerks* and *Education aides*. While this reflects the average actual earnings for these roles, the base wages for these roles may differ from these numbers considerably. For example, the minimum award for *Child carers* is similar to that of residential aged carers. However, residential aged carers may be more likely to work hours at night, on the weekend and in split-shifts, which can attract penalty rates and additional loadings, and therefore increase the average income of these workers. While the actual earnings of care and support workers may be higher than other roles on average, this may not be observable when looking purely at the minimum pay rates.

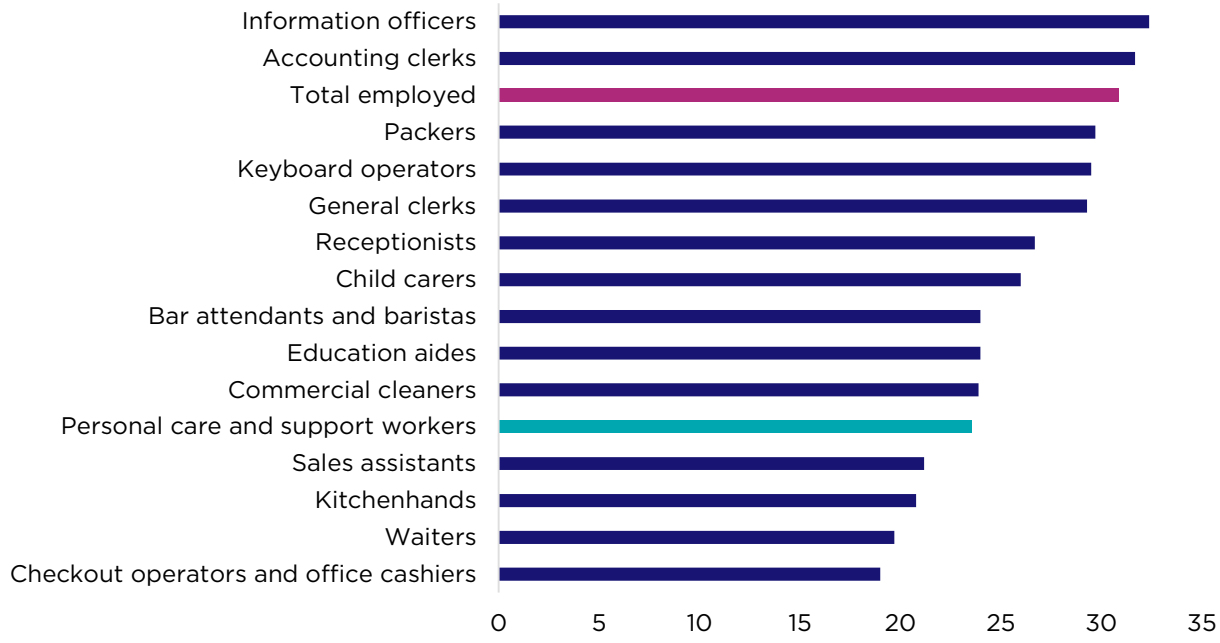
Figure 157: Average hourly earnings, by occupation, May 2018



Source: ABS, Employee Earnings and Hours Microdata, May 2018 in TableBuilder. Ordinary time earnings and weekly time hours paid for. Not specific to care and support industries. Earnings and hours are collected for a sample of employees working in a sample of employing businesses (i.e. neither all jobs, nor necessarily main job).

As shown in Figure 158, the average hours worked by Personal care and support workers were lower than most comparable occupations, including administrative roles (*Information officers*, *Accounting clerks*, *Keyboard operators*) but slightly higher than some retail, cleaning and hospitality occupations (including *Waiters*, *Commercial cleaners*, and *Checkout operators and office cashiers*).

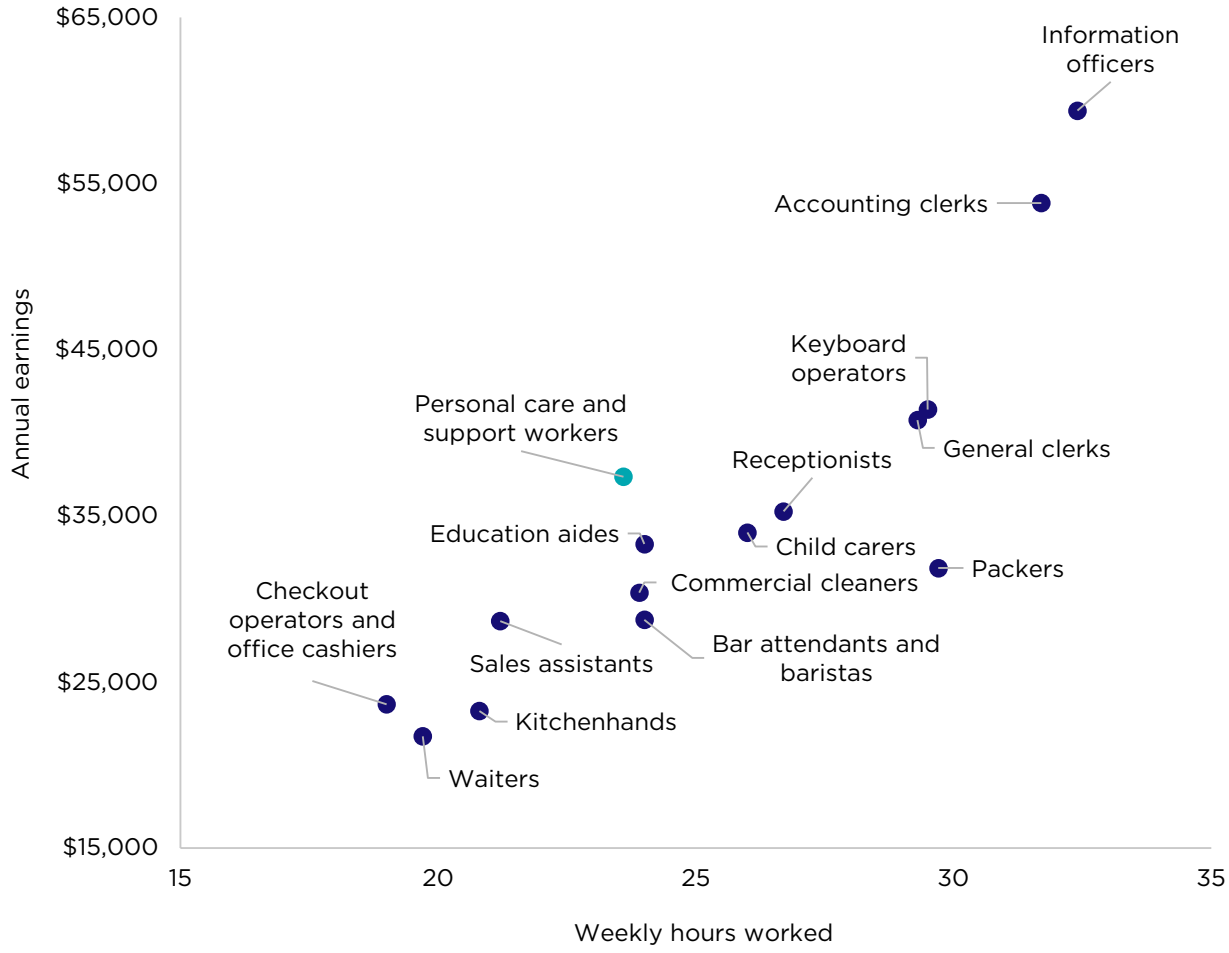
Figure 158: Average weekly hours worked, by occupation, May 2018



Source: ABS, Employee Earnings and Hours Microdata, May 2018. Weekly ordinary time hours paid for. Not specific to care and support industries.

In summary, while the hourly earnings of Personal care workers and support workers are competitive amongst these selected comparison occupations, low hours worked mean the annual earnings of Personal care and support workers are lower (Figure 159). With higher average hours worked, Personal care and support workers would see more competitive annual earnings.

Figure 159: Annual earnings and weekly hours worked, by occupation, 2018-19

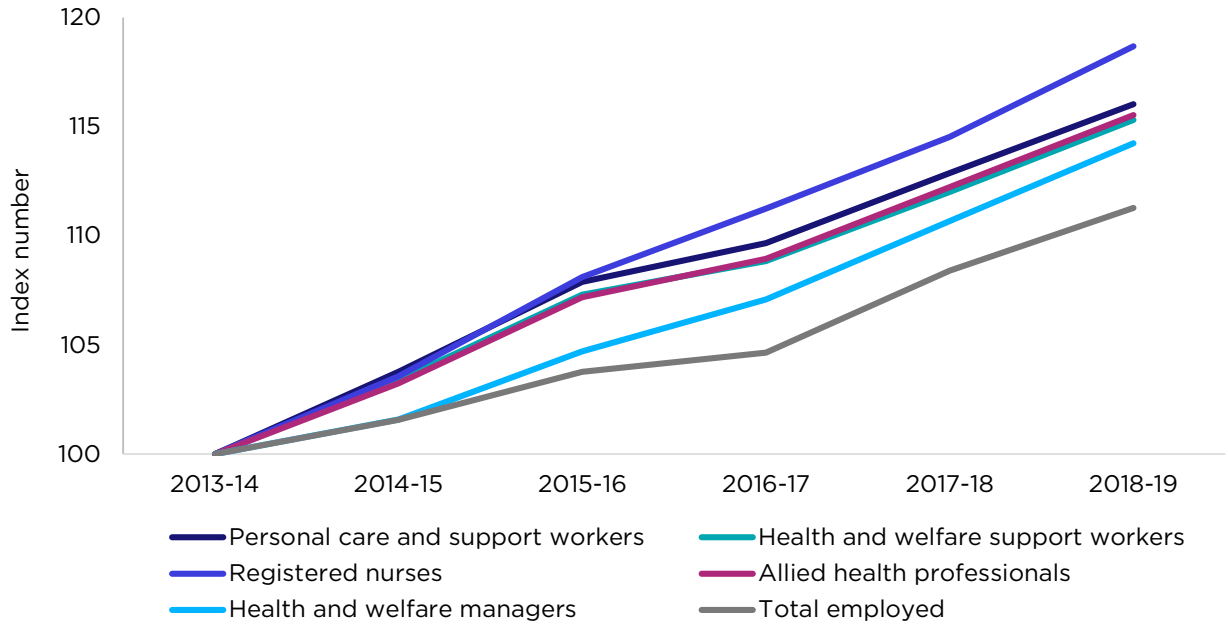


Source: ATO, Taxation statistics, Table 15: individuals, 2018-19. Wage or salary income by ANZSCO 4-digit occupation. ABS, Employee Earnings and Hours Microdata, May 2018. Weekly ordinary time hours paid for. Not specific to care and support industries.

5.11 Earnings have grown across all care and support occupations

The average wage or salary income for care and support workers has grown across all occupation groups each financial year since 2013-14 (Figure 160). All care and support occupation groups have seen average wage growth consistently above the Australian total employed average.

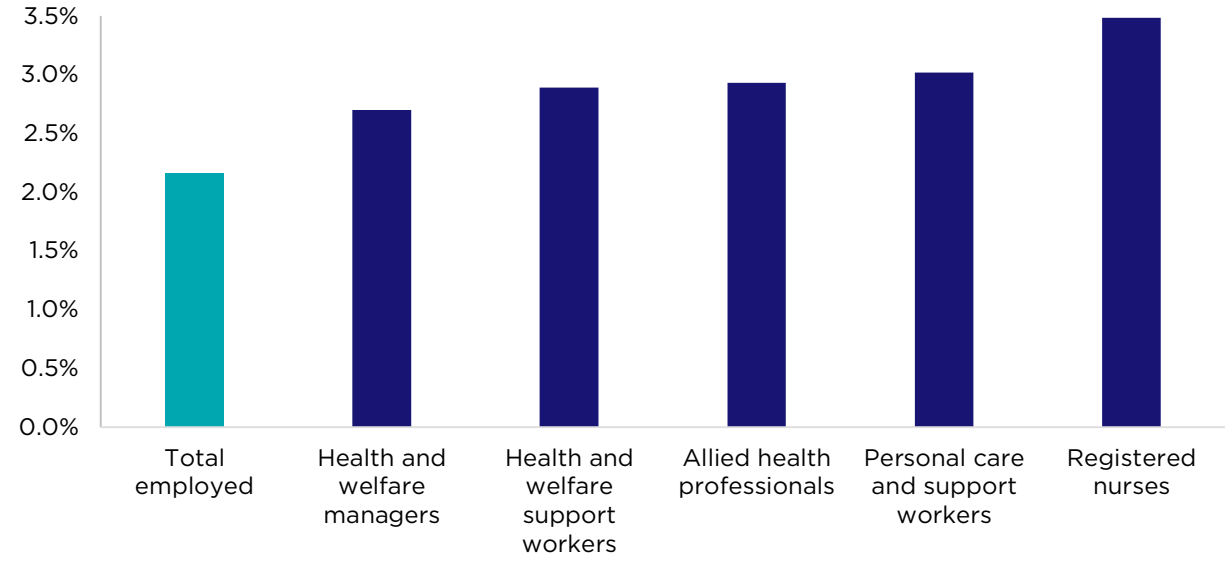
Figure 160: Index - annual wage and salary income by occupation group, 2013-14 to 2018-19



Source: ATO, Taxation statistics, Table 15: individuals, 2013-14 and 2018-19.

Between 2013-14 and 2018-19 the compound annual growth rate was highest for Registered nurses (3.5%), Personal care and support workers (3.0%) and Allied health professionals (2.9%) (Figure 161).

Figure 161: Compound annual growth rate by occupation group, 2013-14 to 2018-19



Source: ATO, Taxation statistics, Table 15: individuals, 2013-14 and 2018-19.

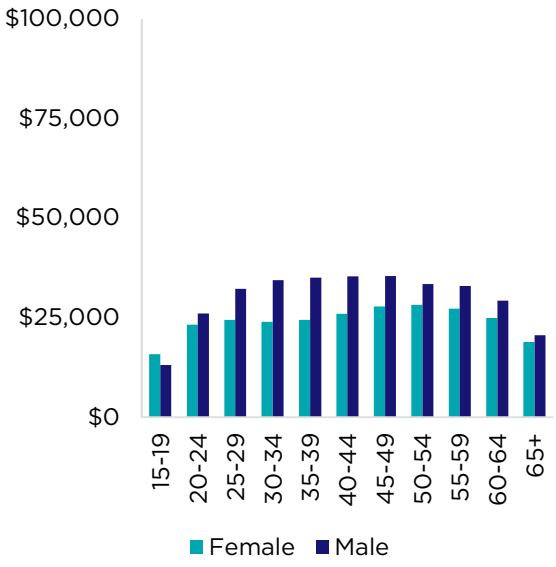
Part 10.2 and Part 10.3 explore modelled sensitivities in relation to wages.

5.12 Data appendix for Part 5

The following charts show the distribution of earnings across occupations, ages and genders.

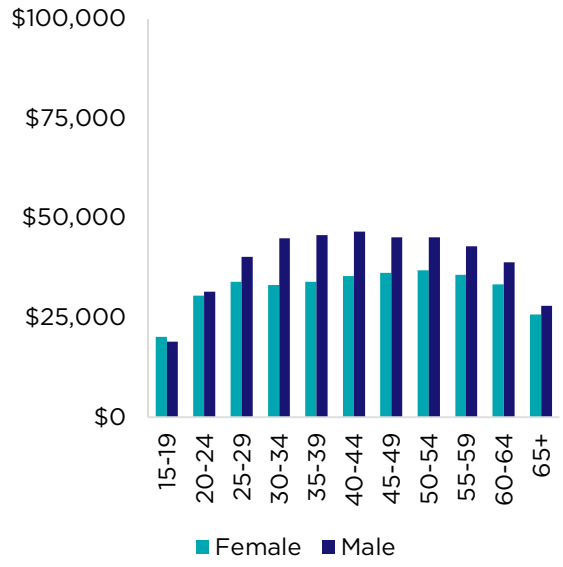
5.12.1 Detailed wage income analysis by occupation

Figure 162: Median annual wage earnings by gender and age, *Aged and disabled carers* (all industries), 2010-11



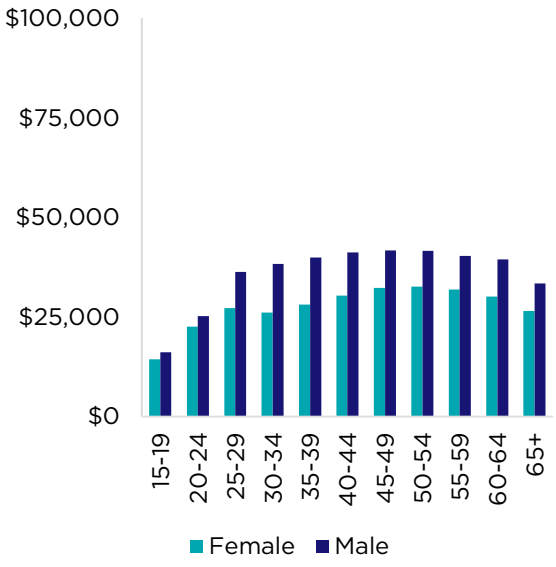
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 163: Median annual wage earnings by gender and age, *Aged and disabled carers* (all industries), 2018-19



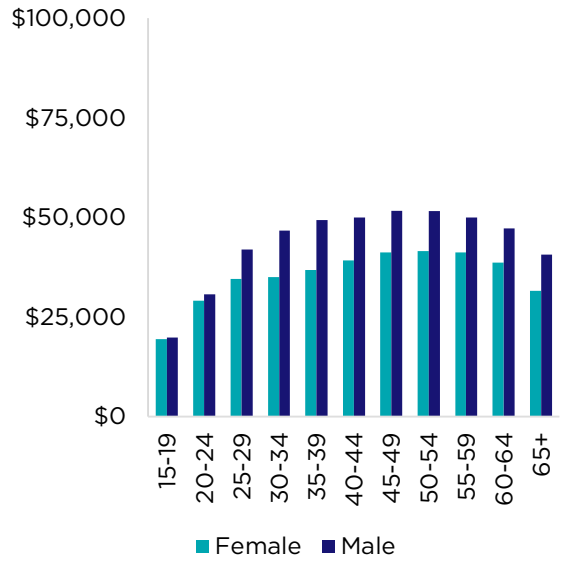
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 164: Median annual wage earnings by gender and age, *Nursing support and personal care workers* (all industries), 2010-11



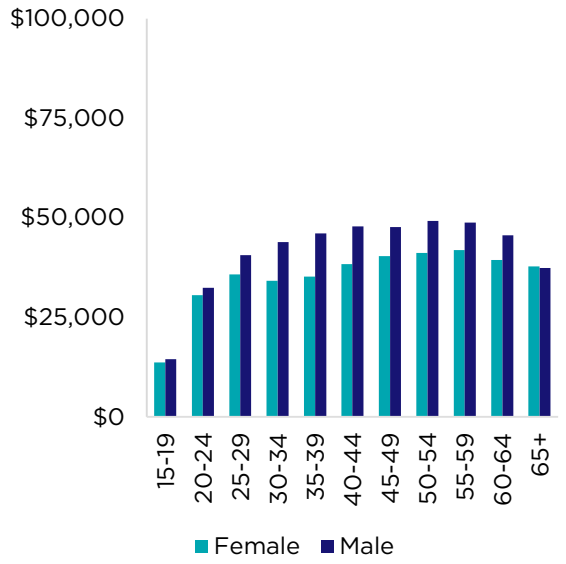
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 165: Median annual wage earnings by gender and age, *Nursing support and personal care workers* (all industries), 2018-19



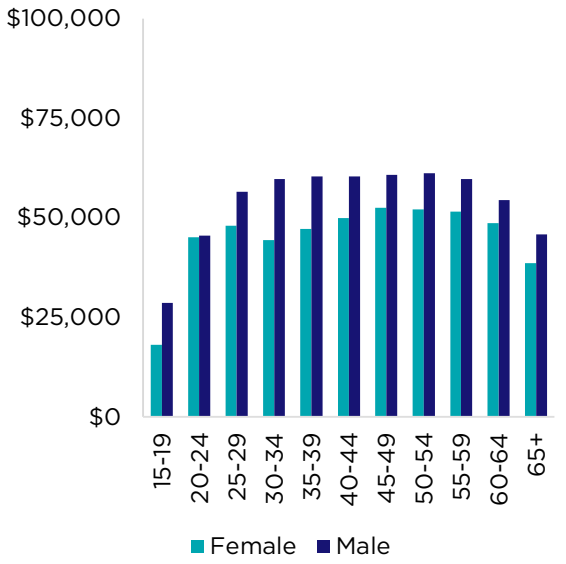
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 166: Median annual wage earnings by gender and age, *Enrolled and mothercraft nurses* (all industries), 2010-11



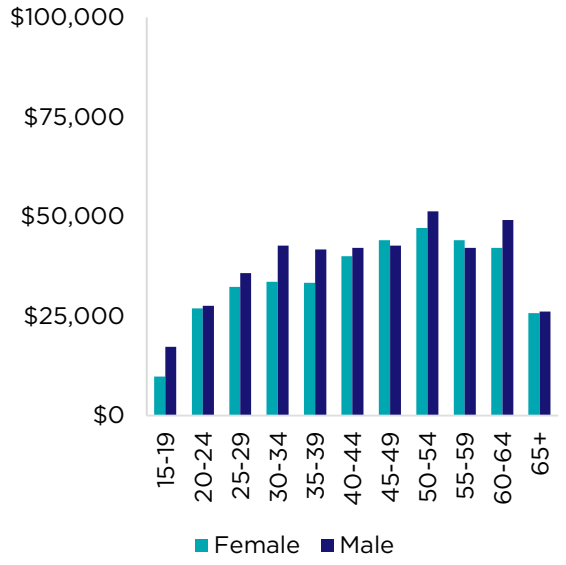
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 167: Median annual wage earnings by gender and age, *Enrolled and mothercraft nurses* (all industries), 2018-19



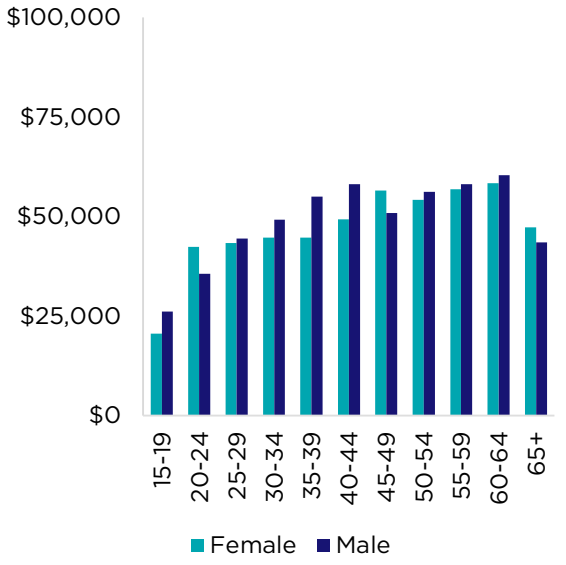
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 168: Median annual wage earnings by gender and age, *Indigenous health workers* (all industries), 2010-11



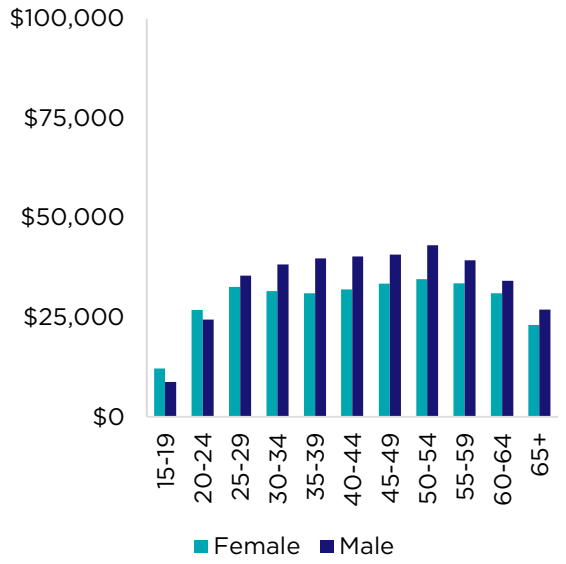
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 169: Median annual wage earnings by gender and age, *Indigenous health workers* (all industries), 2018-19



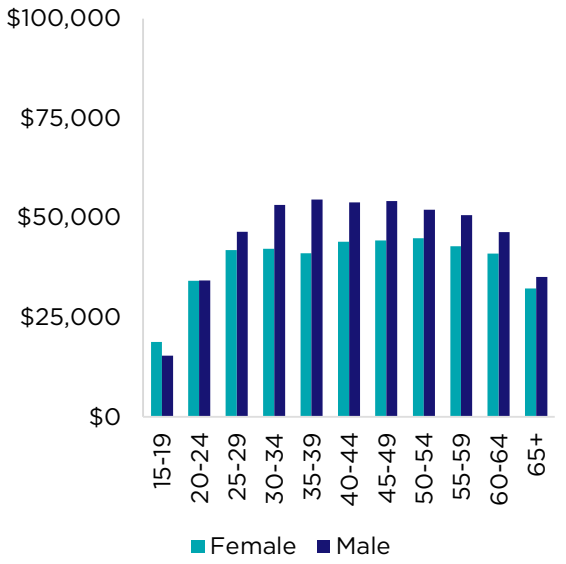
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 170: Median annual wage earnings by gender and age, *Welfare support workers* (all industries), 2010-11



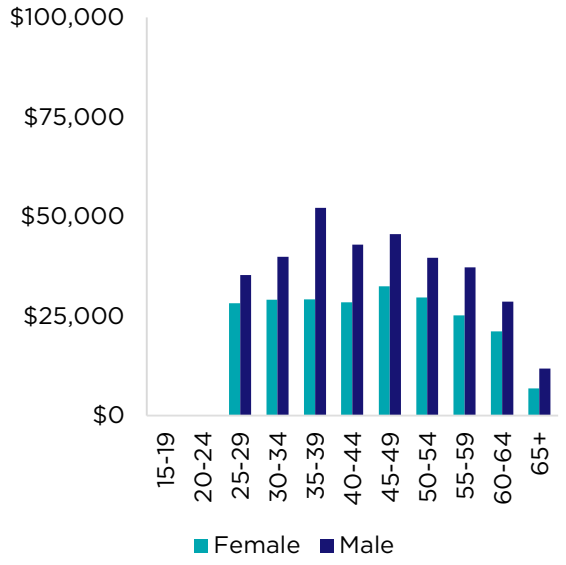
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 171: Median annual wage earnings by gender and age, *Welfare support workers* (all industries), 2018-19



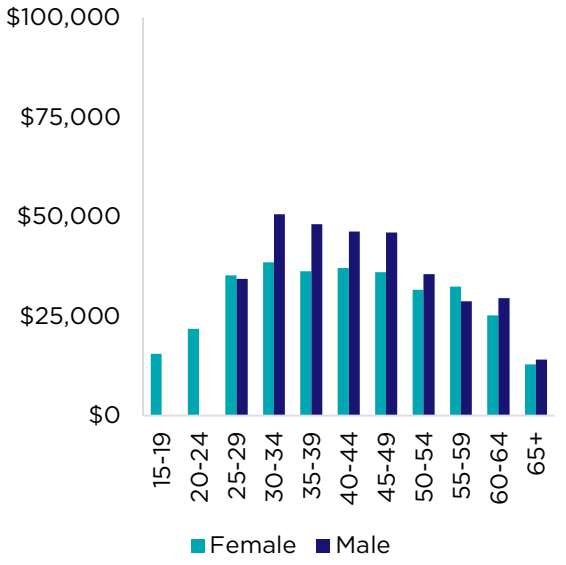
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 172: Median annual wage earnings by gender and age, *Social professionals* (all industries), 2010-11



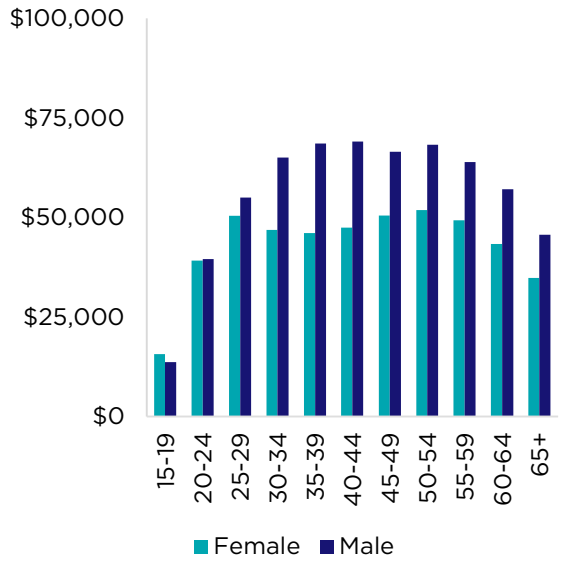
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Due to small counts, data is not available for *Social professionals* aged 15 to 24.

Figure 173: Median annual wage earnings by gender and age, *Social professionals* (all industries), 2018-19



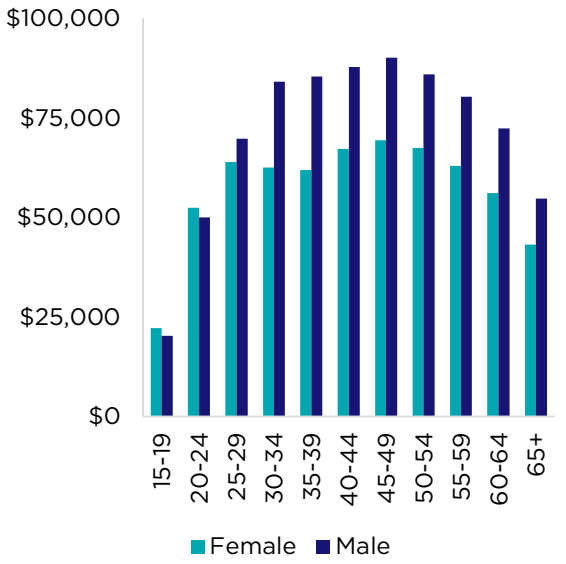
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Due to small counts, data is not available for male *Social professionals* aged 15 to 24.

Figure 174: Median annual wage earnings by gender and age, *Registered nurses* (all industries), 2010-11



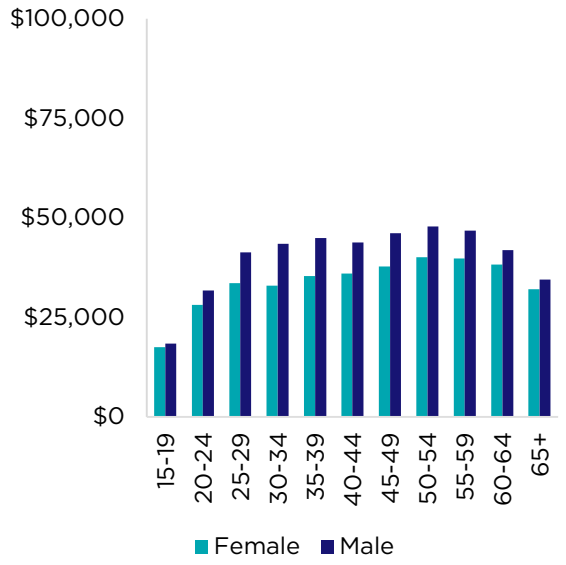
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 175: Median annual wage earnings by gender and age, *Registered nurses* (all industries), 2018-19



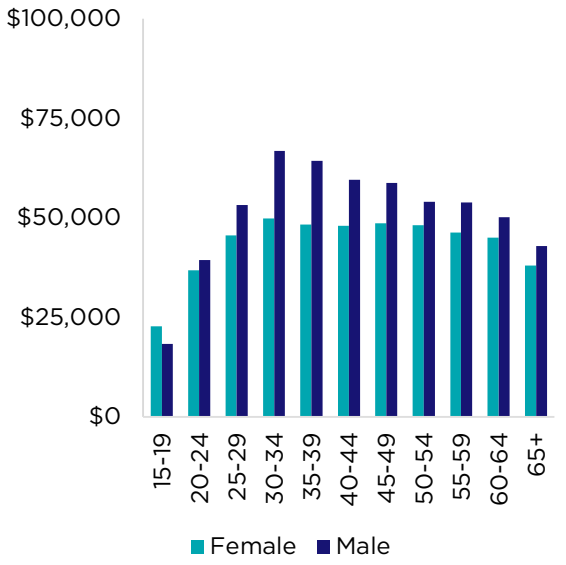
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 176: Median annual wage earnings by gender and age, *Registered nurses (aged care)* (all industries), 2010-11



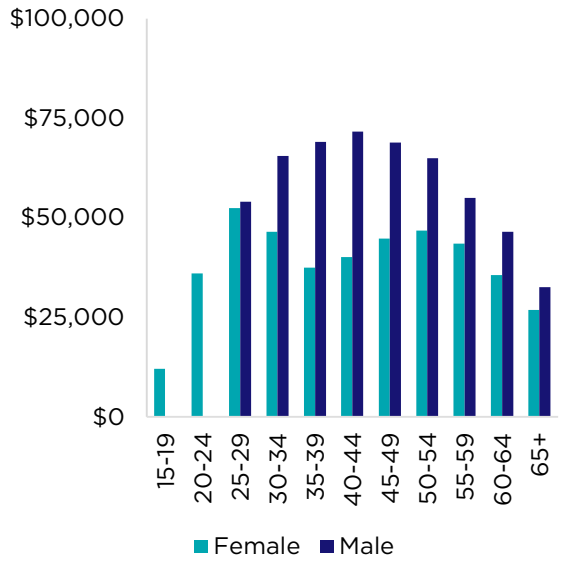
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 177: Median annual wage earnings by gender and age, *Registered nurses (aged care)* (all industries), 2018-19



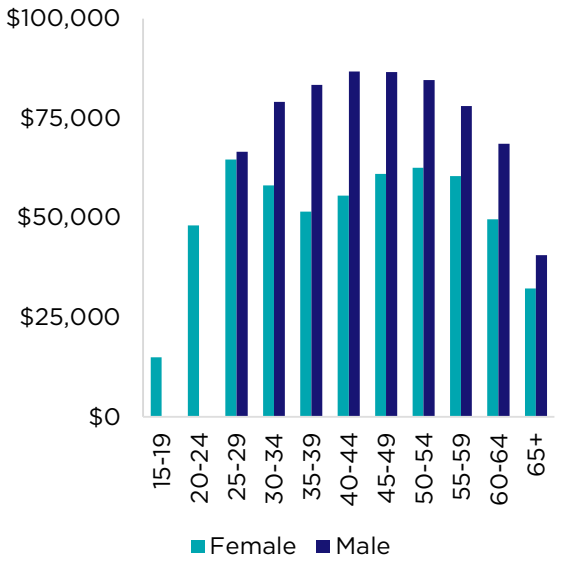
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 178: Median annual wage earnings by gender and age, Allied health professionals (all industries), 2010-11



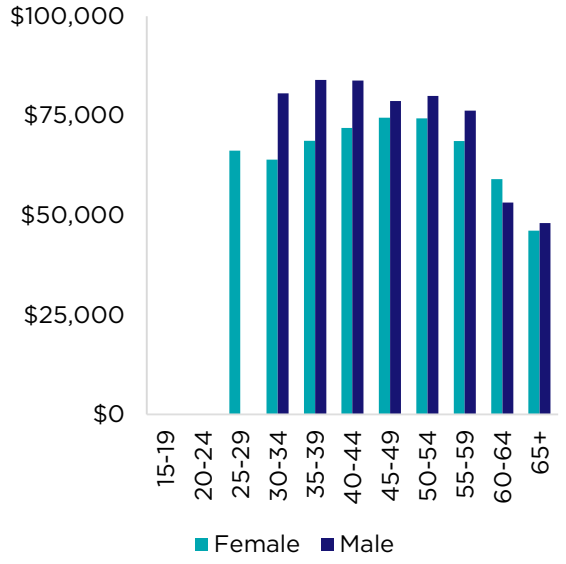
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Allied health professionals refers to the 5 in-scope occupations defined in part 1.3.2. Due to small counts, data is not available for males aged 15 to 24.

Figure 179: Median annual wage earnings by gender and age, Allied health professionals (all industries), 2018-19



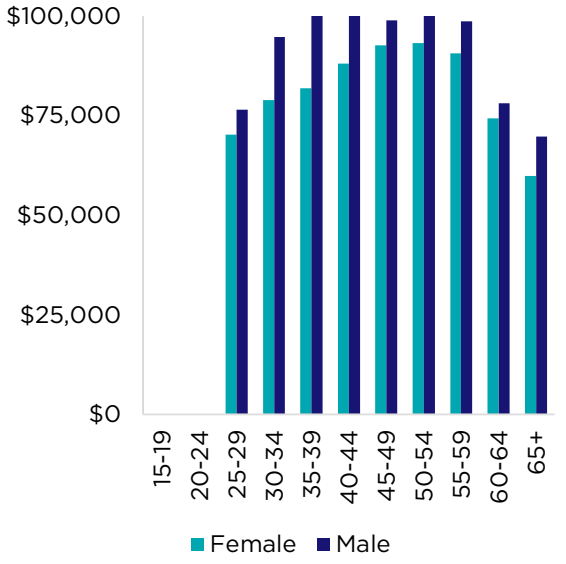
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Allied health professionals refers to the 5 in-scope occupations defined in part 1.3.2. Due to small counts, data is not available for males aged 15 to 24.

Figure 180: Median annual wage earnings by gender and age, *Nurse managers* (all industries), 2010-11



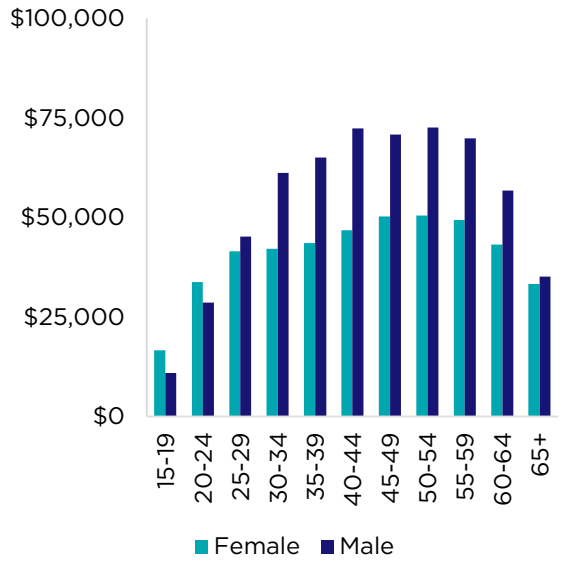
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Due to small counts, data is not available for males aged 15 to 29 or females aged 15 to 24.

Figure 181: Median annual wage earnings by gender and age, *Nurse managers* (all industries), 2018-19



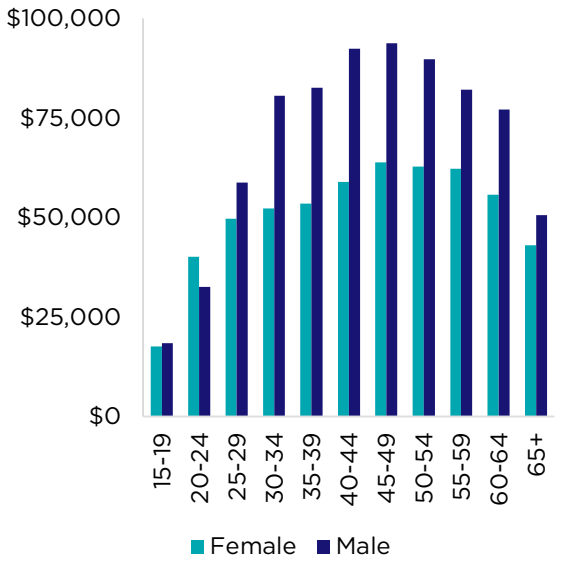
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Due to counts less than 10, data is not available for *Nurse managers* aged 15 to 24.

Figure 182: Median annual wage earnings by gender and age, *Health and welfare services managers* (all industries), 2010-11



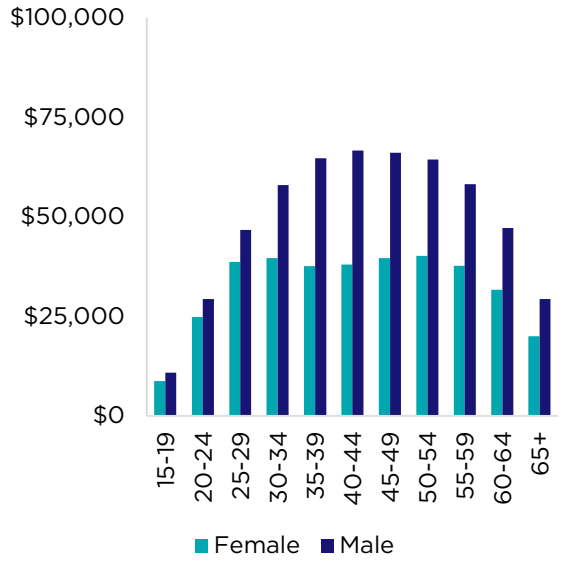
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 183: Median annual wage earnings by gender and age, *Health and welfare services managers* (all industries), 2018-19



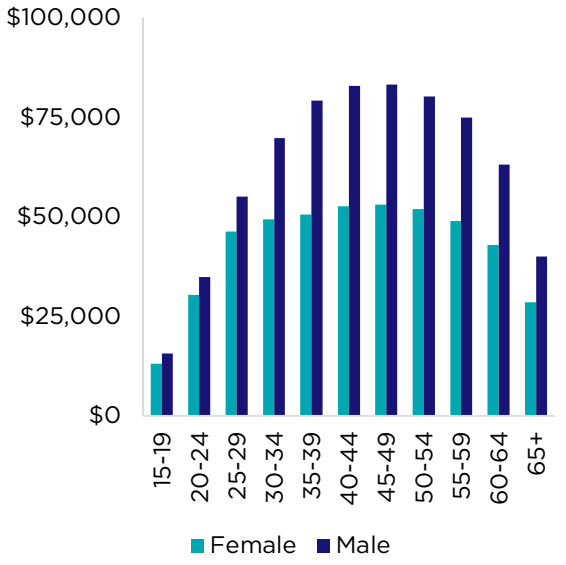
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 184: Median annual wage earnings by gender and age, total employed (all industries), 2010-11



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 185: Median annual wage earnings by gender and age, total employed (all industries), 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Part 6
Qualifications, skills and attributes of the care and support workforce

Part 6 outlines the qualifications and skills of the care and support workforce.

Many providers consulted through the Study also raised the importance of the attributes and values individuals bring to care and support roles. For some providers, attributes and values were seen as more important than qualifications in lower skill level roles.

An educated workforce, although requirements vary

The overall educational attainment of the care and support workforce is relatively high, however there is considerable variation in levels of attainment.

- Over 80% of the care and support workforce have attained a certificate III/IV qualification or higher (in any field of education) compared with 66% in the overall labour market.
- Nine of the 15 in-scope occupations require a bachelor degree or higher as their indicative entry qualification for employment, and 4 of these occupations are accredited and regulated by AHPRA.

However, depending upon the services being provided, the state or territory of practice, the client group and the program under which services are being delivered, a range of other requirements may apply for someone to be able to practice.

While there appears to be a direct link between education and career paths among nurses (both enrolled and registered) and Allied health professionals, the link between education and employment is less clear for Personal care and support workers and Health and welfare support workers.

Education and training pathways

The number of people entering through the higher education pipeline has continued to grow in the last 2 decades and is largely represented by women.

Enrolments in vocational and educational training (VET) training pathways that lead to care and support occupations have shown modest growth, increasing from almost 275,000 enrolments in 2015 to nearly 293,000 in 2019. Although the number of enrolments in care and support qualifications has grown, the number of completions has declined overall. Domestic completions declined from over 87,000 in 2015 to just under 83,000 in 2019.

The complexity evident in other aspects of the care and support sector is also evident in the provision of VET. States and territories decide what qualifications should attract government funding and independently set subsidies (the amount of government support) and policies for student fees and concessions. As a result, qualifications of relevance to the care and support sector are funded differently in each state and territory, resulting in inconsistent student fees and prices across Australia.

While many providers saw attributes and values as more important than qualifications in lower skill level roles, the share of job advertisements specifying a requirement for a certificate level qualification is nonetheless relatively high for Personal care and support workers.

International requirements vary

Internationally, less than half of OECD countries specify minimum qualifications for personal care workers, and where they do these vary from vocational training, high school diplomas or technical degrees after high school. About half of OECD countries require nurses to have a bachelor degree or higher, as is currently required for *Registered nurses* in Australia. Many OECD countries, including Australia, do not require geriatric-specific training for nurses working in aged care.

The workforce uses specialised skills, with digital skills becoming more important

The specialised nature of much of the care and support workforce means that anyone considering transitioning into the care and support workforce from an occupation outside of health and care may have skill gaps that require bridging through formal or on-the-job training.

Along with most of the broader workforce, digital skills will likely grow in importance as technology continues to augment jobs in the care and support workforce. Stakeholders also indicated the increasing importance of digital skills among care and support workers.

6.1 Qualification and professional registration requirements differ across care and support occupations

The qualification and professional registration landscape in the care and support workforce varies considerably across occupations. Table 2 illustrates the common qualifications required for care and support occupations.

However, depending upon the services being provided, the state or territory of practice, the client group and the program under which services are being delivered, a range of other requirements may apply for someone to be able to practice (as outlined in Part 8.2).

There are no minimum qualifications or professional registration requirements for *Aged and disabled carers* and *Nursing support and personal care workers*, however the Certificate III in Individual Support is frequently held by workers in these occupations. A recommendation of the Aged Care Royal Commission included introducing mandatory qualifications for the care and support workforce.

Nursing and some allied health professions are regulated by AHPRA, including registered nurses, enrolled nurses, occupational therapists, physiotherapists, podiatrists, psychologists and Aboriginal and Torres Strait Islander health practitioners. To practice in these occupations, workers must be registered with AHPRA, hold an approved qualification and comply with AHPRA requirements, such as completing ongoing professional development and demonstrating recency of practice. The minimum qualification, while generally a bachelor degree, varies from a diploma for enrolled nurses to a postgraduate degree for other allied health pathways.

Other allied health professions, including nutritionist, dietitian, audiologist, speech pathologist, and social worker are not regulated by AHPRA. Workers in these occupations generally hold a bachelor degree or higher. While not regulated, an individual's skill is often signalled through membership of a professional body or industry group where members are required to demonstrate that they hold recognised qualifications and may be required to complete ongoing professional development. Membership of these professional groups is often specified by employers as a job requirement when advertising. Professional membership is also available for *Diversional therapists* and *Welfare support workers* (although considerably less commonly required by employers), with these roles generally requiring at least a diploma.

Health and welfare services managers tend to have a bachelor degree or higher in a related field, but may also substitute a qualification for extensive relevant experience.

Table 2: Indicative entry qualifications for care and support workforce occupations

ANZSCO code	Occupation	Skill level	AHPRA regulated	Industry membership	Indicative entry qualifications
Personal care and support workers					
4231	Aged and disabled carers	4			Certificate III in Individual Support Certificate IV in Ageing Support Certificate IV in Disability Certificate IV in Mental Health
4233	Nursing support and personal care workers	4			Certificate III in Individual Support Certificate IV in Ageing Support Certificate III/IV in Allied Health Assistance Certificate IV in Health Care
Health and welfare support workers					
2724	Social professionals	1		✓	Diploma of Interpreting*
4114	Enrolled and mothercraft nurses	2	✓		Diploma of Nursing
4115	Indigenous health workers**	2	✓	Depends on role	Various educational pathways from certificate to bachelor degree
4117	Welfare support workers	2		✓	Certificate II/III/IV or Diploma in Community Services Certificate IV in Social Housing Certificate IV/Diploma in Community Development Certificate IV/Diploma in Youth Work Diploma of Mental Health Diploma of Counselling
4113	Diversional therapists	3		✓	Certificate IV in Leisure and Health Diploma of Leisure and Health Bachelor of Recreational Therapy
Registered nurses					
2544	Registered nurses	1	✓		Bachelor of Nursing
Allied health professionals					
2511	Nutrition professionals	1		✓	Bachelor of Nutrition
2524	Occupational therapists	1	✓		Bachelor of Occupational Therapy
2525	Physiotherapists	1	✓		Bachelor of Physiotherapy
2526	Podiatrists	1	✓		Bachelor of Podiatry
2527	Audiologists and speech pathologists/ therapists	1		✓	Master of Audiology Bachelor of Speech Pathology
Health and welfare managers					
2543	Nurse managers***	1			Bachelor of Nursing
1342	Health and welfare services managers	1		Depends on role	Various educational pathways

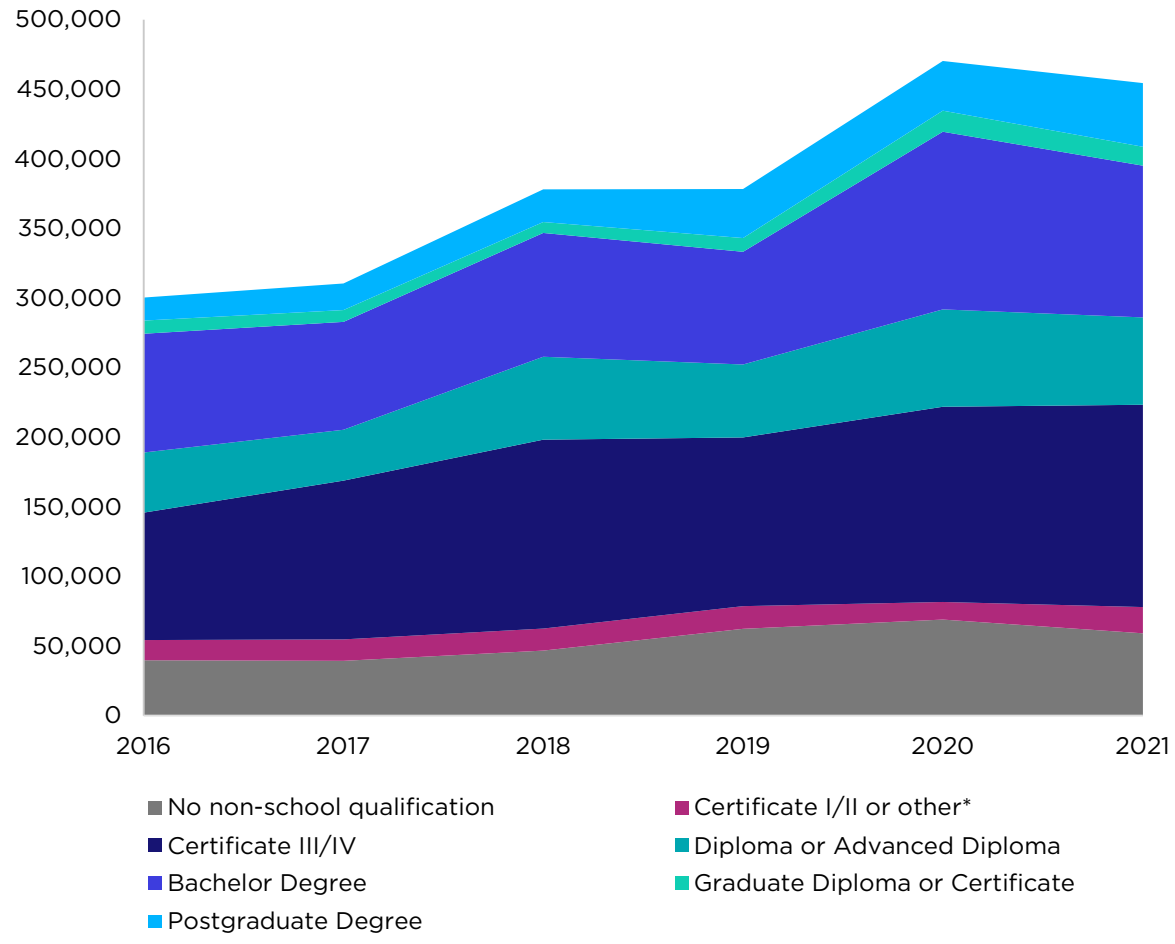
Source: ANZSCO, 2013, Version 1.3; AHPRA website; National Alliance of Self-Regulating Health Professions website; Australian Community Workers Association website; Diversional and Recreational Therapy Australia website. *Indicative entry qualification for *Social professionals (interpreters)*. **AHPRA registration refers to the Aboriginal and Torres Strait Islander Health Worker title. ***While the job title of nurse manager is not AHPRA regulated, to work as a nurse unit manager, a nurse supervisor, or a charge nurse, AHPRA registration (as a registered nurse) may be required by employers.

6.2 The care and support workforce is relatively well-educated with most attaining a non-school qualification in relevant fields of education

The overall educational attainment of the care and support workforce is relatively high, however there is considerable variation in levels of attainment within this workforce. The majority (over 80%) of the care and support workforce have attained a certificate III/IV qualification of higher (in any field of education) (Figure 186) compared with 66% in the overall labour market. However, a lower proportion of care and support workers have a bachelor degree or above when compared with the broader health industry.

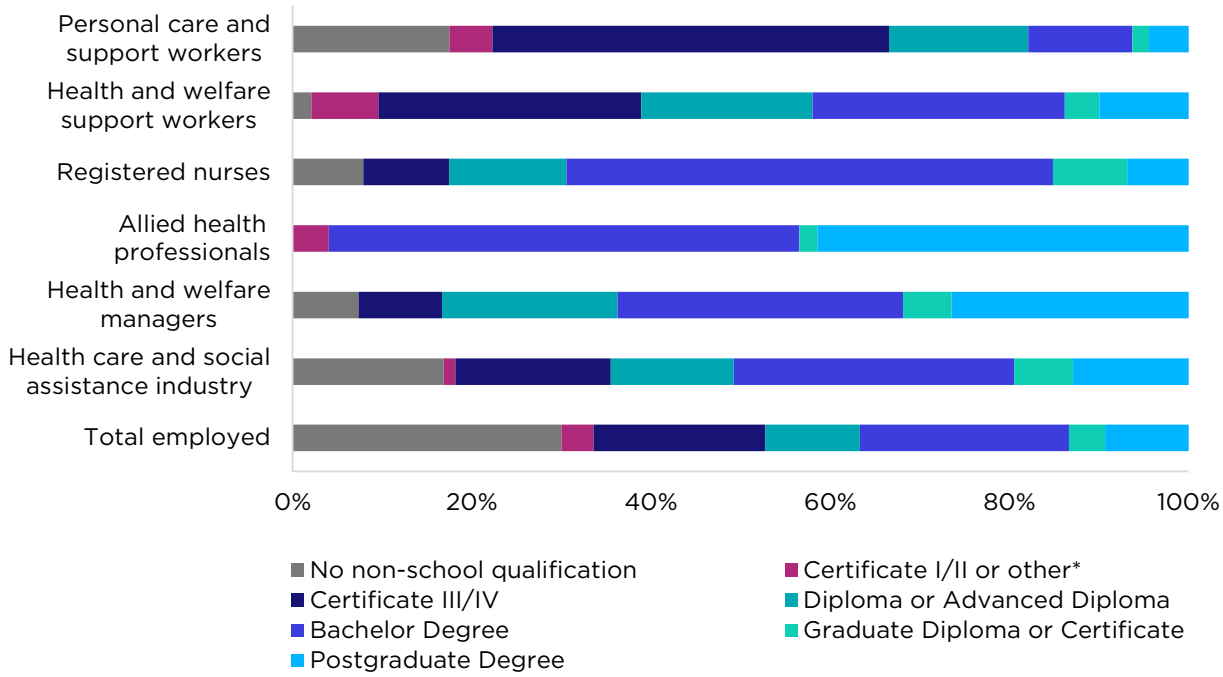
Looking at the occupational groups within the care and support workforce (Figure 187), around 3 in 4 Personal care and support workers have a certificate III/IV or higher qualification. The proportion of Personal care and support workers who have not attained a certificate III/IV or higher (20%) is significantly lower than the national average (32%).

Figure 186: Care and support workforce by highest level of non-school qualification, in-scope industries, February 2016 to February 2021



Source: ABS Participation, Job Search and Mobility, 2016 to 2021 in TableBuilder. Data for 3 in-scope 3-digit ANZSIC industries. *Includes certificates not further defined and qualifications where the level was not determined.

Figure 187: Care and support workforce by highest level of non-school qualification, in-scope industries, February 2021



Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder. Data for 3 in-scope 3-digit ANZSIC industries. *Includes certificates not further defined and qualifications where the level was not determined.

Around 73% of the care and support workforce have attained qualifications in a health-related field such as nursing and rehabilitation studies (including physiotherapy, podiatry, occupational therapy and speech pathology), or society and culture (including human welfare studies and services as well as behavioural science) (Figure 188)[133].

While there appears to be a direct link between education and career paths among nurses (both enrolled and registered) and Allied health professionals, the link between education and employment is less clear for Personal care and support workers and Health and welfare support workers. This illustrates the diverse entry pathways into these occupations, a finding that was also evident in analysis of the 2016 NACWCS.[134]

As illustrated, *Registered nurses* are highly educated. However, there are variations in educational attainment across age groups. Following the introduction of new registration standards for *Registered nurses* in 1984, new entrants are required to hold at least a bachelor degree. Some older *Registered nurses* may not have a bachelor degree, reflecting changes to nursing training, accreditation and registration over time.[135]

Figure 188 shows a person's highest level of non-school qualification. Many *Registered nurses*, for example, also undertake post-graduate studies to specialise in a particular field, which will account for a proportion of those qualifications that are not directly classified as nursing.

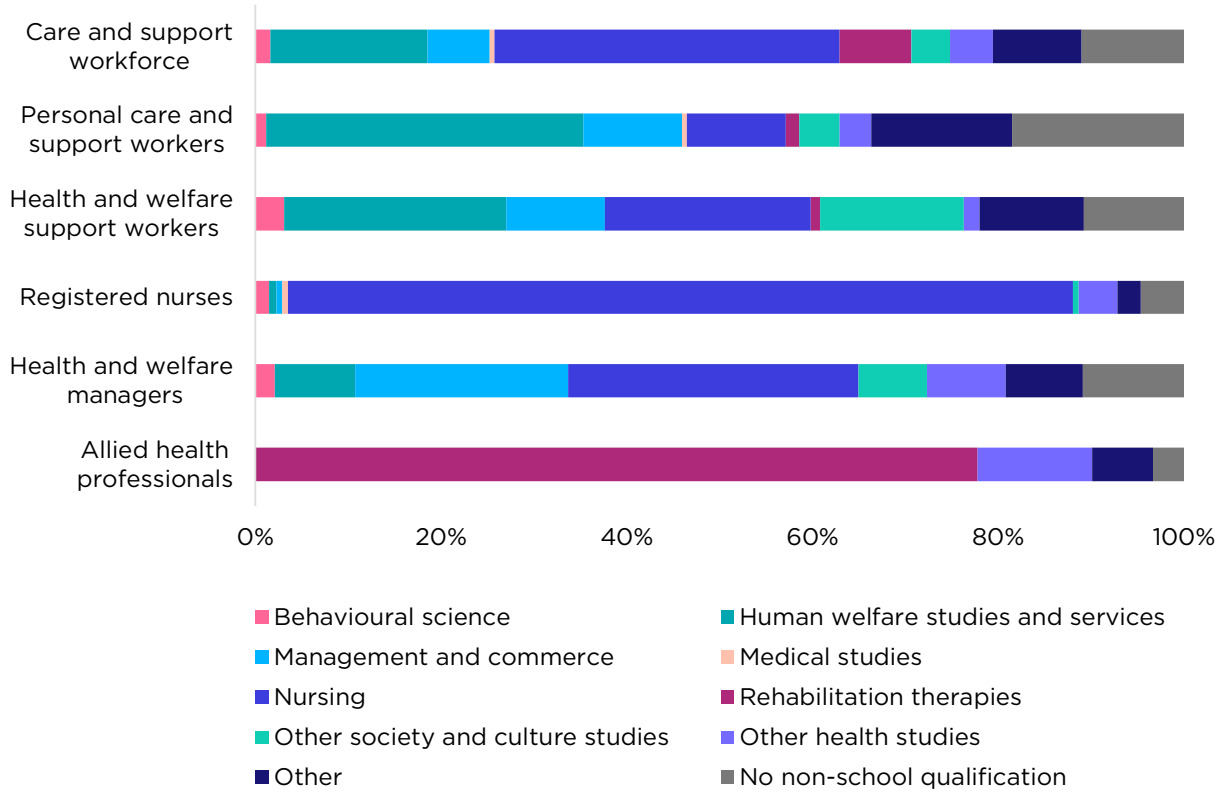
The data also illustrates that those working in manager roles are also more likely to have undertaken studies in the management and commerce field (which includes, along with a range of other fields, training in public and health care administration).

[133] Fields of education are based on the ABS Australian Standard Classification of Education (ASCED), 2001

[134] Mavromaras, et al., *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce*, 2017

[135] Commonwealth Department of Health, *Review of Australian Government Health Workforce Programs, Appendix iv - History of Commonwealth involvement in the nursing and midwifery workforce*, 2013

Figure 188: Main field of education for highest non-school qualification, care and support occupations, all industries, February 2021



Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder. The care and support workforce includes the 15 in-scope ANZSCO 4-digit occupations across all industries.

6.3 Enrolments and completions in education and training

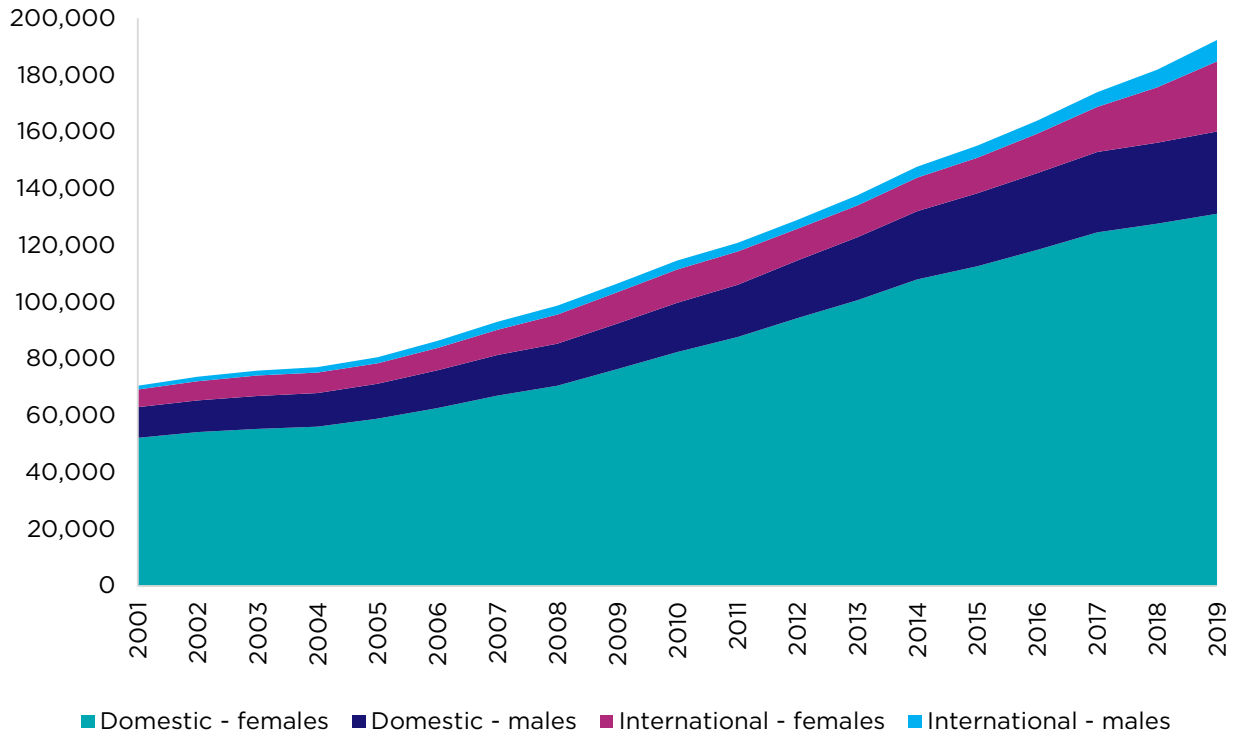
The supply of workers to the care and support workforce is influenced by the skills pipeline from education and training pathways in higher education and VET.

6.3.1 Higher education enrolments and completions

As outlined in Part 6.1, 9 of the 15 in-scope occupations require a bachelor degree or higher as their indicative entry qualification for employment, and 4 of these occupations are accredited and regulated by AHPRA (Table 2).

The number of people entering through the higher education pipeline has continued to grow in the last 2 decades and is largely represented by women (Figure 189). Higher education enrolments in care and support related fields increased by 172% between 2001 and 2019. Female domestic enrolments accounted for over 80% of enrolments in 2019, a proportion that has been consistent since 2001.

Figure 189: Higher education enrolments in care and support related fields, 2001 to 2019



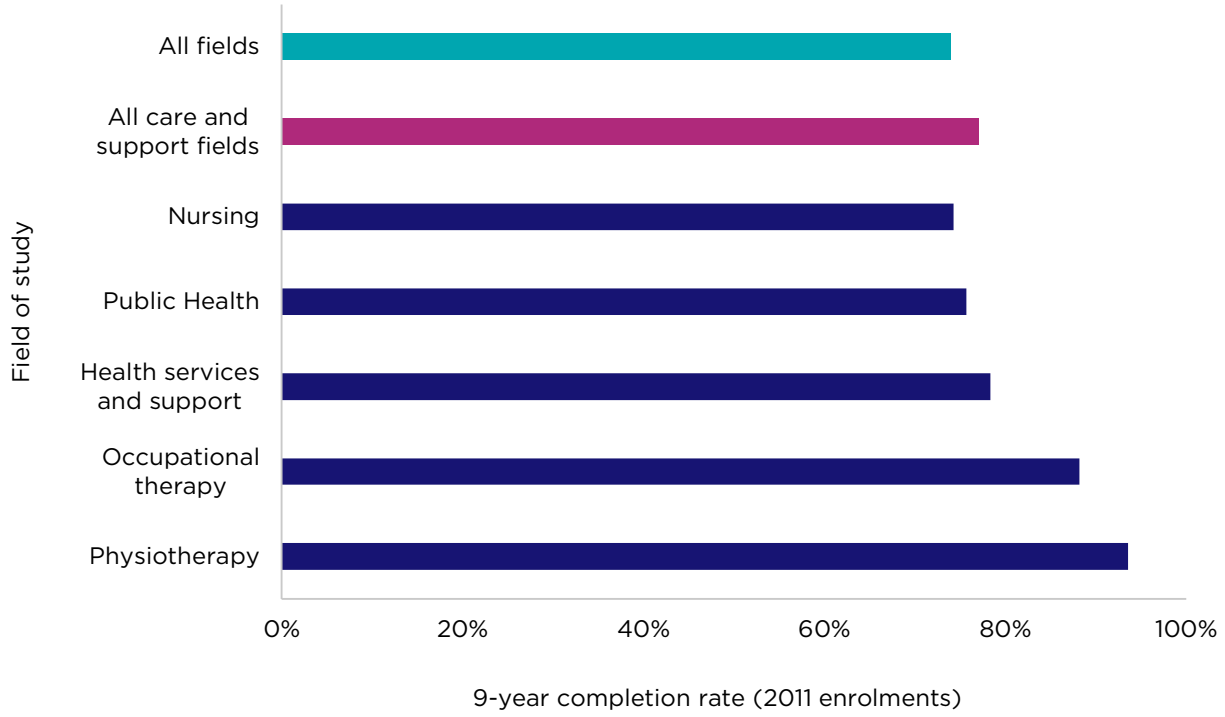
Source: Source: Department of Education, Skills and Employment (unpublished data). Care and support related fields of education defined here includes nursing, public health, rehabilitation therapies (allied health), and human welfare studies and services. Data for 2020 is preliminary and subject to change, therefore not included in analysis.

Some care and support related fields of study in higher education have higher rates of completion compared with all fields of study (Figure 190).

Of the around 45,500 domestic enrolments in care and support related degrees in 2011, 77% had completed by 2019. This was slightly higher compared with the 74% completion rate across all fields of study. The highest domestic completion rates were among physiotherapy related qualifications at over 93% of people who enrolled in the course in 2011 and completed it by 2019.

While there are increasing numbers of enrolments and high rates of completion, it is difficult to ascertain how many graduates are eventually employed in the care and support workforce. It is also difficult to determine the number of graduates who are retained in these settings and the average length of time spent in these roles.

Figure 190: Domestic completion rates for care and support related higher education fields of study, 2011 enrolments (9-year completion rates)



Source: Department of Education, Skills and Employment (unpublished data).

6.3.2 VET enrolments and completions

As highlighted in Part 6.2, 46% of the care and support workforce have a VET certificate III or higher qualification from the VET system (i.e. certificate III to advanced diploma) as their highest educational attainment. Further to this, as seen in Part 3.2, 59% of the care and support workforce are defined as skill level 4, which is equivalent to having training at the certificate II/III level. This highlights the importance of VET pathways into many occupations within the care and support workforce.

Table 3 shows the total number of enrolments for VET courses (including accredited courses and short courses identified by the National Centre for Vocational Education Research (NCVER)) which have a pathway to 11 of the 15 in-scope care and support occupations.[136] The qualifications considered include, but are not limited to, those in Table 2. These data include enrolments from superseded qualifications from prior training packages, accredited courses and short courses.

[136] Each VET course identified by the NCVER relates to one of the in-scope occupations (4-digit ANZSCO) but may not have direct relevance to a care and support setting, given the expanded range of 6-digit ANZSCO occupations that sit within some in-scope occupations.

Table 3: Enrolments in care and support related VET qualifications, domestic and international enrolments, 2015 to 2019

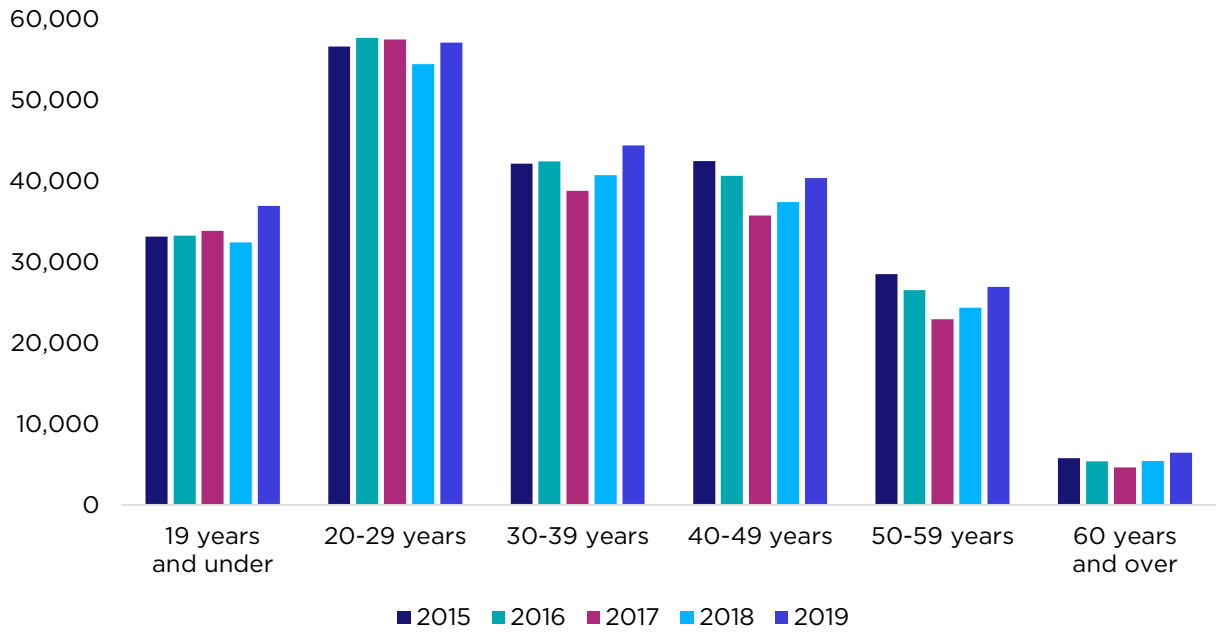
Enrolments	2015	2016	2017	2018	2019
Domestic	266,620	263,175	251,640	252,765	278,195
% of total	97%	96%	94%	94%	95%
International	8300	12,325	15,610	15,065	14,660
% of total	3%	4%	6%	6%	5%
Total	274,920	275,500	267,250	267,830	292,855

Source: VOCSTATS, NCVER, 2021. This includes all VET qualifications as identified by the NCVER with a pathway to in-scope care and support occupations including accredited courses and qualifications superseded by newly developed training packages in the last 5 years. Data for 2020 is preliminary and subject to change, therefore not included in analysis.

Enrolments in fields of education that typically lead to care and support occupations have shown modest growth (Figure 191 and Figure 192), increasing from almost 275,000 in 2015 to nearly 293,000 in 2019.

- Comparatively, enrolments across all VET qualifications have declined since 2016, from over 3 million to over 2.7 million in 2020.
- International enrolments make up a relatively small proportion of total enrolments in care and support VET qualifications at only 5% in 2019.
- For domestic students, the number of female enrolments has been 2-3 times higher than for males over this period. Enrolments have also been the highest for the 20-29 years age group, for both male and female domestic enrolments. Although males represent a smaller share of this cohort, the number of domestic male enrolments has increased by more than 10% between 2015 and 2019, compared with an increase of 1.6% of domestic female enrolments over the same period. This may suggest a growing interest in care and support qualifications by men, although the driver of this interest remains unclear.

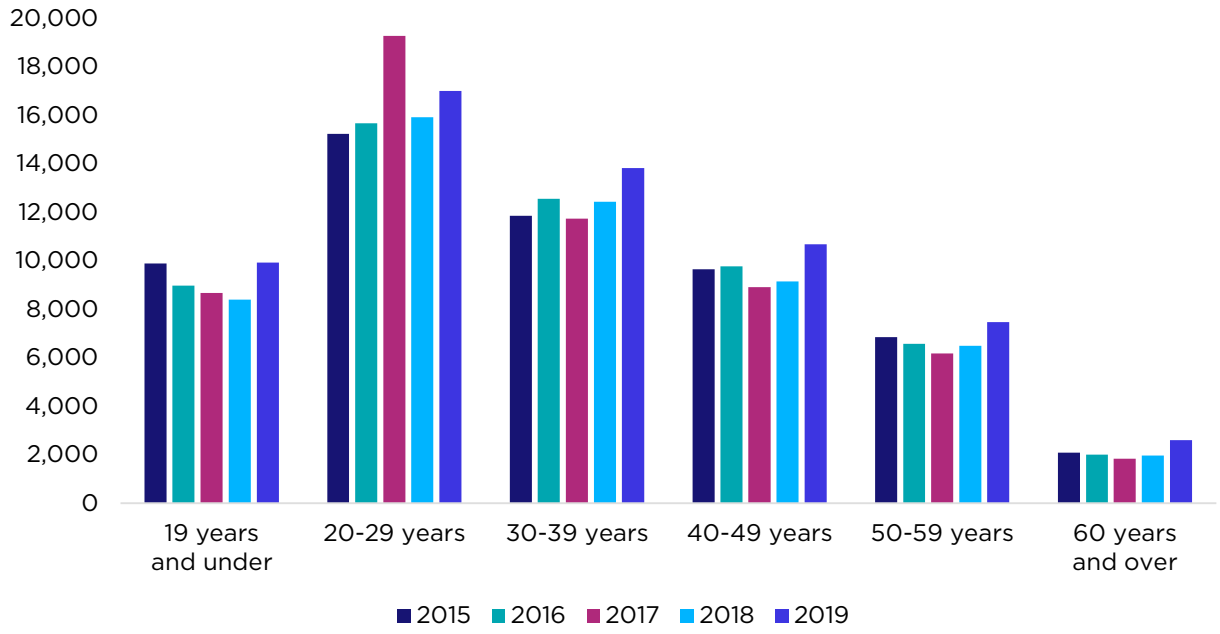
Figure 191: Enrolments in care and support related VET qualifications, domestic students, females, by age group, 2015 to 2019



Source: VOCSTATS, NCVER, 2021. This includes all VET qualifications with a pathway to in-scope care and support occupations including accredited courses outside of training packages and qualifications superseded by newly

developed training packages in the last 5 years. Data for 2020 is preliminary and is subject to change, therefore not included in the analysis.

Figure 192: Enrolments in care and support related VET qualifications, domestic students, males, by age group, 2015 to 2019



Source: VOCSTATS, NCVER, 2021. This includes all VET qualifications with a pathway to in-scope care and support occupations including accredited courses outside of training packages and qualifications superseded by newly developed training packages in the last 5 years. Data for 2020 is preliminary and is subject to change.

Although the number of enrolments in care and support qualifications has grown, the number of completions has declined overall (Table 4). Domestic completions declined from over 87,000 in 2015 to just under 83,000 in 2019. This was largely driven by the decline in female domestic completions over the period, while male domestic completions increased slightly.

The completion ratio is calculated by the NSC as the number of people who complete a qualification, relative to the number who enrol, over a 12-month period. However, this is not equivalent to a completion rate as an actual completion rate tracks individuals from initial enrolment to completion or discontinuation of study. Completion rates can be difficult to estimate due to the variation in the time taken for each individual from enrolment to completion and the potential to take time away from study during the course. As a result, the most accurate estimations of completion rates often have a 2 to 3 year lag on most recent enrolment and completions data.

Between 2015 and 2019, the annual completion ratio for care and support qualifications declined slightly from 0.33 to 0.30 and is within a similar range to the total of all VET qualifications (which increased slightly from 0.31 and 0.34).

Table 4: Completions and annual completion ratios, care and support qualifications, by gender, 2015 to 2019

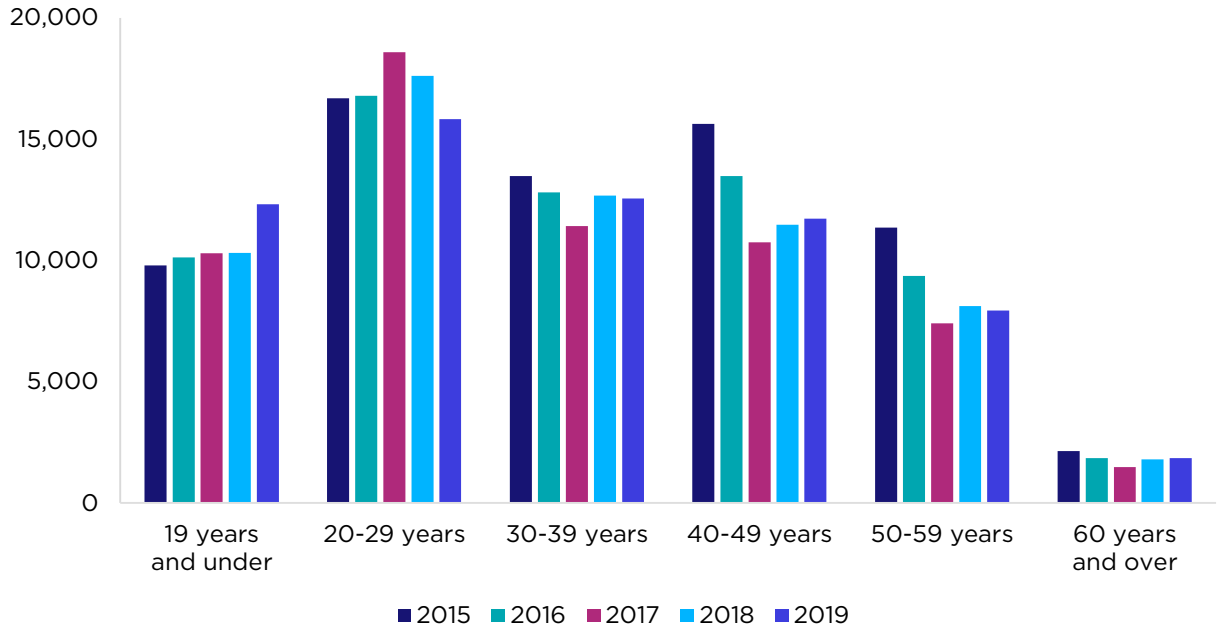
	2015	2016	2017	2018	2019
Male completions	17,755	17,115	17,810	16,630	18,885
Male completion ratio	0.32	0.31	0.31	0.31	0.31
Female completions	69,115	64,405	59,935	62,020	62,290
Female completion ratio	0.33	0.31	0.31	0.32	0.29
Total completions*	87,265	82,235	78,350	80,235	82,975
Overall completion ratio*	0.33	0.31	0.31	0.31	0.30

Source: VOCSTATS, NCVER. This includes all VET qualifications with a pathway to in-scope care and support occupations including accredited courses outside of training packages and qualifications superseded by newly developed training packages in the last 5 years. Data for 2020 is preliminary, therefore not included in the analysis.

As expected, based on the large share of enrolments, the number of completions by female domestic graduates has been 2-3 times higher than male domestic graduates. Further to this, the highest number of completions are also by those in the 20-29 years age group for both female and male domestic graduates (Figure 193 and Figure 194).

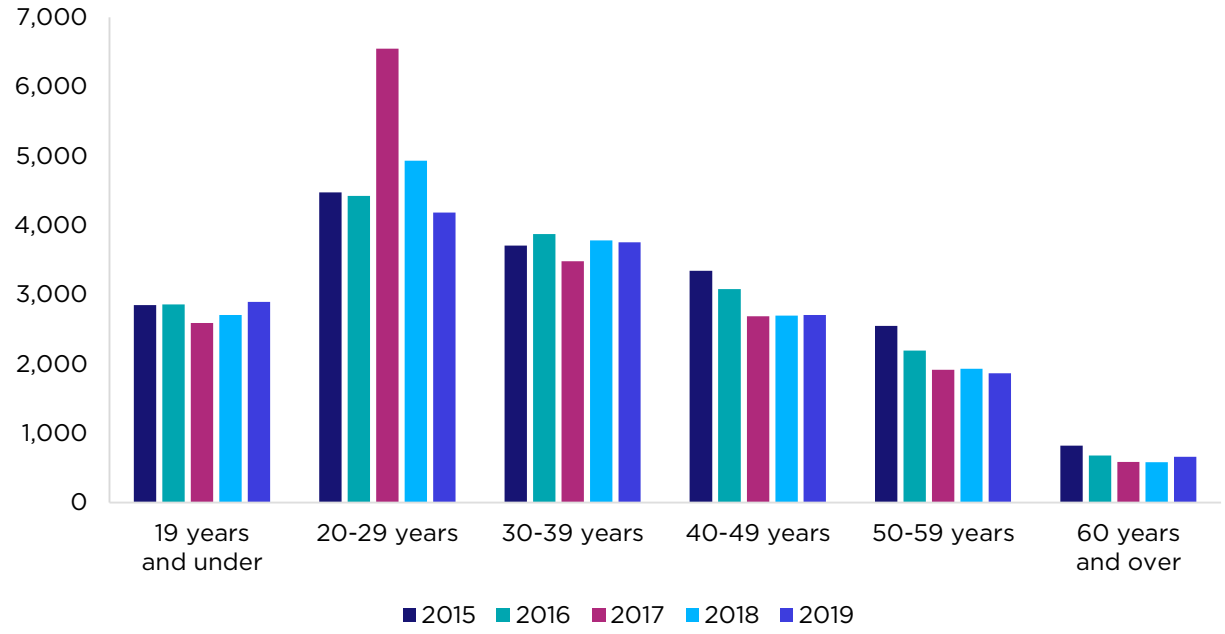
- In 2017, there was almost a 50% increase in the number of males aged 20-29 years completing a care and support qualification compared with 2016. This was largely driven by an almost 10-fold increase in the number of male domestic completions in translating courses accredited by the National Accreditation Authority for Translators and Interpreters, such as the Diploma of Interpreting and Advanced Diploma of Translating. This may be driven by language translators and interpreters seeking to re-certify or re-validate their credentials to provide services to NDIS participants.

Figure 193: Completions in care and support VET qualifications, domestic students, females, by age group, 2015 to 2019



Source: VOCSTATS, NCVER, 2021. This includes all VET qualifications with a pathway to in-scope care and support occupations including accredited courses outside of training packages and qualifications superseded by newly developed training packages in the last 5 years. Data for 2020 is preliminary, therefore not included in the analysis.

Figure 194: Completions in care and support VET qualifications, domestic students, males, by age group, 2015 to 2019



Source: VOCSTATS, NCVER, 2021. This includes all VET qualifications with a pathway to in-scope care and support occupations including accredited courses outside of training packages and qualifications superseded by newly developed training packages in the last 5 years. Data for 2020 is preliminary, therefore not included in the analysis.

6.3.3 Qualifications for *Aged and disabled carers*

As seen in Part 3.1, *Aged and disabled carers* make up almost 40% of the entire care and support workforce. Qualifications that offer students entry to these roles include the Certificate III in Individual Support, Certificate IV in Ageing Support and Certificate IV in Disability, which were all released in 2015.

As expected with the release of a training package update, enrolments for these courses were low in the first year, particularly because it was released in the second half of 2015. The Certificate III in Individual Support superseded 3 other courses (Certificate III in Aged Care, Certificate III in Home and Community Care, and Certificate III in Disability) for the purpose of streamlining and rationalising the delivery of these courses given their high degree of shared course content and competencies.

In 2019, the total number of enrolments across the Certificate III in Individual Support, Certificate IV in Ageing Support and Certificate IV in Disability represented over 39% of all enrolments in care and support qualifications. Enrolments in Certificate III in Individual Support make up 3% of total VET enrolments. Across these 3 qualifications, there were almost 115,000 enrolments and over 41,000 completions in 2019 (Table 5). This is an increase of 137% and 211% respectively when compared with enrolments and completions in 2016. The completion ratio for Certificate III in Individual Support between 2017 and 2019 has been relatively higher than all other care and support VET qualifications (Table 4).

Table 5: Enrolments and completions, and completion ratios for relevant personal care qualifications, 2015 to 2019

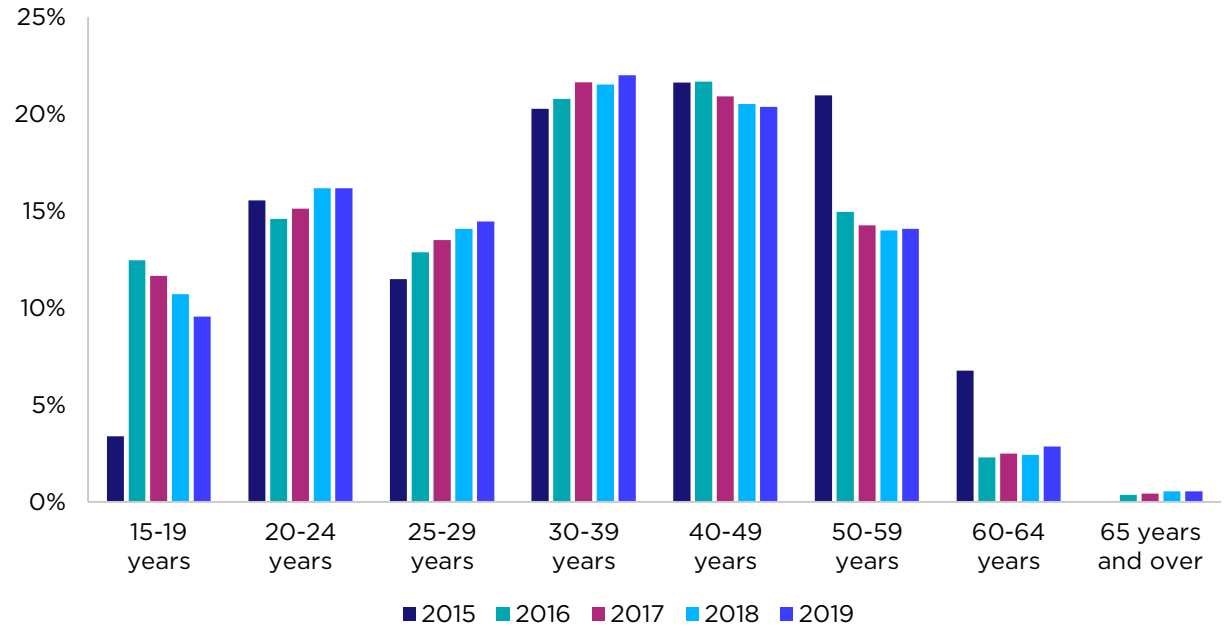
Qualification	Measure	2015	2016	2017	2018	2019
Certificate III in Individual Support	Enrolments	217	35,150	61,747	68,654	79,498
	Completions	36	11,145	25,186	27,369	31,039
	Completion ratio	0.17*	0.32*	0.41	0.40	0.39
Certificate IV in Ageing Support	Enrolments	110	7,467	14,638	19,321	21,295
	Completions	3	1,231	4,384	5,827	6,468
	Completion ratio	0.03*	0.16*	0.30	0.30	0.30
Certificate IV in Disability	Enrolments	26	5,701	9,443	11,157	14,189
	Completions	5	1,016	2,823	3,396	4,143
	Completion ratio	0.19*	0.18*	0.30	0.30	0.29

Source: ASQA, 2021, Enrolment and completions in selected training package qualifications, 2015 to 2019 (Supplied). Data for 2020 is preliminary and subject to change, therefore not included in analysis. *Enrolments and completions in these qualifications are significantly lower in these years due to being newly released in August 2015 as part of the CHC Community Services Training Package release 2.0.

The number of enrolments for Certificate III in Individual Support has grown from over 35,000 in 2016 to almost 80,000 in 2019. Consequently, the number of completions each year has also grown from over 11,000 in 2016 to over 31,000 in 2019.

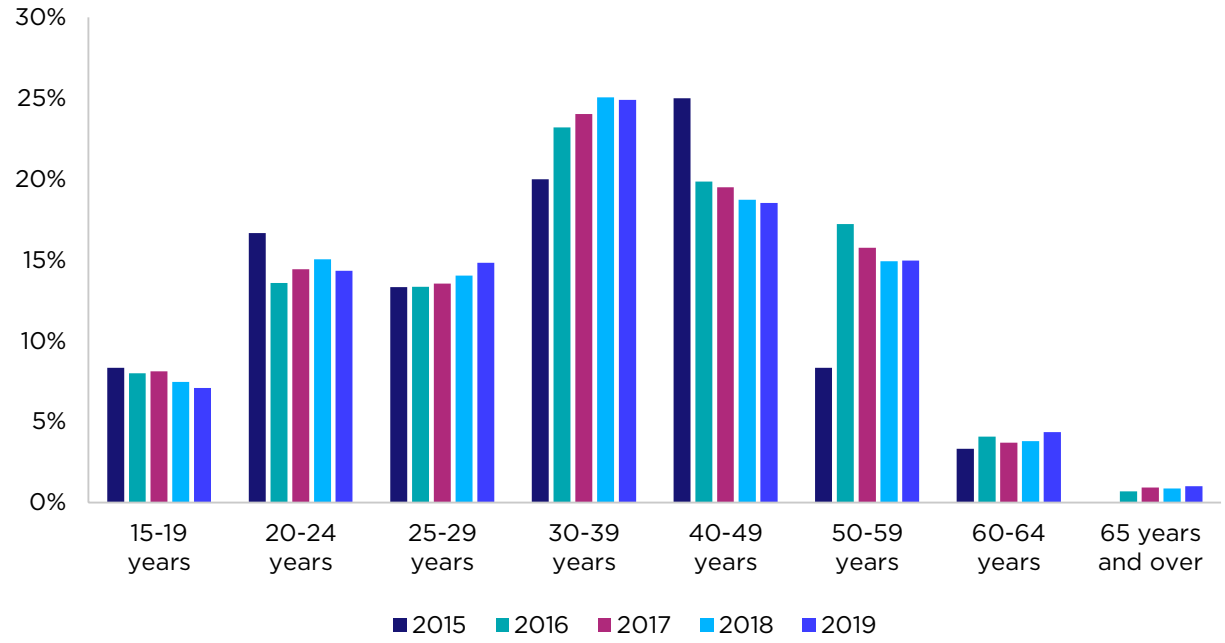
Figure 195 and Figure 196 show the distribution of enrolments in the Certificate III in Individual Support courses by age and gender. For both females and males, the number of enrolments has been increasing across all age groups, however, there has been proportional decline in the 40-49 years and 50-59 years age groups between 2015 and 2019.

Figure 195: Distribution of female enrolments in Certificate III in Individual Support, by age group, 2015 to 2019



Source: ASQA, 2021 (Supplied). Data for 2020 is preliminary and subject to change, therefore not included in analysis.

Figure 196: Distribution of male enrolments in Certificate III in Individual Support, by age group, 2015 to 2019



Source: ASQA, 2021 (Supplied). Data for 2020 is preliminary and subject to change, therefore not included in analysis.

6.3.4 Provision of training

The complexity evident in other aspects of the care and support sector is also evident in the provision of training. States and territories determine which qualifications should attract government funding, and independently set subsidies (the amount of government support) and policies for student fees and concessions. As a result, qualifications of relevance to the care and support sector are funded differently in each state and territory, resulting in inconsistent student fees and prices across Australia.

6.3.4.1 Student fees

Variation is observed in student fees across states and territories for the same qualification, even in jurisdictions with similar fee settings. Some jurisdictions regulate fees (i.e. via a fixed fee) – including New South Wales and Western Australia – while others allow individual training providers to determine the fee that they charge according to local market factors (with some rules applied around fee setting by jurisdiction). Fee settings have an impact on both the range in fees that students may incur with a state or territory, in addition to the ability to observe standard fee settings across jurisdictions.

The Certificate III in Individual Support attracts a fixed (regulated) student fee of $1,450 in New South Wales, compared with $899 in Western Australia (before any concessions in both cases). According to the NSC average price benchmark database, the jurisdiction average fee for this qualification ranges from approximately $250 to $2,400 across all jurisdictions.

The distribution of fees is similar for the Certificate IV in Ageing Support. Fixed fees of $1,990 and $1,345 apply in New South Wales and Western Australia respectively (before concessions), while the lowest jurisdiction average fee observed in NSC's average price data is less than $100.

At higher qualification levels within the VET system, variation in subsidy and pricing policies can become more pronounced in their impact on student fees. For instance, average student fees range from $4,420 to over $15,500 for the Diploma of Nursing, depending on the jurisdiction in which a student is located.

6.3.4.2 Total price

Not only do students pay different amounts to study the same qualification (and noting that many students might also be eligible for fee concessions), training providers in different jurisdictions also receive different subsidies. As a result, the price – where price equals the sum of the student contribution (the fee) and the government contribution (the subsidy) – of key qualifications relevant to the care and support sector differs markedly across jurisdictions, as shown in Figure 197.

Figure 197: Price range and median price per qualification for select care and support related qualifications, across states and territories

Source: NSC Average Price Benchmark database.

6.4 Attributes of care and support workers

In addition to the qualifications and skills (Part 6.6.1) used across the care and support workforce, many providers consulted through the Study raised the importance of the attributes and values individuals bring to care and support roles. While not disagreeing with the importance of these behaviours, feedback from unions suggested that the attributes referred to by providers were in fact skills. Views were varied on what these attributes should be for care and support roles.

For many providers, attributes and values were seen as more important than qualifications in lower skill level roles.

A 2017 survey of care and support employers found that employee attributes were very important to aged care and disability providers. This was particularly the case for disability providers, with employers ranking personal qualities as more important than both qualifications and experience.[137] In line with this, some providers consulted through the Study stated they placed a greater emphasis on employee attributes over qualifications when recruiting.

Analysis of tools used by employers for recruitment screening, including those used for the Australian Government's *Launch into Work Program*, outline a range of attributes and values. These include cultural sensitivity and awareness, dependability, attention to detail, willingness to learn new things and communication. *Launch into Work* commenced as a pilot to test whether values and attributes-based recruitment could lead to better retention rates. The pilot was subsequently expanded to a small program following positive pilot results.

The NDIS Workforce Capability Framework articulates expectations about the attitudes, skills and knowledge of all workers providing services to participants who are funded under the NDIS. The framework translates the NDIS principles, Practice Standards and Code of Conduct into observable behaviours that providers and workers should demonstrate when delivering services to people with disability. Core capabilities identified in the framework include communicating effectively, building trusting relationships, and showing self-awareness.[138]

Internationally, there is some focus on recruiting for values-based attributes of care and support workers, including England's Skills for Care.

England's Skills for Care – values-based recruitment

England's peak strategic body for workforce development in adult social care, Skills for Care, promote a values-based recruitment method to improve staff retention and care quality. This approach works under the premise that recruiting staff with the desirable attitudes and values will increase retention in the workforce, while enabling better skill development and knowledge sharing. This recruitment method focuses on social care values such as respect, empathy and compassion; treating people with dignity; integrity; and communication, rather than focusing entirely on qualification or work experience.

A 2016 study of social care employers showed that 72% of employers who adopted a values-based recruitment method found that it resulted in better performing staff compared to those who recruited through traditional methods. Roughly three-quarters of employers also reported that values-based recruitment led to an overall increase in social care values exhibited by staff. The study found that staff turnover reduced by 5.6 percentage points, down to 19% over 12 months. Values-based recruitment also led to an increase in care quality, while reducing costs for care providers.[139]

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[137] Department of Jobs and Small Business, *The labour market for personal care workers in the disability and aged care sector – Australia 2017*, 2017

[138] NDIS Quality and Safeguards Commission, *NDIS Workforce Capability Framework*, 2021

[139] Consilium Research and Consultancy, *Study into the impact of a values based approach to recruitment and retention*, 2016

6.5 International qualifications

The 2020 OECD report on the long-term care workforce, *Who Cares? Attracting and Retaining Care Workers for the Elderly,* focuses on personal care workers and nurses in caring roles outside of the hospital sector.[140] While the scope of this publication does not fully align with the definition of the care and support workforce used in this Study, it provides an interesting point of comparison.

In most OECD countries there are low barriers to become a long-term care worker. Personal care workers tend to have lower educational levels than the overall OECD long-term care workforce, similar to the situation in Australia.

In the OECD, 70% of personal care workers have medium education levels – defined as "upper secondary education or a post-secondary non-tertiary education – vocational schools". Given that over 70% of *Aged and disabled carers* and *Nursing support and personal care workers* in Australia have at least a Certificate III/IV or higher, it can be inferred that Australia is similar to the OECD average.

Less than half of OECD countries specify minimum qualifications for personal care workers. Where they do, these vary from vocational training, high school diplomas or technical degrees after high school.

About half of OECD countries require nurses to have a bachelor degree or higher, as is currently required for *Registered nurses* in Australia. Many OECD countries, including Australia, do not require geriatric-specific training for nurses working in aged care.

[140] OECD, *Who Cares? Attracting and retaining care workers for the elderly*, 2020

6.6 Skills of the care and support workforce

The skills required by the care and support workforce are broad ranging and vary across each of the 15 in-scope occupations and 5 occupation groups. Understanding the skills of the workforce at a granular level not only informs training requirements, but also highlights the degree of transferability of skills within the labour market and potential skill gaps for career progression within the workforce.

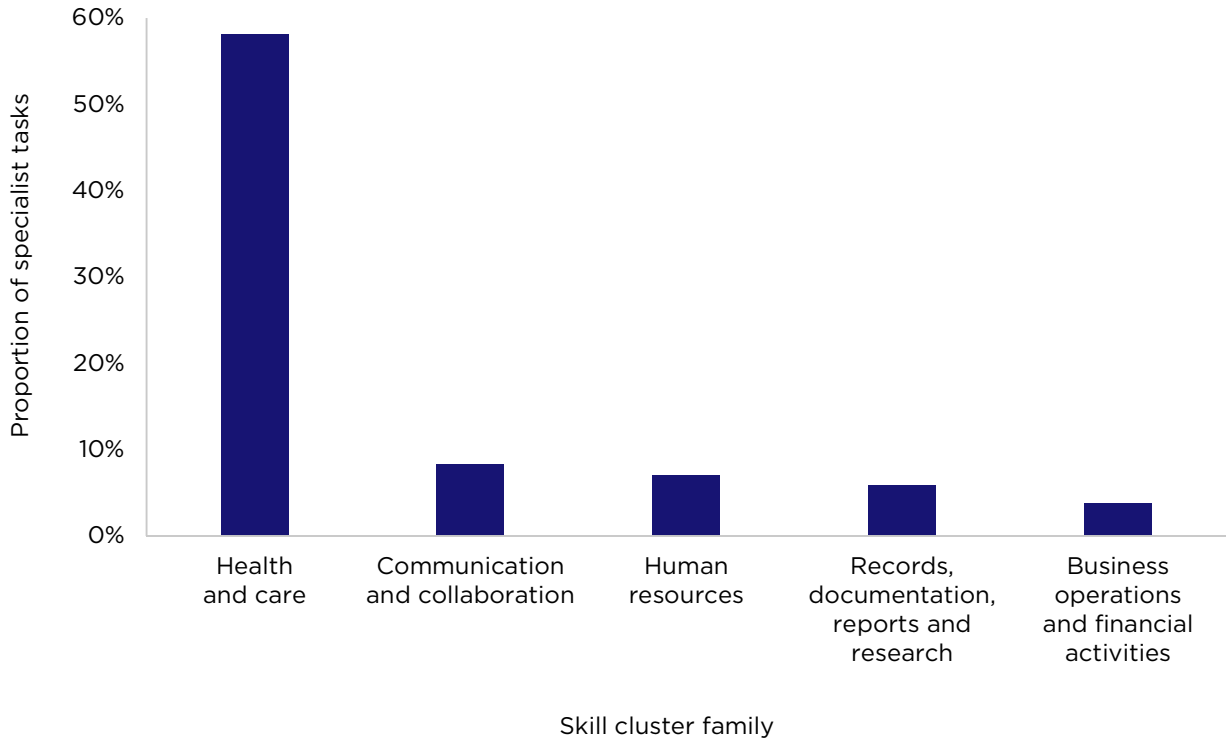
6.6.1 Skills profile of care and support occupations

The Australian Skills Classification, developed by the NSC, offers a common language of skills enabling stakeholders to identify and articulate skills using a comprehensive and universal taxonomy.[141] The Australian Skills Classification sets out the key core competencies, specialist tasks and technology tools required for around 600 occupations in Australia.

Every occupation in the Australian labour market is underpinned by specialist tasks that are required to undertake a specific job. The Australian Skills Classification groups specialist tasks into skills clusters and skill cluster families.

For the specialist tasks required across the entire care and support workforce, more than half (58%) belong to the Health and care skills cluster family (Figure 198) and this skills cluster family is required in all in-scope occupation groups except for Health and welfare managers. This is followed by Communication and collaboration (8%), Human resources (7%), Records, documentation, reports and research (6%) and Business operations and financial activities (4%) skills cluster families. Communication and collaboration specialist tasks, in particular, are required across all 5 care and support occupation groups.

Figure 198: Top 5 skill cluster families in the care and support workforce based on the proportion of specialist tasks, 2021

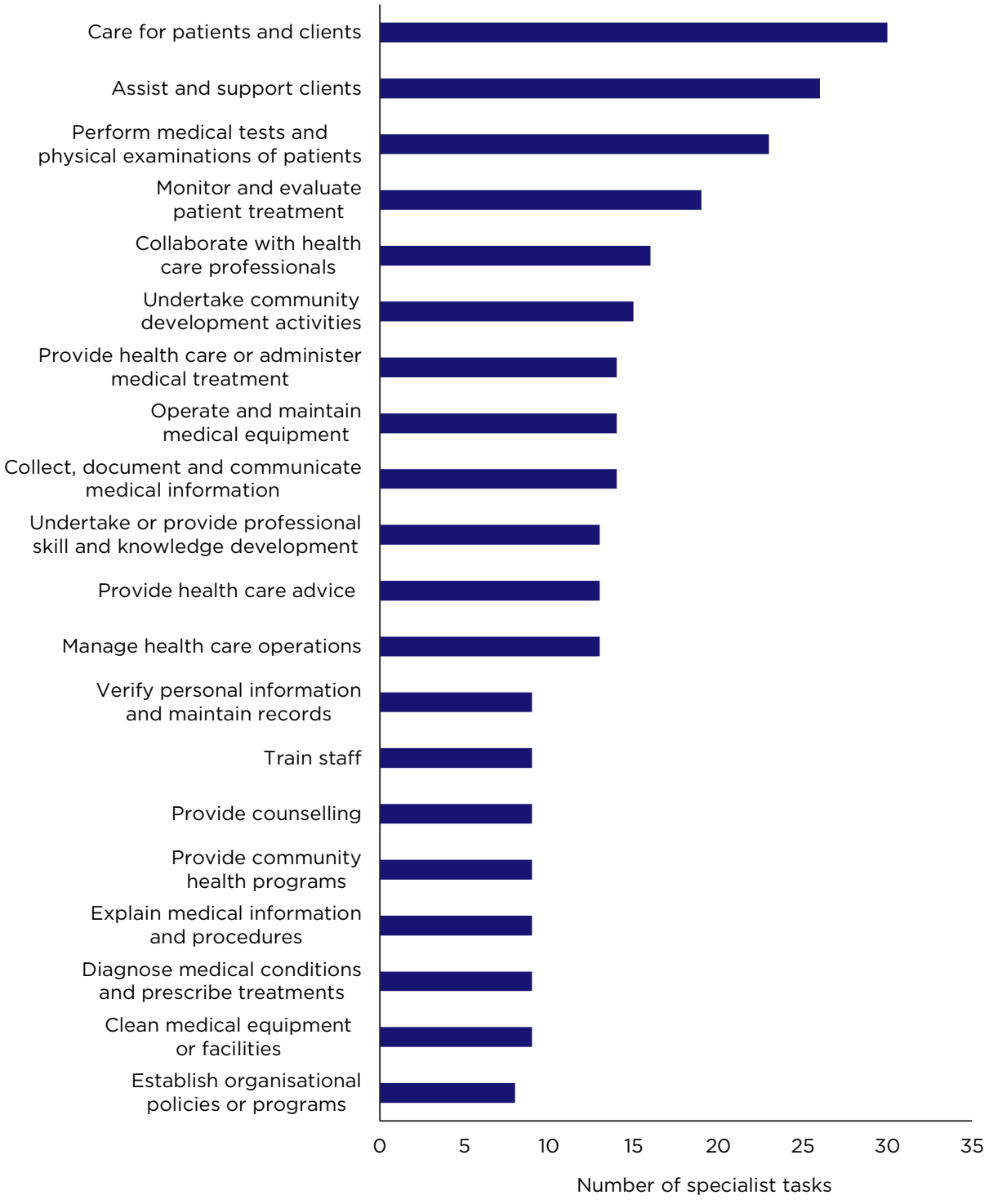


Source: Australian Skills Classification (Version 1.1), 2021.

[141] NSC, *Australian Skills Classification (Version 1.1)*, 2021

Skills clusters are specific to occupations or groups of occupations rather than skills cluster families. There are 92 skill clusters across the entire care and support workforce. As seen in Figure 199, the most common skills clusters based on the number of specialist tasks within the cluster are Care for patients and clients (30), Assist and support clients (26), Perform medical tests and physical examinations of patients (23), Monitor and evaluate patient treatment (19) and Collaborate with health care professionals (16).

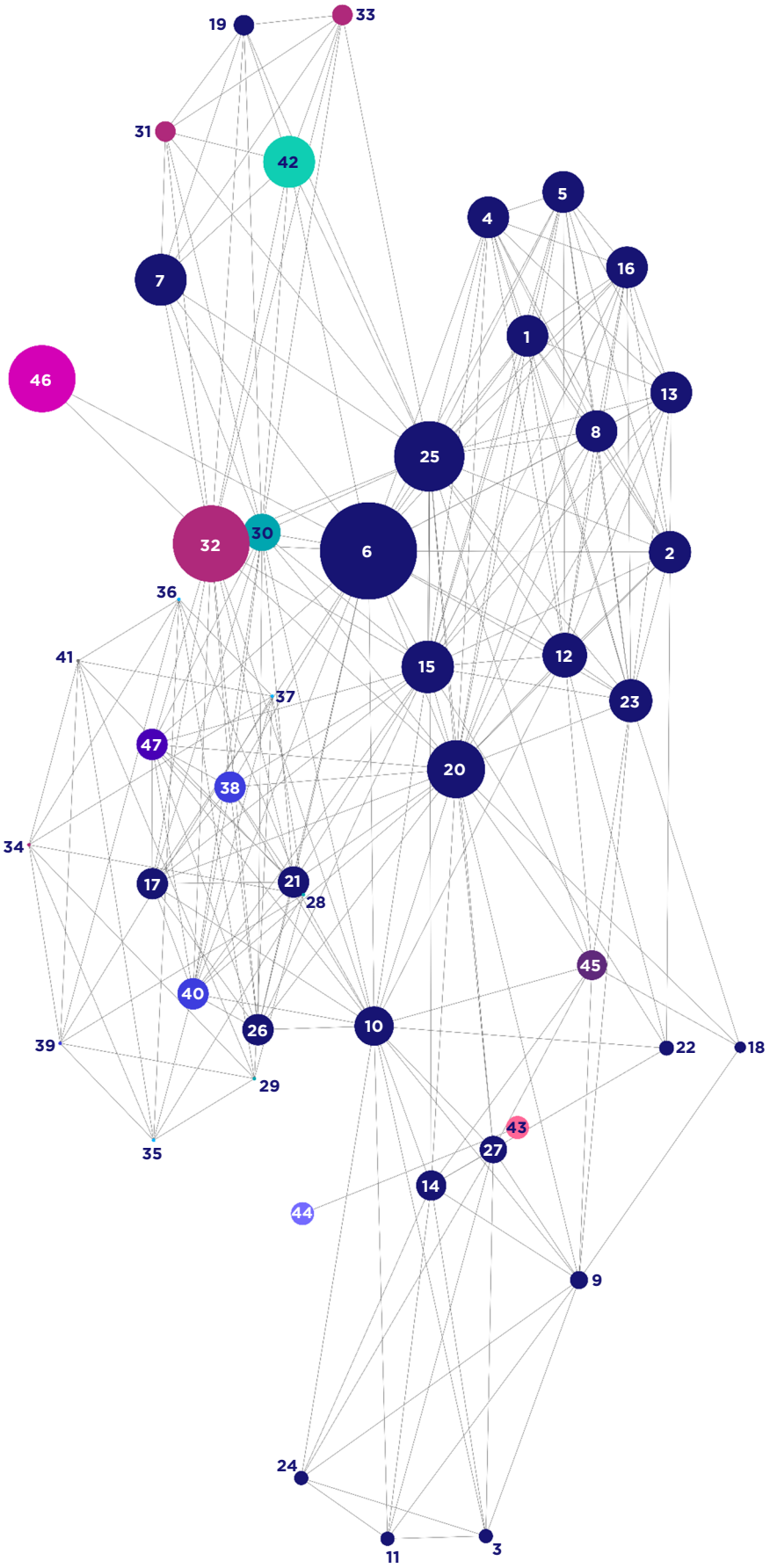
Figure 199: Top 20 skills clusters across the care and support workforce based on the number of specialist tasks, 2021



Source: Australian Skills Classification (Version 1.1), 2021.

Figure 200 shows the relationship of different skills clusters across the care and support workforce. The size of each bubble represents the number of care and support workers with that skill, and the connecting lines represent skills which are held by the same people. The colours of the bubbles indicate the skills cluster family to which they belong. Health and care is the predominant skills cluster family in the care and support workforce, indicating skills transferability, job transitions and career paths are likely to be within this workforce, rather than being readily accessed from the wider labour market. Although the care and support workforce require skills beyond this cluster family, they are not as interconnected based on the similarity of occupations that share them.

Figure 200: Diagram of skill cluster relationships within the care and support workforce, 2021



Source: NSC analysis, Australian Skills Classification (Version 1.1), 2021.

Skills Family

- Health and care
- Communication and collaboration
- Teaching and education
- Data analytics and databases
- Records, documentation, reports and research
- Archiving, recording and translating
- Cleaning and maintenance
- Human resources
- Performance evaluation and efficiency improvement
- Production processes and machinery
- Vehicle operation
- Work activities preparation

Skills Cluster

- **1** Administer medications or immunisations
- **2** Administration of medical facility records and activities
- **3** Analyse medical research and data
- **4** Assist and support clients
- **5** Assist health care practitioners for medical procedures
- **6** Assist individuals with accessibility needs
- **7** Care for patients and clients
- **8** Care for patients and clients using psychological therapies and supports
- **11** Develop, follow and ensure compliance with health care quality and safety procedures
- **12** Direct medical or health care programs
- **13** Establish medical standards and protocols
- **14** Explain medical information and procedures
- **15** Manage health care operations
- **16** Monitor and evaluate patient treatment
- **17** Perform drug screening
- **18** Provide alternative medicine treatments
- **19** Provide basic health care
- **20** Provide community health programs
- **21** Provide counselling
- **22** Provide health care advice
- **23** Provide health care or administer medical treatment
- **24** Provide training to health care professionals
- **25** Treat patients with physical therapy
- **26** Undertake community development activities
- **27** Undertake health care documentation
- **28** Assess and advise on public opinions
- **29** Collect information from people
- **30** Provide advice on social or educational issues
- **31** Discuss child learning or development with parents or guardians
- **32** Teach health management or hygiene practices
- **33** Teach life skills
- **34** Teach tertiary and vocational courses
- **35** Research or prepare historical objects or data
- **36** Undertake research and analyse data
- **37** Verify accuracy of data or documents
- **38** Prepare reports or evaluations
- **39** Review or prepare research or technical reports
- **40** Verify personal information and maintain records
- **41** Translate information
- **42** Clean medical equipment or facilities
- **43** Schedule staff or assign work
- **44** Staff performance management
- **45** Design, repair or fabricate medical equipment
- **46** Direct or drive passenger vehicles
- **47** Analyse and evaluate documentation or technical information

The skills clusters in the care and support workforce which are transferable from other occupations in the labour market are mostly related to communication and collaboration, human resources and business operations and financial activities. Although skills clusters in health and care are generally transferrable across occupations in health settings, these skills are also transferrable from other person-centric occupations such *Student counsellors*, *Child care workers*, and *Youth workers*.

The skill profile of the care and support workforce indicates that anyone considering transitioning into the care and support workforce from an occupation outside of health and care may have skills gaps that require bridging through formal or on-the-job training.

6.6.2 Trending and emerging skills across care and support occupations

Trending skills are not necessarily new skills but are those that have grown in frequency in job advertisements over the past 5 years for a particular occupation. Emerging skills are trending skills that are also new to a particular job in the last 5 years. Table 6 outlines some of the trending and emerging skills in the 15 in-scope care and support occupations. For example, infection control is a trending skill in 9 of the 15 occupations and has emerged in 2 occupations: *Diversional therapists* and *Welfare support workers*. Telehealth is a skill which has emerged for *Indigenous health workers* and has been trending for *Occupational therapists*. The trend and emergence of these 2 skills in care and support occupations is likely driven by COVID-19 pandemic responses.

Data analysis and data management is a trending skill for *Social professionals* and social media for *Welfare support workers*, which can be attributed to the growth in technology use, and its augmentation of daily work activities, as well as changing consumer preferences.

Table 6: Trending and emerging skills for in-scope care and support occupations, 2015 to 2020

ANZSCO code	Occupation	Trending skills	Emerging skills
Personal care and support workers			
4231	Aged and disabled carers	Infection control	Nil
4233	Nursing support and personal care workers	Infection control, Equipment cleaning, Patient care	Nil
Health and welfare support workers			
4113	Diversional therapists	Medical assistance	Infection control
4114	Enrolled and mothercraft nurses	Infection control, interaction with patients and medical personnel, Primary care	Nil
4115	Indigenous health workers	Infection control, Primary care	Telehealth
4117	Welfare support workers	Social media (community workers)	Infection control, Primary care (residential care officers)
2724	Social professionals	Data analysis, Data management	Nil
Registered nurses			
2544	Registered nurses	Infection control, Primary care	Nil
Allied health professionals			
2511	Nutrition professionals	Infection control, Medical assistance, Clinical reasoning	Nil
2524	Occupational therapists	Telehealth, Treatment planning	Nil
2525	Physiotherapists	Treatment planning	Nil
2526	Podiatrists	Infection control, Medical assistance	Nil
2527	Audiologists and speech pathologists/therapists	Infection control, Medical assistance	Primary care
Health and welfare managers			
2543	Nurse managers	Infection control	Nil
1342	Health and welfare services managers	Nil	Nil

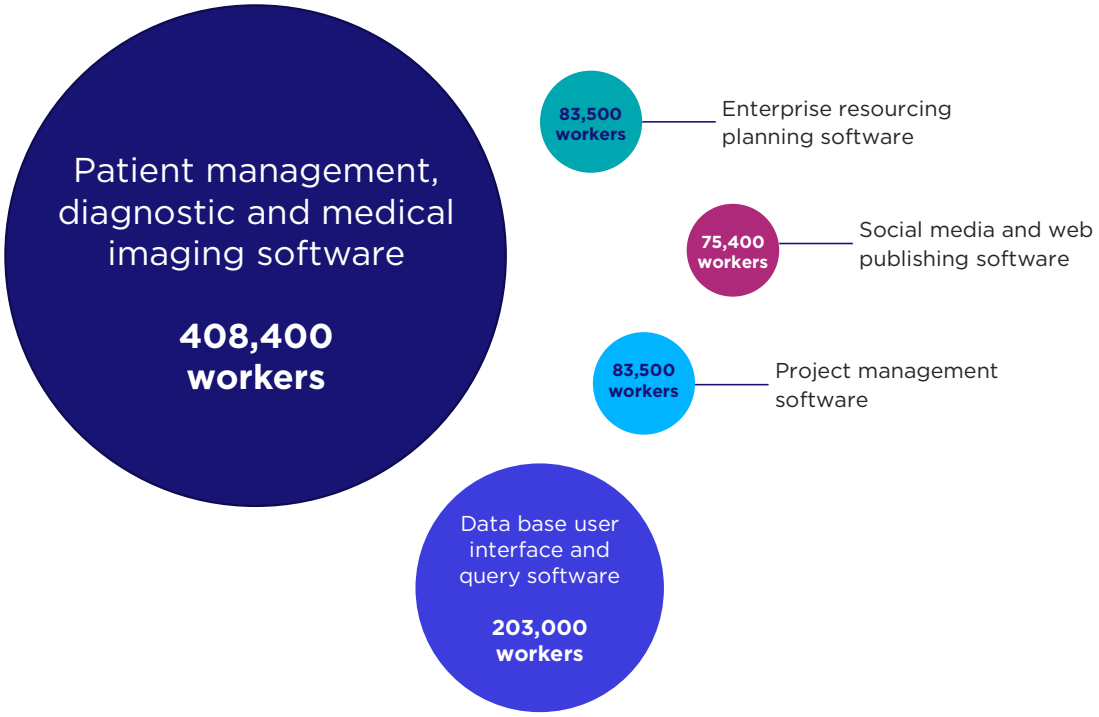
Source: NSC analysis, Burning Glass Technologies.

Further to the identified trending and emerging skills, as with most occupations, digital skills will likely grow in importance as technology continues to augment jobs in the care and support workforce. The skills profiles in the Australian Skills Classification also identify the technology tools which may be required in the day-to-day activities of each occupation. This includes software and hardware specific to an occupation, while more common technology tools such as search engines and emails are considered within the core competencies for all occupations as digital engagement.

All care and support occupations require technology tools, with some of these more common across all occupations (Figure 201). Patient management, diagnostic and medical imaging software is currently used by approximately 407,000 care and support workers (approximately 88% of the entire care and support workforce). Specific examples include electronic medical

record software and Healthcare Common Procedure Coding System. The widespread use of these types of patient management software indicates the growing importance of digital skills, including digital engagement and literacy for the care and support workforce. Stakeholders also indicated the increasing importance of digital skills among care and support workers. The opportunities and challenges of technology for the care and support workforce are discussed further in Part 8.2.3.

Figure 201: Common technology tools in the care and support workforce by number of workers, 2021



Source: Australian Skills Classification (Version 1.1), 2021; ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Care and support workforce includes 15 in-scope occupations (ANZSCO 4-digit level) across 3 in-scope industries (ANZSIC 3-digit level).

6.7 Skill and qualification requirements in job vacancies

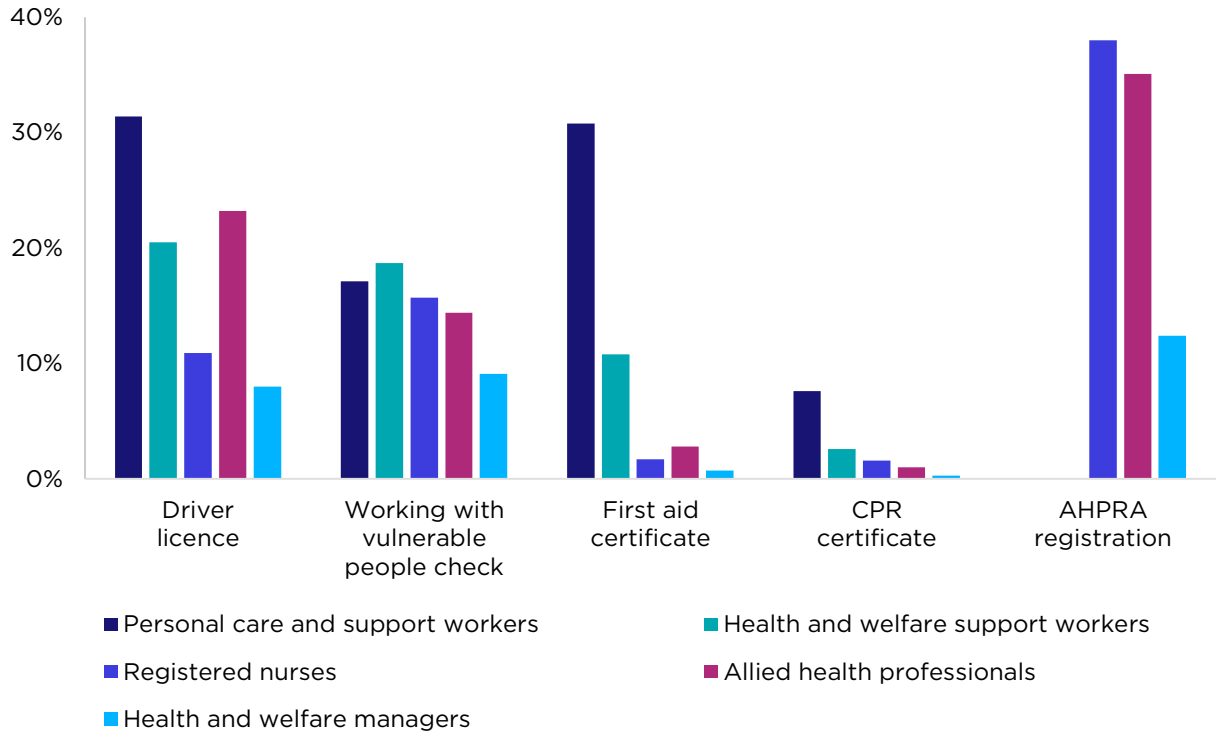
Job vacancies are an important measure of workforce demand and can provide valuable insights about the roles, skills and certifications that employers are seeking.

6.7.1 Certification and qualifications in job advertisements

The certification and registration requirements mentioned in job advertisements varies significantly by occupation group. Driver's licences, which may be required of workers who travel between facilities or participant's homes, were most commonly mentioned in advertisements for Personal care workers and Allied health professionals (Figure 202). Working with vulnerable people checks were broadly consistent across advertisements for all occupation groups, except for Health and welfare managers where they were somewhat lower.

First aid certificates were mentioned mostly in advertisements for Personal care and support workers, with very few advertisements for Registered nurses, Allied health professionals and Health and welfare managers listing them. CPR certificates were the least common certification, with only 8% of advertisements for Personal care and support workers requiring them. Unsurprisingly, a large share of advertisements for Registered nurses and Allied health professionals mentioned AHPRA registration, with a small share of Health and welfare managers advertisements also mentioning this registration.[142]

Figure 202: Certifications mentioned in online job advertisements (%), by occupation group, 2015 to 2020



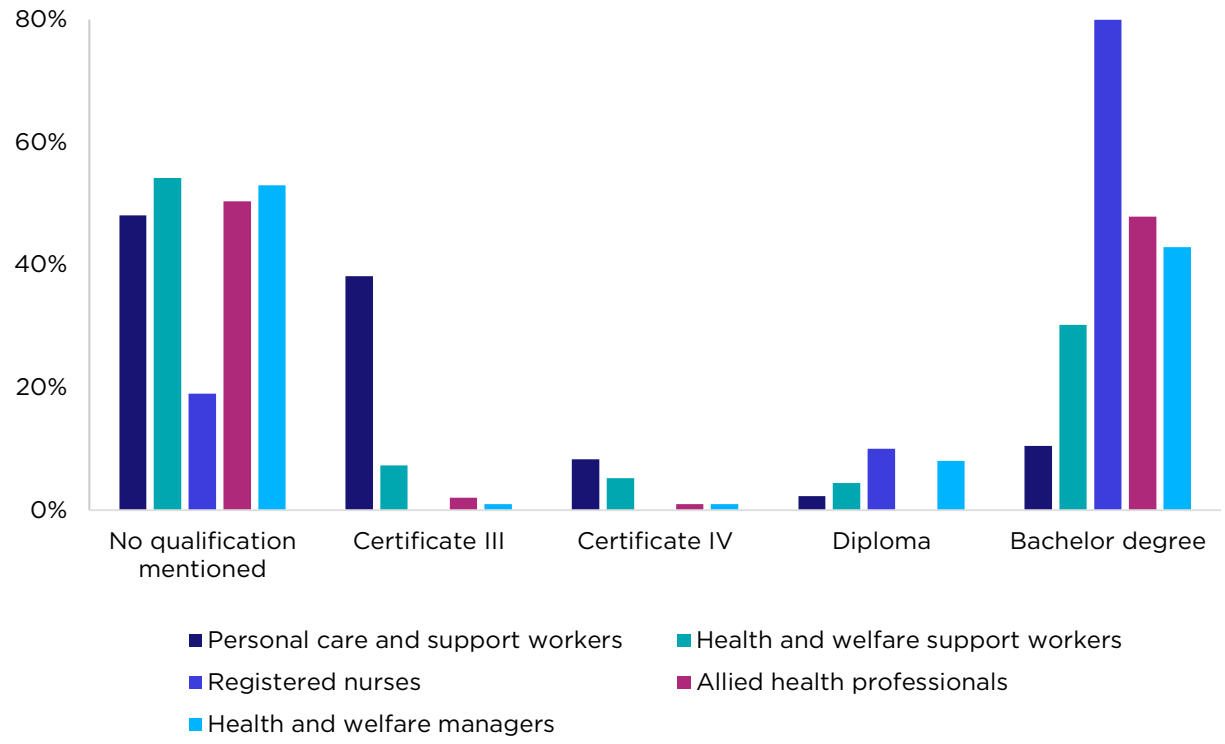
Source: Burning Glass Technologies, 2015-2020, NSC analysis. Online job advertisements by care and support occupations and certification name.

The qualification requirements mentioned in online job advertisements also vary between occupation groups, with lower skill level occupations less likely to require a tertiary level qualification. Only 19% of online advertisements for Registered nurses did not mention a

[142] It is important to note that these figures represent the proportion of online job advertisements that explicitly mentioned these requirements and may not reflect the proportion of jobs that actually require these certifications. For example, while only 38% of online job advertisements explicitly mentioned AHPRA registration, all Registered nurses in Australia require this registration.

qualification, compared with approximately 50% for other occupation groups (Figure 203). Certificate III was the most common qualification for Personal care and support workers, mentioned in 38% of advertisements. Certificate IV was the least commonly mentioned qualification level, only occurring in 8% of Personal care and support worker advertisements. Diplomas were also uncommon, occurring in 8% of Health and welfare managers advertisements. Bachelor degrees were the most common qualification level for all occupation groups other than Personal care and support workers.[143]

Figure 203: Qualifications mentioned in online job advertisements (%) by occupation group, 2015-2020



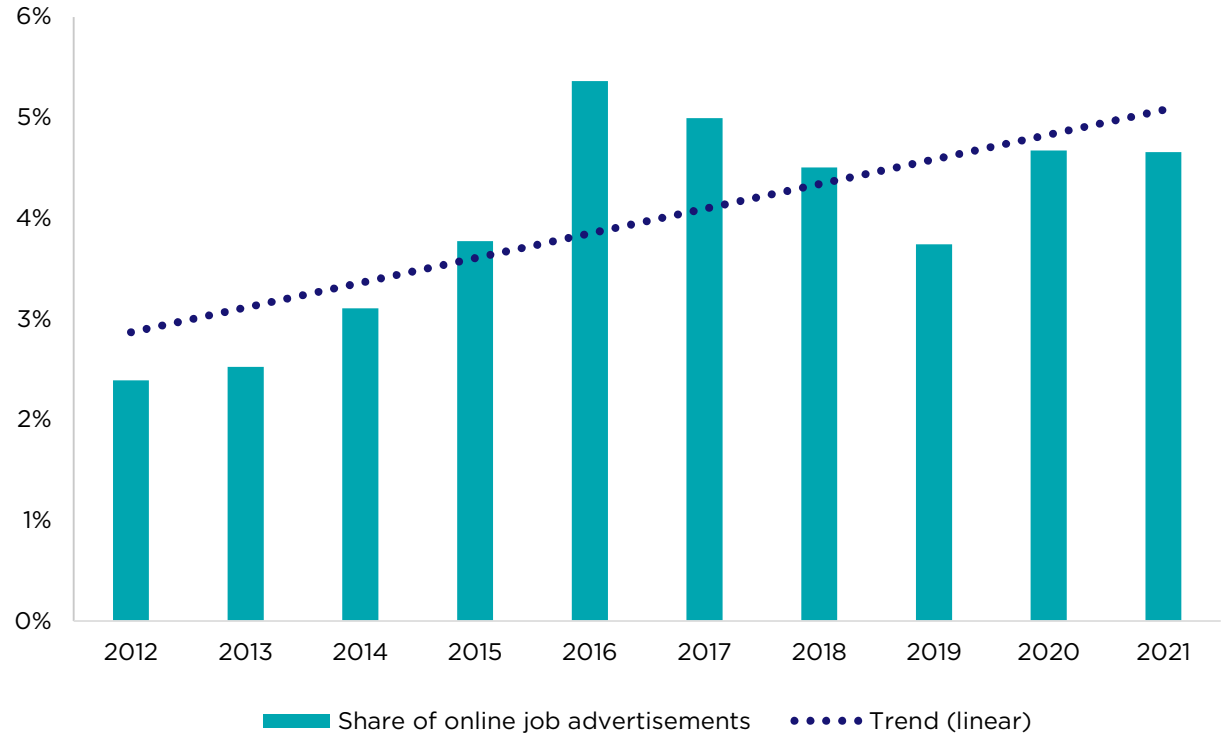
Source: Burning Glass Technologies, 2015-2020, NSC analysis. Online job advertisements by care and support occupation groups, qualification name.

[143] It is important to note that these figures represent the proportion of online job advertisements that explicitly mentioned these requirements and may not reflect the proportion of jobs that actually require these qualifications. For example, while only 80% of online job advertisements explicitly mentioned a bachelor degree, a Bachelor of Nursing is a standard requirement in Australia.

6.7.2 Skills in online job advertisements

The trend towards in-home care can also be seen in the skill requirements of online job advertisements. Across the care and support occupations, the occurrence of 'home care' specific skills has almost doubled between 2012 and 2021 (Figure 204). Home care skills were most common in advertisements for Personal care and support workers (12.1% in 2020).

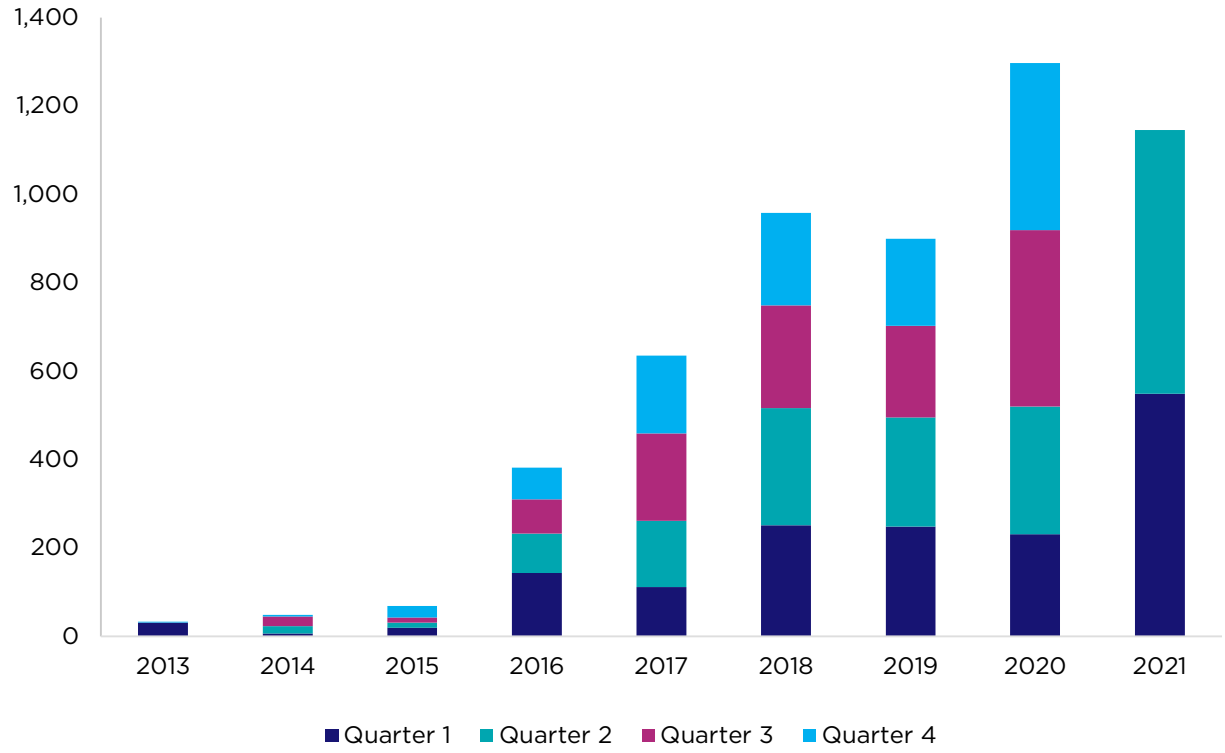
Figure 204: Frequency of home care skills in online job advertisements (%), care and support occupations, 2012-2021



Source: Burning Glass Technologies 2013-21, NSC analysis. Online job advertisements by care and support occupations and skill name.

Online job advertisements also show the impact of the NDIS rollout. While it is not possible to identify all online advertisements related to the NDIS, by looking at those with a specific reference to this program, a trend can be observed. Throughout 2013 to 2015 there were fewer than 100 online job advertisements a year that specifically mentioned the NDIS in the title (Figure 205). As the program rollout has matured, the number of online job advertisements mentioning the NDIS has grown considerably. This small sample of advertisements provides an indication of how the NDIS introduction has gradually increased the demand for care and support workers over time.

Figure 205: NDIS mentions in online job advertisements, 2015-2021



Source: Burning Glass Technologies, 2013-2021, NSC analysis. Online job advertisements by care and support occupations.

Part 7
Flows into and out of the care and support workforce

Part 7 uses detailed data to examine the flows into and out of the care and support workforce. As with other aspects of the workforce, there tends to be a bifurcation between lower skill level roles (which have a tendency toward higher turnover) and higher skill level roles (lower turnover). Flows from the training and education system are also examined.

Macroeconomic factors may present challenges and opportunities

At a macro level a number of factors that have supported growth in the care and support workforce over recent decades are unlikely to enable similar growth into the future.

- In particular, female labour force participation is unlikely to rise over coming decades as it has in the past; while trends in female education attainment suggest that lower skill level care and support occupations may not see the same supply of domestic female entrants as in the past.
- The competition for migrant workers may also intensify in the years ahead due to a globally ageing population.

The possible heightened competition for workers, and the smaller future pool from which to draw from highlights the importance of productivity.

- From a demand perspective for care and support workers, stronger productivity growth within the sector could contribute to lowering future workforce demand. While from a supply perspective, stronger productivity growth across the economy as a whole could increase the potential supply of workers for the care and support sector.

The nature of flows into and out of the care and support workforce

The number of people joining care and support occupations has increased over recent years. The number of people moving to most care and support occupations from different occupations outside the care and support workforce has also increased in recent years.

- Most people who transition into the *Aged and disabled carer*s occupation from elsewhere in the workforce move from either a skill level 4 or skill level 5 occupation. A far smaller proportion transition into the occupation from a higher skill level occupation.
- Similar to *Aged and disabled carers*, *Nursing support and personal care workers* are more likely to transition into the occupation from skill levels 4 and 5 and transition out of the occupation into higher skill level occupations.

Transitions across the care and support workforce are often to higher skill level occupations, indicating workers are forging both formal and informal career paths.

- There are higher rates of transition to and from *Aged and disabled carers*, *Nursing support and personal care workers*, and *Welfare support workers* compared to higher skill level occupations, such as *Registered nurses* and Allied health professionals.
- For *Nursing support and personal care workers* who left the occupation in 2017-18, almost half (48%) transitioned into a skill level 1 occupation, with a further 16% transitioning to a skill

level 2 occupation. There appears to be an established pathway, in practice, between the *Nursing support and personal care workers* and *Registered nurses* occupations.

- That said, it is unclear if those who transition into higher skill level roles, such as *Registered nurses*, remain in the care and support workforce or move to other parts of the *Health care and social assistance* industry.

Exits from the workforce are most likely to occur within the first few years, and higher skill level occupations generally see greater retention

Exits from the care and support workforce are most likely to occur within the first couple of years of joining the care and support workforce.

- Turnover in the first year is a significant challenge for providers employing people in the *Aged and disabled carers* occupation.
- A large proportion of people who reported working in the *Nursing support and personal care workers* occupation also spend a relatively short duration of time within the occupation.
- Similarly, the *Welfare support workers* occupation also demonstrates significant turnover after a relatively short period of time (particularly for those in the younger age group).

Higher skill level roles, namely *Registered nurses* and Allied health professionals tend to see longer duration (i.e. higher retention).

Some new workers could come through jobactive placements, although skill mismatches may present a barrier

While the pool of potential workers without a job may not have the skills and attributes to meet all care and support workforce needs, a subset could transition into these roles, particularly those with related skills and qualifications.

- There were around 13,500 job placements per financial year in a care and support occupation in 2020-21. The majority of jobactive placements into the care and support workforce were into either the *Aged and disabled carers* or *Nursing support and personal care workers* occupations.

The education and training pipeline is important when it comes to meeting workforce needs

The supply of skilled workers through the VET training system can be viewed as a pipeline with several conversion points from enrolment to employment. Given the nature of this pipeline, to place one individual in a relevant care and support job from this pipeline (based on current state), close to 2 individuals would need to be enrolled in the respective VET qualification.

A consistent theme highlighted by stakeholders throughout the Study was the importance of high-quality training for the care and support workforce. While there were differing views on whether this should be formal or on-the-job training, all agreed there were core skills and competencies needed for these roles.

Evolving job design, emerging skills and person-centred models of practice all contribute to the need for workforce enablers, like the education and training systems, to be responsive to these changes. Stakeholder contributions to the Study highlighted that the training system might not be keeping pace with some of these workforce requirements.

- Areas highlighted by stakeholders included cultural competency, dementia, mental health, trauma-informed and palliative (end of life) care.

With mixed views surrounding training for care and support occupations, it will be important to develop data-informed measures of training outcomes for care and support qualifications, particularly when considering policy options for worker registration requirements and mandatory qualifications.

The Aged Care Royal Commission recommended that the Certificate III in Individual Support (Ageing) should be the minimum mandatory qualification required for personal care workers performing paid work in aged care.

- There may be a range of potential benefits associated with mandating an entry level qualification, including standardising of skills and competencies, improving job readiness and increased professionalism.
- In the short to medium term, however, introducing such requirements may limit the pool of candidates available to fill existing skills gaps and act as a barrier to staying in the workforce. Mandatory qualifications may also pose a risk of being a disincentive for older and more experienced workers seeking to transition from other sectors in the economy to work in care and support.

Global competition for care and support workers may increase in the future

Against the backdrop of increasing demand for care and support workers from global population ageing and proportional decreases in the working age population, competition for migrant care and support workers is increasing.

Most OECD countries, including Australia, do not have specific migration channels for care and support workers and tend to rely on 'incidental' migrant workers to supplement local care and support workforces. Despite this, foreign-born workers comprise a high proportion (around 20%) of the long-term care workforce in OECD countries.

Recognising the growing competition for care and support workers, many OECD countries have implemented measures to influence attraction of migrant care and support workers. These include simplifying recruitment and migration procedures for care and support workers (Spain, Canada and Finland), lifting quotas (Austria) or providing exemptions from quotas for certain care occupations (Italy), and recognising long-term services and support occupations on a skills shortage list (United Kingdom).

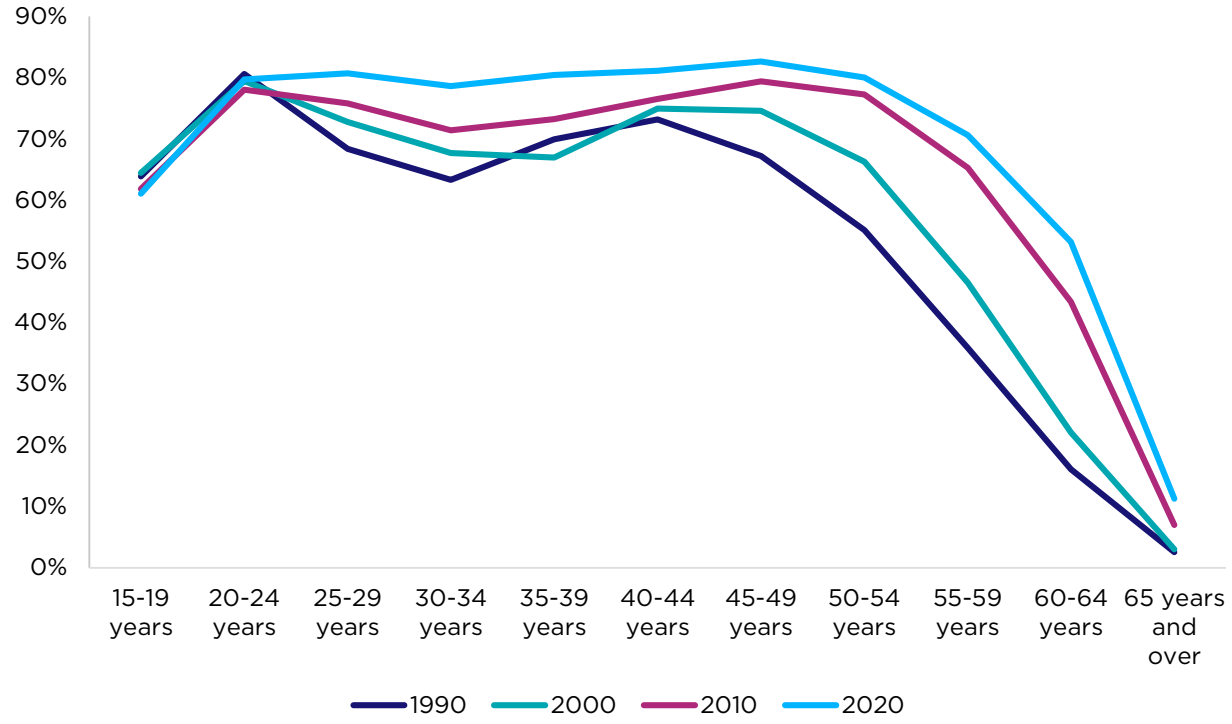
7.1 Labour market and the macroeconomic context

Over the past few decades, a number of macroeconomic factors have come together to enable the care and support sector to broadly meet aggregate workforce demand. These include: high levels of migration; rising levels of workforce participation; and greater participation in post-secondary education and training.

Over recent decades increased levels of female labour market participation, in particular, has supported the growth in the care and support workforce. Overall, women's workforce participation has steadily increased from 43.5% in February 1978 to 61.4% in July 2021, driven by strong participation by women aged between 25 and 54 years (Figure 206).

However, female labour force participation is unlikely to rise over coming decades as it has in the past; while trends in female education attainment suggest that lower skill level care and support occupations may not see the same supply of domestic female entrants as in the past.

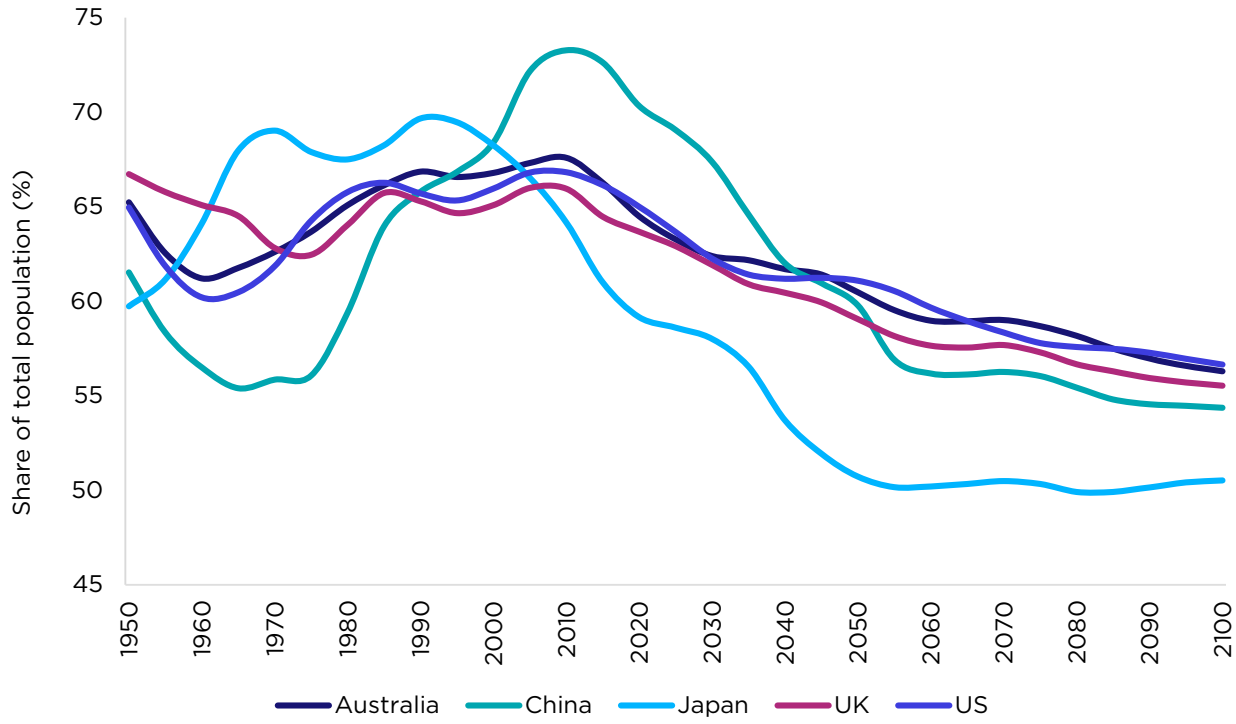
Figure 206: Female labour force participation rate, by age, 1990 to 2020



Source: ABS Labour Force Survey.

Within the context of an ageing population and shrinking pool of domestic workers (Figure 207), care and support providers are likely to face greater competition for employees and new graduates – not only from within the sector, but also from other health and non-health industries. That could make migration an important lever for increasing Australia's working age population, now and into the future.

Figure 207: Working age population as a percentage of total population – Australia comparison with major economies, 1950 to 2100



Source: United Nations, World Population Prospects 2019. Medium fertility variant, 2020-2100.

That said, competition for migrant workers may also intensify in the years ahead due to a globally ageing population and a shrinking pool of care and support workers[144] among traditional migrant receiving countries – particularly as many countries around the world are faced with their own ageing profiles (Figure 207), and shift from being a migrant source to a destination.[145]

The possible heightened competition for workers, and the smaller future pool from which to draw from, highlights the importance of productivity. From a demand perspective for care and support workers, stronger productivity growth within the sector could contribute to lowering future workforce demand. While from a supply perspective, stronger productivity growth across the economy as a whole could increase the potential supply of workers for the care and support sector.

[144] Global Ageing Network, Filling the Care Gap: Foreign-Born Workers in Aged Care, 2018

[145] Migration Policy Institute, The Global Tug-of-War for Health Care Workers, 2004

7.2 Care and support workforce entrants and exits

Against this labour market context:

- The number of people joining care and support occupations from outside the workforce (i.e. no wage or tax return in previous year) has increased over recent years.
- The number of people moving into care and support occupations from different occupations outside the care and support workforce has also increased in recent years, following a decline between 2011-12 and 2015-16.
- More workers stay in the care and support workforce (and in the same occupation) than leave, although there is significant movement across care and support occupations.
- Transitions across the care and support workforce are often into higher skill level occupations, indicating workers are forging both formal and informal career paths.
    - There are higher rates of transition to and from *Aged and disabled carers*, *Health and welfare services managers*, *Nursing support and personal care workers*, and *Welfare support workers* compared to higher skill level occupations, such as *Registered nurses* and Allied health professionals.
- Transferability of skills are predominantly between occupations that usually operate within *Health care and social assistance* sectors and particularly within the care and support workforce.
- Exits from the care and support workforce are most likely to occur within the first couple of years of joining the care and support workforce.
- Exits out of the workforce have increased in recent years as the Baby Boomer generation has commenced reaching retirement age, and now outpace transitions to other parts of the economy. This trend is expected to continue.

The remainder of this section examines transitions in and out of the care and support occupations,[146] as well as the durations spent in these occupations, using detailed data from MADIP. This data allows for detailed analysis at the occupation level for the period 2010-11 to 2018-19. The key concepts explored within this section are:

- **Transitions** are measured by comparing the occupation of an individual between one year, and the year either immediately preceding (previous occupation) or immediately after (next occupation). A transition in (or out) of the workforce is measured by whether an individual had no wage (or no tax return),[147] noting that this may provide an overestimate of transitions out of the workforce where the submission of an income tax return has been delayed.
- **Duration** in an occupation is measured as the number of years where this occupation was reported in an individuals' income tax return. For the purposes of this analysis, these years do not have to be consecutive, but measure the total number of years with a relevant occupation reported between 2010-11 and 2018-19. Those with 9 years duration over this period have been reported as 9+ years for the purpose of this analysis. Duration analysis has been undertaken separately for males and females, and for those aged 44 years and under, and 45 years and over. People who had left the occupation by 2018-19 are denotated as *left the occupation* (or 'completed' duration), while those who remained in the occupation in 2018-19 are denoted as *still in occupation* (or 'ongoing' duration).

It is important to note that the analysis presented below is for people who reported an occupation within the care and support workforce **across all industries.** For example, data for *Registered nurses* should be treated with caution as it includes all people working in this occupation across both the care and support workforce, and the broader *Health care and social assistance* industry.

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[146] It is assumed that the occupation recorded in the income tax return is the main occupation of an individual for a given year. Given that this field is auto-filled in subsequent years (after an initial entry), this field may not be accurately updated in subsequent years, leading to an overestimate in duration (and underestimate of transitions).

[147] This analysis may provide an overestimate of transitions out of the workforce where the submission of an income tax return has not yet been completed.

- Given the level of disaggregation in the charts presented below, analysis for the following occupations is not available due to small data counts:
  - *Diversional therapists*
  - *Enrolled and mothercraft nurses*
  - *Indigenous health workers*
  - *Social professionals*
  - *Nurse managers.*
- Allied health professionals in the analysis below includes:
  - *Nutrition professionals*
  - *Occupational therapists*
  - *Physiotherapists*
  - *Podiatrists*
  - *Audiologists and speech pathologists/therapists.*

There are a range of reasons why people may transition to other roles in the care and support workforce, exit completely, or influence the length of time in a care and support role.

Stakeholders consistently noted that turnover is a significant challenge in the care and support workforce, and the analysis confirms this as particularly significant in the first year for Personal care and support workers, underscoring the importance of workforce strategies aimed at successfully onboarding workers into the care and support workforce and supporting them in the early stages of these roles.

7.2.1 *Aged and disabled carers*

For detailed charts see Figure 216 to Figure 225 in the data appendix to this Part.

7.2.1.1 Duration

The average duration of time spent working in the *Aged and disabled carers* occupation is relatively short, with around 3 in 5 (59%) people who reported working in this occupation between 2010-11 and 2018-19 spending 3 years or less in the occupation (including those with both completed and ongoing duration). Around 1 in 10 (10%) were still working in the occupation in 2018-19, having spent at least 9 years working in the occupation *Aged and disabled carers*.

The high rates of turnover are particularly evident for younger people (aged 44 years and under) with around 1 in 4 (24%) spending just one year in the occupation (and having already left by 2018-19). While older women (45 years and over) were the most likely to have spent a relatively long time working in the occupation (15% had worked 9+ years on an ongoing basis and were still in the occupation at 2018-19), a slightly higher proportion (17%) had left the occupation after just one year.

> This analysis suggests that turnover in the first year is a significant challenge for providers employing people in this occupation.

Across all cohorts, at least half of the people who had recorded working in the occupation *Aged and disabled carers* for at least one period between 2010-11 and 2018-19 had already left the occupation, ranging from 53% for women aged 44 years and under to 55% for men aged 44 years and under.

7.2.1.2 Transitions

While a significant proportion of people who have worked in the *Aged and disabled carers* occupation have a relatively short duration in the occupation, the share of people remaining in the occupation has improved slightly over recent years (with 82% of people working as an *Aged and*

disabled carer in 2018-19 having also worked in the occupation in the previous year, up from 76% in 2011-12).

Most people who transition into the *Aged and disabled carers* occupation from elsewhere in the workforce move from either a skill level 4 or skill level 5 occupation (27% and 34% respectively in 2018-19). A far smaller proportion transition into the occupation from a higher skill level occupation; with this pattern remaining consistent over the period 2010-11 to 2018-19.

On exiting the *Aged and disabled carers* occupation, people are more likely to transition into an occupation with a higher skill level, with 31% moving into a skill level 1 occupation in 2018-19 and a further 28% into a skill level 2 occupation.

Detailed analysis of transitions into individual occupations suggest that a significant proportion of these movements out of the *Aged and disabled carers* occupation and into higher skill level occupations are shifting to work as either *Registered nurses* (20% of transitions into other occupations in 2018-19) or *Welfare support workers* (18%).

7.2.2 *Nursing support and personal care workers*

For detailed charts see Figure 226 to Figure 235 in the data appendix to this Part.

7.2.2.1 Duration

> A large proportion of people who report working in the *Nursing support and personal care workers* occupation spend a relatively short duration of time within the occupation.

Around a quarter of people aged 44 years and under (26% of women and 24% of men) had a duration of around one year and had already left the occupation, while 13% of younger women and 11% of younger men in this cohort had worked in the occupation for one year but were still employed as at 2018-19. There is also significant turnover for these age groups after 2 years, with 14% of women and 14% of men aged 44 years and under having left the occupation by 2018-19 after a duration of 2 years.

As with the *Aged and disabled carers* occupation, there is a subset of workers within the *Nursing support and personal care workers* occupation who have spent a relatively long time working within the sector. Around 15% of women and 20% of men aged 45 years and over, who were working in the *Nursing support and personal care workers* occupation for at least one year over the period 2010-11 to 2018-19 had duration of 9+ years and were still employed in the occupation in 2018-19.

7.2.2.2 Transitions

The share of people remaining within the *Nursing support and personal care workers* occupation has also improved in recent years, with around 4 in 5 (78%) of people working in the occupation in 2018-19 having also worked in the same occupation in 2017-18.

Over the past decade, the share of people joining the occupation from other occupations within the care and support workforce has declined (from 10% in 2011-12 to 3% in 2018-19), as have movements out of the occupation to other parts of the care and support workforce (from 14% in 2010-11 to 9% in 2017-18).

Similar to *Aged and disabled carers*, people are more likely to transition into the occupation from skill levels 4 and 5 and transition out of the occupation into higher skill level occupations. For *Nursing and support workers* who left the occupation in 2017-18, almost half (48%) transitioned into a skill level 1 occupation, with a further 16% transitioning to a skill level 2 occupation.

There appears to be an established pathway between the *Nursing support and personal care workers* and *Registered nurse* occupations. Around 2 in 5 (39%) people who left the *Nursing support and personal care workers* occupation in 2017-18 for another occupation moved into the *Registered nurses occupation* in 2018-19.

The second most common transition is to the *Aged and disabled carers* occupation, although this proportion has declined from 27% in 2010-11 to 15% in 2017-18.

7.2.3 *Welfare support workers*

For detailed charts see Figure 236 to Figure 245 in the data appendix to this Part.

7.2.3.1 Duration

> The *Welfare support workers* occupation also demonstrates significant turnover after a relatively short period of time, particularly for those in the younger age group.

In 2018-19, around 20% of females and 21% of males aged 44 years and under had already left the occupation under one year. A further 11% and 12% respectively had a duration of 2 years (and had already left the occupation).

The patterns of duration in the occupation are relatively similar for women and men aged 45 years and over, with around 11% of women and 12% of men having worked in the occupation for 9 or more years in 2018-19. However, a significant proportion of older workers also have a relatively short duration within the occupation (33.8% of women aged 45 years and over and 36.1% of men aged 45 years and over had a duration of 3 years or under and have already left the occupation).

7.2.3.2 Transitions

While turnover has been relatively high for this occupation over the past 9 years, more recently an increasing proportion of those working in the *Welfare support workers* occupation have been retained. For example, the proportion of people working as *Welfare support workers* in 2017-18 who remained in the occupation in 2018-19 stood at 81% (up from 74% in 2010-11).

Of the people who moved into the *Welfare support workers* occupation in 2018-19 from other occupations, around 38% had previously worked in a skill level 4 occupation and 25% in a skill level 5 occupation.

More detailed analysis suggests that key occupations which people transition into the *Welfare support workers* occupation from include *Aged and disabled carers* (12% in 2018-19, down from 22% in 2011-12) and *Labourers* (excluding *Commercial cleaners*)[148] (11% in 2018-19, up from 8% in 2011-12).

7.2.4 *Registered nurses*

For detailed charts see Figure 246 to Figure 255 in the data appendix to this Part.

7.2.4.1 Duration

> Compared with many other occupations within the care and support workforce, a larger share of those working in the *Registered nurses* occupation have a relatively longer reported duration.

For example, of the women aged 45 years and over who reported working in the occupation for at least one year between 2010-11 to 2018-19, over a third (36%) had worked in the occupation for each of the 9 years over that period (and likely some had worked for many years longer), and were still in the occupation at 2018-19. This was similar for males aged 45 years and over, with 36% having a duration of 9+ years (and still working in the occupation).

For younger people working in the *Registered nurses* occupation, around 17% of women aged 44 years and under, and 20% of men aged 44 years and under, had a duration of 3 years or less (and had already left the occupation).

[148] The 1-digit *Labourers* ANZSCO occupation includes occupations such as Freight Handlers and Shelf Fillers, Garden Labourers, Food and Drink Factory Workers, Fast Food Cooks, Food Trades Assistants, Kitchenhands, Domestic Cleaners, Housekeepers, Laundry Workers and Building and Plumbing Labourers.

7.2.4.2 Transitions

With relatively high retention, the majority of people working as *Registered nurses* in one year continue to do so in the next year (89% of people working as *Registered nurses* in 2017-18 continued working in the occupation in 2018-19). Of those who do leave the occupation, most leave the workforce completely (around 7%), while a small share (2%) move to a different occupation within the care and support workforce.

The majority of people entering the *Registered nurses* occupation have transitioned from occupations with a lower skill level with most entering from a skill level 4 occupation (48% in 2018-19).

While the rate of departures for the *Registered nurses* occupation to work in other occupations is relatively low, of those who do so, around 40% who left the occupation in 2017-18 moved to another skill level 1 occupation in 2018-19, with a further 28% moving to a skill level 4 occupation and 22% moving to a skill level 2 occupation.

Of those who joined the *Registered nurses* occupation in 2018-19, and who had previously worked in a different occupation, around 1 in 5 (21%) were previously *Nursing support and personal care workers* and 12% were *Aged and disabled carers*, indicating that a sizeable proportion of people are likely to be engaged within the care and support workforce while undertaking their nursing degree.

For those who left the *Registered nurses* occupation in 2017-18 to enter a new occupation in 2018-19, around 11% moved to the *Aged and disabled carers* occupation, while 10% moved to the *Nursing support and personal care workers* occupation (down from 17% in 2010-11). This also indicates that as people leave the *Registered nurses* occupation there is some potential to retain them in the broader care and support workforce.

7.2.5 Allied health professionals

For detailed charts see Figure 256 to Figure 259 in the data appendix to this Part.

7.2.5.1 Duration

> A large cohort of people across all age groups working as Allied health professionals are retained in the occupation group for long periods of time.

For women 44 years and under, 58% had worked in an allied health occupation for at least 3 years and were still employed within the occupation group. In total, only one quarter (25%) of women aged 44 years and under had already left the occupation group by 2018-19, regardless of their duration.

For women aged 45 years and over, around 41% had a duration of 9+ years and were still working in the occupation group in 2018-19, with only 7% recording a duration of one year and having already left. There was a similar pattern evident for men aged 45 years and over, with 43% having a duration of 9+ years (and still working in the occupation group) and just 8% recording a duration of one year between the period 2010-11 and 2018-19 and having already left the occupation group.

7.2.5.2 Transitions

Transitions analysis has not been taken for Allied health professionals for this Study due to small numbers of people transitioning in and out of this occupation group each year.

7.2.6 *Health and welfare services managers*

For detailed charts see Figure 260 to Figure 269 in the data appendix to this Part.

7.2.6.1 Duration

> There are relatively high rates of turnover evident in the *Health and welfare services managers* occupation, with around 19% of women aged 45 years and over and 24% of men aged 45 years and over having left the occupation with a total duration of around one year.

These shares are even higher for younger people working in this occupation, with 26% of women aged 44 years and under and 27% of men aged 44 years and under recorded as leaving the occupation after only one year.

Across all cohorts, around half of the people who had worked in the *Health and welfare services managers* occupation between 2010-11 and 2018-19 had already left the occupation, ranging from 49% of women aged 45 years and over to 58% of men aged 45 years and over.

7.2.6.2 Transitions

While turnover has been relatively high for the *Health and welfare services managers* occupation over the past 9 years, there are some signs of improvement. In 2018-19, around 80% of people working in the occupation had also worked in the occupation in 2017-18 (up from 66% in 2010-11).

People who move into the *Health and welfare services managers* occupation have typically been working in either another skill level 1 occupation (38% in 2018-19), or a skill level 4 occupation (29% in 2018-19), indicating that there may be dual pathways into this occupation – either via promotion into the occupation, or a sideways move into the industry.

More detailed analysis suggests that those transitioning from other skill level 1 occupations are most likely to have come from either the *Registered nurses* occupation (18% in 2018-19, up from 5% in 2011-12) or the (1-digit ANZSCO) *Professionals* occupation (excluding *Registered nurses*) (13% in 2018-19). Those entering from skill level 4 occupations are likely to be transitioning from the *Receptionist* occupation (9% in 2018-19, down from 14% in 2011-12).

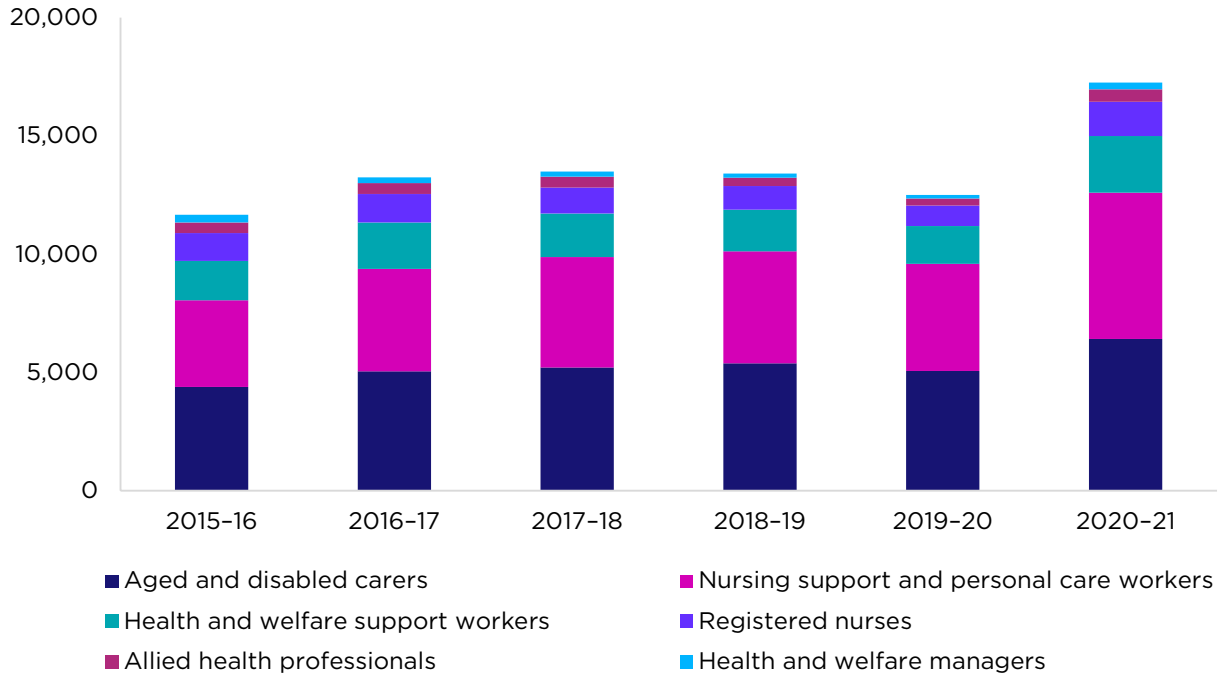
A very small proportion of people who had worked as either *Aged and disabled carers* (2%) or *Nursing support and personal care workers* (2%) moved into the *Health and welfare services managers* occupation in 2018-19 indicating that this is unlikely to present a direct career pathway for the broader care and support workforce.

7.2.7 Unemployment and the supply of workers to the care and support workforce

Between 1 July 2015 and 30 June 2021, there were 81,578 job placements for jobactive participants in care and support occupations, equating to an average of around 13,500 job placements per financial year (Figure 208). These placements represented around 4% of the total jobactive placements each financial year. While there has been a recent increase in jobactive placements in care and support occupations (from 12,503 in 2019-20 to 17,524 in 2020-21, or 38%), this increase is lower than the overall increase in total jobactive placements over the same period (64%).

In 2020-21, the majority of jobactive placements into the care and support workforce were into either the *Aged and disabled carers* or *Nursing support and personal care workers* occupations.

Figure 208: Jobactive placements in care and support occupations, 2015-16 to 2020-21



Source: Department of Education, Skills and Employment (unpublished data). Jobactive placement data should be interpreted with caution as there is some evidence to suggest that occupation coding, particularly for the *Aged and disabled carers* occupation may not be accurate. Occupations in the Personal care and support workers occupation group (*Aged and disabled carers* and *Nursing support and personal care workers*) have been presented separately due to the relatively large number of placements in each occupation.

The pool of Australians without a job may represent a potential source of current and future supply to the care and support workforce. There were nearly 810,000 unemployed Australians in February 2021 – however the pool of *potential* workers is much larger than this, with many people who wanted to work but were not actively looking.[149] There were around 1.8 million potential workers in February 2021 – around 1 million females (56% females) and 820,000 males (44%).[150]

Females without a job are most likely to actively look for work when they are young (15–24 years) while men are more likely to actively look when they are a bit older (25–44 years) (Figure 209). However, there is a higher share of women who want work but are *not* actively looking across all ages while this is only the case for young men (15–24 years) and mature age men (55 years and over) (Figure 210). These cohorts could represent an untapped workforce supply.

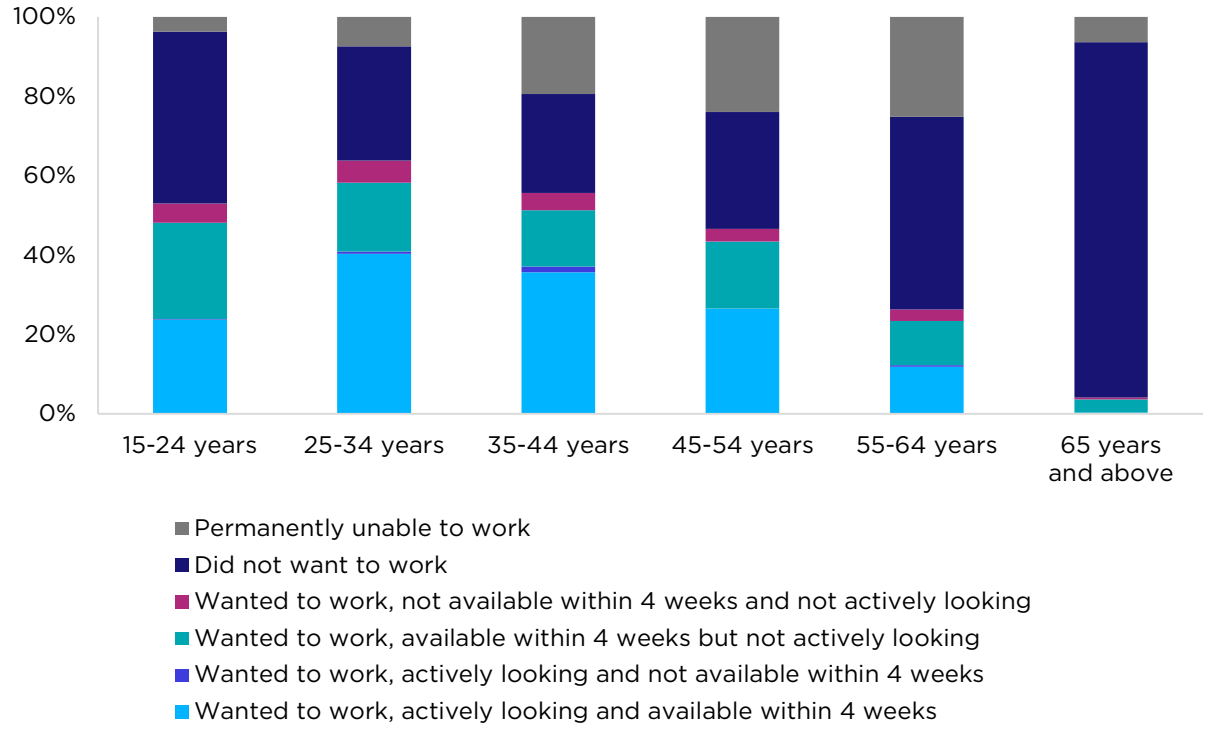
[149] Persons in unemployment are defined by the ABS as all those of working age who were not in employment, carried out activities to seek employment during a specified recent period and were currently available to take up employment given a job opportunity.

[150] In this survey, the ABS has defined potential workers as persons who: wanted to work, actively looking and available within 4 weeks; wanted to work, actively looking and not available within 4 weeks; wanted to work, available within 4 weeks but not actively looking; and wanted to work, not available within 4 weeks and not actively looking.

Figure 209: Share of female population without a job, by age and expanded labour force status, February 2021

Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder.

Figure 210: Share of male population without a job, by age and expanded labour force status, February 2021

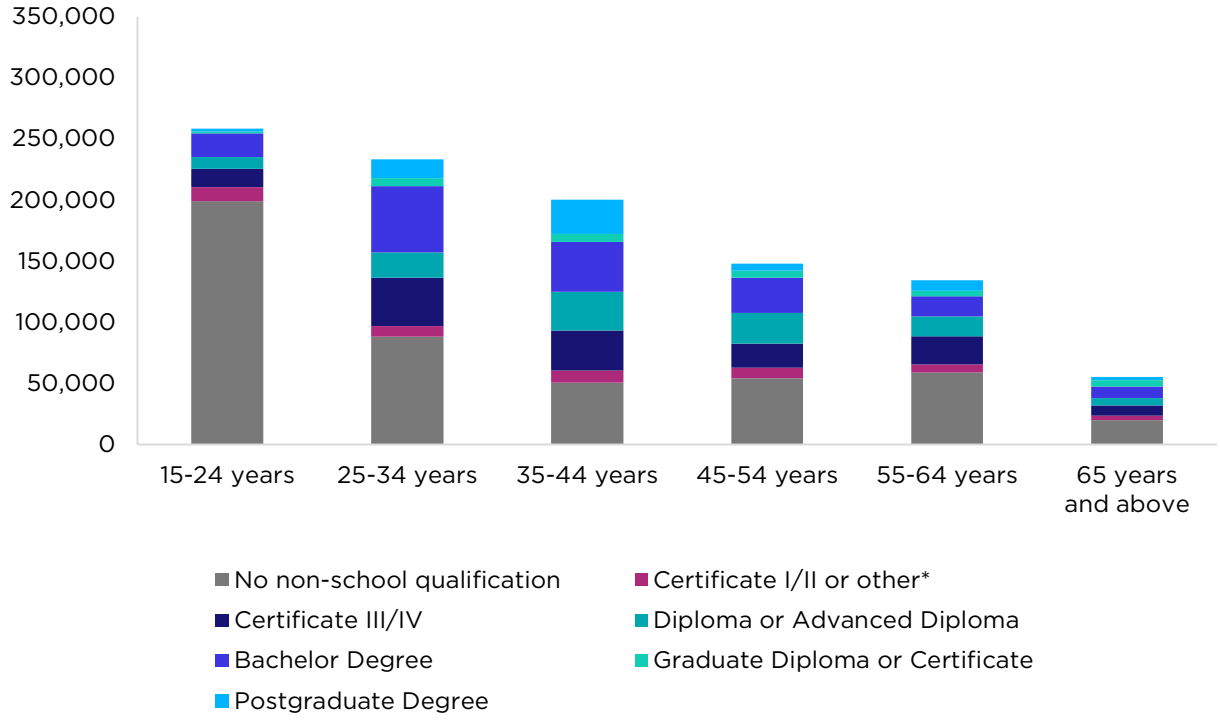


Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder.

Female potential workers are more educated than their male counterparts, with around 260,000 women with a bachelor degree or higher without a job in February 2021 but wanting to work (compared with 157,000 men). A further 187,000 female potential workers had a certificate level qualification (compared with 162,000 men). Of those with a non-school qualification, around 125,000 (7% potential workers) – mainly females – reported having attained a qualification within a care and support field of education, while another 107,000 (6%) had completed qualifications in other health or society and culture studies.

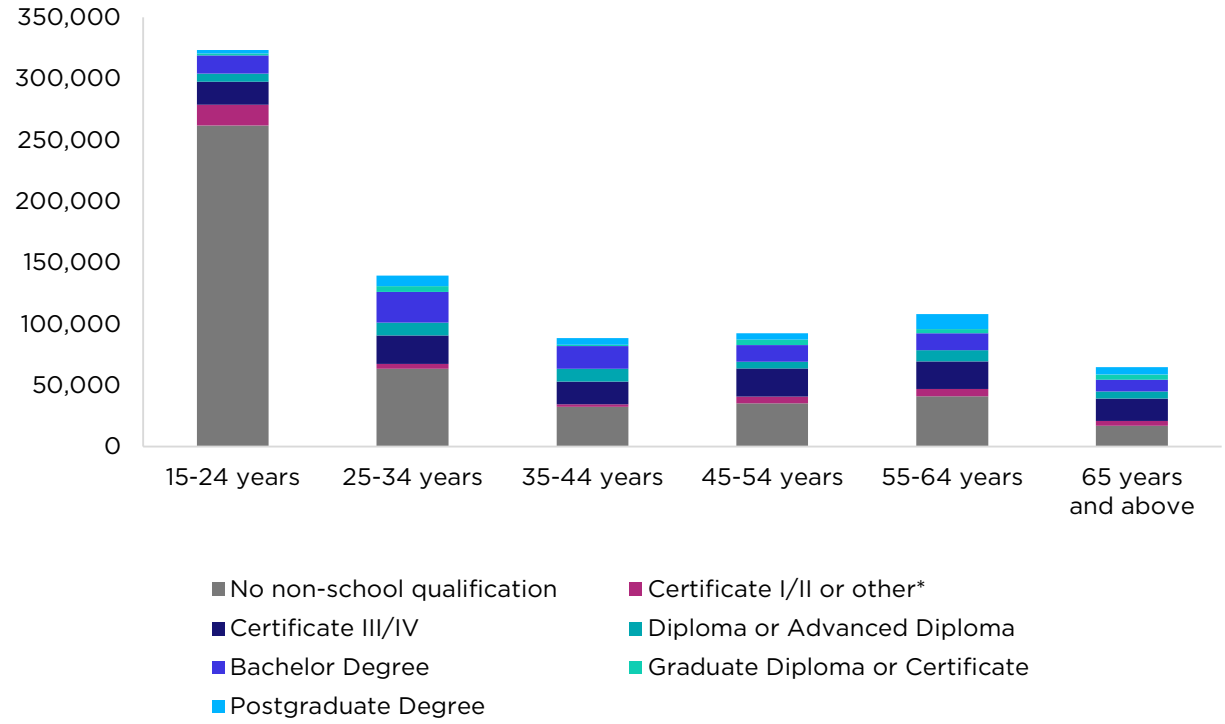
As shown in Figures 211 and 212, around half of potential workers (920,000) in February 2021 had no non-school qualifications, with men less likely to pursue further education than women (55% of male potential workers compared with 46% female).

Figure 211: Potential female workers, by age and level of highest non-school qualification, February 2021



Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder. *Includes certificates not further defined and qualifications where the level was not determined.

Figure 212: Potential male workers, by age and level of highest non-school qualification, February 2021

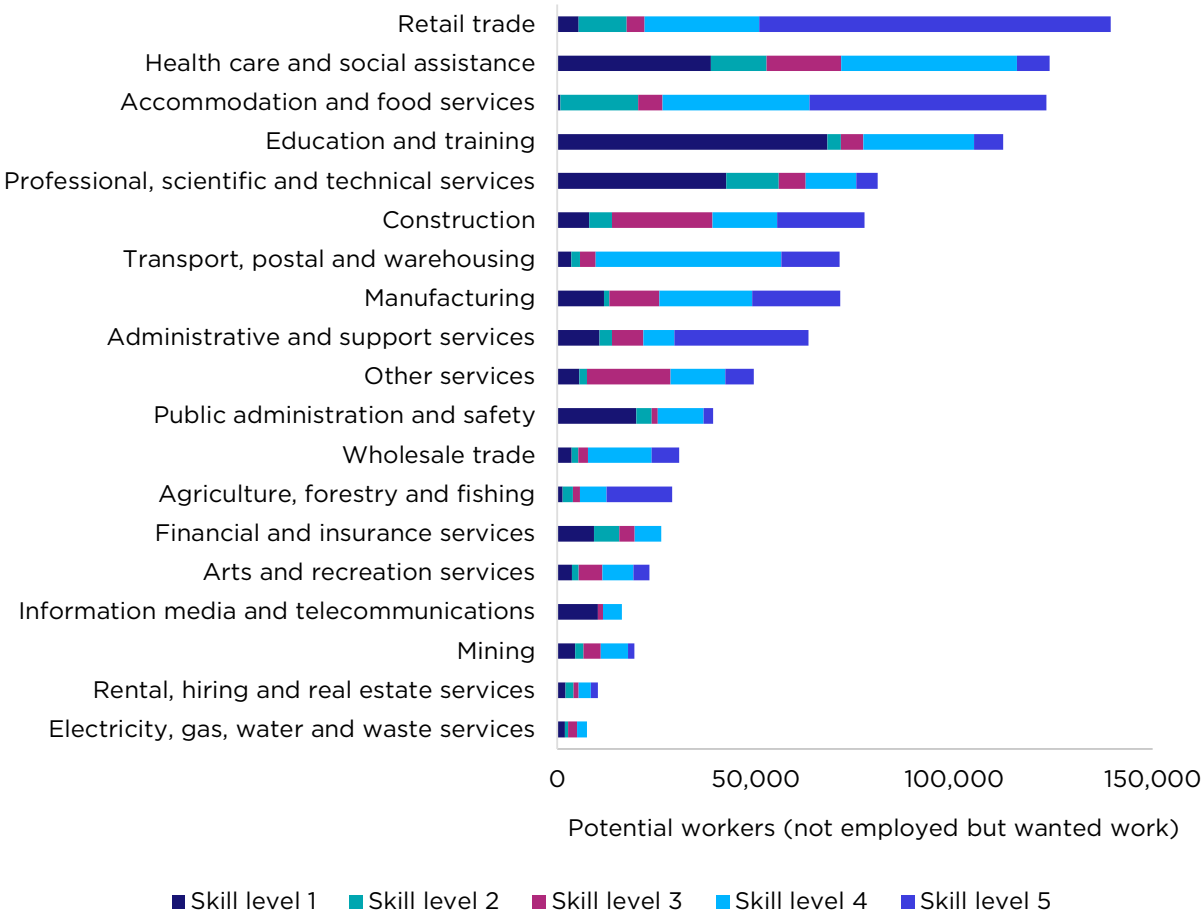


Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder. *Includes certificates not further defined and qualifications where the level was not determined.

The top 3 industries in which potential workers were previously employed in their last job includes *Retail trade, Health care and social assistance,* and *Accommodation and food services* – around 395,000 potential workers in February 2021, many of whom held roles with a 3–5 skill level (Figure 213). Among this cohort, around 39,000 reported being employed in the care and support workforce in their last job – around 29% of whom lost their jobs, while around 58% left their jobs, mostly for family reasons.[151]

[151] Family reasons listed in ABS Participation, Job Search and Mobility includes married, children, looked after others, holiday, moved or spouse transferred.

Figure 213: Number of potential workers, by industry of last job and skill level, February 2021



Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder.

While the pool of potential workers without a job is unlikely to have the skills and attributes to transition into care and support workforce roles, a subset could potentially transition, particularly those with related skills and qualifications.

7.3 The pipeline of graduates through the training system

Like all industries, care and support workforce plans focus on attracting more workers and graduates to meet shortfalls in labour supply and increasing demands for services.

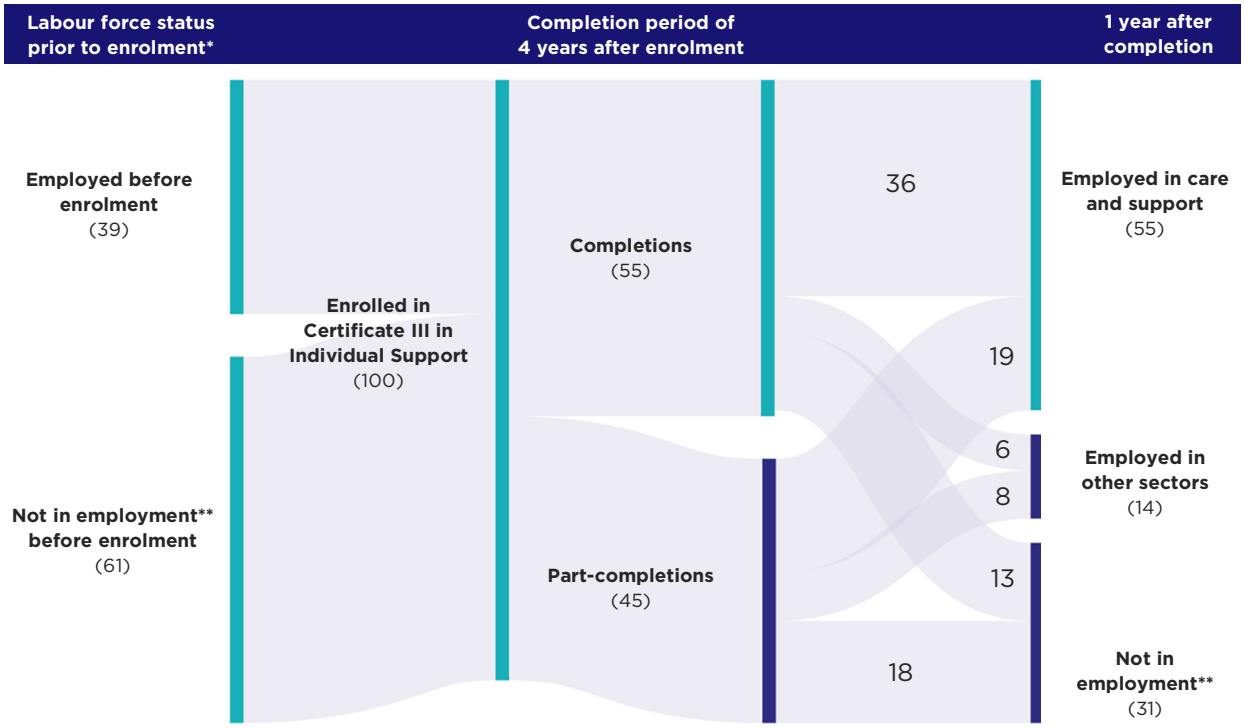
For new or prospective entrants, qualifications offer exposure to the nature of the work prior to securing employment in care and support roles. This includes entry pathways through apprenticeships and traineeships.

To efficiently meet demand for skilled workers in the care and support workforce through the training system, it is important to understand that supply is not solely dependent on attracting new entrants through enrolments, as not all enrolments will lead to completion or employment in a relevant care and support role. The supply of skilled workers through the training system can be viewed as a pipeline with several conversion points from enrolment to employment.

- An increase in successful conversion rates at every stage of the skills pipeline from enrolments, completion rates, relevant job placements and retention will be important into the future.

To illustrate the importance of each conversion stage of the qualification pipeline, the transitions from enrolment to employment in a Certificate III in Individual Support are shown in Figure 214. Based on the data available, out of 100 individuals enrolling in this course, it is estimated that 39 are employed (in any occupation, part-time and full-time) at the time of enrolment. Approximately 55 of the 100 enrolments are estimated to complete the qualification within a period of 4 years. Out of all enrolments 55 will find employment in the care and support workforce, 14 will find employment in other sectors and 31 will be unemployed in the first year after completion or discontinuing their studies. This means that to place one individual in a relevant care and support job from this pipeline (based on current state), close to 2 individuals would need to be enrolled for this qualification. Reducing this ratio will be critical for achieving a better return on investment on the training system to meet future workforce and skills demand.

Figure 214: An illustrative conversion pipeline for the Certificate III in Individual Support



Source: NSC analysis of National Centre for Vocational Education Research (NCVER), 2020. Total VET activity data and 2020 National Student Outcomes Survey. Completion rate is estimated from students who completed the course within 4 years from enrolment in 2016. * Labour Force status prior to enrolments excludes unknowns. ** Not in employment includes both unemployed and not in the labour force.

Further, of the people employed in the care and support workforce, 36 would have completed the Certificate III in Individual Support (65% of all course completions) compared to 19 who did not (42% of part-completions). Course completion increases the chance of securing employment in a care and support role compared to a non-completion by more than 50%.

- This may be driven by course completers having a higher competency level in the relevant skills that are desired by employers, however this trend can also be attributed to the likelihood of course completers having a stronger personal drive to pursue employment in the care and support sector.
- Overall, it suggests that course completion may be an important conversion point to lift the supply of skilled workers through the pipeline.

While measures to increase enrolments will continue to be important in the context of attracting people to the sector, stakeholders raised the value of pre-vocational suitability assessments to ensure students enrolling were a 'good fit' for the care and support workforce. Further increasing completion rates and attachment to the care and support workforce is also critical for recruitment and retention of a skilled and capable workforce, including the value of job placements in training (Part 7.3.1).

It is important to note other limitations in quantifying the pipeline of qualifications as with the example above. Firstly, data collection on VET outcomes are dependent on surveys, therefore estimations of outcomes after completions or part-completions are based on the number of respondents. This can vary across different training packages and in different survey cycles, which inevitably leads to inconsistencies in the quality of the data collected. It is also possible that those who did not complete the qualification are less likely to participate in student outcome surveys compared to those who completed a course, which leads to further uncertainty on the actual outcomes and labour market status of this cohort.

Nonetheless, based on data from the 2020 VET student outcomes survey,[152] out of the 74% of graduates who found employment after completing a Certificate III in Individual Support, 83% were employed as *Community and personal service workers* (the 1-digit ANZSCO group that includes *Aged and disabled carers* and *Nursing support and personal care workers*). From this same group, regardless of occupation, 86% were employed in the *Health care and social assistance* industry.[153] These outcomes were similar for those who found employment after completing a Certificate IV in Ageing Support or Certificate IV in Disability.

JobTrainer Fund

The JobTrainer Fund was established as a time-limited measure as part of the Australian Government's economic response to COVID-19. It is co-funded by the Australian and state and territory governments, and provides free or low-fee training for job seekers and young people to upskill in areas of identified skills need.

As at 31 July 2021, the Certificate III in Individual Support was the most popular course under the JobTrainer Fund, accounting for 6.9% of JobTrainer course enrolments. The Certificate IV in Disability and the Certificate IV in Ageing Support accounted for 1.2% and 0.5% of JobTrainer course enrolments, respectively.

The JobTrainer Fund has been extended to 31 December 2022 and will fund an additional 33,800 training places in aged care related VET courses. These additional places will also support existing care workers seeking to upskill or gain further qualifications, as well as anyone seeking to study a course related to aged care, regardless of age or employment status.

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[152] It is important to note the limitations of the National Student Outcomes Surveys as data collection on outcomes after completion or part-completion are based on a sample of students invited based on a defined sample frame. The survey is taken as a point in time measure which captures the outcomes of students between 6 to 20 months after completion. Further, more course completers responded to the survey compared to part-completers (34% vs 27%), which leads to further uncertainty on the actual outcomes and labour market status of students.

[153] NCVER, VET qualification completer outcomes by qualification 2020, 2021

7.3.1 Satisfaction with training outcomes

Student satisfaction is relatively high for care and support qualifications, with 92% of students who completed community services training package courses and 89% of health training package courses, satisfied with the overall quality of their training.[154] Further to this, 93% of surveyed students who completed a Certificate III in Individual Support were satisfied with their training.[155] Comparatively, 88% of completers across all VET courses were satisfied with the overall quality of their training.[156]

The pipeline of VET qualifications may also be impacted by the views of employers on the quality of the training system. In 2019, more than 77% of employers in the *Health care and social assistance* industry were satisfied with VET as a way to meet their skills needs.[157] This was more than a 3 percentage point decline from 2017, but higher than the level of satisfaction across all employers that require a VET qualification as a job requirement (72%). However, the satisfaction of training meeting employer skills needs has declined significantly in the *Health care and social assistance* industry by almost 10 percentage points since 2009 (87%) and more than 11 percentage points across all industries (83%) over the same period.

7.3.2 Views on the training landscape

A consistent theme highlighted by stakeholders throughout the Study was the importance of high-quality training for the care and support workforce. While there were differing views on whether this should be formal or on-the-job training, all agreed there were core skills and competencies needed for these roles. The value of work placements in formal training was reiterated by providers, unions and other stakeholder groups, with many noting these were not always occurring; impacting both the quality of care provided and workforce turnover, as new employees step into work environments underprepared. Further, stakeholders were critical of the current training system and its ability to keep pace with changes in care delivery. Some stakeholders also noted that the mix of unregistered NDIS providers, which are often sole traders and small businesses, may result in constrained capacity for work placements, on-the-job supervision and opportunity to grow the care and support workforce.

Evolving job design, emerging skills and person-centred models of practice all contribute to the need for workforce enablers, like the education and training systems, to be responsive to these changes. Stakeholder contributions to the Study consistently questioned if the training system was keeping pace with workforce requirements. Key areas stakeholders highlighted included cultural competency, dementia, mental health, trauma-informed and palliative (end of life) care.

The main entry level qualification for *Aged and disabled carers* and *Nursing support and personal care workers* is the Certificate III in Individual Support, along with the Certificate IV in Ageing Support and Certificate IV in Disability. These qualifications were developed in 2015 prior to the ramp up of the NDIS roll out and expansion of the CHSP and HCPP. Industry-led reviews of these qualifications are currently underway with updated qualifications expected to be released by the end of 2021. The updated qualifications are expected to have person-centred care as a foundational element.

Notwithstanding the general view about training not keeping pace, the responsive capacity of the training system was demonstrated during the COVID-19 pandemic with the rapid development and release of the Entry into Care Roles and Infections Control Skill Sets. Further, a new framework for prioritising training package development (agreed by Skills Ministers in October 2020) provides a mechanism for the Australian, state and territory governments to fast-track the development of short courses and skill sets to address unmet skills needs in the care sector going forward.

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[154] NCVER, VET student outcomes 2020 [DataBuilder], 2021

[155] NCVER, VET qualification completer outcomes by qualification 2020, 2021

[156] NCVER, VET student outcomes 2020 [DataBuilder], 2021

[157] NCVER, *Employers' use and views of the VET system 2019*, 2019

Australian, state and territory governments are committed to improving the VET system through skills reform. This includes a focus on improving the relationship between employers and the VET system. In response to the 2019 review of Australia's VET system, the HSSO is 1 of 3 pilots funded by the Australian Government to drive industry and training partnership.[158] In January 2021, the HSSO began trialling a new *Entry into Care Roles* skill set which was developed in partnership with industry stakeholders. The skill set aims to provide job seekers basic entry level skills to immediately begin working in the aged and disability care and support workforce and provides a pathway to complete a full qualification (Certificate III in Individual Support).[159]

Another issue raised by stakeholders was the consistency of training across registered training organisations and the variability in the post-qualification competencies of workers. In particular, stakeholders did not feel they could fully rely on qualifications as evidence of a worker's skills, competencies, attributes, suitability and preparedness to work in care and support. This view aligns with the reasons cited for recruitment difficulty (Part 9.1.1). Stakeholders outlined a number of reasons for dissatisfaction with the training outcomes of graduates, including:

- availability of online courses with no to low face-to-face attendance and limited opportunities for applied practical skill development
- quality and length of work placements and limited exposure to 'real-world' work context for prospective workers
- disconnect between training content and skills, knowledge and capabilities required on-the-job
- inconsistencies in the student assessment processes.

These views stand somewhat in contrast to the analysis of job advertisements (Part 6.7) which shows many employers include reference to qualifications in their advertised job requirements, suggesting ongoing value is placed on workers holding relevant qualifications. Further, student views of their training experience are more favourable. As discussed in Part 7.3.1, 93% of surveyed students who studied the Certificate III in Individual Support were satisfied with the quality of their training.[160]

There were mixed stakeholder views on how skills and capabilities should be developed and assessed for roles where a qualification is not mandatory. Stakeholders indicated that on-the-job training is important yet also noted it can be variable and is often not recognised as transferable between employers, or able to be adequately delivered given supervisory capacity limitations (both relevant supervisory skills, and time and funding constraints).

With such mixed views surrounding training for care and support occupations, it will be important to develop data-informed measures of training outcomes for care and support qualifications, particularly when considering policy options for worker registration requirements and mandatory qualifications.

7.3.3 Mandatory qualifications may create a barrier to workforce supply

The Aged Care Royal Commission recommended that the Certificate III in Individual Support (Ageing) should be the minimum mandatory qualification required for personal care workers performing paid work in aged care including residential, home-based, respite, restorative and palliative care.[161] There may be a range of potential benefits associated with mandating an entry level qualification, including standardising of skills and competencies, improving job readiness and increased professionalism.

In the short to medium term, introducing such requirements may limit the pool of candidates available to fill existing skills gaps and act as a barrier to staying in the workforce. However, this

[158] Department of the Prime Minister and Cabinet, *Strengthening Skills*, 2019

[159] DESE, Entry into Care Roles Skill Set FAQs, 2021

[160] NCVER, VET student outcomes 2020 [DataBuilder], 2021

short-term disruption may be offset by gains in better quality training, and improved alignment of industry expectations and skills taught by training providers. Improving skills alignment may reduce the risk of skills mismatches which will have positive effects on overall productivity in the care and support workforce in the long-term.

Mandatory qualifications may also pose a risk of being a disincentive for older and more experienced workers seeking to transition from other sectors in the economy to work in care and support. Compulsory completion of a qualification may be viewed as a potential financial burden and a significant investment of time, and could be a disincentivise for prospective workers transitioning to the care and support workforce and may make other sectors without mandatory requirements more attractive.

The Study notes, the HSSO is developing a Recognition of Prior Learning toolkit for the Certificate III in Individual Support qualification to recognise the skills of people currently working in Personal care and support occupations who do not currently hold formal direct care qualifications.

However, mandatory skill sets or short courses such as the Entry into Care Roles skill set, as discussed in Part 7.3.2, may contribute to the supply pipeline by providing new entrants the basic skills and competency to commence work without making an investment in a full qualification. As discussed in Part 8.2.2.3, micro-credentials may also offer workers with existing qualifications opportunities to bridge any skill gaps that may prevent or discourage seeking employment in care and support.

Stakeholder feedback was consistent in the need for a nationally consistent approach to ensure employers and professional bodies recognise micro-credentials as a genuine record of skills and competencies that are required to engage in care and support work.

7.4 Migration contributes to the supply of the care and support workforce

As discussed in Part 4.5, overseas-born workers comprise around 40% of the care and support workforce in Australia, with the share of recent migrants relatively high for the care and support workforce compared with the *Health care and social assistance* industry and the overall workforce.[162]

Australia's skilled migration program supports access to some care and support workers, predominantly those in occupations at higher skill levels. These occupations include registered nurses, some allied health occupations, and medical occupations involved in clinical care and support (including mental health) such as general practitioners, resident medical officers, and psychiatrists.

A small number of company-specific Labour Agreements under the temporary skilled migration program facilitate access to overseas workers in skill level 4 aged care occupations not on the skilled migration occupation lists.

Skilled migrants who are not sponsored by an employer and do not have a job already organised in Australia may also seek initial employment in lower skill level jobs (including in the care and support workforce). Committee for Economic Development of Australia (CEDA) research in 2021 highlighted that nearly a quarter – or about 23 per cent – of permanent skilled migrants (not employer sponsored)[163] in Australia were working in a job beneath their skill level.[164]

The ABS Characteristics of Recent Migrants survey data shows students represent the greatest share of recent migrants in the care and support sector in Australia, accounting for around 6% of the care and support workforce as at November 2019 (up from 4% in 2016) followed by family and skilled migrants (Figure 215).[165]

The proportion of student and family migrants (as a share of all recent migrants and temporary residents) increased between 2016 and 2019, while the proportion of all other migrants declined. Student and family migrant workers were also the 2 youngest cohorts among recent migrants.[166]

[162] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

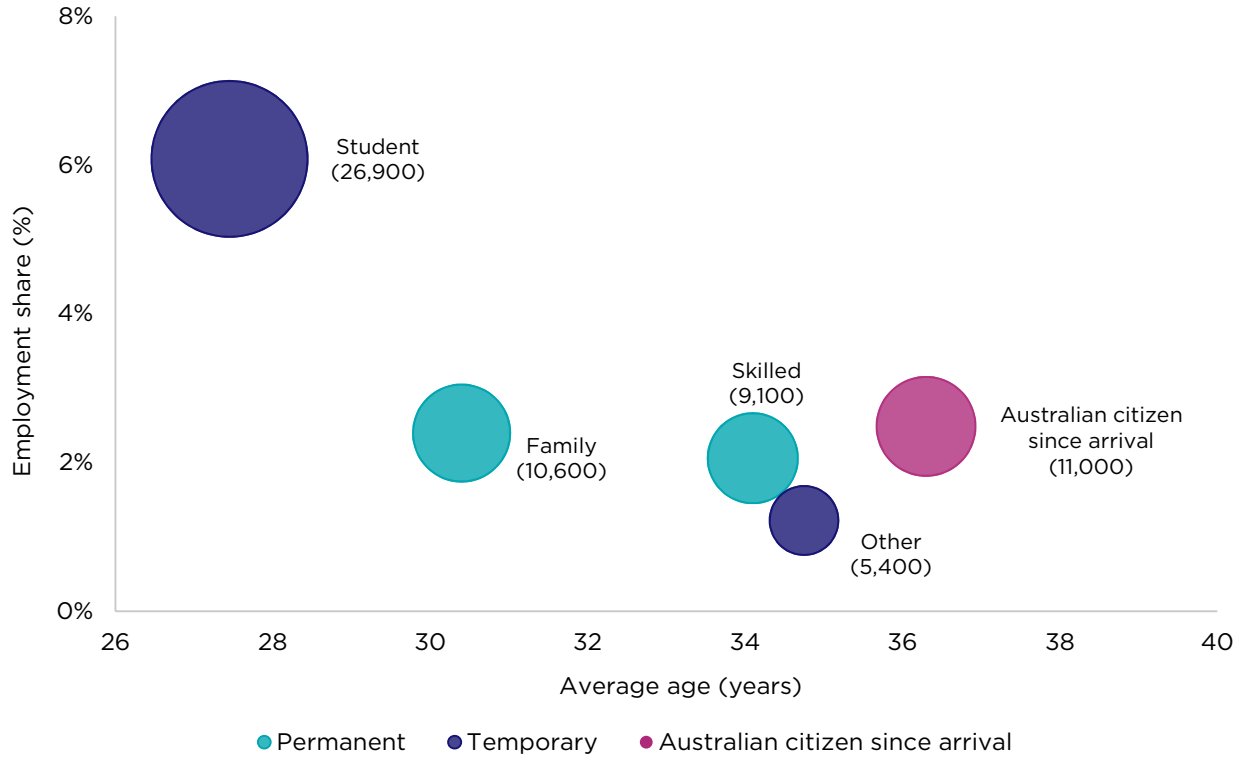
[163] Primary applicant (the person whose skills or proposed activities in Australia determine whether a visa application is granted) not under the employer sponsored programs of the permanent skilled migration program.

[164] CEDA, *A good match: Optimising Australia's permanent skilled migration*, 2021

[165] ABS, Characteristics of recent migrants, November 2019, 2020; ABS, Characteristics of recent migrants, November 2016, 2017

[166] ABS, Characteristics of recent migrants, November 2019, 2020; ABS, Characteristics of recent migrants, November 2016, 2017

Figure 215: Recent migrants or temporary residents in the care and support workforce, by average age and employment size, November 2019



Source: Characteristics of Recent Migrants, 2019. Recent migrants and temporary residents are defined using the ABS definitions in the survey.

7.4.1 There is global competition for workers in the care and support workforce and countries are trialling creative migration strategies

Against the backdrop of increasing demand for the care and support workforce from global population ageing and proportional decreases in the working age population, competition for migrant care and support workers is increasing.

Most OECD countries, including Australia, do not have specific migration channels for care and support workers and tend to rely on 'incidental' migrant workers to supplement their local care and support workforce. Despite this, foreign-born workers comprise a high proportion (around 20%) of the long-term care workforce in OECD countries; with the highest proportions of foreign-born care workers in Israel (71%), Ireland (48%), Canada (34%), Switzerland (31%) and Australia (29%).[167]

Recognising the growing competition for care and support workers, many OECD countries have implemented measures to influence attraction of migrant care workers. These include simplifying recruitment and migration procedures for care and support workers (Spain, Canada and Finland),[168] lifting quotas (Austria) or providing exemptions from quotas for certain care occupations (Italy),[169] and recognising long-term services and support occupations on a skills shortage list (United Kingdom).[170]

[167] OECD, *Who Cares? Attracting and retaining care workers for the elderly*, 2020

[168] Piyasiri Wickramasekara and Nilim Baruah, *Fair Recruitment for Low-Skilled Migrant Workers: Issues and Challenges*, 2017

[169] Giovanni Lamura et al., *Migrants Workers in the Long-Term Care Sector: Lessons from Italy*, Geneva Association Information Newsletter, Health and Ageing, vol. 2, 2010

[170] PP+G Review, Migrant Care Workers in Canada: Policy Changes and Future Directions, 2021

Some OECD countries are trialling targeted migration strategies, mainly based on bilateral agreements and global skill partnerships for attracting and recruiting migrant care workers with or without a pathway to permanent residence.[171]

International examples of specific migration strategies for care and support workers

Israel's bilateral agreement allows sourcing care workers through private recruitment agencies from Sri Lanka and Nepal. Workers receive training in their own country and then can work in Israel for up to 5 years without a pathway to permanent residence.

Canada's Caregiver Program is an employer-driven occupation specific migration pilot scheme for caregivers who meet specified language and qualification requirements. Caregivers can work with multiple employers in care occupations to qualify for permanent residence after 2 years of caregiving work.

Japan's economic partnership agreements allow sourcing certified nurses and care workers from Indonesia, the Philippines, and Vietnam to work indefinitely in Japan upon acquiring language proficiency and passing national exams.

Germany's Triple Win program for nurse recruitment with dual country training component from multiple countries. Focuses on fair and sustainable placement of nurses in Germany from Serbia, Bosnia, the Philippines and Tunisia where nurses undergo a German trade qualification.

Germany's nurse pilot program aims at attracting personnel from Vietnam to train and work as nurses in Germany. Nurses undertake a state-funded training program organised in cooperation with the Goethe-Institut in Hanoi for 13 months on German language skills, intercultural training and practical preparation for working as a nurse in Germany.

Australia has recently introduced temporary initiatives in response to the COVID-19 pandemic for migrant workers to help meet immediate care and support workforce needs. These include relaxing work hour limitations for student visa holders to work in aged and disability care and support,[172] waiving visa application charges, allowing flexibility in working holiday maker extensions,[173] and in the Pacific Labour Scheme for workers to take up new roles, including in aged care and disability support.[174]

In the short-term, migration has also been disrupted by COVID-19 and extended international border closures. Accordingly, migration-related inflows to the care and support workforce are likely to be significantly reduced.

[171] N. Ajahaf et. al, *Triple Win Migration through Global Skill Partnerships, paper presented at the United Nations Thematic Session for the Global Compact for Migration (GCM): Contributions of migrants to all dimensions of sustainable development: enabling framework for contributions,* 2017

[172] Department of Home Affairs, Temporary relaxation of working hours for student visa holders, 2021

[173] Department of Home Affairs, COVID-19 and the border, Working Holiday Maker visa, 2021

[174] Department of Home Affairs, COVID-19 and the border, Seasonal worker, 2021

7.5 Data appendix to Part 7

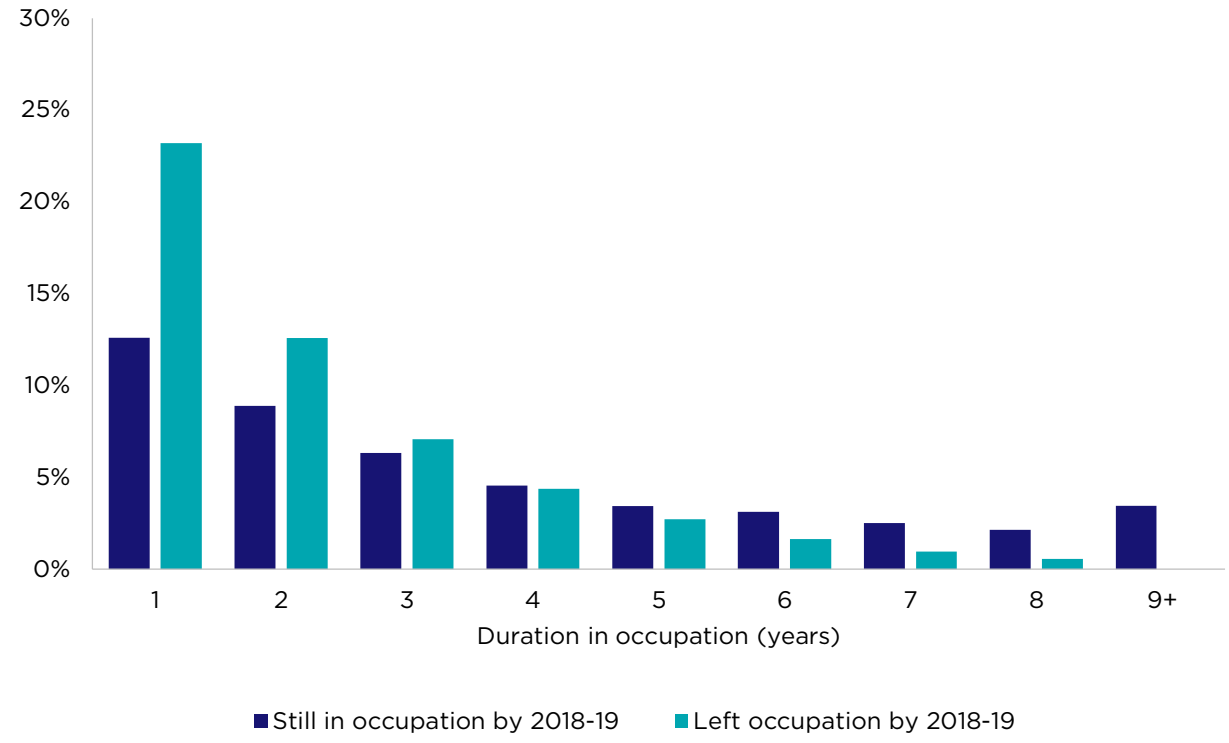
Duration in an occupation is measured as the number of years where this occupation was reported in an individuals' income tax return. For the purposes of this analysis, these years do not have to be consecutive, but measure the total number of years with a relevant occupation reported between 2010-11 and 2018-19. Those with 9 years duration over this period have been reported as 9+ years for the purpose of this analysis. Duration analysis has been undertaken separately for males and females, and for those aged 44 years and under, and 45 years and over. People who had left the occupation by 2018-19 are denotated as *left the occupation* (or 'completed' duration), while those who remained in the occupation in 2018-19 are denoted as *still in occupation* (or 'ongoing' duration).

Transitions are measured by comparing the occupation of an individual between one year, and the year either immediately preceding (previous occupation) or immediately after (next occupation). A transition in (or out) of the workforce is measured by whether an individual had no wage (or no tax return),[175] noting that this may provide an overestimate of transitions out of the workforce where the submission of an income tax return has been delayed.

7.5.1 *Aged and disabled carers* - charts

7.5.1.1 Duration in occupation – charts

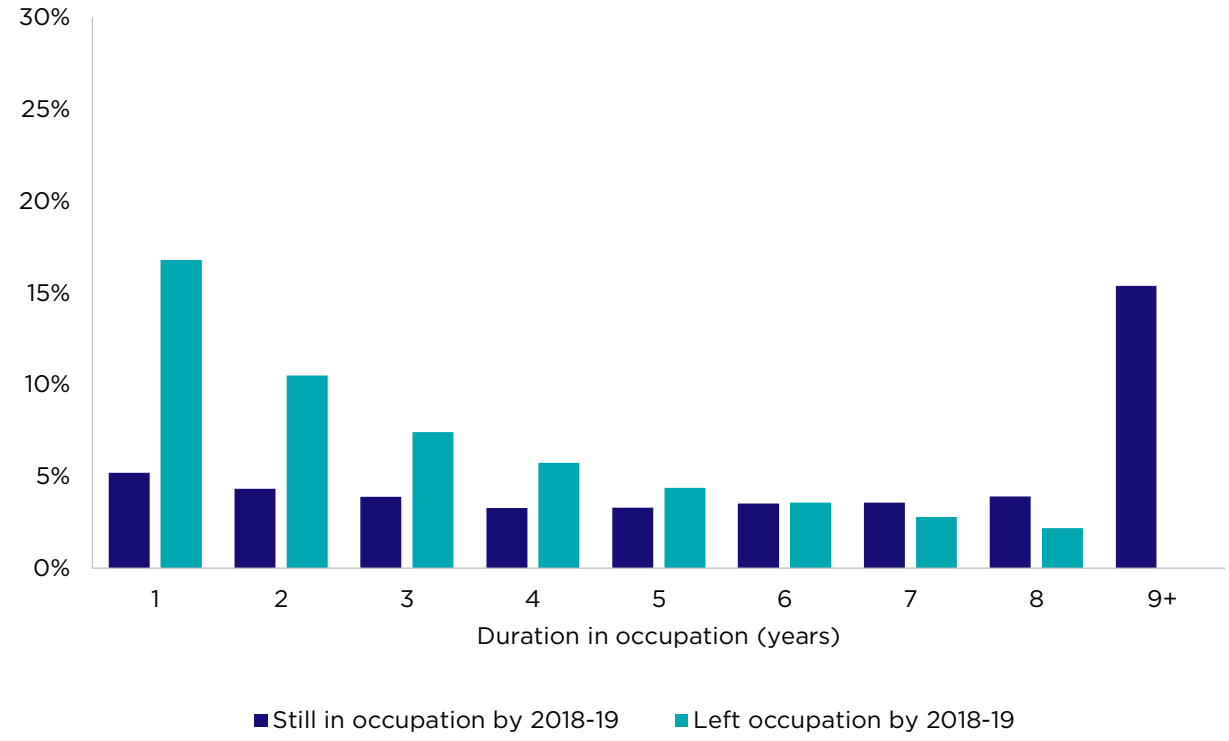
Figure 216: *Aged and disabled carers* (all industries), duration in occupation (%), females 44 years and under, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

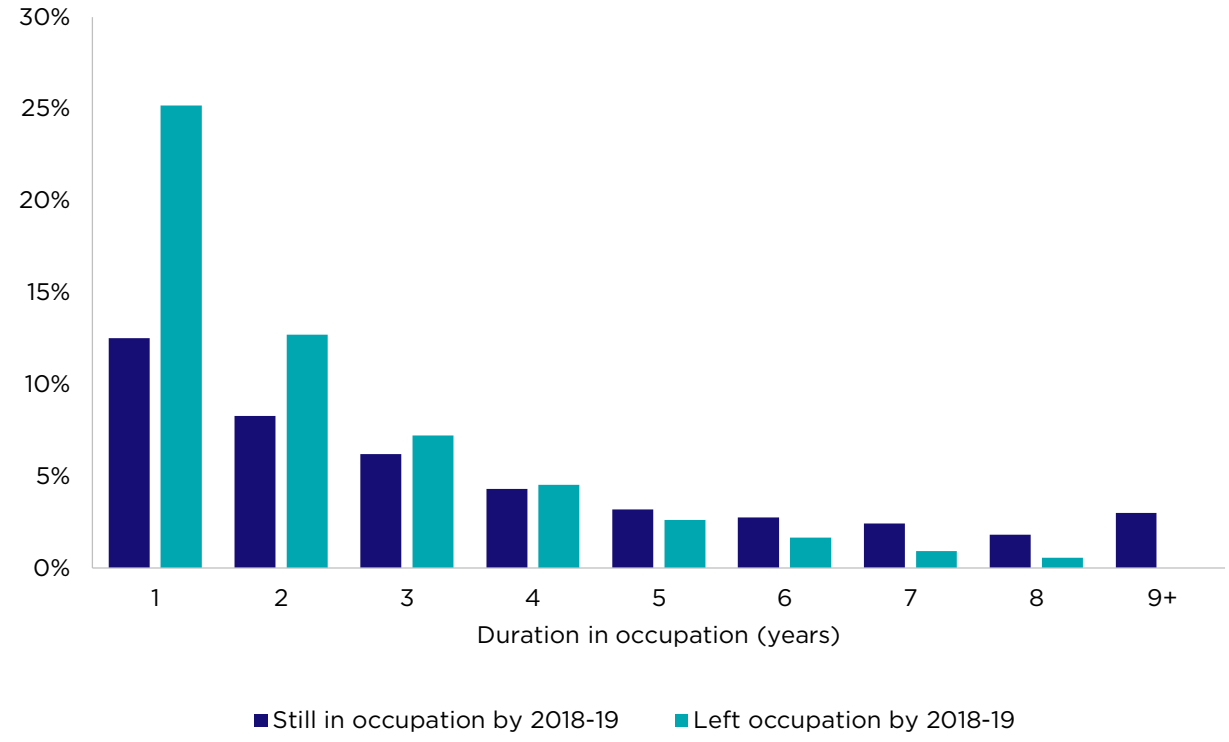
[175] This analysis may provide an overestimate of transitions out of the workforce where the submission of an income tax return has not yet been completed.

Figure 217: *Aged and disabled* carers (all industries), duration in occupation (%), females 45 years and over, 2018-19



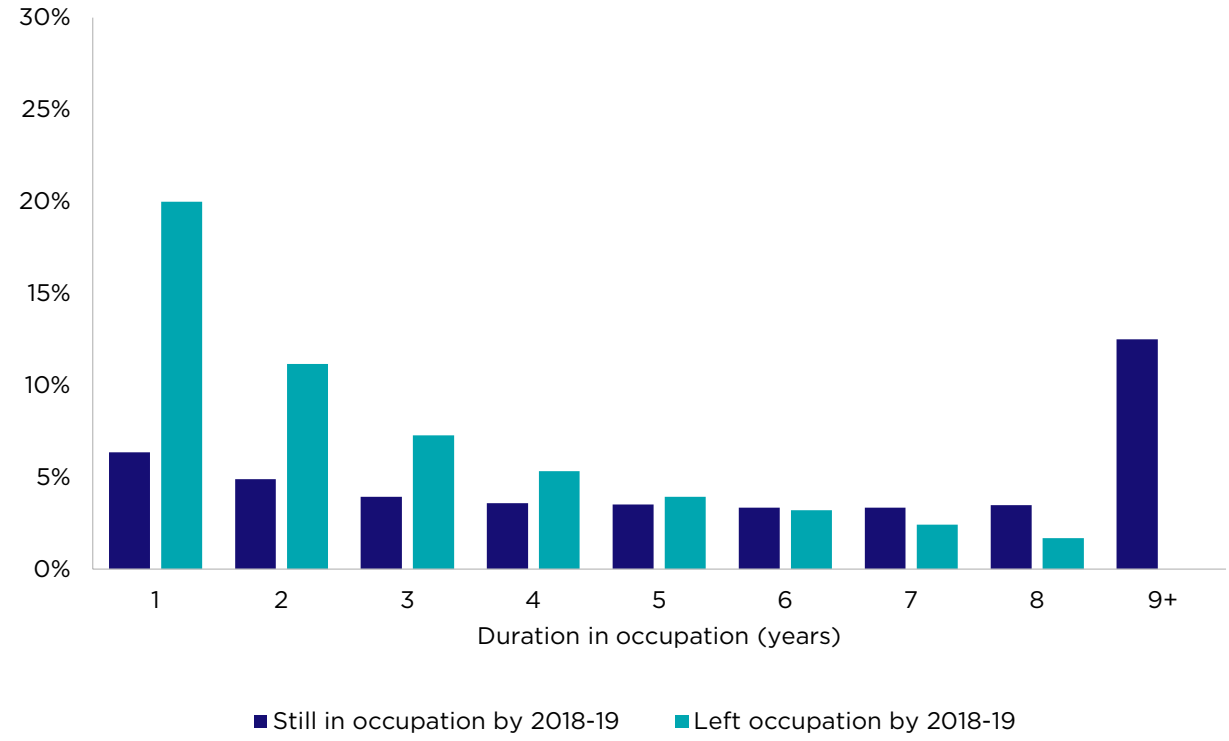
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 218: *Aged and disabled carers* (all industries), duration in occupation (%), males 44 years and under, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 219: *Aged and disabled carers* (all industries), duration in occupation (%), males 45 years and over, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

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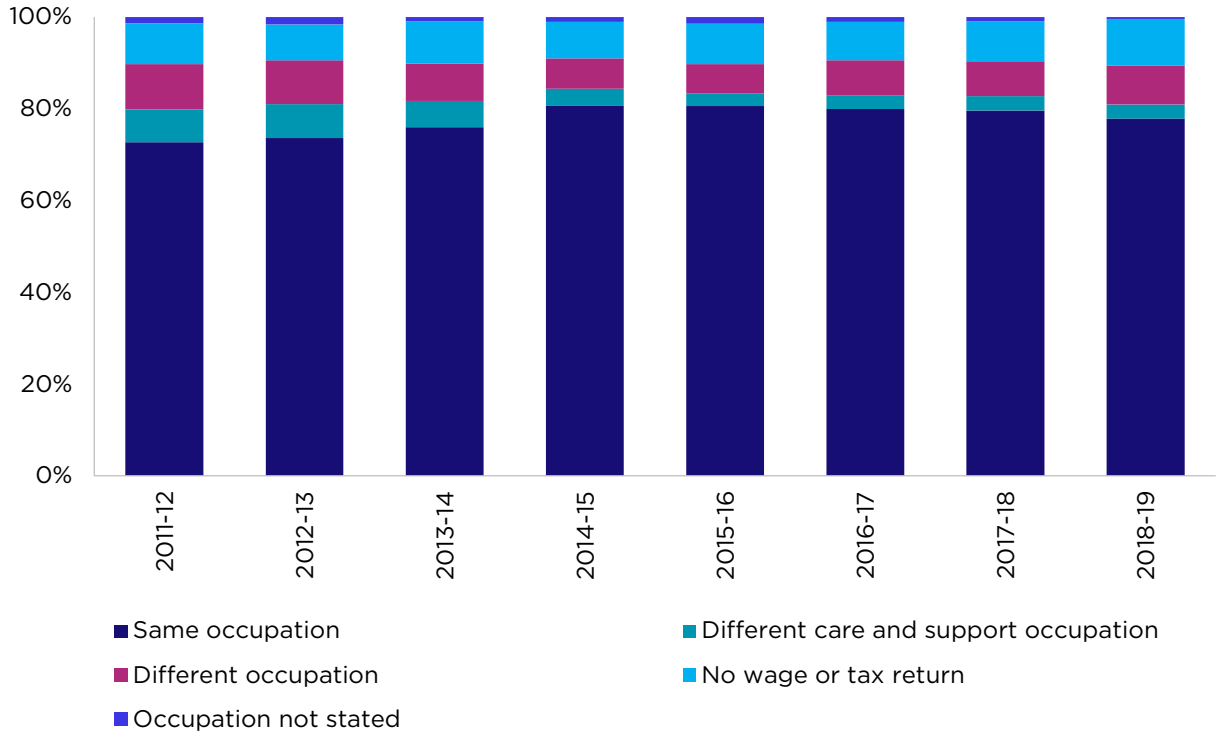
7.5.1.2 Transitions, previous and next occupation, summary - charts

Figure 220: *Aged and disabled carers* (all industries), transitions from previous occupation (%), 2011-12 to 2018-19



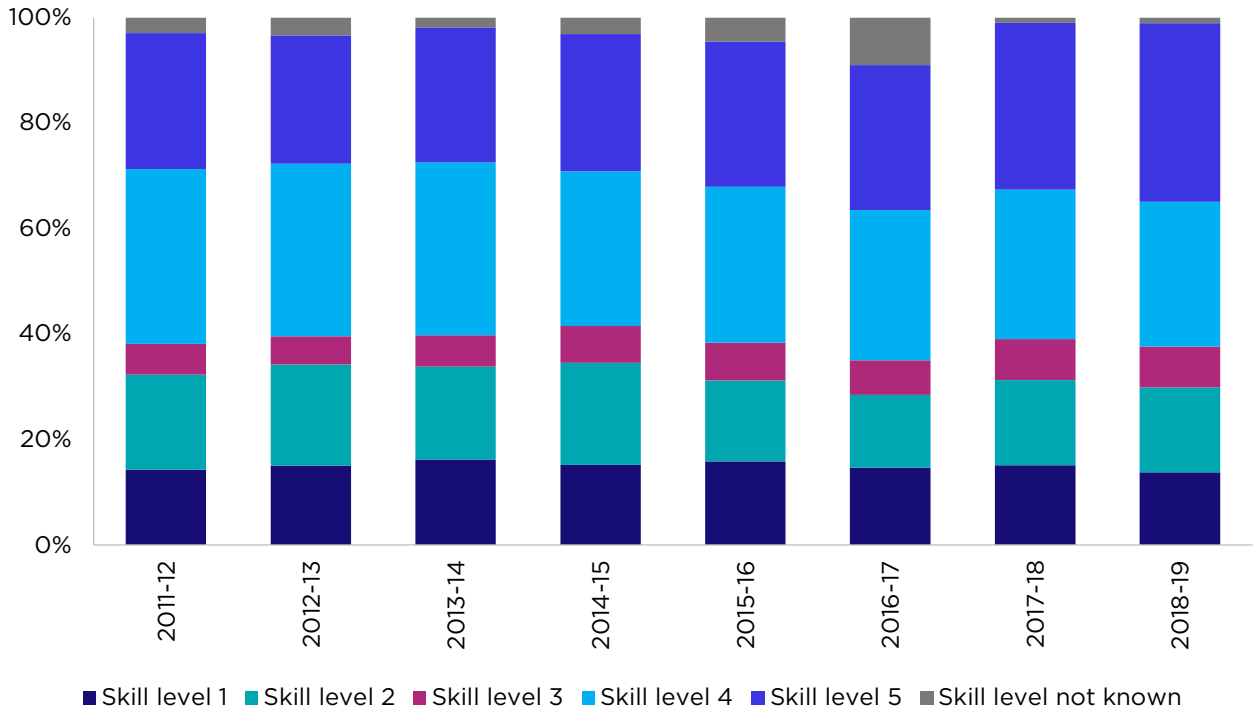
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 221: *Aged and disabled carers* (all industries), transitions to next occupation (%), 2010-11 to 2017-18

Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

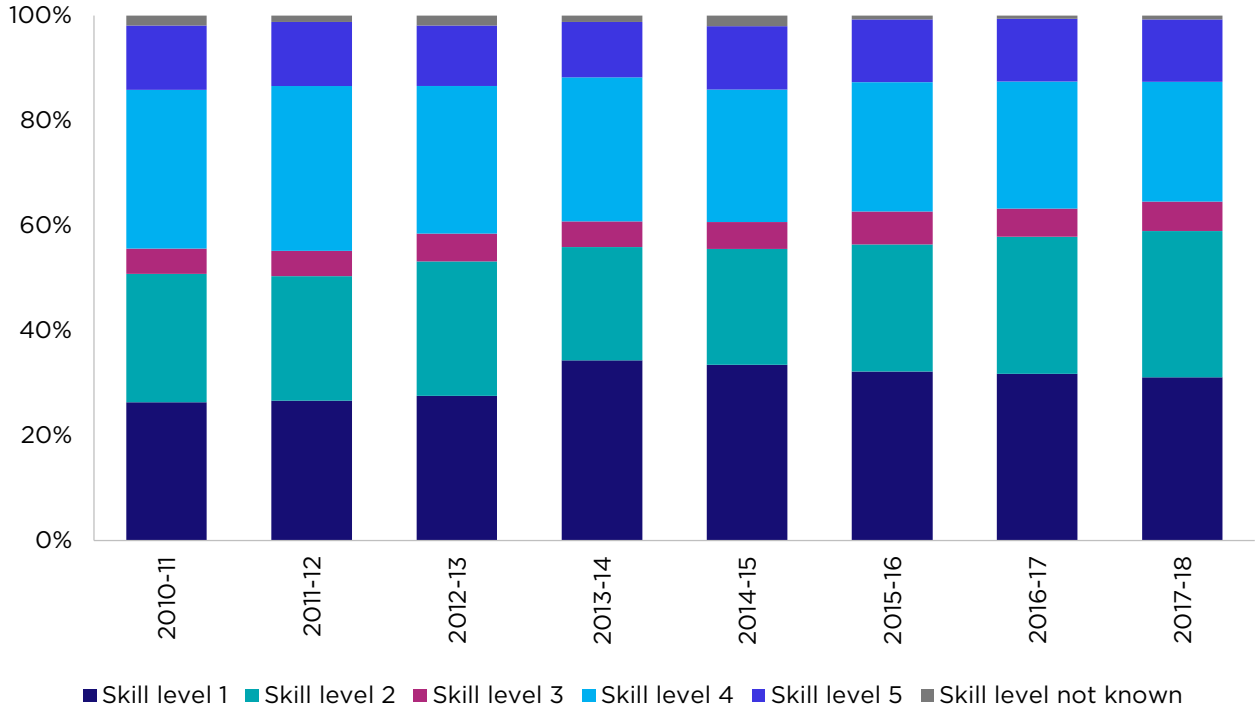
7.5.1.3 Transitions, previous and next occupation, by skill level – charts

Figure 222: *Aged and disabled carers* (all industries), transitions from previous occupation, by skill level (%), 2011-12 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

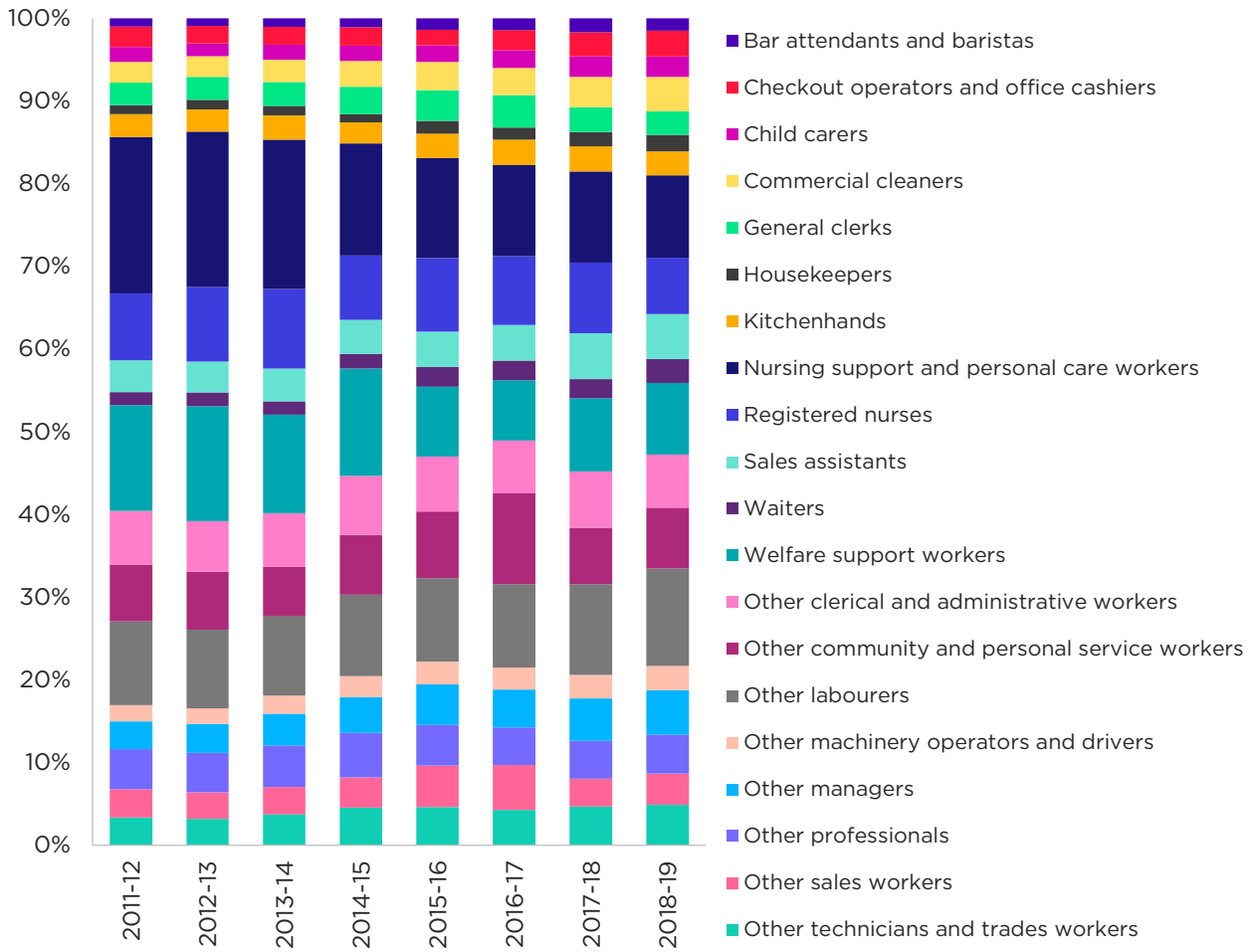
Figure 223: *Aged and disabled carers* (all industries), transitions to next occupation, by skill level (%), 2010-11 to 2017-18



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

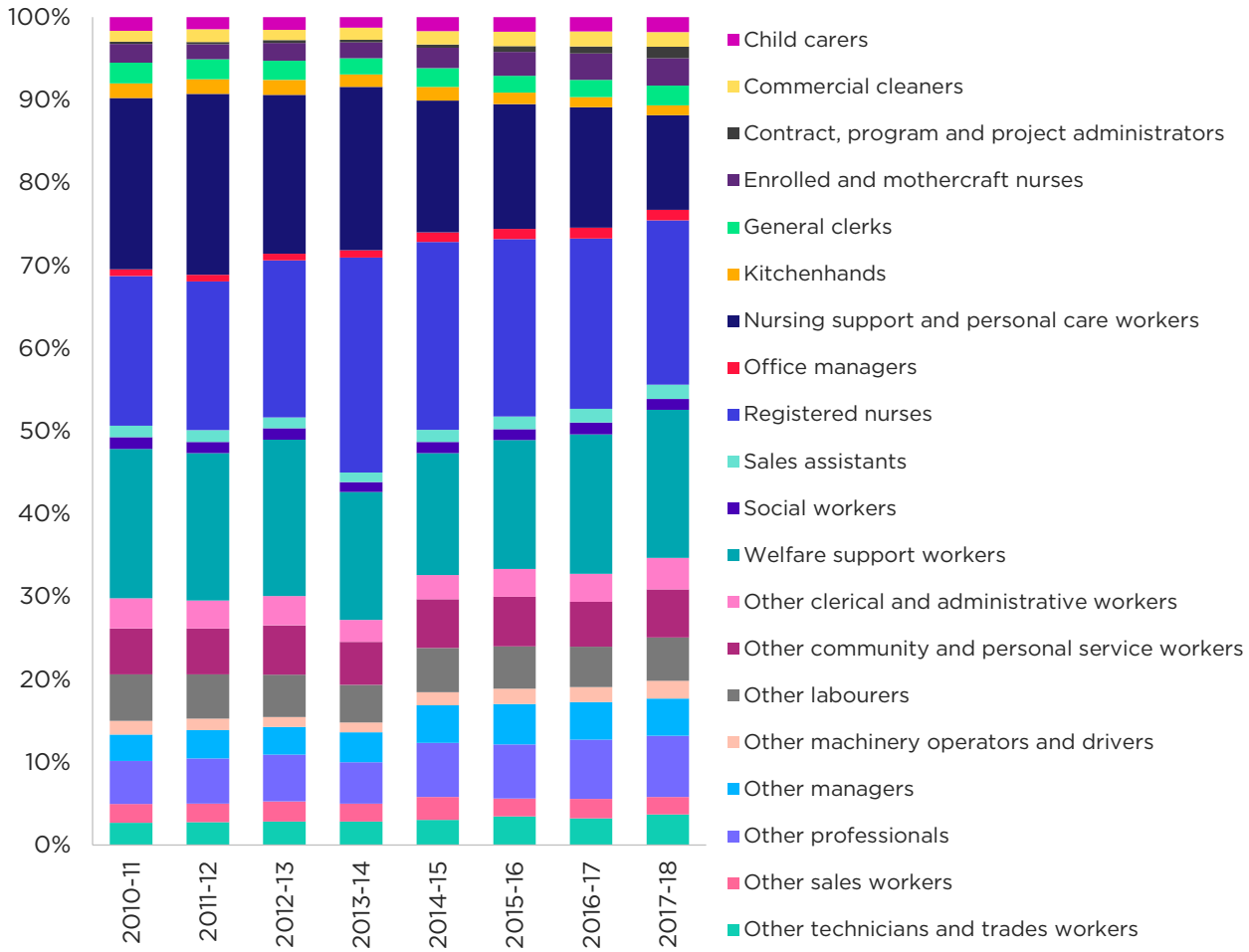
7.5.1.4 Transitions, previous and next occupation, by detailed occupation - charts

Figure 224: *Aged and disabled carers* (all industries), previous occupation (%), 2011-12 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Excludes people working in the same occupation and those with no tax return submitted.

Figure 225: *Aged and disabled carers* (all industries), next occupation (%), 2010-11 to 2017-18

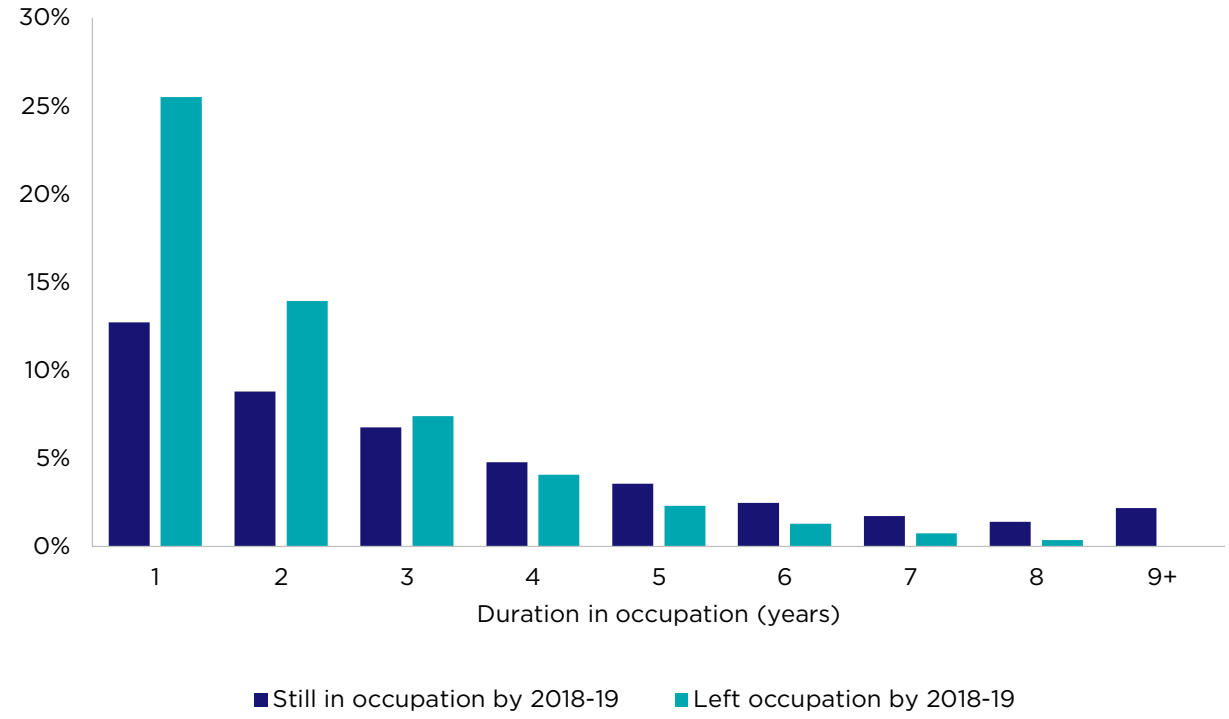


Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Excludes people working in the same occupation and those with no tax return submitted.

7.5.2 *Nursing support and personal care workers* – charts

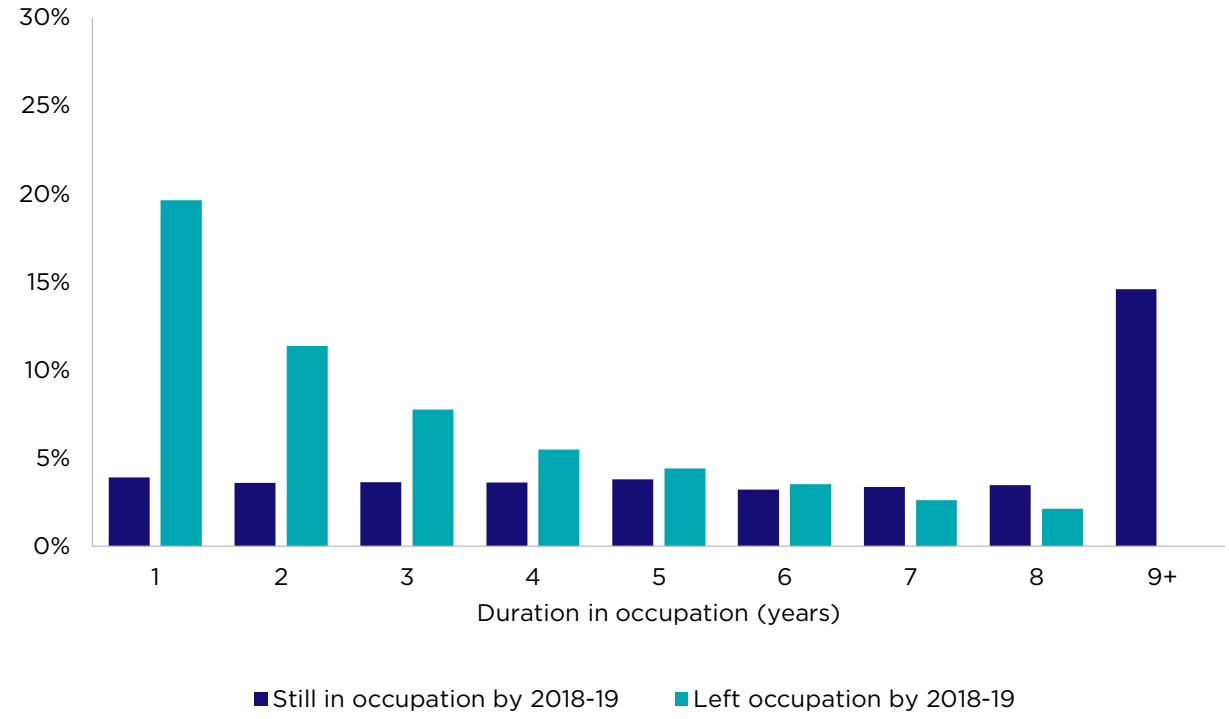
7.5.2.1 Duration in occupation – charts

Figure 226: *Nursing support and personal care workers* (all industries), duration in occupation (%), females 44 years and under, 2018-19



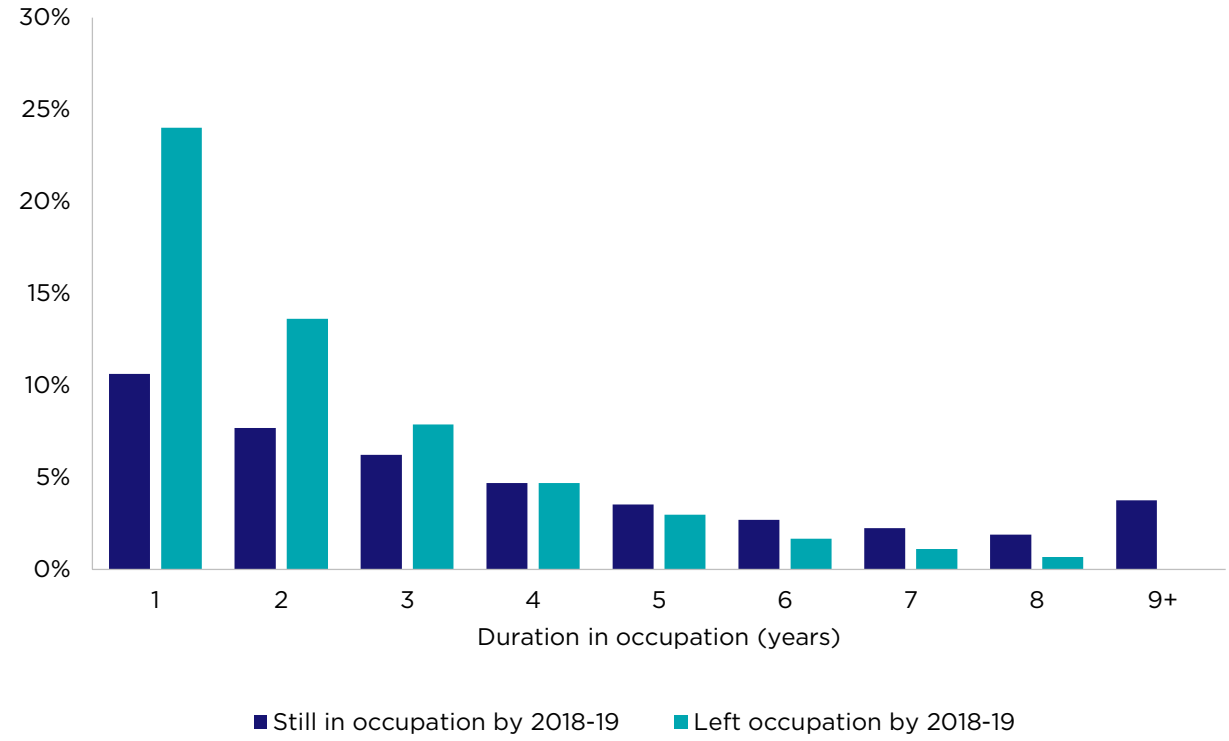
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 227: *Nursing support and personal care workers* (all industries), duration in occupation (%), females 45 years and over, 2018-19



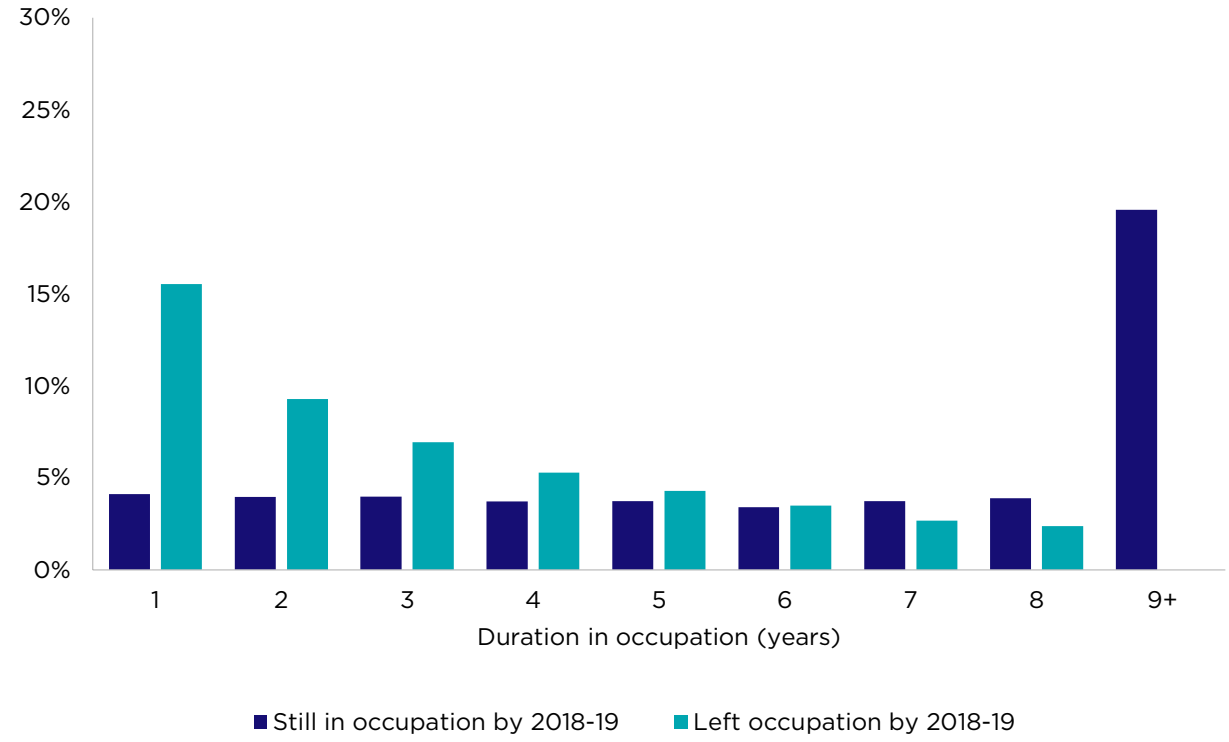
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 228: *Nursing support and personal care workers* (all industries), duration in occupation (%), males 44 years and under, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 229: *Nursing support and personal care workers* (all industries), duration in occupation (%), males 45 years and over, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

7.5.2.2 Transitions, previous and next occupation, summary – charts

Figure 230: *Nursing support and personal care workers* (all industries), transitions from previous occupation (%), 2011-12 to 2018-19

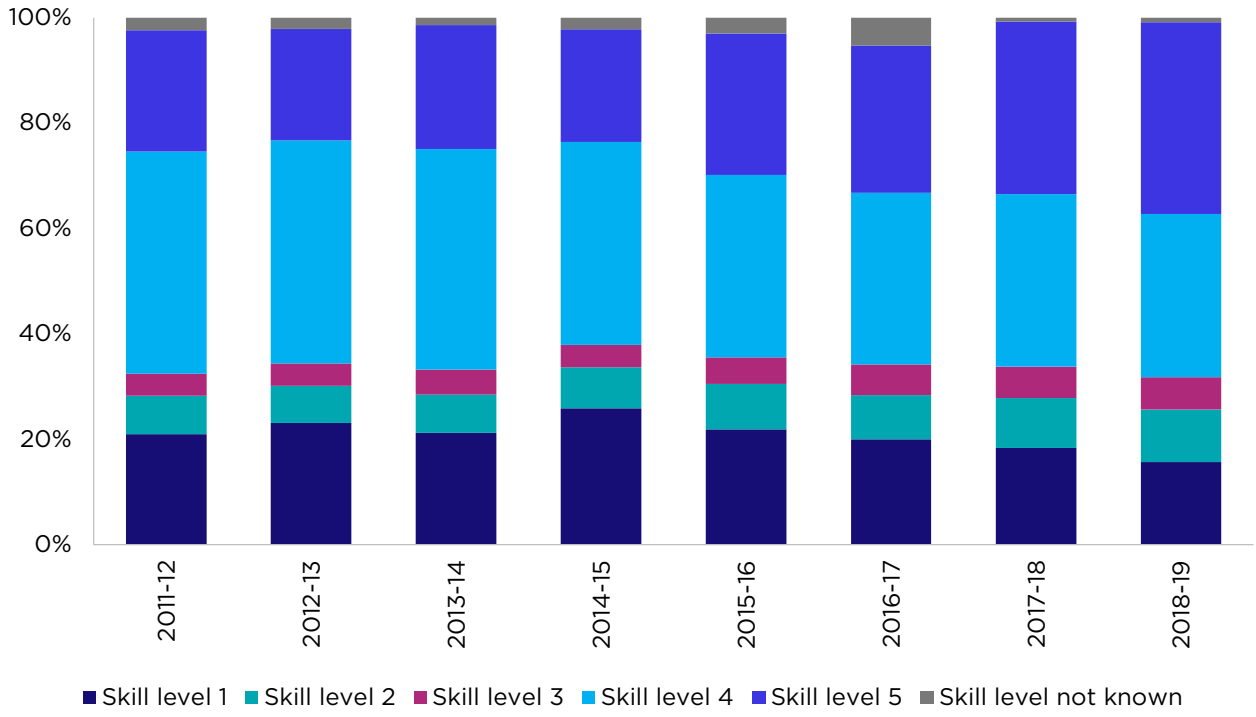
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 231: *Nursing support and personal care workers* (all industries), transitions to next occupation (%), 2010-11 to 2017-18

Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

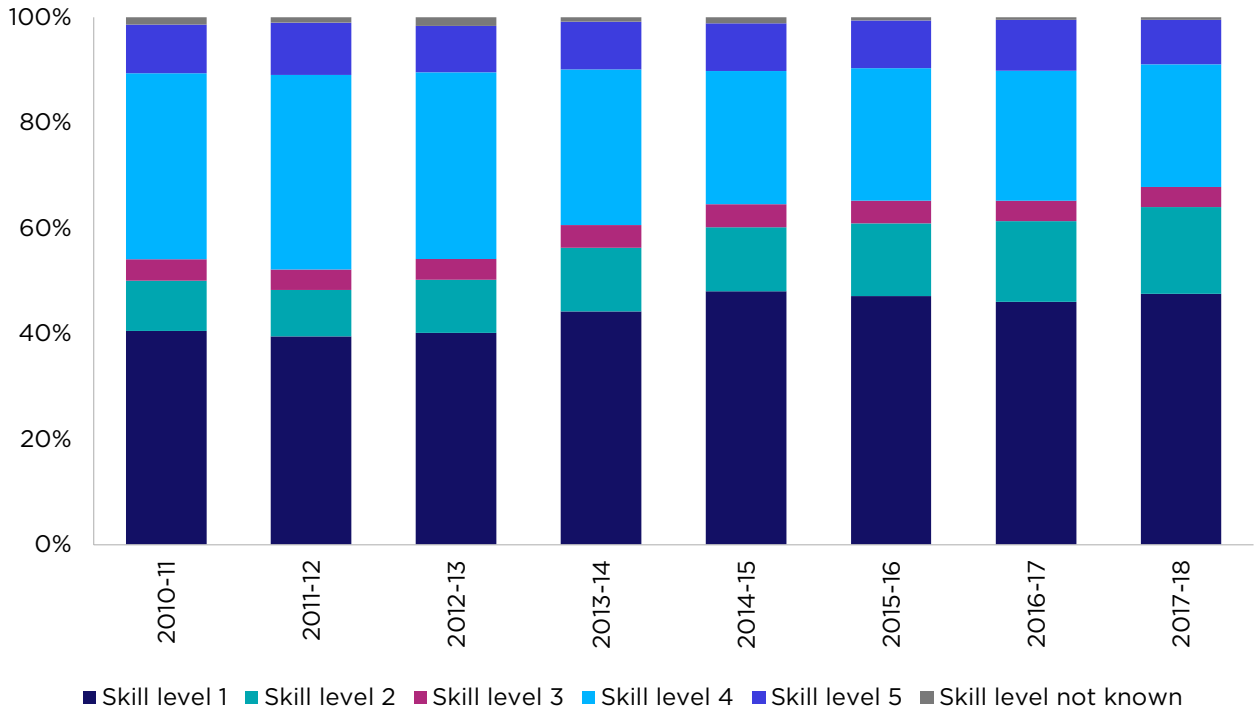
7.5.2.3 Transitions, previous and next occupation, by skill level – charts

Figure 232: *Nursing support and personal care workers* (all industries), transitions from previous occupation, by skill level (%), 2011-12 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

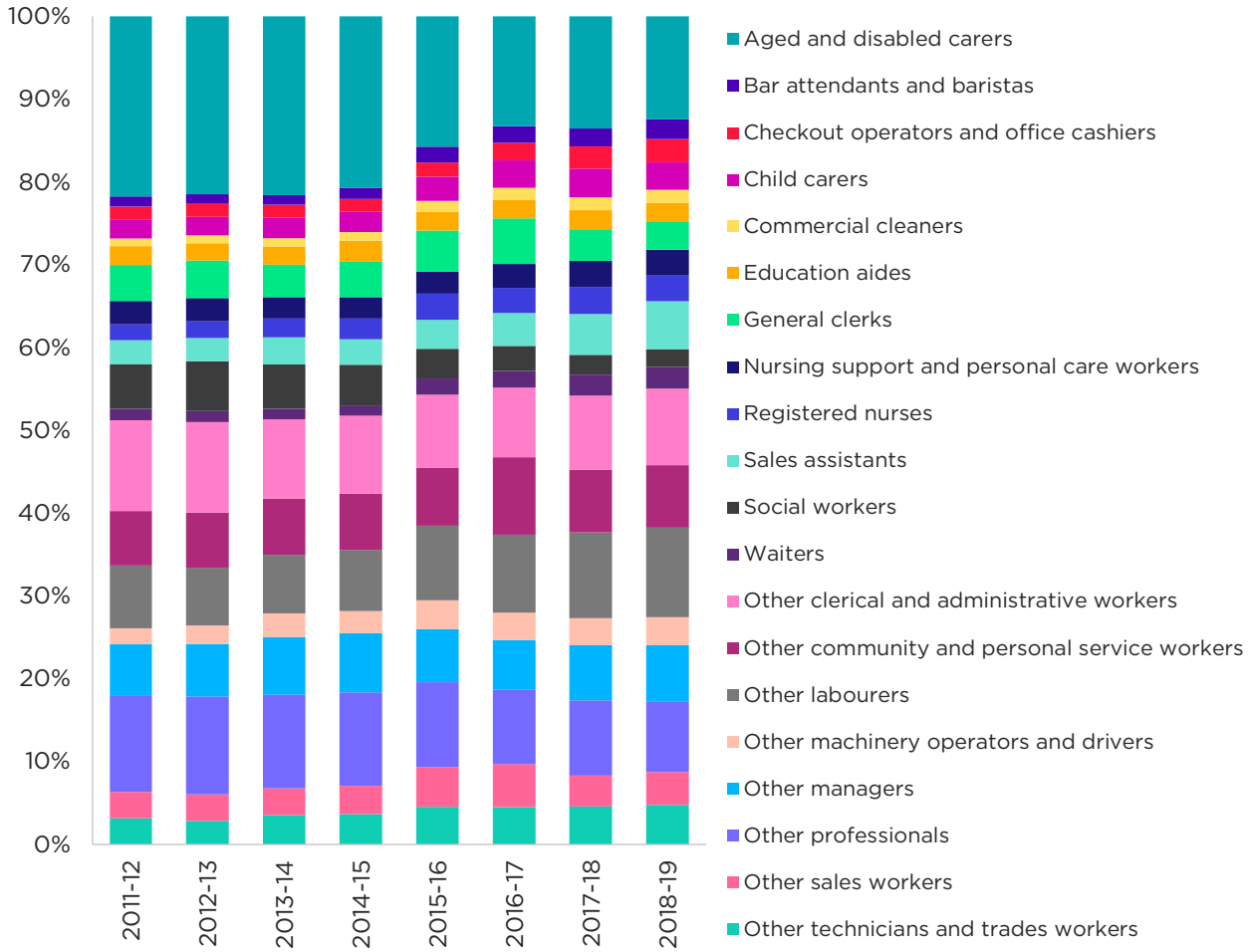
Figure 233: *Nursing support and personal care workers*, transitions to next occupation, by skill level (%), 2010-11 to 2017-18



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

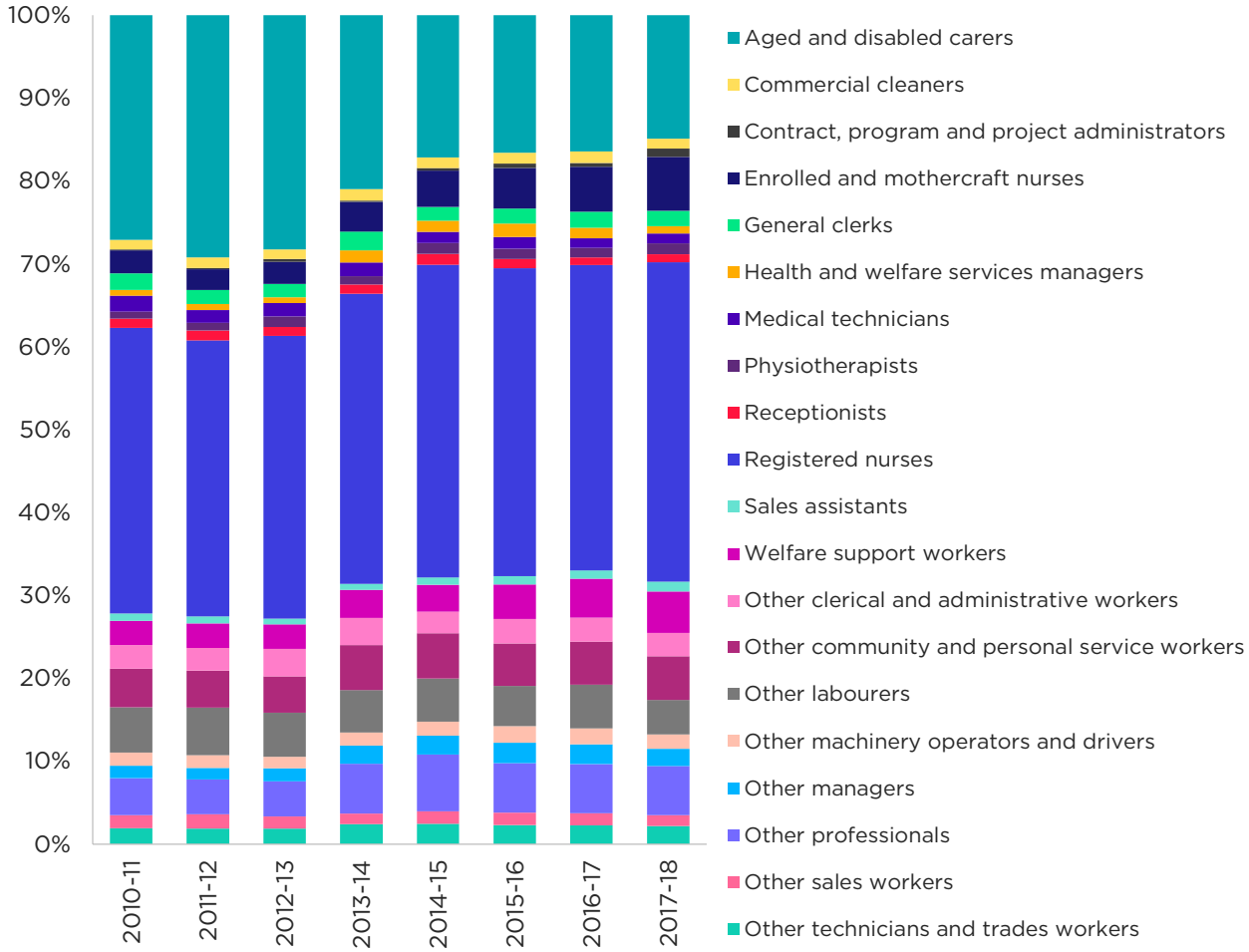
7.5.2.4 Transitions, previous and next occupation, by detailed occupation – charts

Figure 234: *Nursing support and personal care workers* (all industries), previous occupation (%), 2011-12 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Excludes people working in the same occupation and those with no tax return submitted.

Figure 235: *Nursing support and personal care workers* (all industries), next occupation (%), 2010-11 to 2017-18

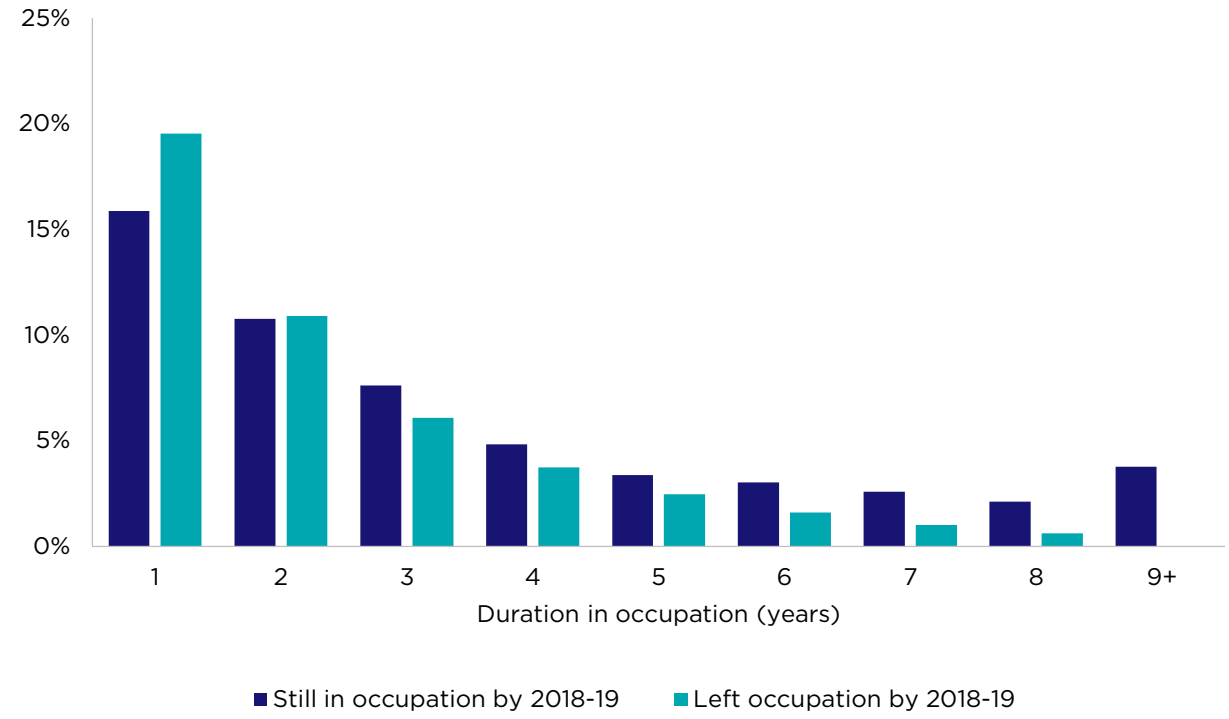


Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Excludes people working in the same occupation and those with no tax return submitted.

7.5.3 *Welfare support workers* – charts

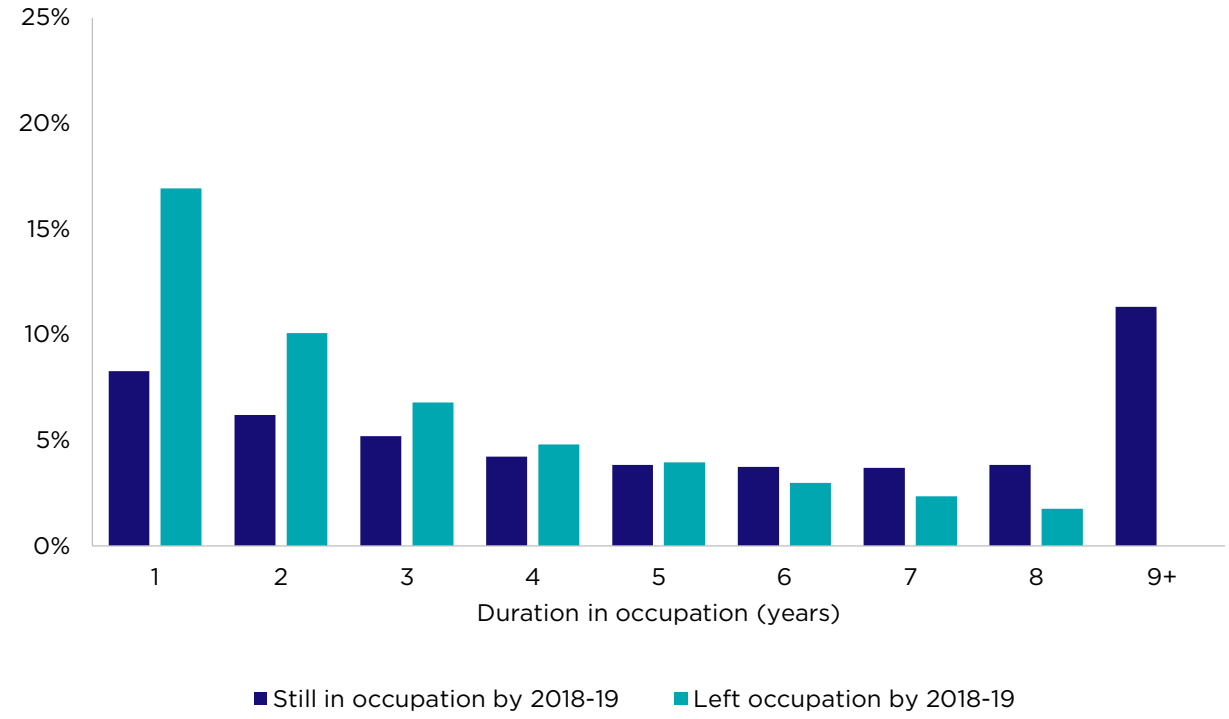
7.5.3.1 Duration in occupation – charts

Figure 236: *Welfare support workers* (all industries), duration in occupation (%), females 44 years and under, 2018-19



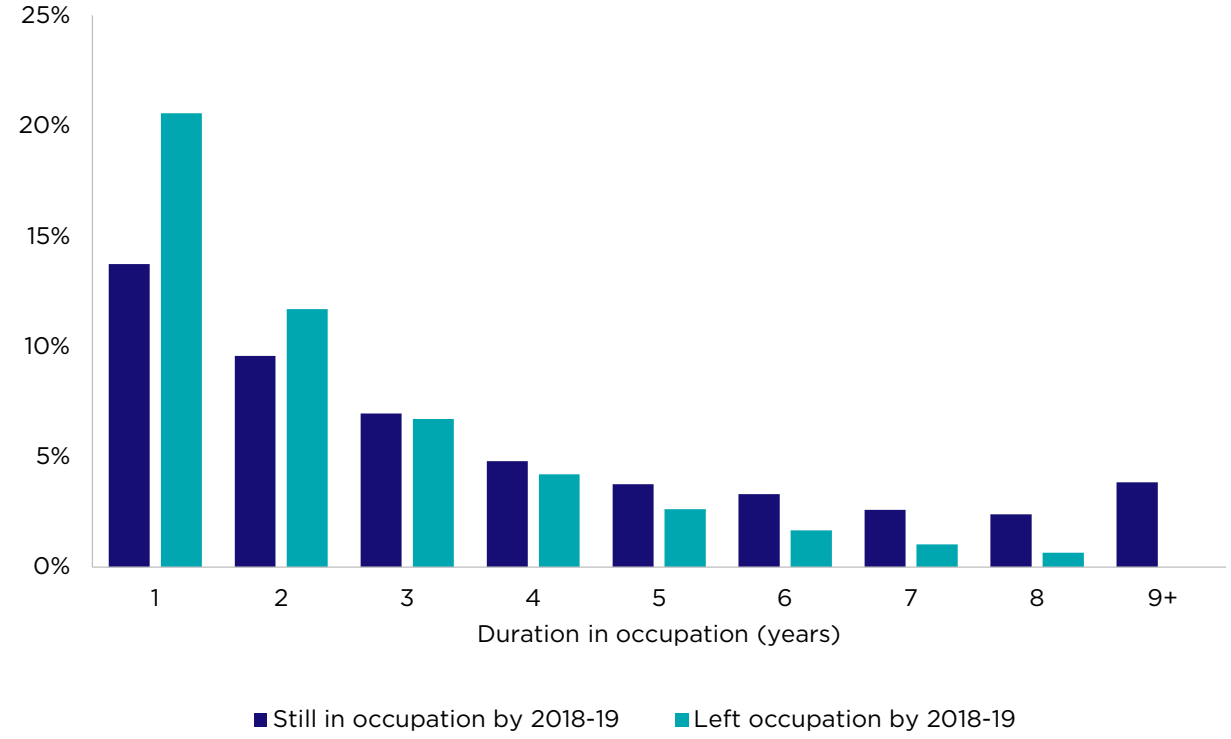
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 237: *Welfare support workers* (all industries), duration in occupation (%), females 45 years and over, 2018-19



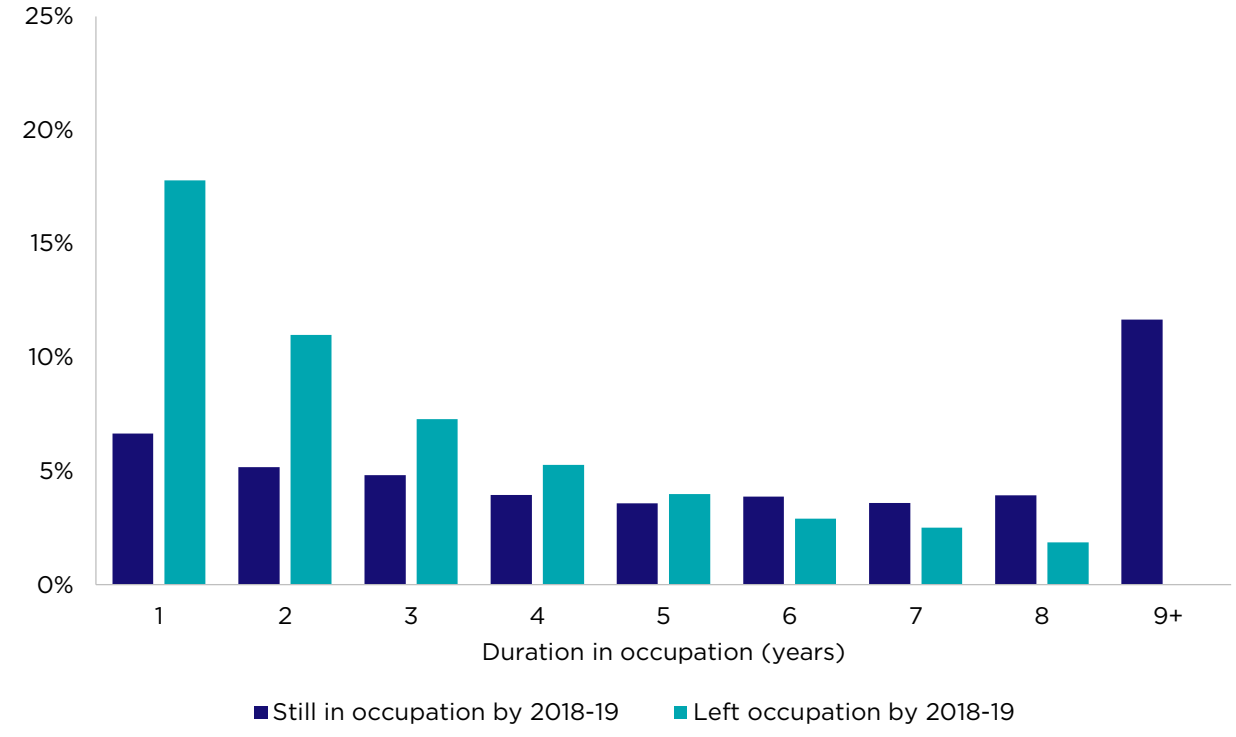
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 238: *Welfare support workers* (all industries), duration in occupation (%), males 44 years and under, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

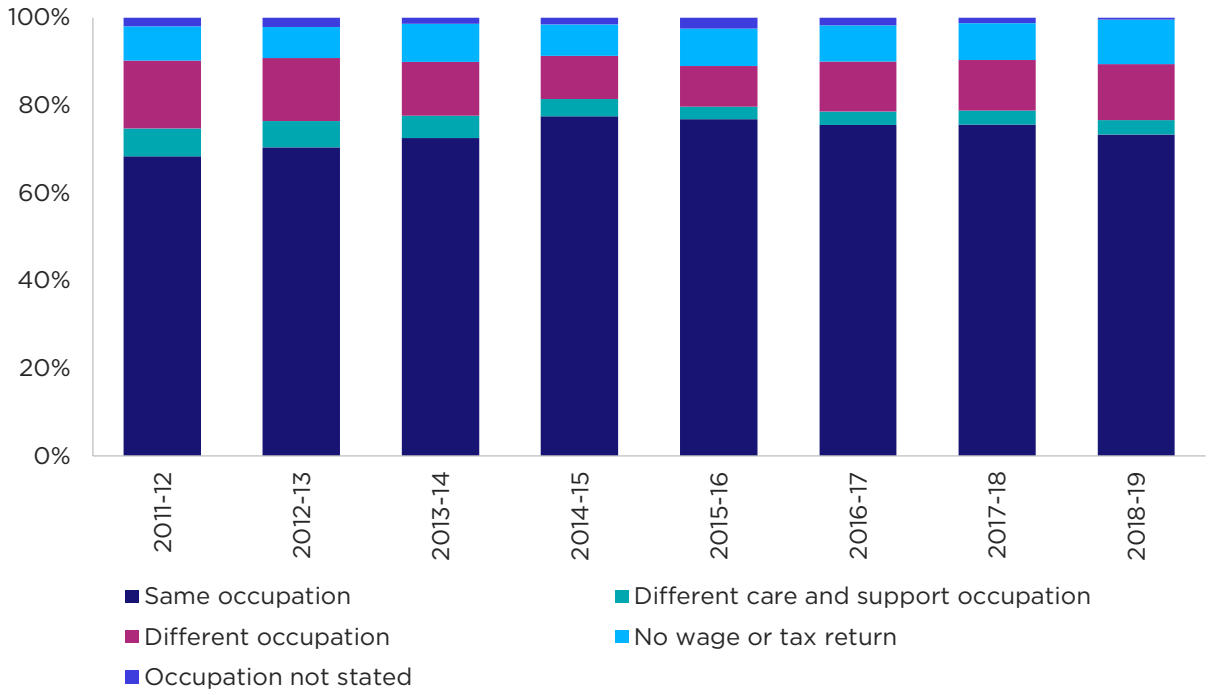
Figure 239: *Welfare support workers* (all industries), duration in occupation (%), males 45 years and older, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

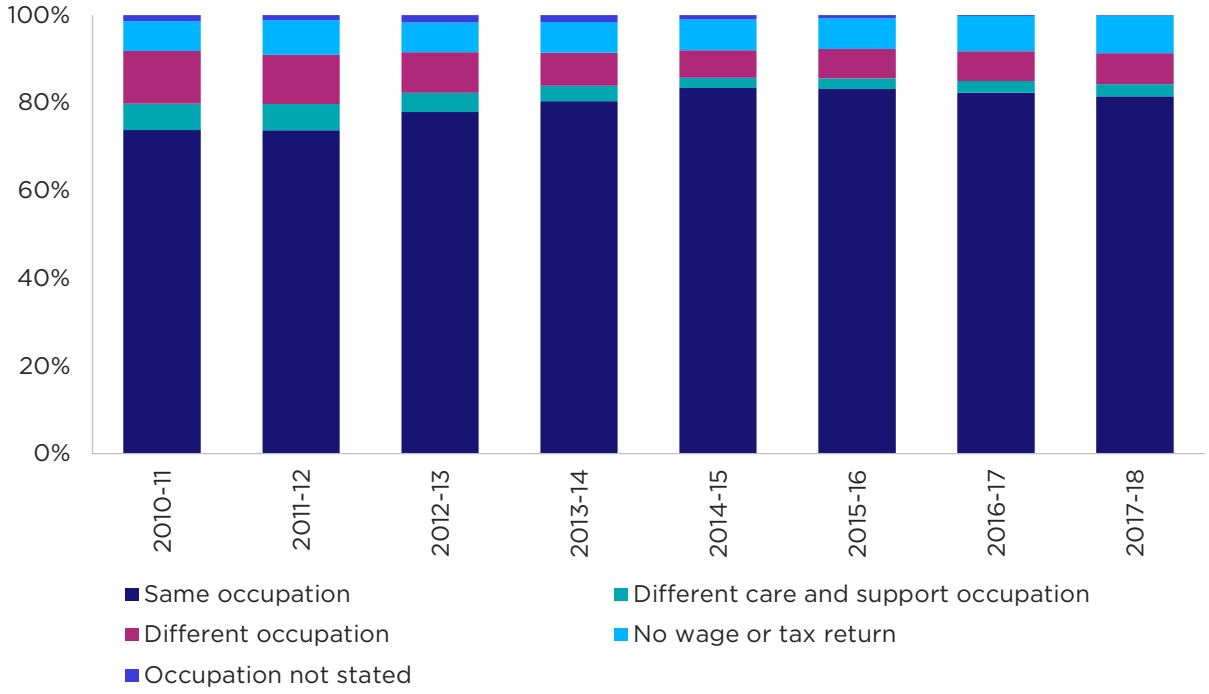
7.5.3.2 Transitions, previous and next occupation, summary – charts

Figure 240: *Welfare support workers* (all industries), transitions from previous occupation (%), 2011-12 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

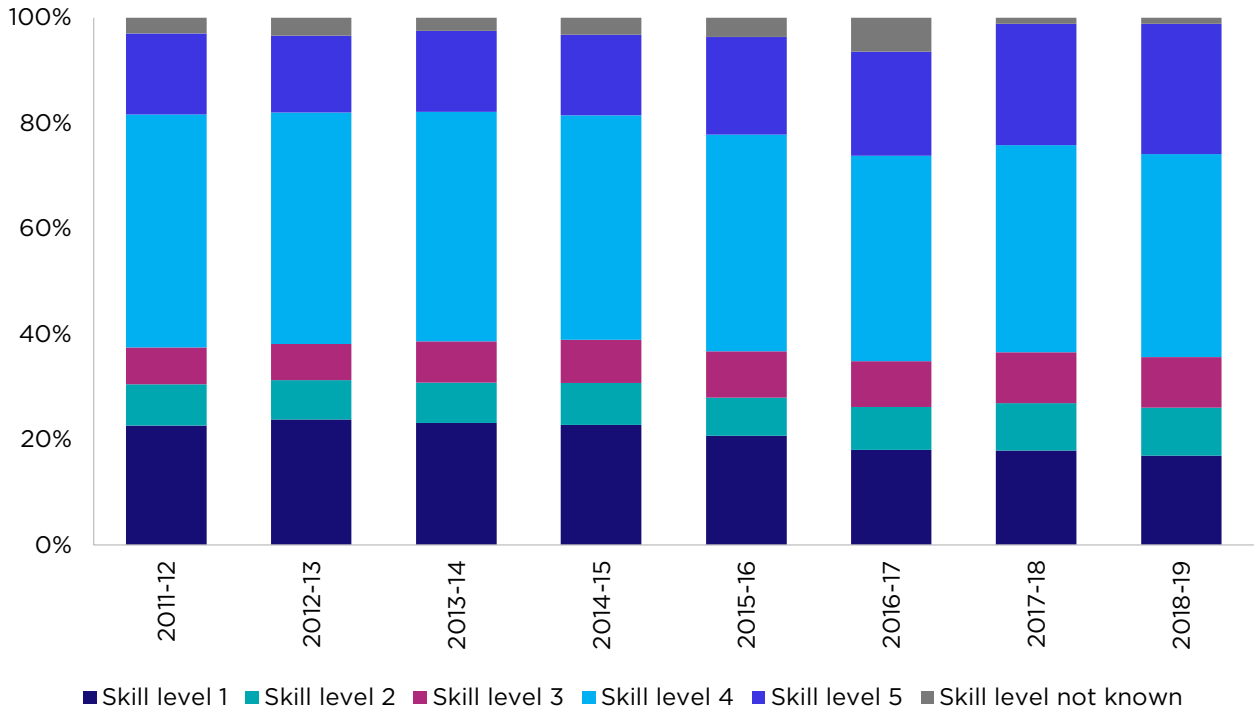
Figure 241: *Welfare support workers* (all industries), transitions to next occupation (%), 2010-11 to 2017-18



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

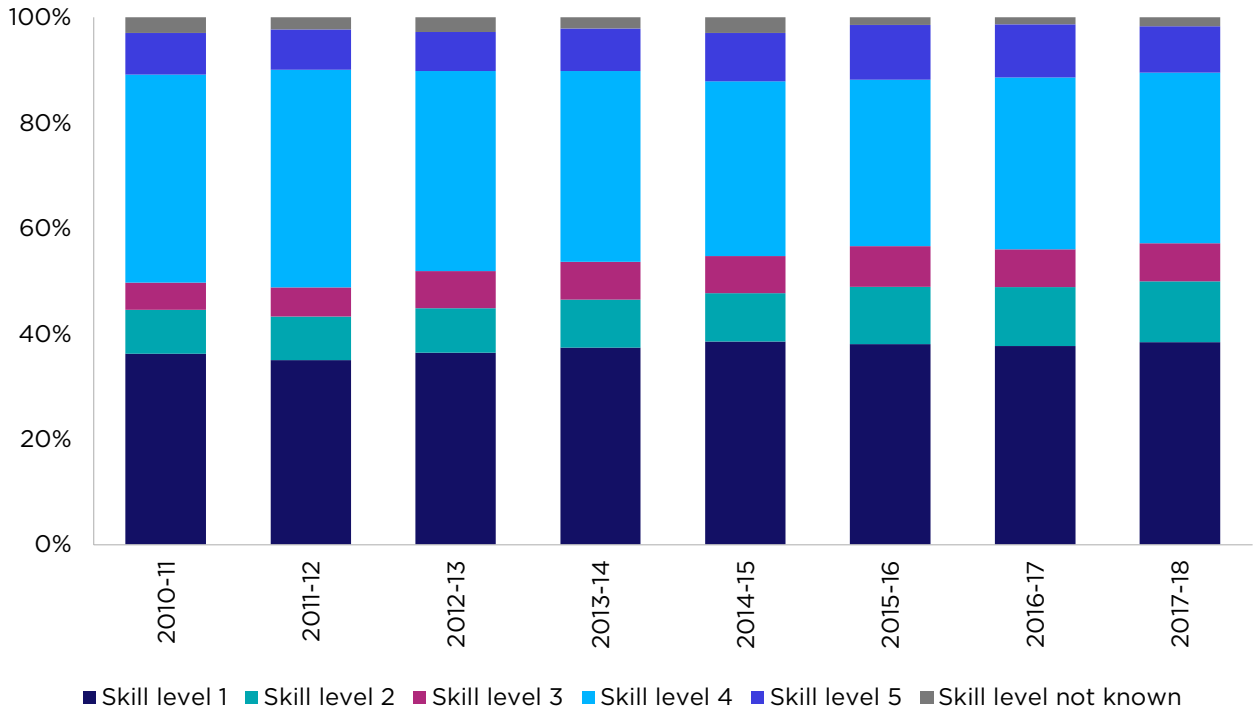
7.5.3.3 Transitions, previous and next occupation, by skill level – charts

Figure 242: *Welfare support workers* (all industries), transitions from previous occupation, by skill level (%), 2011-12 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

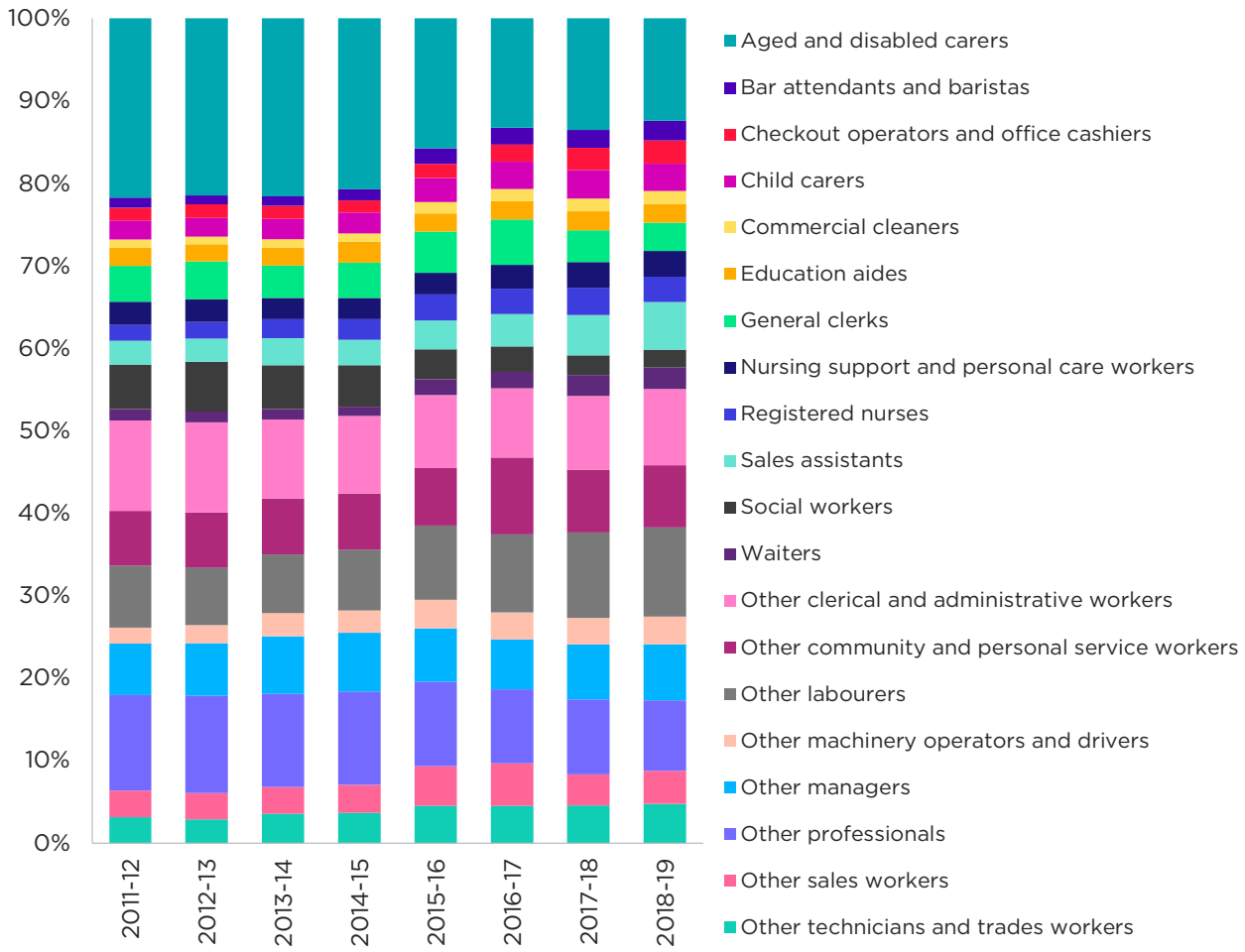
Figure 243: *Welfare support workers* (all industries), transitions to next occupation, by skill level (%), 2010-11 to 2017-18



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

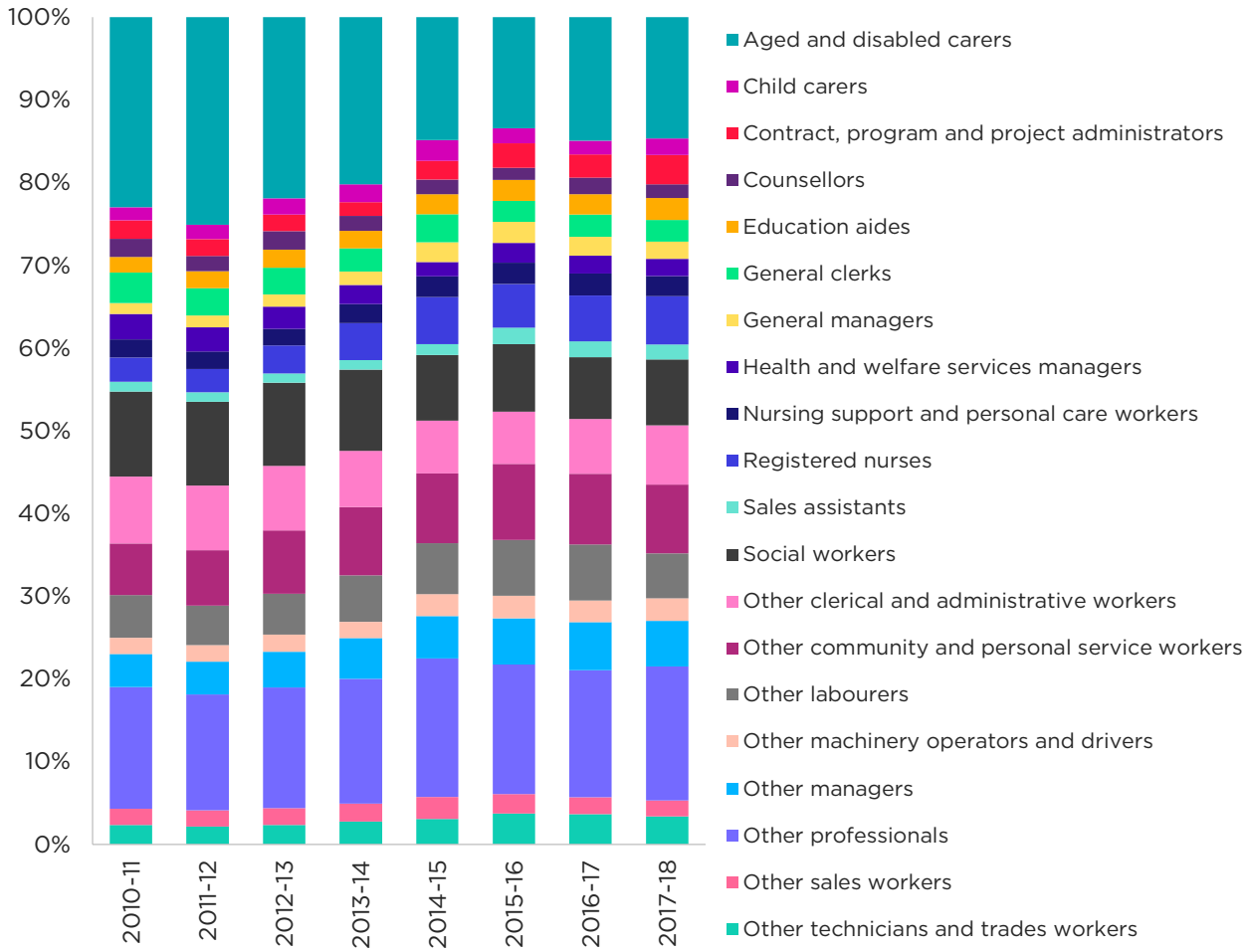
7.5.3.4 Transitions, previous and next occupation, by detailed occupation – charts

Figure 244: *Welfare support workers* (all industries), previous occupation (%), 2011-12 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Excludes people working in the same occupation and those with no tax return submitted.

Figure 245: *Welfare support workers* (all industries), next occupation (%), 2010-11 to 2017-18

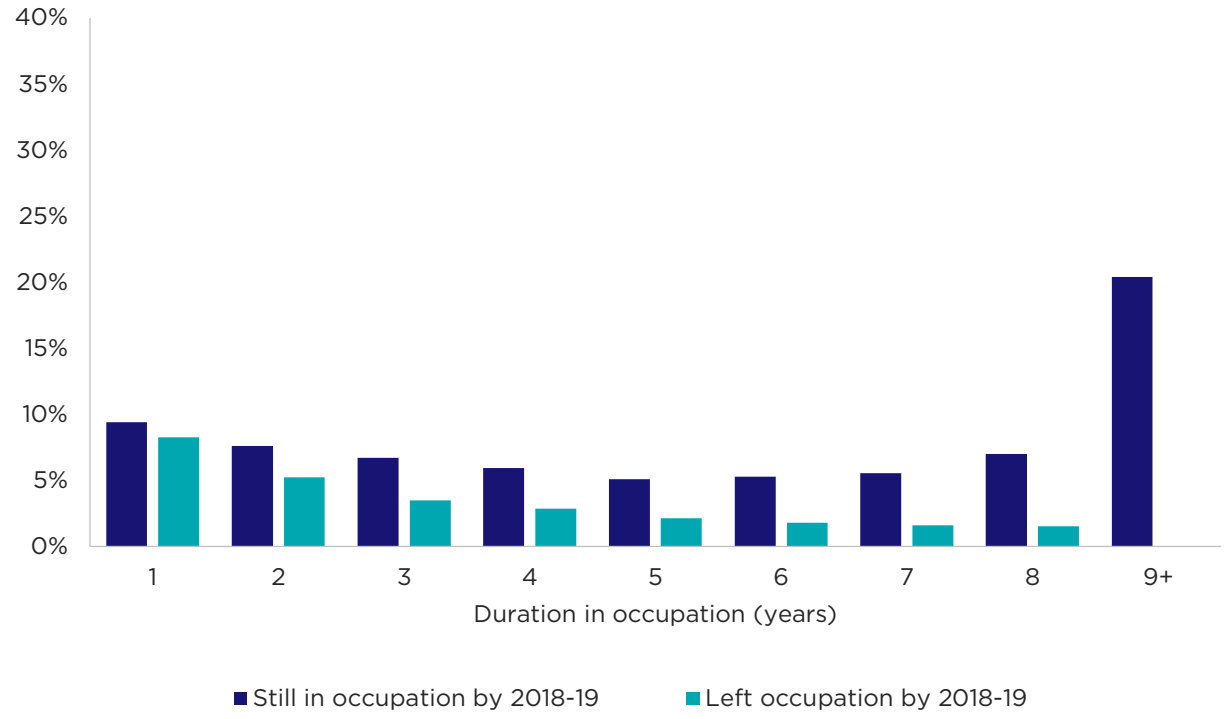


Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Excludes people working in the same occupation and those with no tax return submitted.

7.5.4 *Registered nurses* – charts

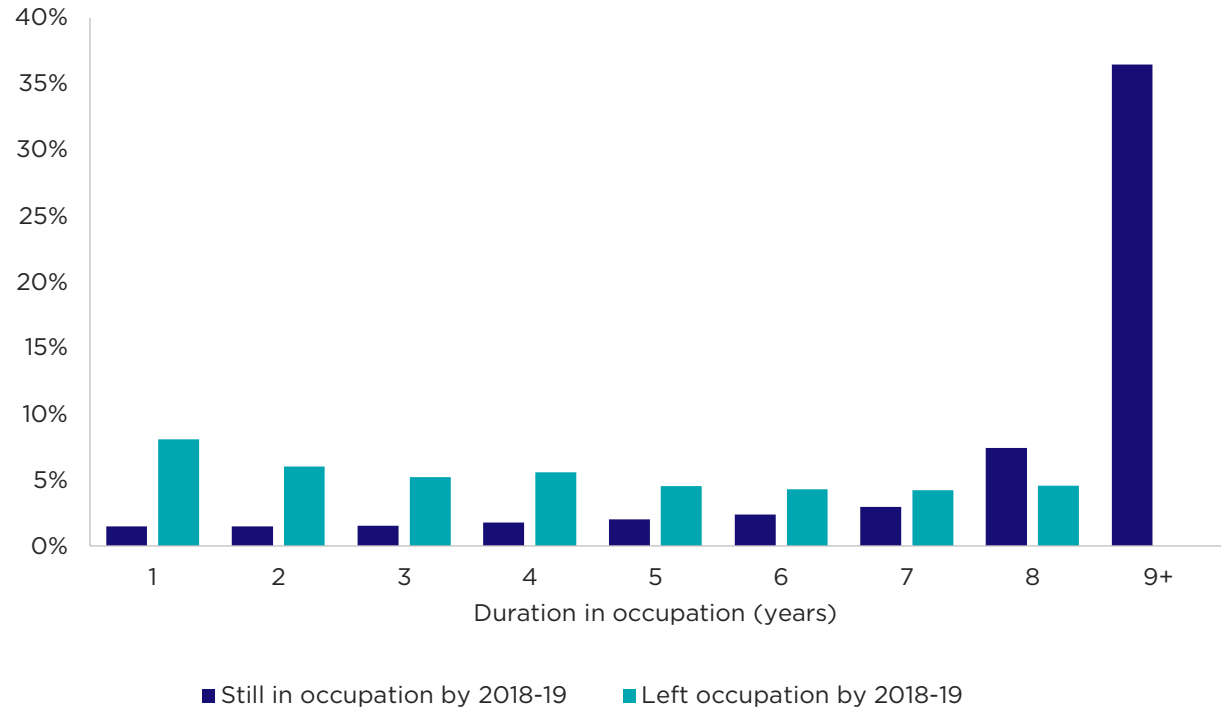
7.5.4.1 Duration in occupation – charts

Figure 246: *Registered nurses* (all industries), duration in occupation (%), females 44 years and under, 2018-19



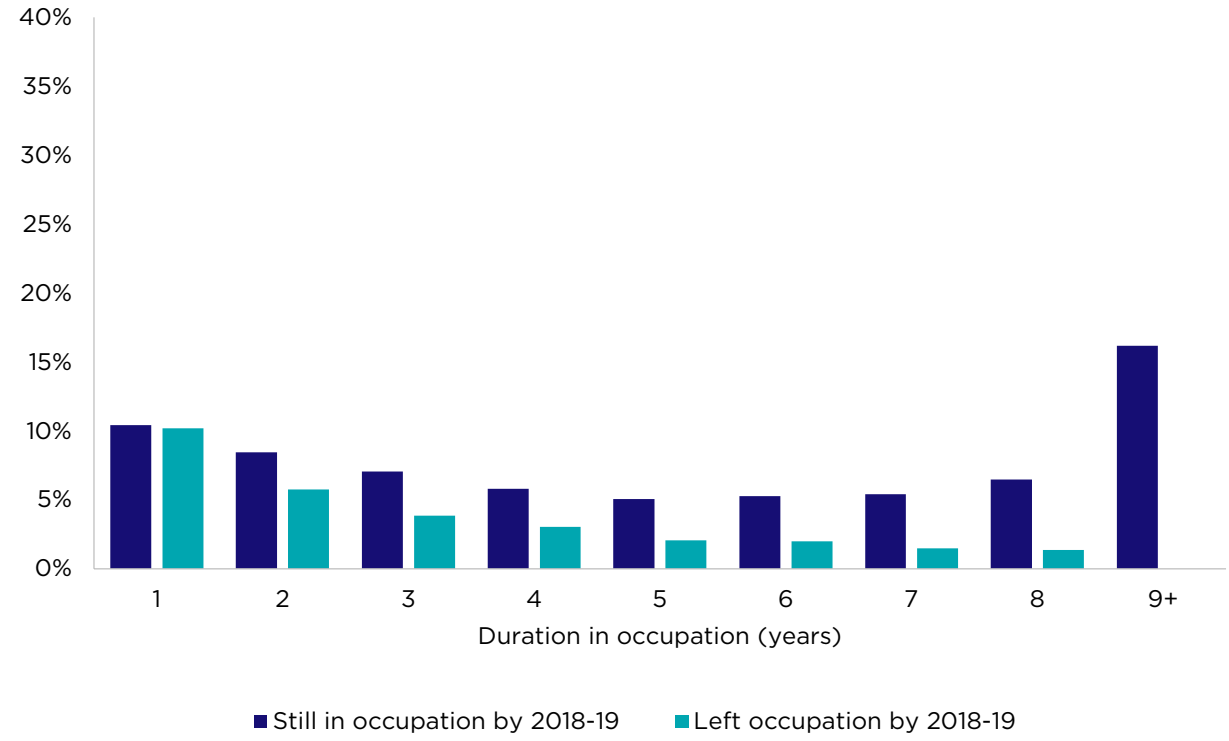
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 247: *Registered nurses* (all industries), duration in occupation (%), females 45 years and over, 2018-19



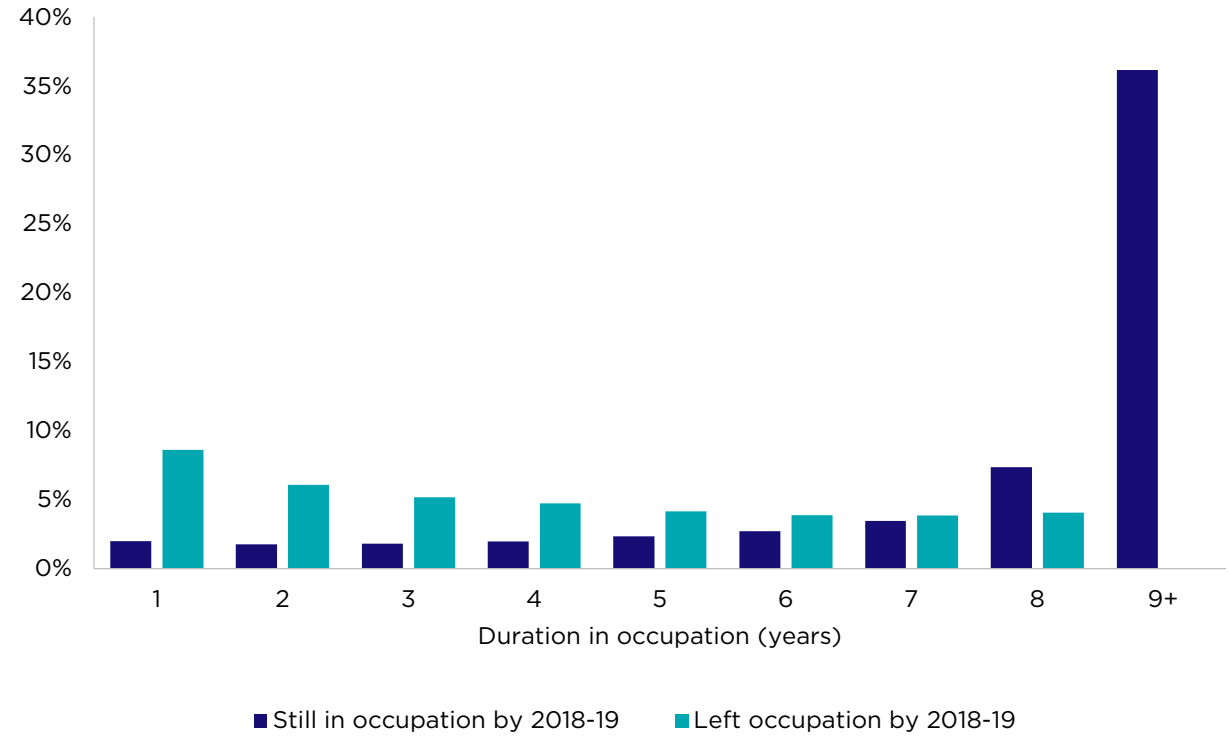
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 248: *Registered nurses* (all industries), duration in occupation (%), males 44 years and under, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

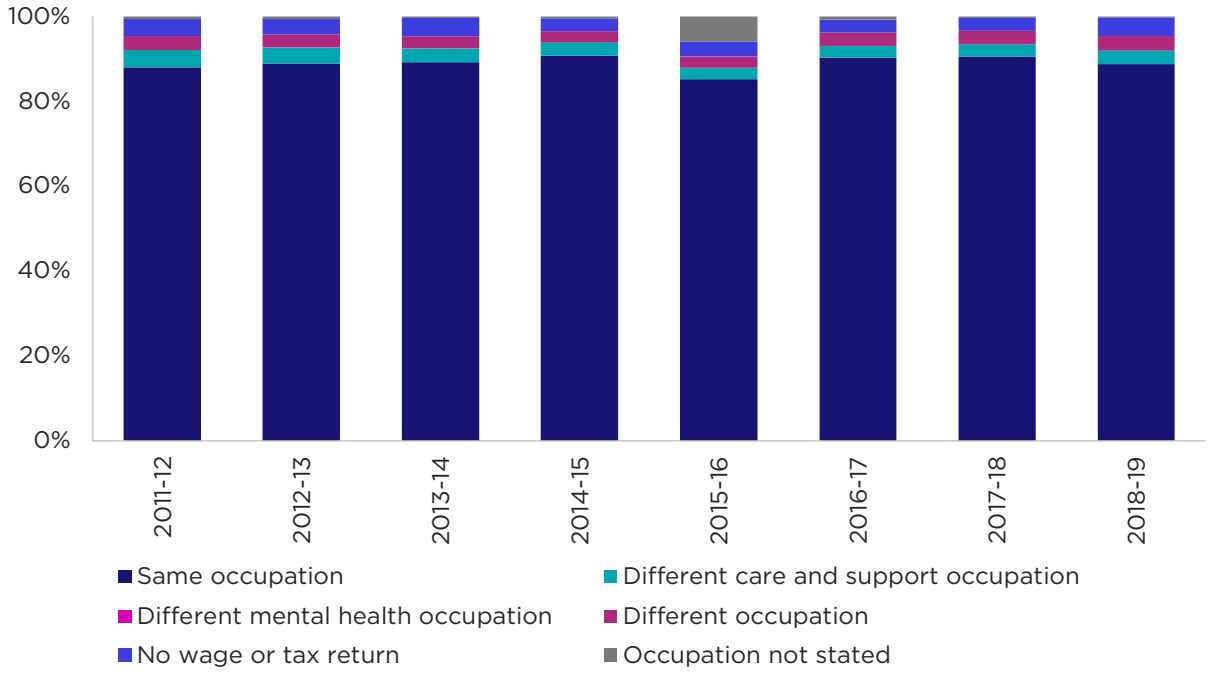
Figure 249: *Registered nurses* (all industries), duration in occupation (%), males 45 years and over, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

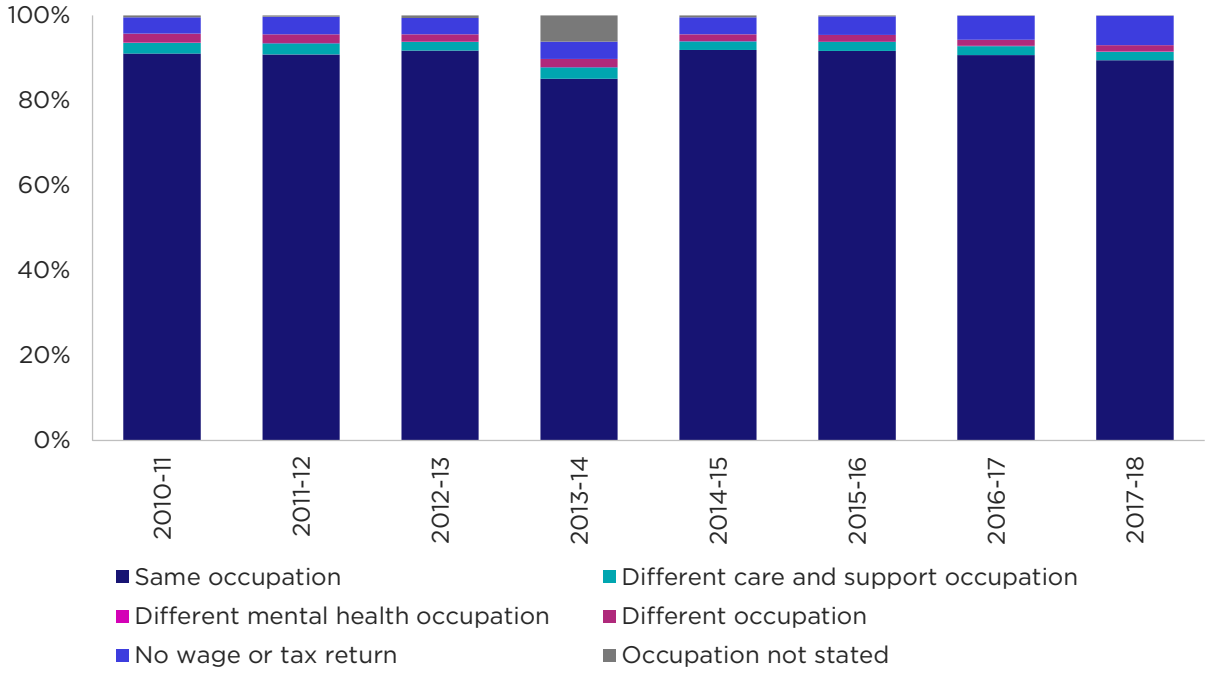
7.5.4.2 Transitions, previous and next occupation, summary – charts

Figure 250: *Registered nurses* (all industries), transitions from previous occupation (%), 2011-12 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

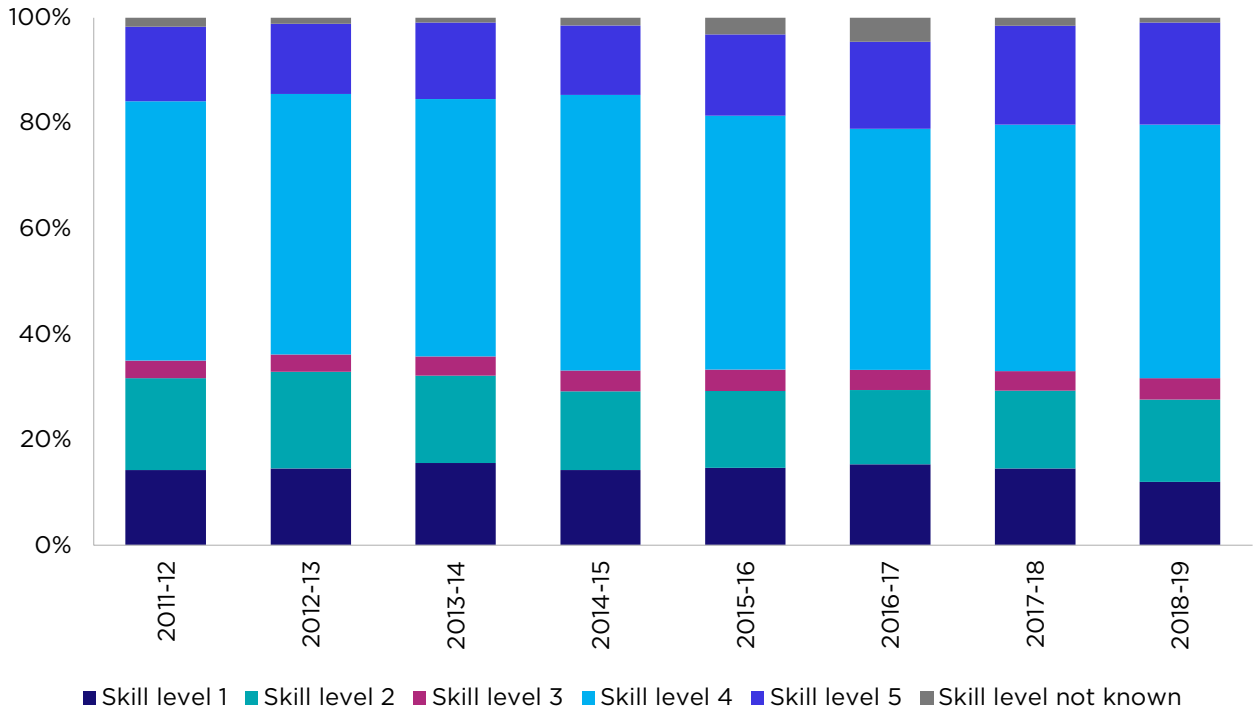
Figure 251: *Registered nurses* (all industries), transitions to next occupation (%), 2010-11 to 2017-18



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

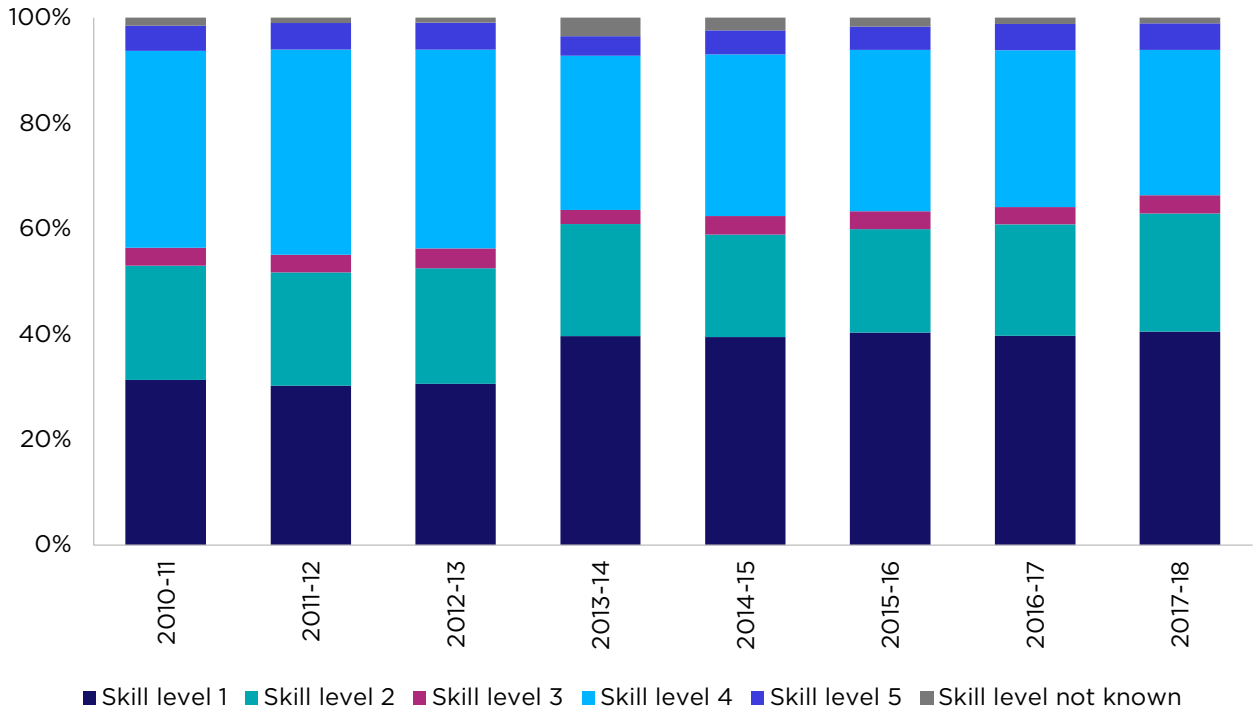
7.5.4.3 Transitions, previous and next occupation, by skill level – charts

Figure 252: *Registered nurses* (all industries), transitions from previous occupation, by skill level (%), 2011-12 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

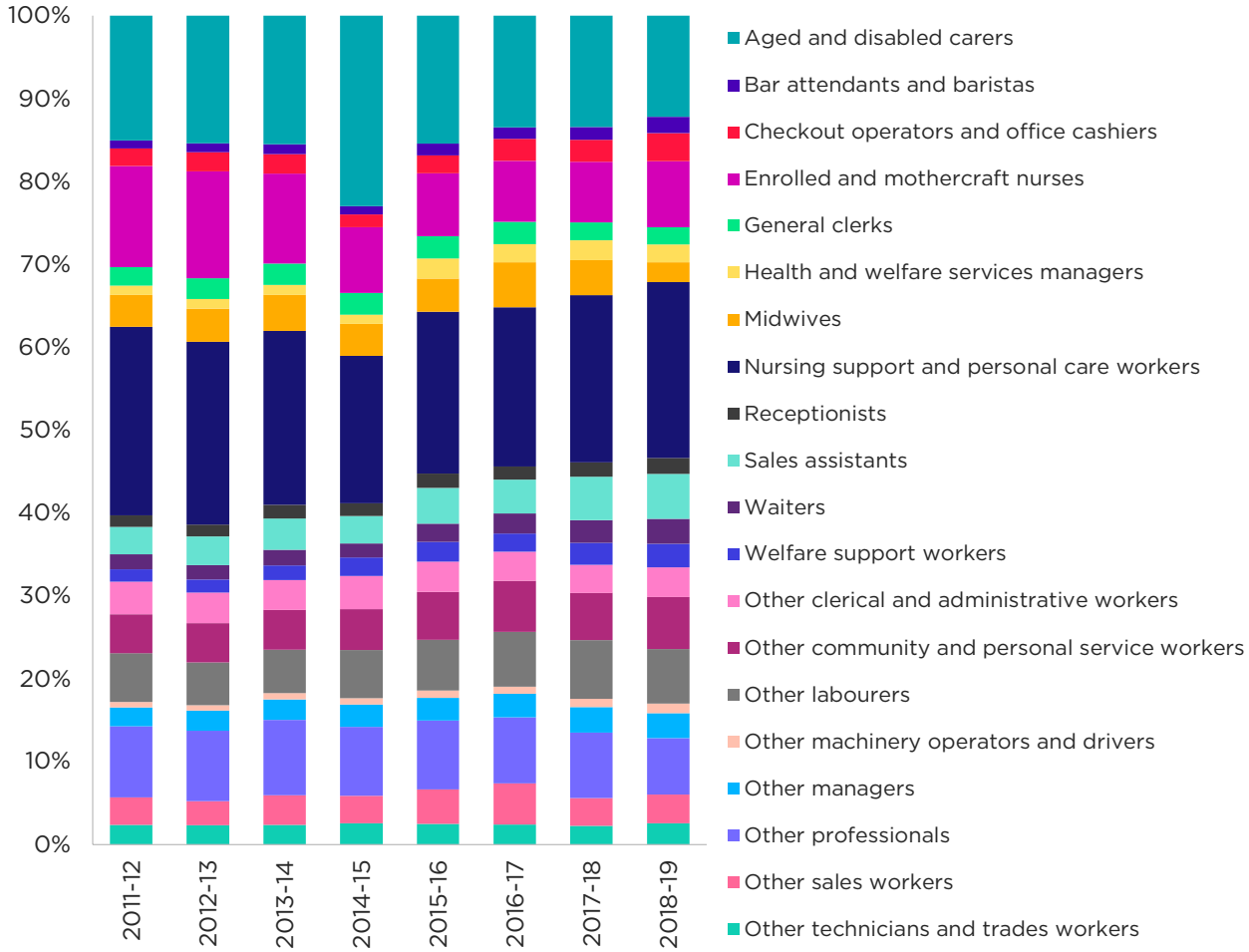
Figure 253: *Registered nurses* (all industries), transitions to next occupation, by skill level (%), 2010-11 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

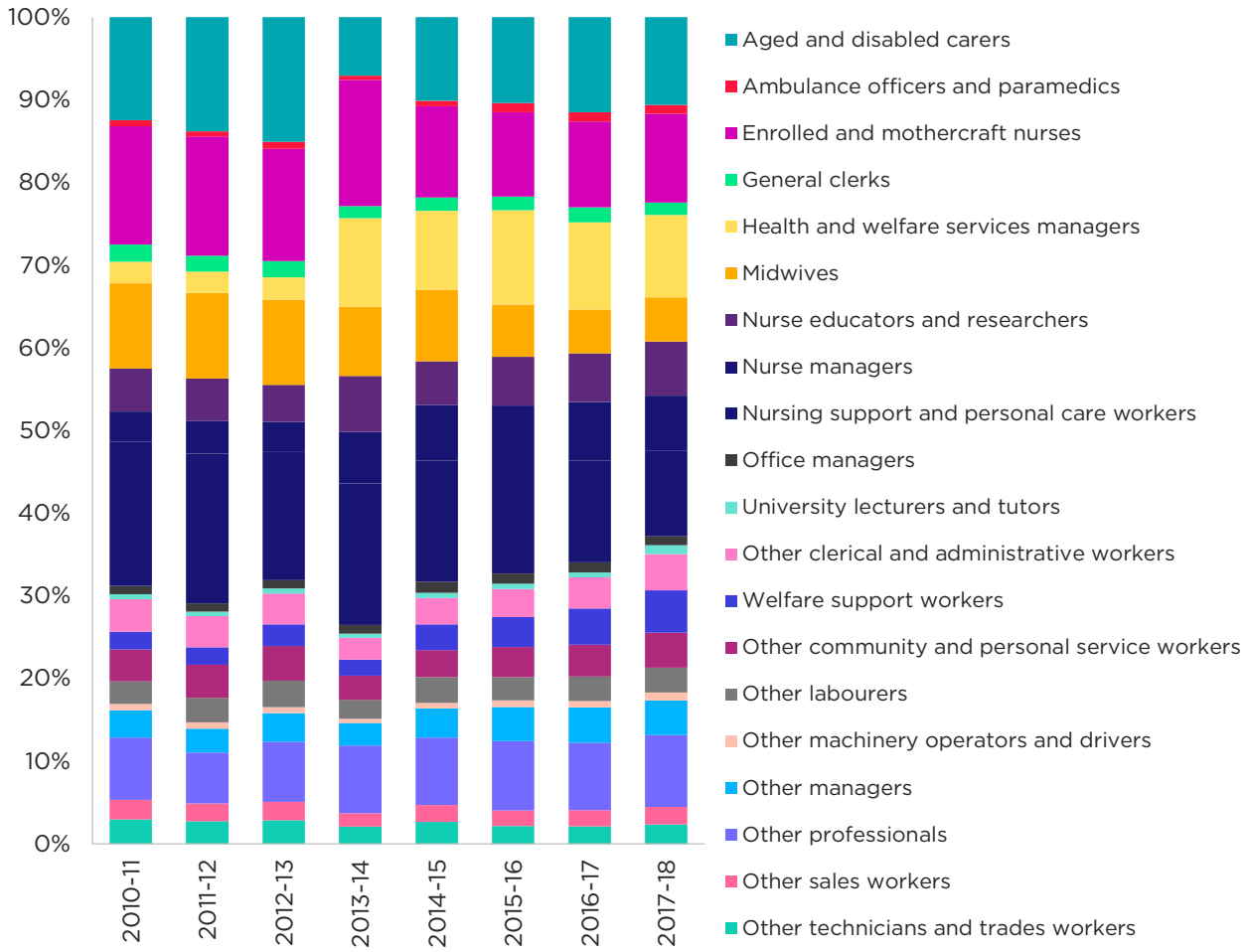
7.5.4.4 Transitions, previous and next occupation, by detailed occupation – charts

Figure 254: *Registered nurses* (all industries), previous occupation (%), 2011-12 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Excludes people working in the same occupation and those with no tax return submitted.

Figure 255: *Registered nurses* (all industries), next occupation (%), 2010-11 to 2017-18

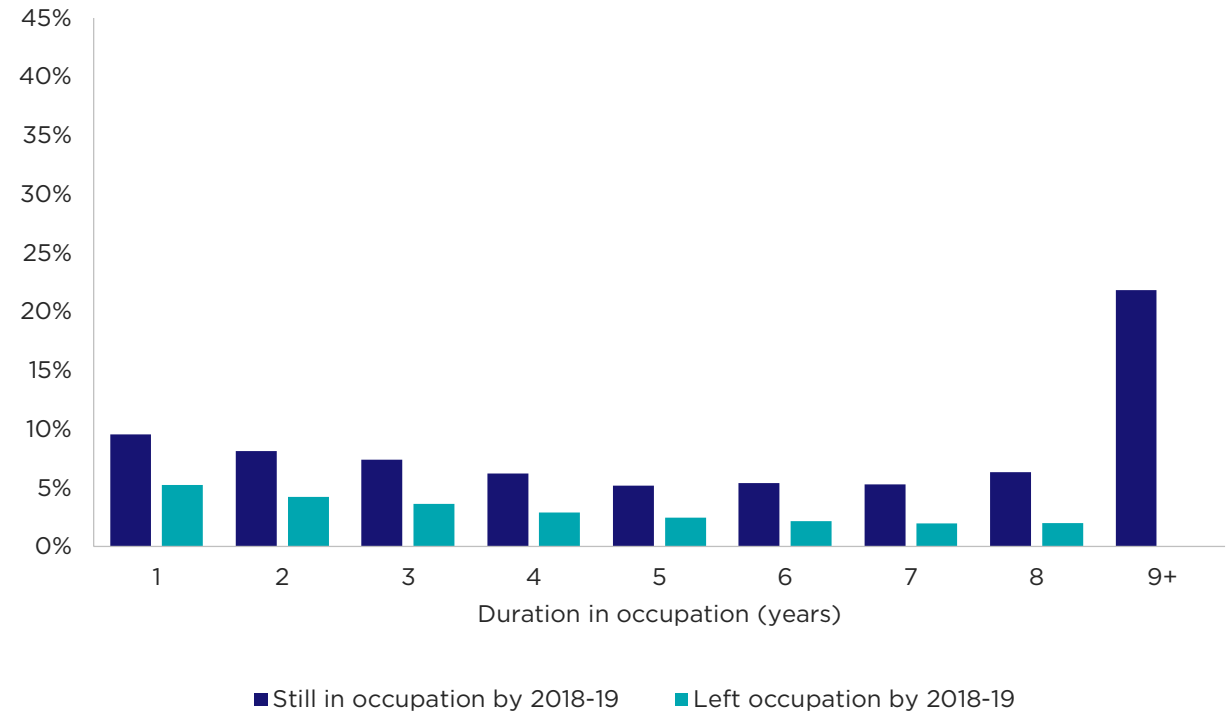


Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Excludes people working in the same occupation and those with no tax return submitted.

7.5.5 Allied health professionals – charts

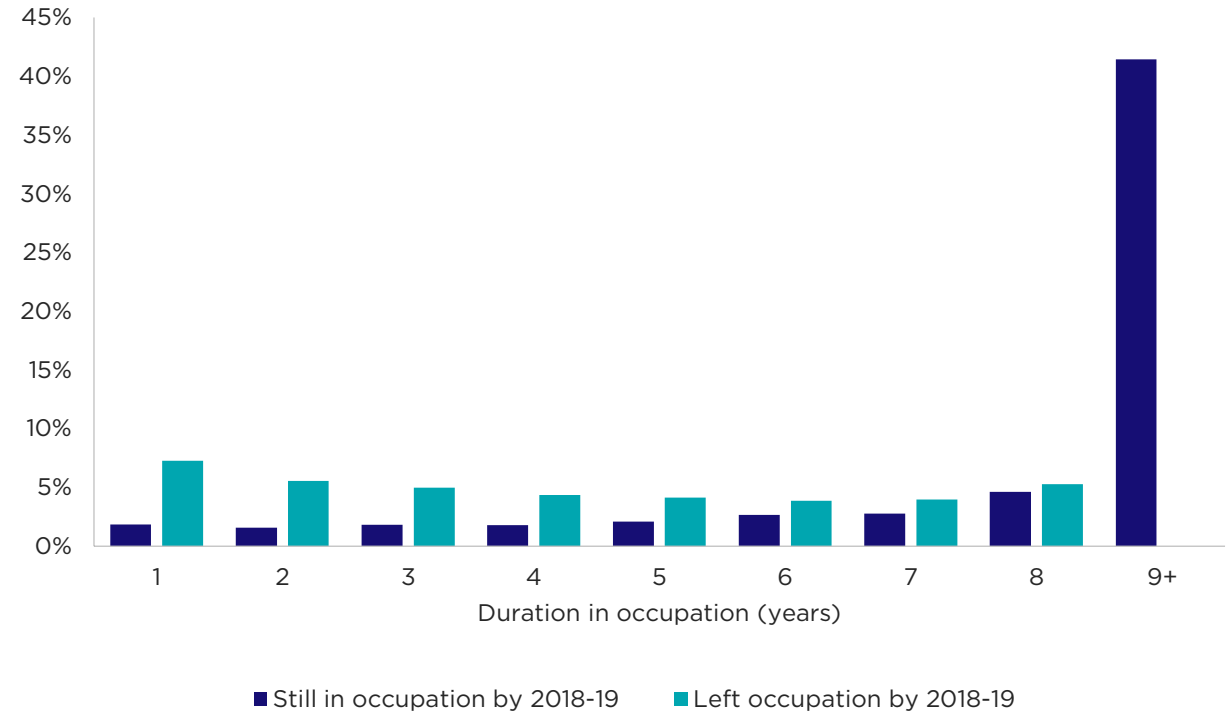
7.5.5.1 Duration in occupation – charts

Figure 256: Allied health professionals (all industries), duration in occupation (%), females 44 years and under, 2018-19



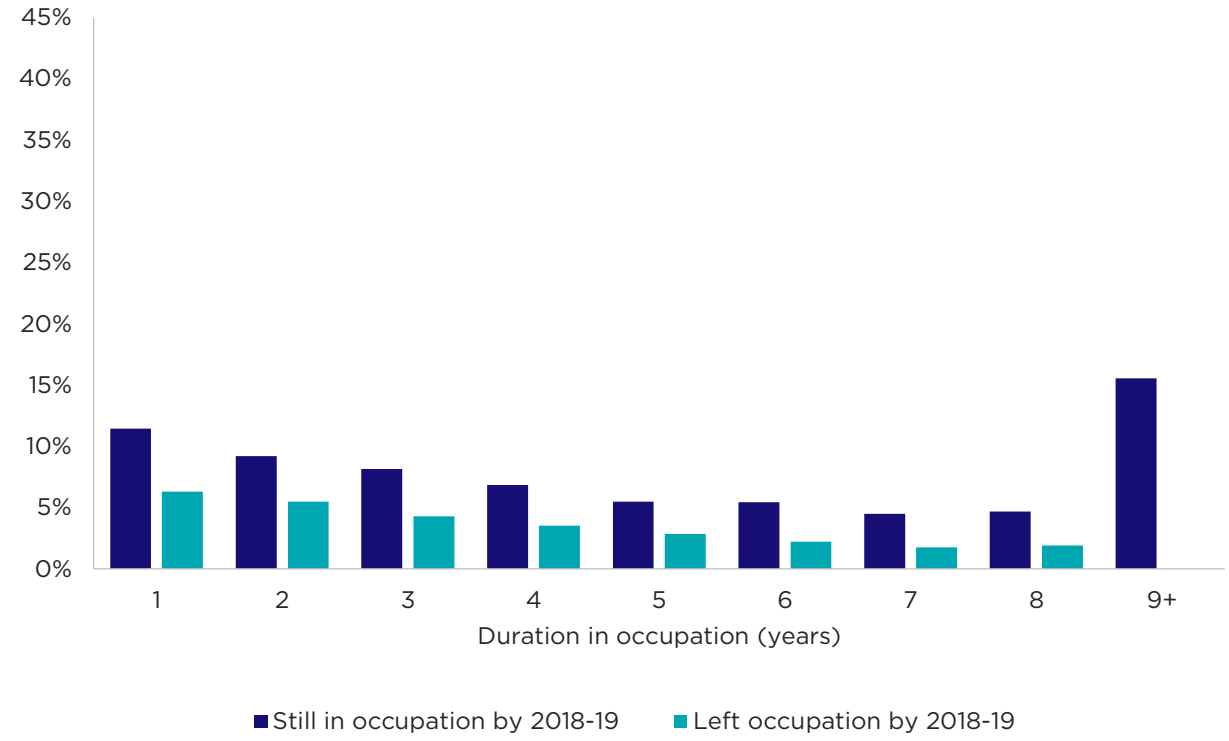
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 257: Allied health professionals (all industries), duration in occupation (%), females 45 years and over, 2018-19



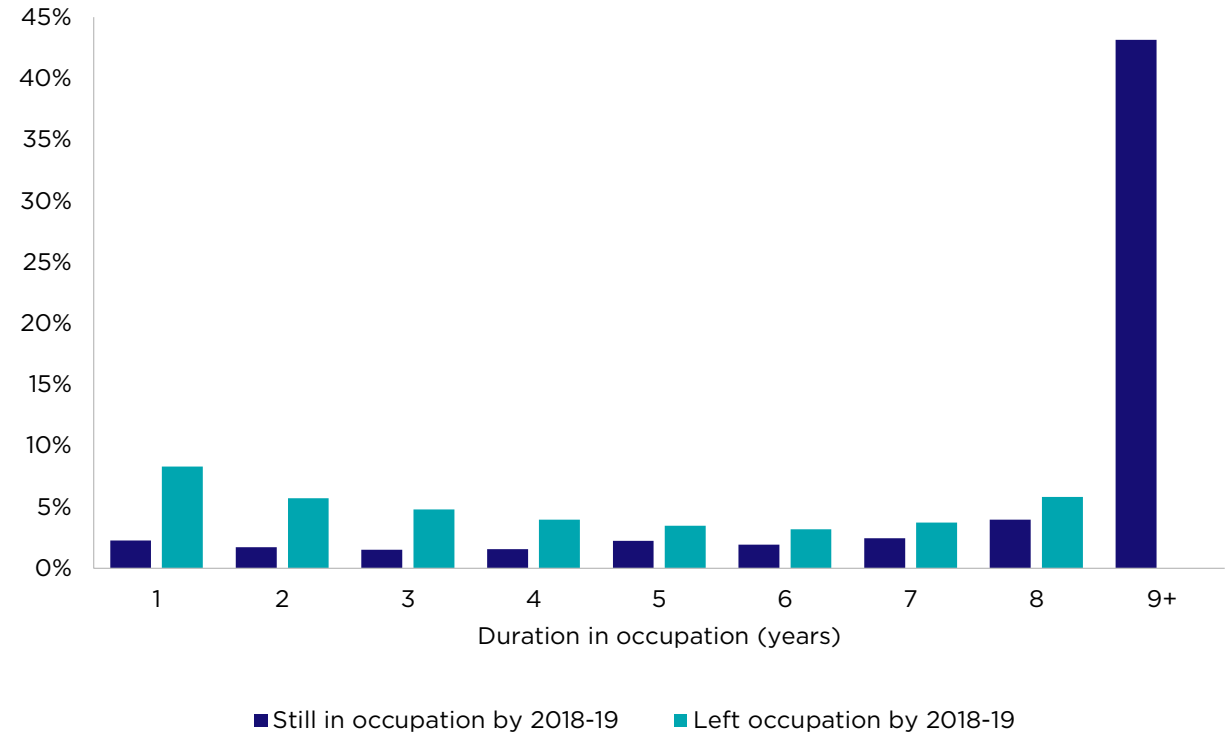
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 258: Allied health professionals (all industries), duration in occupation (%), males 44 years and under, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 259: Allied health professionals (all industries), duration in occupation (%), males 45 years and over, 2018-19

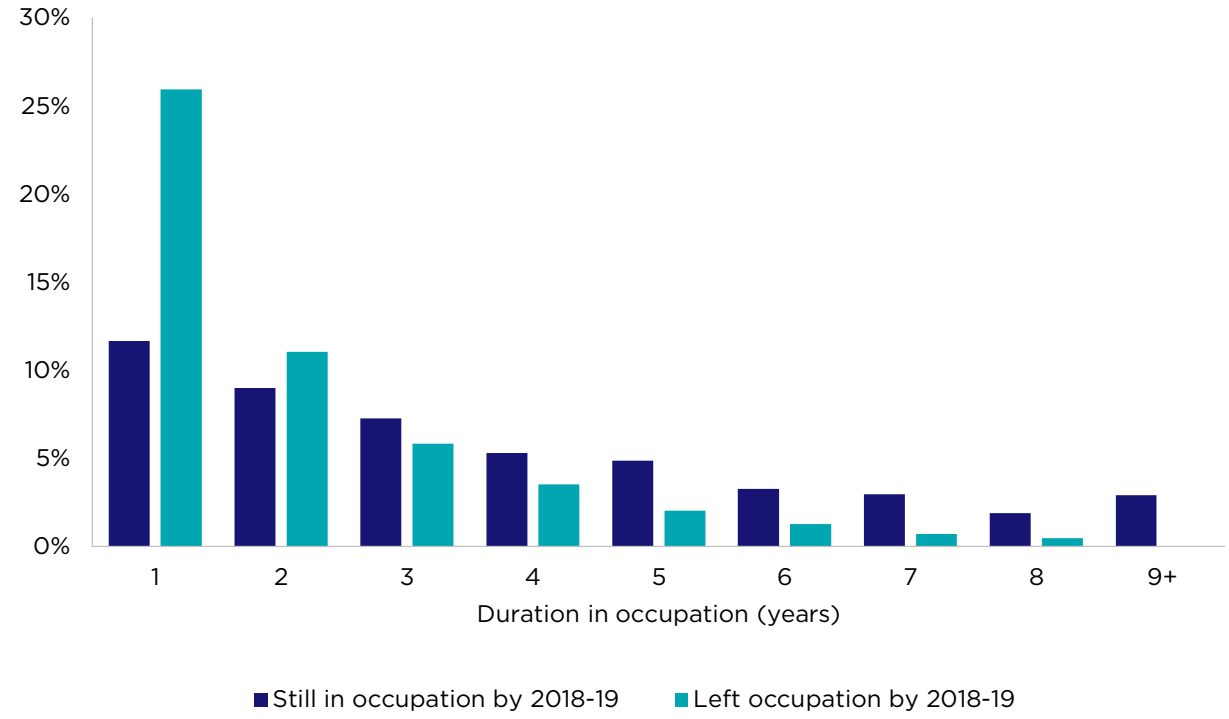


Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

7.5.6 *Health and welfare services managers* - charts

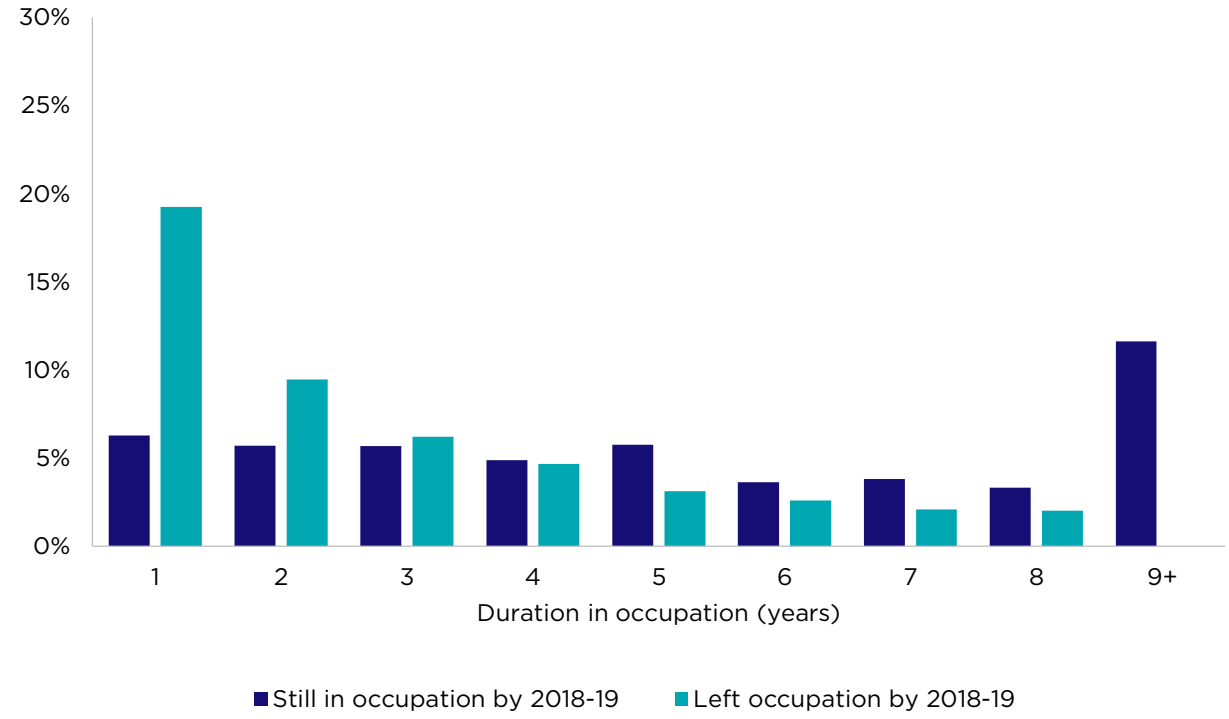
7.5.6.1 Duration in occupation – charts

Figure 260: Health and welfare services managers (all industries), duration in occupation (%), females 44 years and under, 2018-19



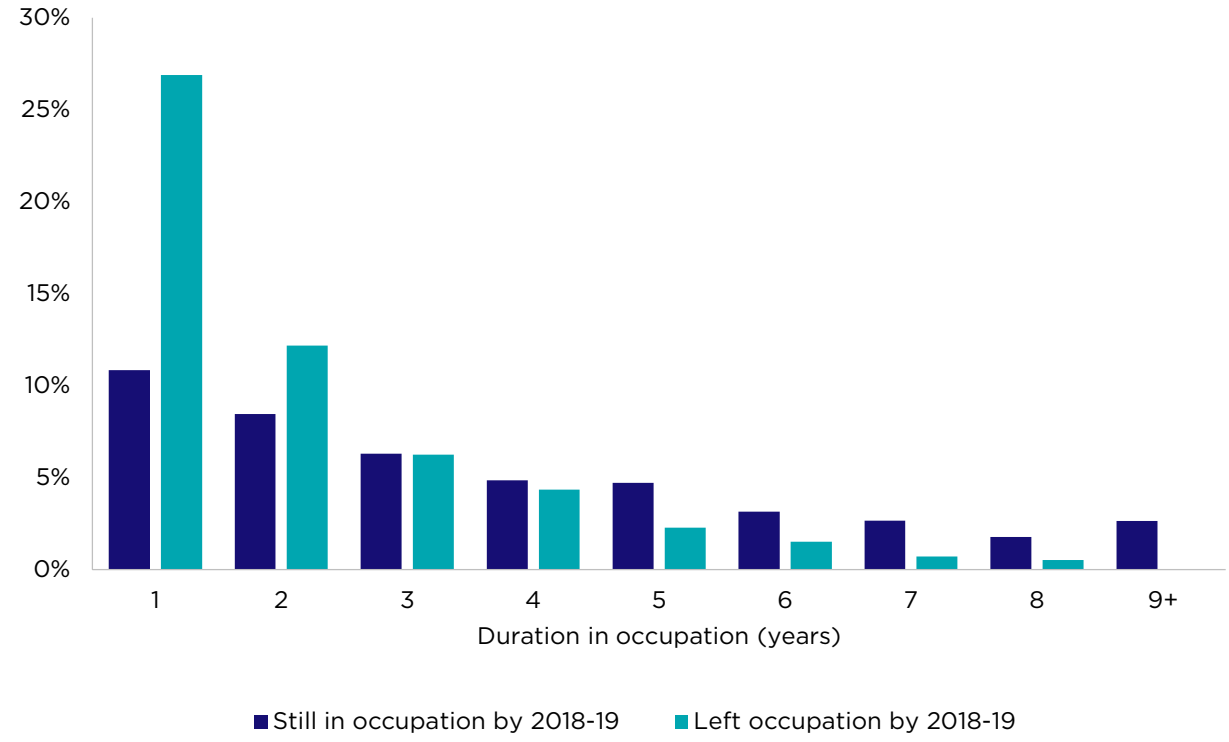
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 261: Health and welfare services managers (all industries), duration in occupation (%), females 45 years and over, 2018-19



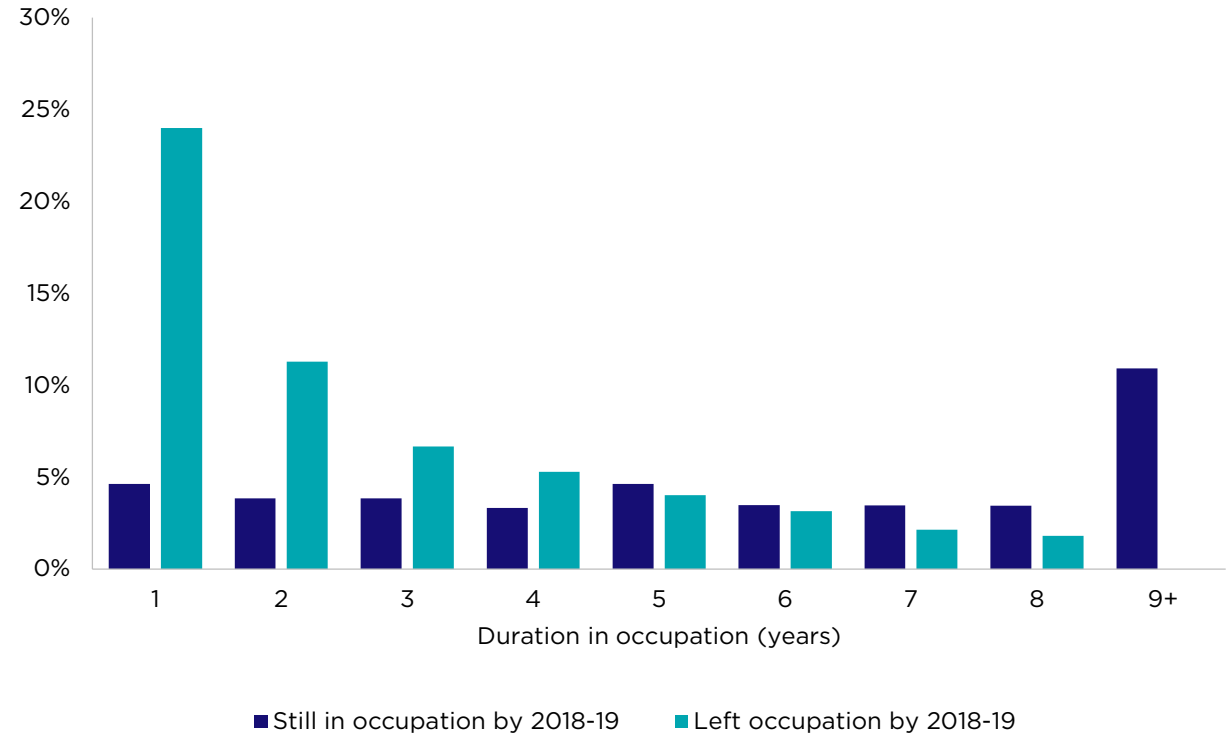
Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

Figure 262: Health and welfare services managers (all industries), duration in occupation (%), males 44 years and under, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

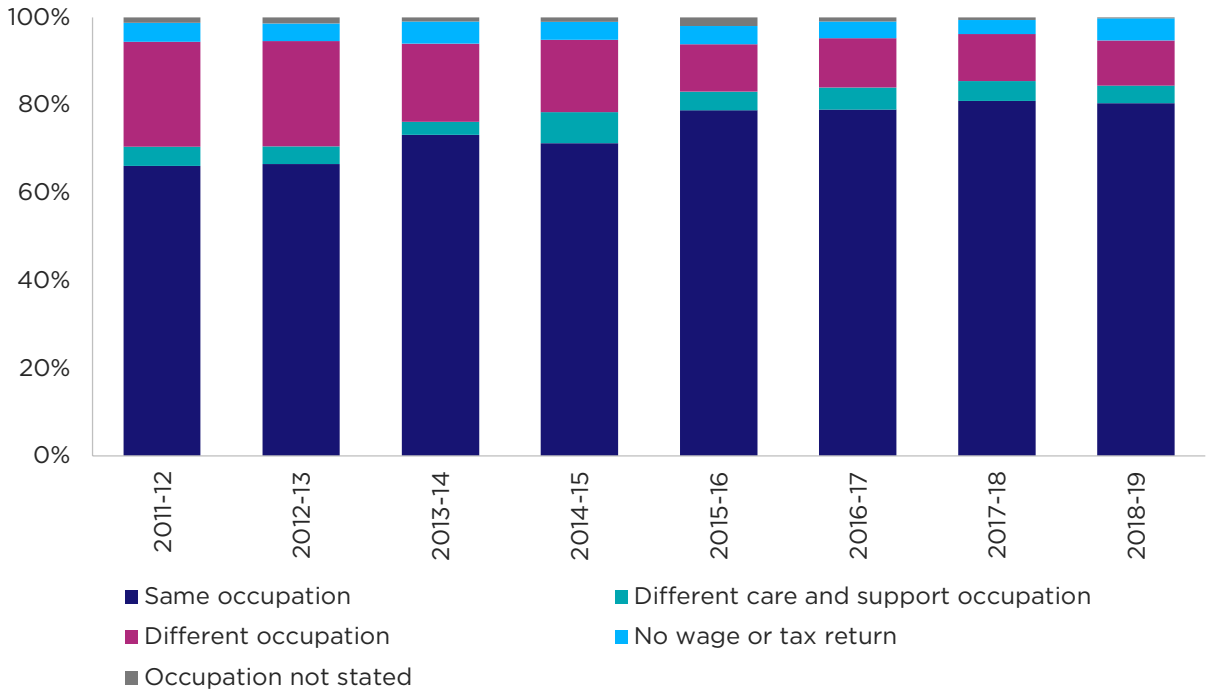
Figure 263: Health and welfare services managers (all industries), duration in occupation (%), males 45 years and over, 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

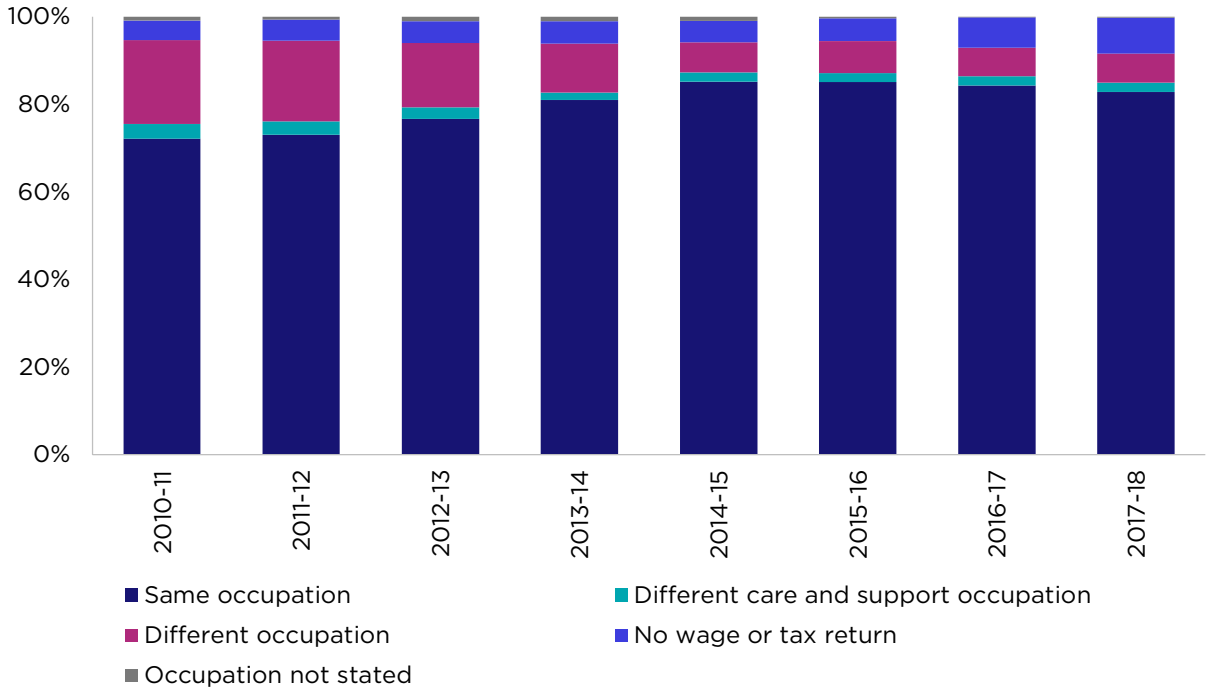
7.5.6.2 Transitions, previous and next occupation, summary – charts

Figure 264: *Health and welfare services managers* (all industries), transitions from previous occupation (%), 2011-12 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

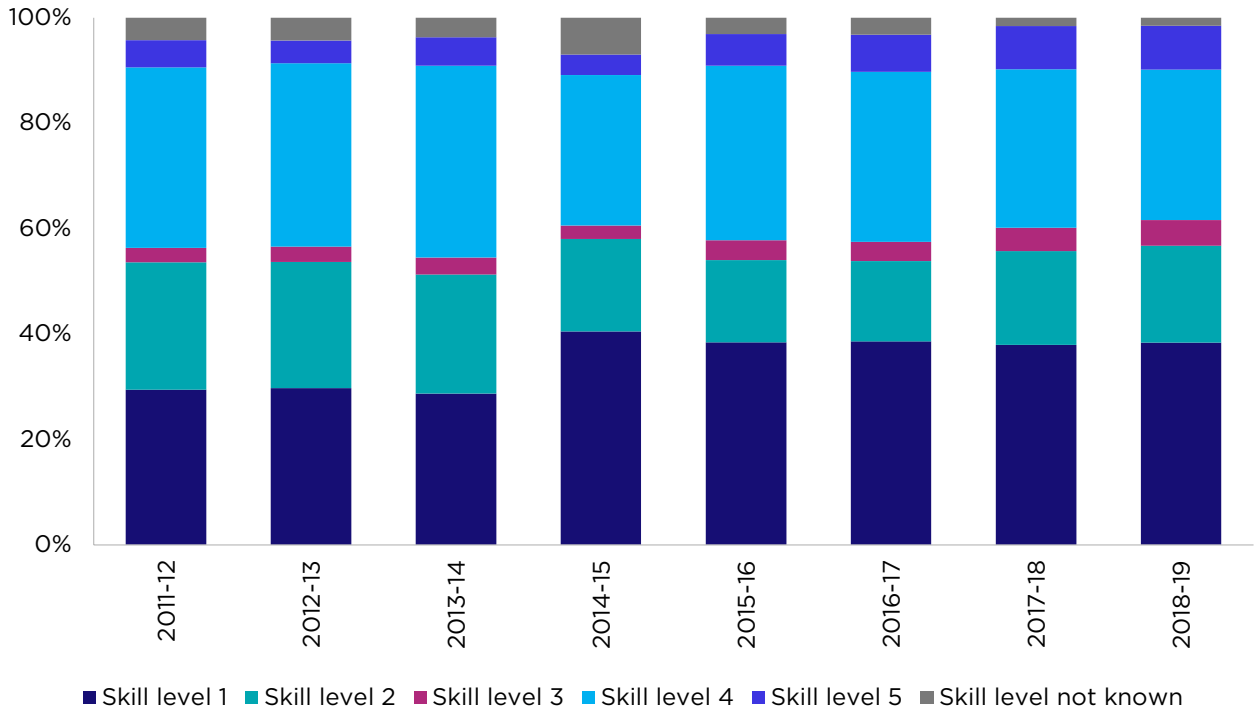
Figure 265: *Health and welfare services managers* (all industries), transitions to next occupation (%), 2010-11 to 2017-18



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

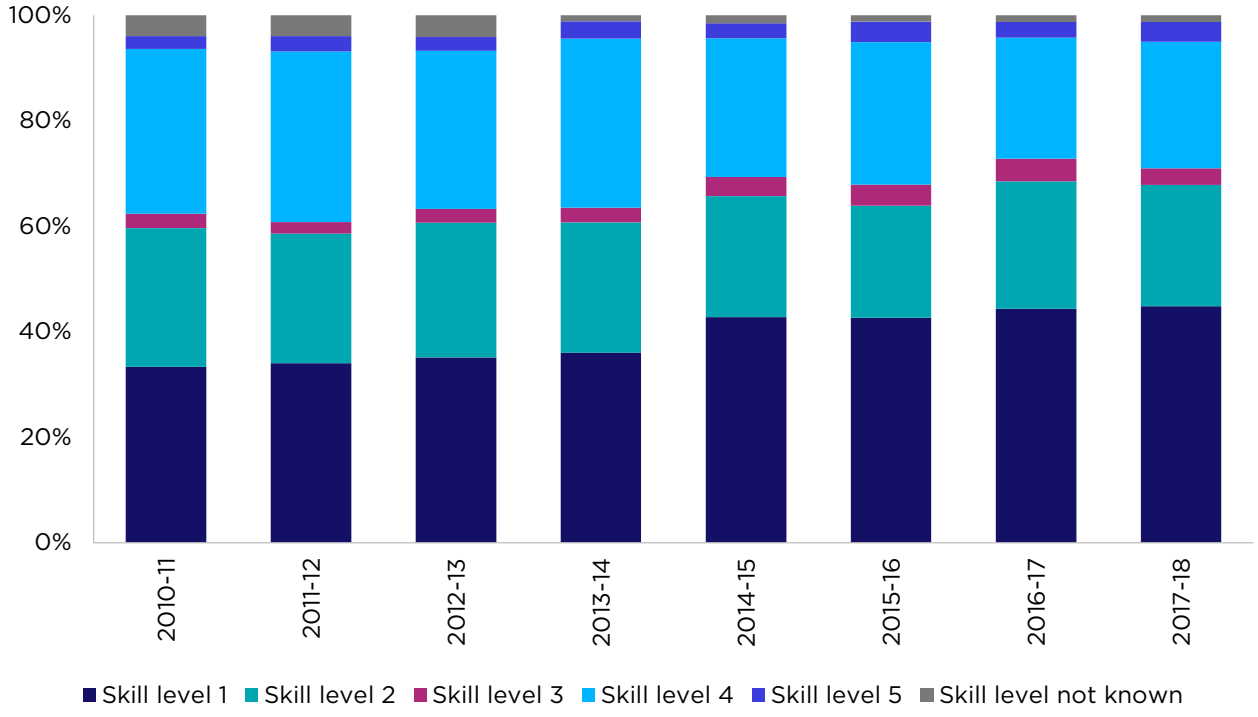
7.5.6.3 Transitions, previous and next occupation, by skill level – charts

Figure 266: *Health and welfare services managers* (all industries), transitions from previous occupation, by skill level (%), 2011-12 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

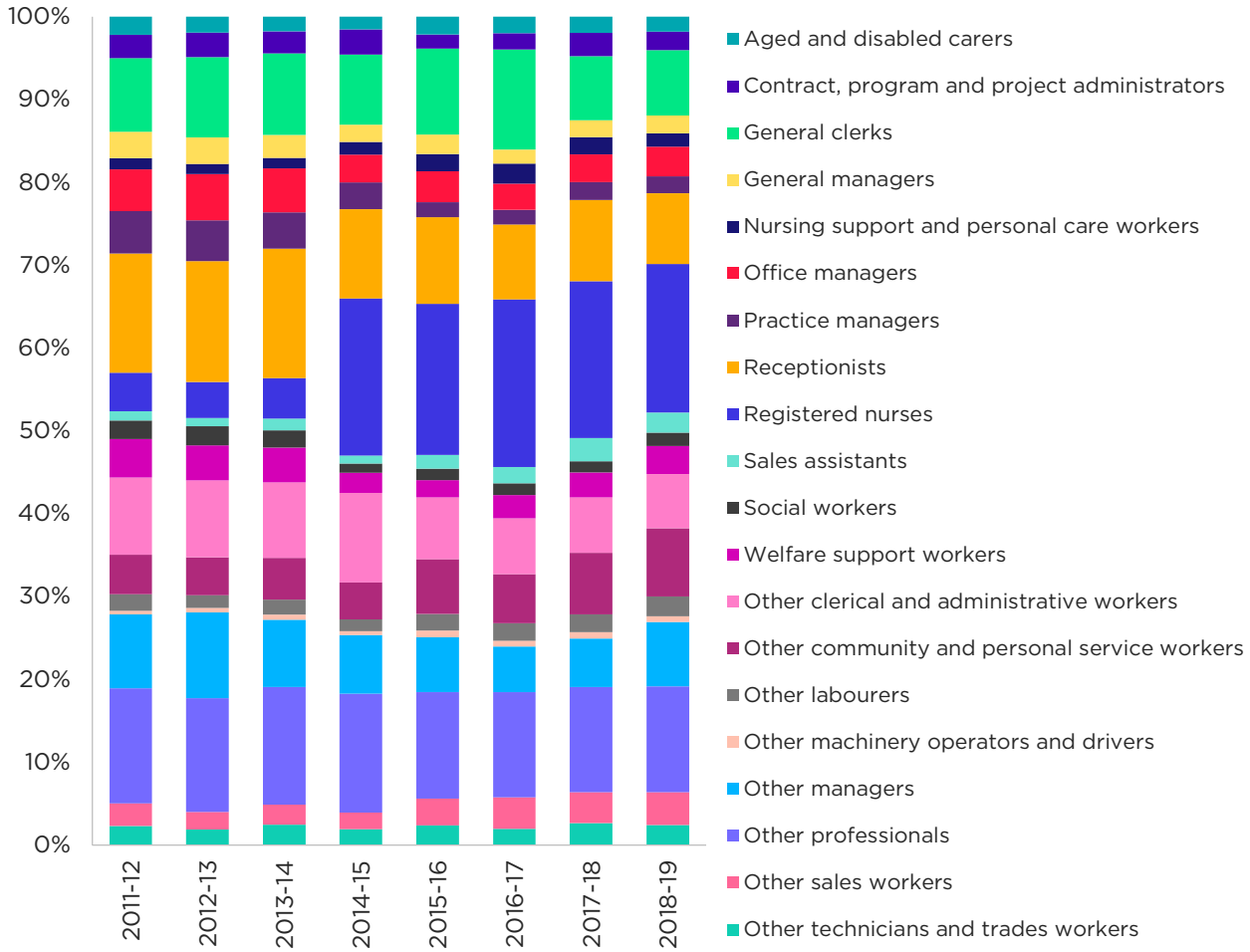
Figure 267: *Health and welfare services managers* (all industries), transitions to next occupation, by skill level (%), 2010-11 to 2017-18



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries.

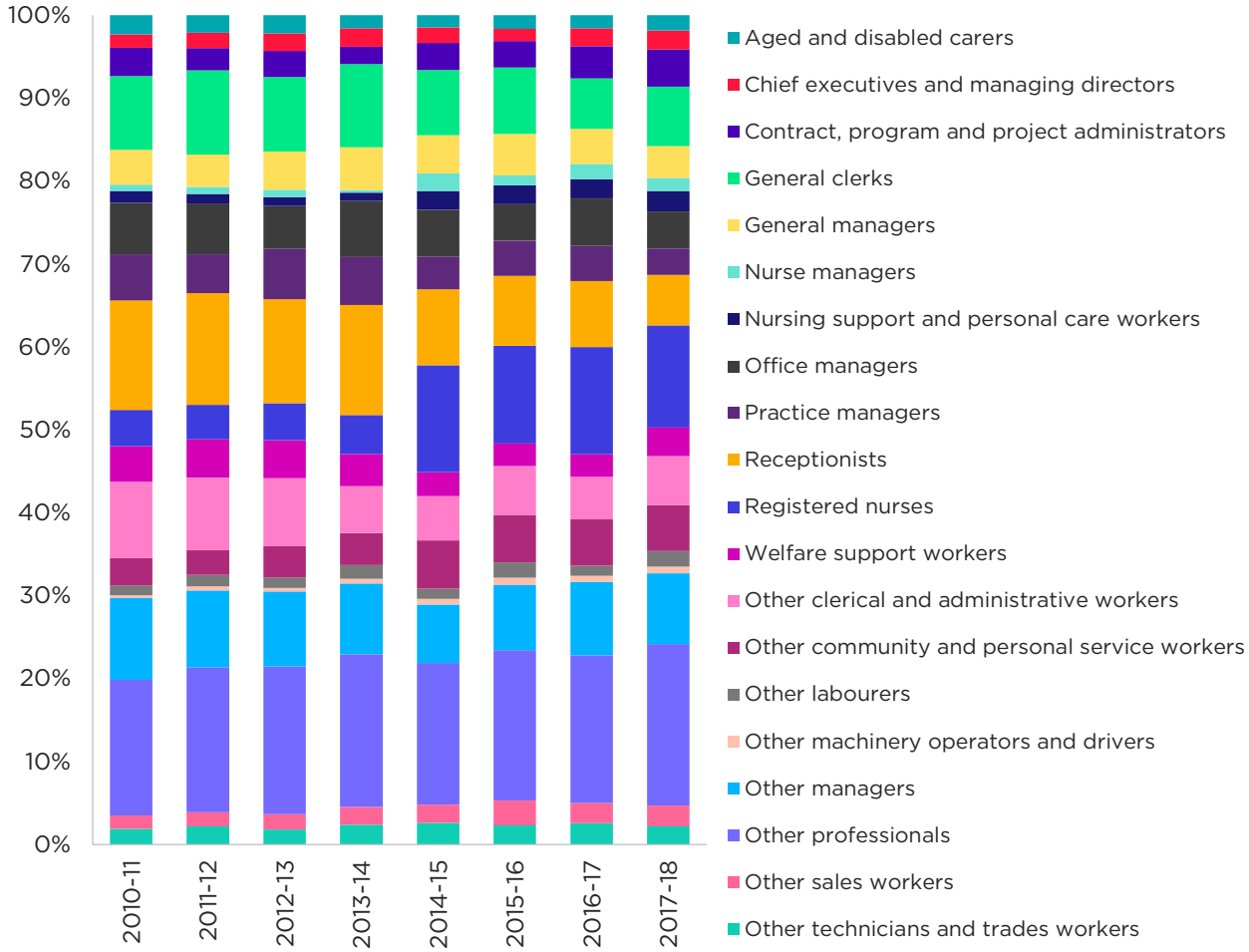
7.5.6.4 Transitions, previous and next occupation, by detailed occupation – charts

Figure 268: *Health and welfare services managers* (all industries), previous occupation (%), 2011-12 to 2018-19



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Excludes people working in the same occupation and those with no tax return submitted.

Figure 269: *Health and welfare services managers* (all industries), next occupation (%), 2010-11 to 2017-18



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Excludes people working in the same occupation and those with no tax return submitted.

Part 8
Factors influencing retention and supply of the care and support workforce

Part 8 outlines a range of factors that can influence workforce supply. These range from perceptions around the nature of work, career paths and the intersection of modern awards and program design.

There are a number of aspects of working conditions for the care and support workforce, highlighted by the Aged Care Royal Commission, that can erode job satisfaction and contribute to staff turnover. These include high workloads, work pressures, inadequate staffing and skill mixes, working conditions and arrangements including pay. The Aged Care Royal Commission also highlighted the importance of good leadership, supervision and support, as well as training and skills development. Many of these issues are also evident in industry surveys in the disability sector.

The various examples provided in Part 8 across worker screening, provider regulation, awards, pricing, and taxation speak to the significant complexity of operating within and across the care and support system. Given this, it is important that the workforce implications of regulatory and operating frameworks are considered both in their program specific context, and also from a whole-of-care and support system perspective. Without this, the potential for disincentives and unintended consequences is high, and risks exacerbating service delivery and workforce gaps.

Opportunities for progression are mixed

A factor in workforce attraction and retention is the availability of opportunities for workers to grow, progress and advance their careers. Stakeholders consulted during the Study highlighted the importance of career paths for the care and support workforce. The term 'career path' was used in a range of different contexts however most can be summarised as progression through roles that lead to more pay and/or responsibility. This could be through one job or through a series of jobs.

- At higher skill levels, career paths in care and support occupations are more clearly articulated with minimum qualifications, registration, placement, supervision and ongoing professional development, advancement and transition opportunities well-established.
- This contrasts with career paths for Personal care and support workers where the benefits of accumulating skills and qualifications through additional training and professional development is not clearly linked to career progression.
- Limited career development opportunities was the most common reason cited by people who were either unsure if they would be working, or would not be working in the sector, in 5 years' time. The importance of developing career paths for direct care workers was also highlighted by the Aged Care Royal Commission.
- Like most awards, the Aged Care Award includes a number of pay points or levels that represent the different rates of pay workers are eligible to receive. For personal care workers there are only 5 pay points in the Aged Care Award, compared with 25 pay points for *Registered nurses* in the Nurses Award. While the Study does not have a view on the

appropriate number of pay points (greater complexity in an award may not be desirable), the room for wage progression in the Aged Care Award appears comparatively limited.

Training and professional development are important for workforce capability

Ongoing professional development was consistently highlighted by stakeholders as a key enabler of the care and support workforce. This was considered especially important given the evolving and complex work context in which care and support workers are required to practice.

Stakeholders noted several features of care and support work that necessitate structured ongoing professional development, including high levels of regulation and compliance, changing policy and legislative landscape, interpersonal interactions with individuals with complex needs, and work settings which required independent application of knowledge and skills under limited supervision.

For some care and support roles, such as the occupation group Personal care and support workers, ongoing professional development is not formally required. Some stakeholders also noted that when professional development is offered it may be linked to compliance measures and regulatory/policy changes, rather than focused on workforce capability uplift.

Person-centred approaches are shaping and changing the job roles in the care and support workforce but are yet to be fully captured in articulations of job design. Throughout the Study, stakeholders pointed to job design as an enabler for defining career paths, dispelling negative perceptions of working in care and support roles, ensuring training is well suited to job requirements and ongoing professional development, and underpinning better understanding of scopes of practice within and across care and support occupations.

A range of other factors can impact turnover

Turnover can be related aspects of a person's work as well as unrelated factors.

For example, for experienced workers in the residential aged care sector, moving away, or moving to a different location is a common reason for leaving a care and support role. Some care and support work can be physically demanding, and for those in older age groups, their own health or physical capacity is likely to impact upon their ability to continue in a caring role.

Research suggests early career allied health workers and nurses are at risk of worker turnover, while stakeholders often spoke of high turnover among new Personal care and support workers, indicating the need for tailored retention strategies for younger, or early career cohorts.

- In this regard, attraction and retention strategies are often closely intertwined and for some providers, retention strategies begin even before recruitment. Many stakeholders spoke about ensuring that the right candidates with a passion for the job are recruited and that students are appropriately supported during training.

Regional and remote areas face unique challenges including workforce retention.

- The importance of developing a local Aboriginal and Torres Strait Islander workforce was reiterated strongly during the consultation process, including engaging with the local Aboriginal and Torres Strait Islander community to link people to health systems and of attracting community members with the right skills to the care and support workforce – a workforce that is local, embedded with cultural capability and understanding of the place-based context.
- Key factors that positively impact upon retention of allied health workers and nurses in regional areas can include access to training and career development, a supportive work environment and adequate clinical support.

Negative perceptions need to be addressed and worker sentiment collected

Persistence of negative perceptions about working in care and support may drive an undervaluing of the care and support workforce and be an ongoing barrier to people: understanding the wide variety of opportunities, job roles and careers available; considering and being attracted to a care and support role as a career of choice; and remaining in the care and support workforce.

Internationally, campaigns have also been implemented to improve the public perception of working in care and support roles.

While Australian workforce strategies recognise the need to incorporate feedback from recipients of care and support into workforce planning, the lack of data on the perspectives of care and support recipients (which would provide valuable insights into their needs and preferences) is a challenge.

Methods and frequency of collecting worker sentiment are variable across programs, with no detailed cross-cutting data available.

Technology will drive change

Advances in technology will expand the range of interventions available to Australians, increasing their choices around health care as well as how they receive care and support.

That said, occupations in the direct care and support workforce tend to inherently need human contact to listen and respond to diverse and changing client needs, making these roles less likely to be automated. However, this does not imply that these occupations are not subject to task change and augmentation.

- For example, in the care and support workforce, administrative tasks in managing client records can be streamlined through software and business automation tools.

Stakeholders also viewed technology as a useful tool to improve the quality of care and the data used to determine individual care and support needs.

- Innovations in smart-home monitoring and integrated technology using sensors, GPS tracking and artificial intelligence may improve the overall quality of patient care, and assist in personalising individual's care and support needs.
- Technology may also have a positive impact on care and support workers as improved outcomes of clients may boost overall job satisfaction and general wellbeing.

Technology may therefore ultimately have the potential to reduce the high labour intensity in care and support work.

The award system plays a significant role in the care and support workforce

Although most care and support workers are employed on a collective agreement, the award system is a substantial driver of wages and conditions in the sector, as noted by the Aged Care Royal Commission.

However, the current award system does not entirely reflect the distinct roles and responsibilities of workers in care and support settings. For example, the Aged Care Award is an industry award which covers many different occupations under a single title: 'aged care employee'.

- This means the same minimum pay rates and conditions apply for a wide range of roles, including cleaners, maintenance workers, pay clerks, personal care workers, gardeners, drivers, and cooks.

As a result, the award does not recognise the skills or responsibilities that may be specific to personal care and support, cleaning, gardening or food services in residential aged care, nor does it take into consideration whether these roles should attract different minimum pay rates.

The award system can also be complex, and it can be difficult for employers and employees to understand its interconnections with care and support programs. With the introduction of person-centred care models such as in the NDIS, there are elements of tension with award arrangements which pre-date these models.

- Under the Social, Community, Home Care and Disability Services (SCHADS) Award, casual workers are entitled to a 2-hour minimum engagement period. In an NDIS trial site in October 2015, 78% of service requests were at or less than 2 hours. This can have implications for workers, providers and participants.
- People with disability may choose to seek support services at the beginning and end of their day. Under the SCHADS Award, workers who have a break between shifts (other than a meal

break) are entitled to additional allowances. This can mean it is more cost effective for providers to employ multiple disability support workers to provide services to one participant.

The Study notes that matters such as minimum engagements and broken shifts are currently before the FWC as part of the 4 yearly modern award reviews.

Other elements of system design can impact workforce arrangements

Stakeholders pointed to the shift to person-centred care and the interaction with program funding and pricing settings as incentivising providers to employ workers on short-hour casual or part-time contracts – leading to the rise of an 'on-demand' workforce. This approach ensures there is sufficient workforce coverage to meet the increasingly complex and diverse consumer needs, as well as keep operating costs low within an increasingly competitive market environment, and enables scaling of operations in line with the incremental rollout of the NDIS.

The Study is not – of course – suggesting that workforce considerations should override issues of system design which are focused around needs of participants; but rather that there are relationships between the two.

Fringe benefits tax (FBT) concessions can be an attractive feature of the care and support sector for some workers, improving its competitiveness against other parts of the economy. Many non-profit organisations, including care and support providers, are eligible for the FBT exemption and can pass on to their employees a proportion of their wages as a reimbursement of personal expenses. Salary packaging often features in online job advertisements for Personal care and support workers, highlighting the use of non-wage benefits providers use to attract workers.

The regulatory environment also matters for the workforce

The regulatory environments for aged care, NDIS and veteran care programs are often disconnected from one another, creating different and separate requirements for workers and providers in each program. This also introduces a range of incentives and disincentives to operate in each program market. The workforce implications of this system complexity and misalignment of regulatory environments are significant and create barriers to workforce mobility across programs.

- The NDIS Worker Screening check is recognised under both the aged care and NDIS legislation, however the police check requirements for workers in aged care is not recognised for NDIS purposes, as police checks are point-in-time and not as comprehensive as an NDIS check.
- That said, the *NDIS National Workforce Plan* recognises the need to further align worker regulation across care and support programs, and the Australian Government announced funding in the 2021-22 Budget to implement a care and support code of conduct and a nationally consistent pre-employment screening process across aged, veteran and disability care and support services.

Regulation is, of course, an important and necessary part of the delivery of care and support services to ensure quality service and outcomes for those Australians who rely on these services. However, many stakeholders noted that regulation is biased toward measuring compliance and may not incentivise innovation in care and support.

Ensuring regulatory settings have the appropriate checks and balances, while ensuring quality outcomes are achieved, and productivity and innovation enhancements are not dampened, is a significant challenge which impacts workforce utilisation (and may matter more into the future if workforce gaps arise).

8.1 Retention is complex, and many factors impact decisions to stay or leave a job

There are many factors that can influence workforce retention and turnover. These include job satisfaction, working conditions and pay, workplace and management support, the strength of a person's connection to their workplace and community, job control, and professional and career development opportunities. Methods and frequency of collecting worker sentiment vary across programs, with no detailed cross-cutting data available. Examples include:

- 2016 NACWCS and 2020 ACWC, noting that only employers were surveyed in 2020, which provides limited insights from the perspectives of aged care workers and limits analysis across periods.
- NDS State of the Disability Sector Report 2020 and Victorian NDIS Workforce Longitudinal Research Study.
- Industry surveys such as the Health Employees Superannuation Trust Australia (HESTA) member survey and union workforce surveys, such as the Australian Nursing and Midwifery Federation's National Aged Care Survey and the Health Services Union's survey of Australia's disability workforce.

While it is possible to distil broad themes relating to attraction, retention, turnover and churn, more granular and comparative analysis of worker sentiment across care and support roles is limited and it is difficult to assess how each compares to other care and support programs or across the workforce as a whole.

8.1.1 Job satisfaction

Job satisfaction is a key factor in retention, and the nature of care and support occupations can provide strong intrinsic satisfaction for many care and support workers. This includes knowing their work makes a positive difference to the lives of the people they support and developing close relationships with clients.[176]

There are a number of aspects of working conditions for the care and support workforce, highlighted by the Aged Care Royal Commission, that can erode job satisfaction and contribute to staff turnover. These include high workloads, work pressures, inadequate staffing and skill mixes, working conditions and arrangements including pay.[177] The Aged Care Royal Commission also highlighted the importance of good leadership, supervision and support, as well as training and skills development.[178] Many of these issues are also evident in industry surveys in the disability sector.[179]

The Aged Care Census Database, developed by ACWIC and BPA Analytics, shows that between 2017 and 2019, around 45% of aged care workers believed their sector was successful at retaining quality staff; an improvement from 34% at the beginning of the decade. Further, worker sentiment in aged care has generally improved over the last decade, with many remaining working in aged care for people-related reasons, including 'resident/client interaction' (26%) and 'colleagues/staff' (15%).[180] The HESTA 2021 aged care workforce insights report found that job satisfaction in the aged care workforce increased over the year to 2020, although they still experienced the lowest job satisfaction across the health sectors surveyed.

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[176] Mavromaras, et al., *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce*, 2017; HESTA, *State of the sector: 2021 - Aged care workforce insights*, 2021; Royal Commission into Victoria's Mental Health System, *Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform*, 2021; L. Chenoweth et al., *A systematic review of what factors attract and retain nurses in aged and dementia care*, J Clin Nurs, vol. 19, no. 1-2, 2010; L. D. Xiao et al., *Care workers' perspectives of factors affecting a sustainable aged care workforce*, Int Nurs Rev, vol. 68, no. 1, 2021

[177] Royal Commission into Aged Care Quality and Safety, *Royal Commission into Aged Care Quality and Safety final report: care, dignity and respect*, 2021

[178] Royal Commission into Aged Care Quality and Safety, *Royal Commission into Aged Care Quality and Safety final report: care, dignity and respect, Final Report - Volume 3A: The new system*, 2021

[179] N Cortis and G Van Toorn, *Working in new disability markets: A survey of Australia's disability workforce*, 2020

[180] ACWIC and BPA Analytics, *Aged Care Census Database*, 2021

Within the NDIS workforce, the impact of low and variable hours on earnings, limited career progression opportunities, limited opportunities for training, disconnection from colleagues and high administrative burden[181] may impact upon job satisfaction and turnover. That said, the Victorian NDIS Workforce Longitudinal Research Study found that there was little change in worker sentiment between 2018 and 2019, with around half of surveyed workers feeling positive about their work and most workers wanting to stay in the sector.[182] The survey also highlighted some core areas of high workforce dissatisfaction, many of which are also recognised in the *NDIS National Workforce Plan*.

For the mental health sector, the Victorian Royal Commission into Victoria's Mental Health System found that job satisfaction is impacted by a range of factors including workload pressures, burnout and occupational violence.[183]

8.1.2 Career development

Opportunities for career development and professional development are also important factors in retention.[184] While there are formalised career paths in nursing, career options for Personal care and support workers are more limited. For example, in the qualitative research undertaken as part of the Victorian NDIS Workforce Longitudinal Research Study, some NDIS workers raised that there were limited options for those who want progression or variety in their careers. The limited opportunities for promotion and career development within some roles in the care and support sector are demonstrated in Figure 270. In February 2021, only 3% of people working as Personal care and support workers reported having received a promotion from their current employers within the last 12 months – less than half the proportion of workers promoted in the overall labour market and the *Health care and social assistance* industry (both 7%).[185]

[181] DSS, *NDIS National Workforce Plan: 2021 - 2025*, 2021; Victorian Government & Ipsos Public Affairs, *Understanding the workforce experience of the NDIS - Year Two*, 2019; NDS, *State of the Disability Sector Report 2020*, 2020

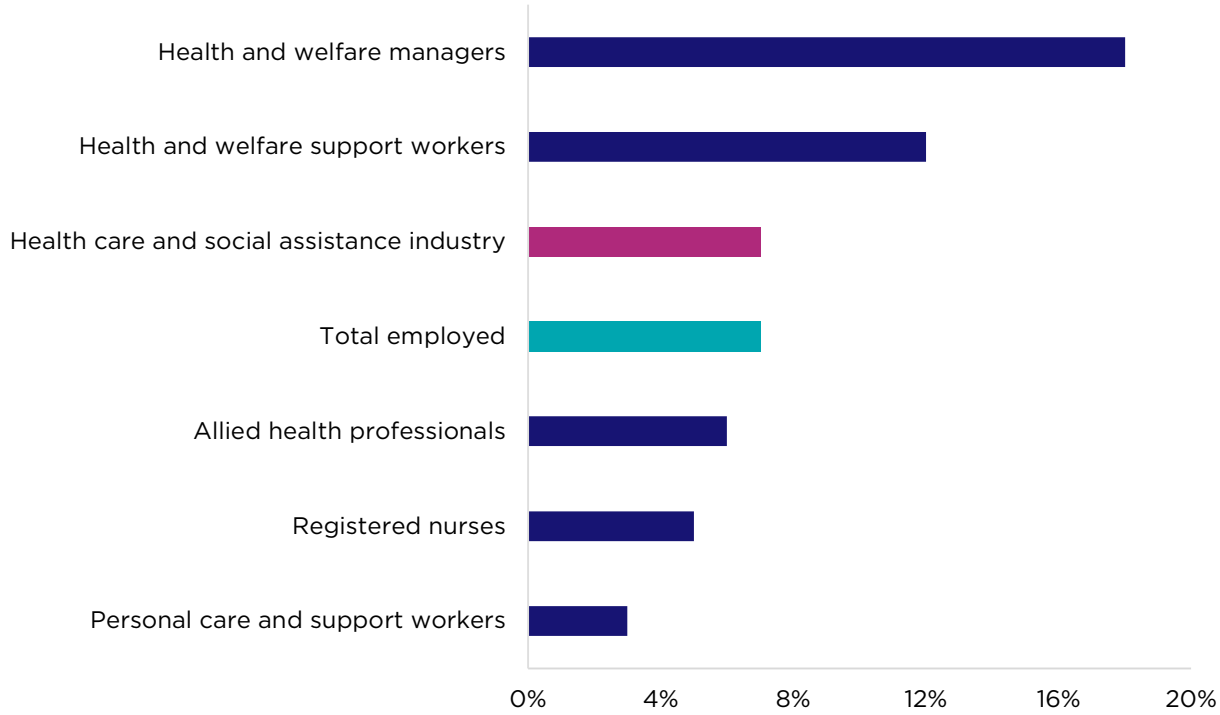
[182] Victorian Government & Ipsos Public Affairs, *Understanding the workforce experience of the NDIS - Year Two*, 2019

[183] Royal Commission into Victoria's Mental Health System, *Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform*, 2021

[184] Chenoweth et al., *A systematic review of what factors attract and retain nurses in aged and dementia care*, J Clin Nurs, vol. 19, no. 1-2, 2010; Xiao et al., *Care workers' perspectives of factors affecting a sustainable aged care workforce*, Int Nurs Rev, vol. 68, no. 1, 2021; G. Gallego et al., *Should I stay or should I go? Exploring the job preferences of allied health professionals working with people with disability in rural Australia*, Hum Resour Health, vol. 13, 2015

[185] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

Figure 270: Proportion of workforce promoted with current employer in last 12 months, care and support industries, February 2021



Source: ABS Participation, Job Search and Mobility, 2021 in TableBuilder. Due to data perturbation by the ABS, discrepancies may occur between sums of the component items and totals.

Limited career development opportunities was the most common reason cited by people who were either unsure if they would be working, or would not be working in the disability sector, in 5 years' time.[186] The importance of developing career paths for direct care workers was also highlighted by the Aged Care Royal Commission.[187] The importance of job design for career paths is discussed in Part 8.2.2.

8.1.3 Other factors affecting worker retention and turnover

In a regional context, the strength of a person's links to their community is positively associated with retention,[188] while some research suggests that stronger workplace connection can either assist with retention or conversely reduce intention to leave.[189]

Stakeholders raised community connection as particularly important for Aboriginal and Torres Strait Islander care and support workers. While not specific to the care and support workforce, some factors that have been found to assist with retention for Aboriginal and Torres Strait Islander health workers are mentoring, supportive colleagues and management, culturally safe workplaces, and cultural supervision. Instances of racism, high workloads and pressures, limited

[186] Victorian Government & Ipsos Public Affairs, *Understanding the workforce experience of the NDIS - Year Two*, 2019

[187] Royal Commission into Aged Care Quality and Safety, *Royal Commission into Aged Care Quality and Safety final report: care, dignity and respect, Final Report - Volume 3A: The new system*, 2021

[188] S. Keane et al., *Retention of the rural allied health workforce in New South Wales: a comparison of public and private practitioners*, BMC Health Serv Res, vol. 13, 2013; C. Cosgrave, M. Maple, and R. Hussain, *An explanation of turnover intention among early-career nursing and allied health professionals working in rural and remote Australia - findings from a grounded theory study*, Rural Remote Health, vol. 18, no. 3, 2018; C. Cosgrave, *The Whole-of-Person Retention Improvement Framework: A Guide for Addressing Health Workforce Challenges in the Rural Context*, Int J Environ Res Public Health, vol. 17, no. 8, 2020

[189] K. Radford, K. Shacklock, and G. Bradley, *Personal care workers in Australian aged care: retention and turnover intentions*, J Nurs Manag, vol. 23, no. 5, 2015; B. Heritage, M. Quail, and N. Cocks, *How important is embeddedness in predicting Australian speech-language pathologists' intentions to leave their jobs and the profession?*, Int J Speech Lang Pathol, vol. 21, no. 2, 2019; O. E. Reitz, *The Job Embeddedness instrument: an evaluation of validity and reliability*, Geriatr Nurs, vol. 35, no. 5, 2014; O. E. Reitz, M. A. Anderson, and P. D. Hill, *Job embeddedness and nurse retention*, Nurs Adm Q, vol. 34, no. 3, 2010

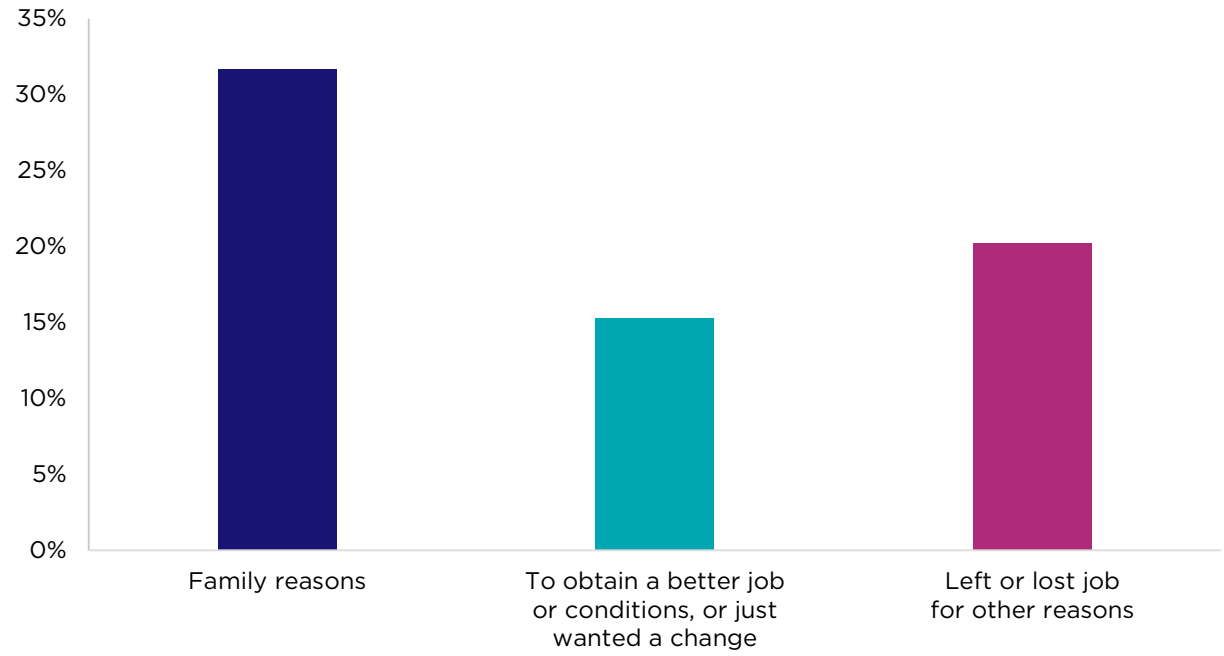
job security and poor salary negatively affect retention. For Aboriginal and Torres Strait Islander health workers proximity to community can also bring pressures, including difficulty maintaining work/life balance and managing expectations of their community.[190]

Turnover can be related to aspects of a person's work as well as unrelated factors. For example, for experienced workers in the residential aged care sector, moving away, or moving to a different location is a common reason for leaving a care and support role,[191] as well as choosing to retire or a person's financial situation. Some care and support work can be physically demanding, and for those in older age groups, their own health or physical capacity is likely to impact upon their ability to continue in a caring role.

ABS Participation, Job Search and Mobility data shows that in February 2021, there were around 155,000 people whose last job was in the care and support workforce – noting a proportion of this group may have left their last job years earlier. The main reasons why this group left the care and support workforce included retirement, ill-health and injury, and family reasons (Figures 271 to 273).

For people aged 65 years and over, retirement is the predominant reason for leaving a job in the care and support workforce. For those aged 45-64 years, the main reason for leaving a job as a carer or aide is due to own ill health or injury, in part, likely reflecting the physically demanding tasks that can be associated with caring. For those aged 15-44 years, the most common reasons for leaving a job in the care and support workforce were 'family reasons', 'left or lost job for other reasons', and 'to obtain a better job or conditions, or just wanted a change'.[192]

Figure 271: People aged 15-44 years whose last job was in the care and support workforce, in-scope industries, top 3 reasons for leaving, February 2021



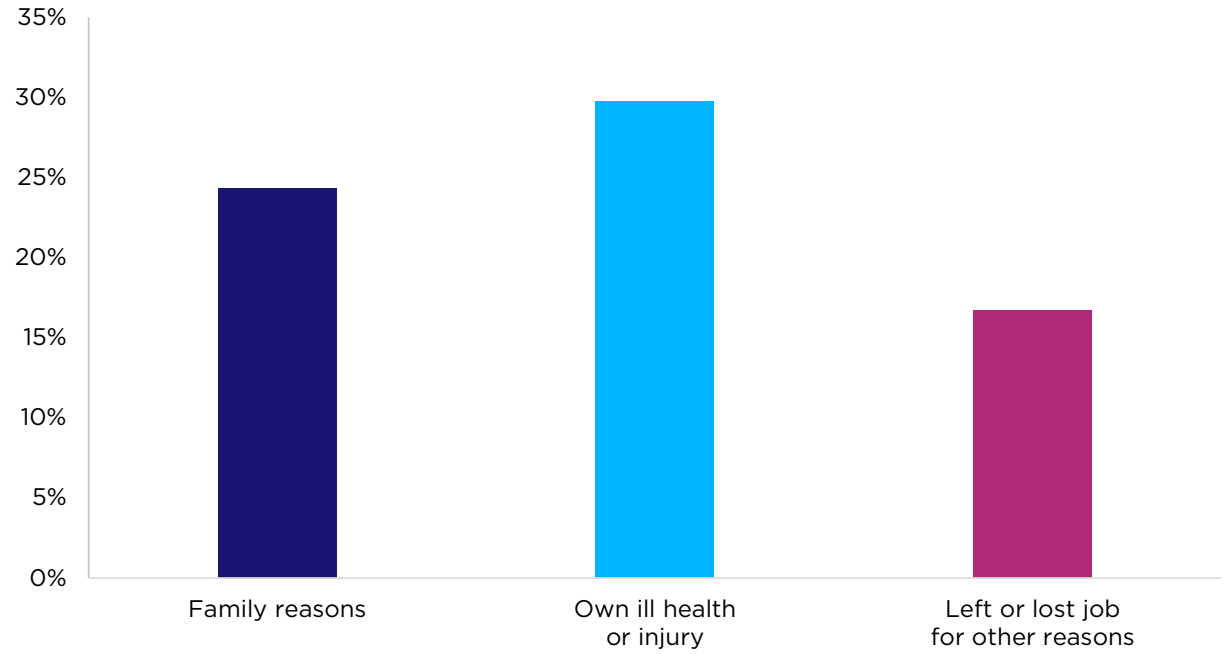
Source: ABS, Participation, Job Search and Mobility, 2021. Population: 15 in-scope occupations (ANZSCO 4-digit level) across 3 in-scope industries (ANZSIC 3-digit level). Due to small sample sizes only the top 3 categories for each age group are displayed. Left or lost job for other reasons is a not further defined category that excludes people who left their job due to a business closing, or their own business opening, being dismissed or retrenched, a temporary job ending or returning to their studies, or leaving due to unsatisfactory work arrangements or pay.

[190] S. Deroy and H. Schütze, *Factors supporting retention of Aboriginal health and wellbeing staff in Aboriginal health services: a comprehensive review of the literature*, Int J Equity Health, vol. 18, no. 1, 2019; G. C. Lai et al., *Factors Affecting the Retention of Indigenous Australians in the Health Workforce: A Systematic Review*, Int J Environ Res Public Health, vol. 15, no. 5, 2018

[191] Mavromaras, et al., *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce*, 2017

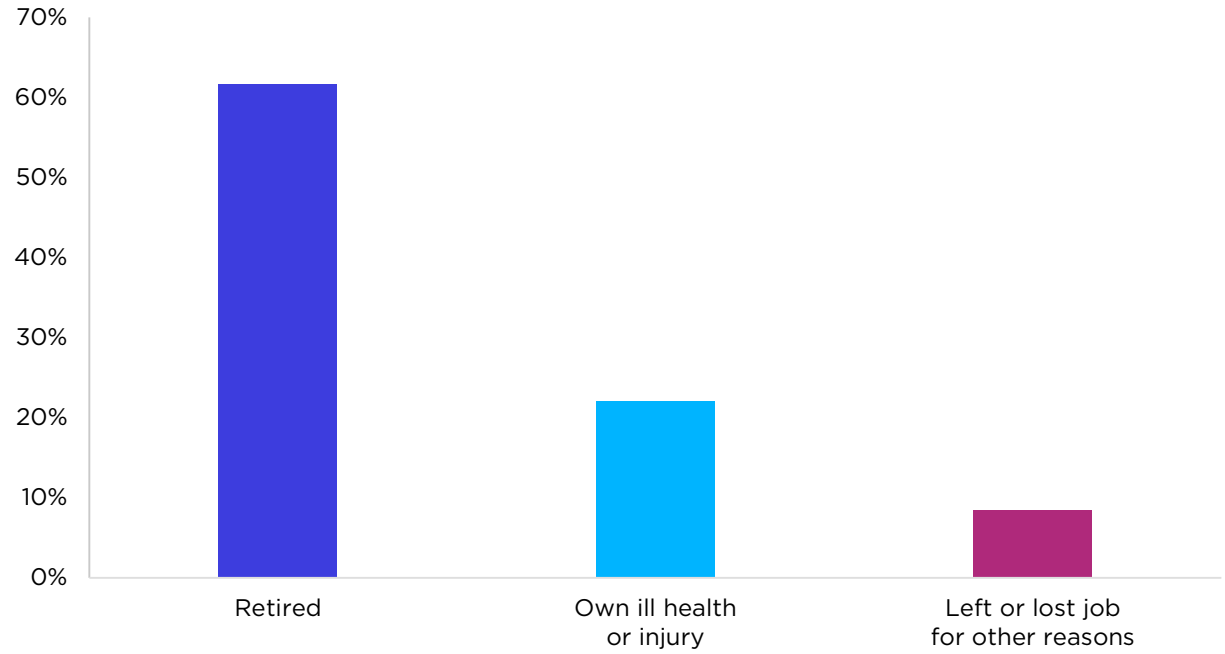
[192] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

Figure 272: People aged 45-64 years whose last job was in the care and support workforce, in-scope industries, top 3 reasons for leaving, February 2021



Source: ABS, Participation, Job Search and Mobility, 2021. Population: 15 in-scope occupations (ANZSCO 4-digit level) across 3 in-scope industries (ANZSIC 3-digit level). Due to small sample sizes only the top 3 categories for each age group are displayed. Left or lost job for other reasons is a not further defined category that excludes people who left their job due to a business closing, or their own business opening, being dismissed or retrenched, a temporary job ending or returning to their studies, or leaving due to unsatisfactory work arrangements or pay.

Figure 273: People aged 65 years and over whose last job was in the care and support workforce, in-scope industries, top 3 reasons for leaving, February 2021



Source: ABS, Participation, Job Search and Mobility, 2021. Population: 15 in-scope occupations (ANZSCO 4-digit level) across 3 in-scope industries (ANZSIC 3-digit level). Due to small sample sizes only the top 3 categories for each age group are displayed. Left or lost job for other reasons is a not further defined category that excludes people who left their job due to a business closing, or their own business opening, being dismissed or retrenched, a temporary job ending or returning to their studies, or leaving due to unsatisfactory work arrangements or pay.

Recognising retention is a workforce challenge in aged care, the 2021-22 Australian Budget introduced a retention bonus for some registered nurses working in aged care who work for the same aged care provider for a 12-month period.

8.1.4 Regional and remote retention and turnover

As outlined in Part 2.2.5, regional and remote areas face unique challenges including workforce retention. Research has shown that having a rural background is positively associated with remaining in the rural health workforce, as well as exposure to training in a rural setting and the length of that training.[193] Feedback from multiple stakeholders strongly supported the development of local workforces and highlighted that the high turnover of workers can negatively impact on continuity of care for the community and its health outcomes. The importance of developing a local Aboriginal and Torres Strait Islander workforce was reiterated strongly during the consultation process, including engaging with the local Aboriginal and Torres Strait Islander community to link people to health systems, and of attracting community members with the right skills to the care and support workforce – a workforce that is local, embedded with cultural capability and understanding of the place-based context.

Other key factors that positively impact upon retention of allied health workers and nurses in regional areas is access to training and career development, a supportive work environment and adequate clinical support.[194] Stakeholders spoke of the difficulty of providing training and upskilling in more remote areas and the need to take advantage of technology to provide supervision and clinical support, as well as upskilling those in the local area to be able to provide supervision themselves. However limited connectivity in some regional and remote areas was noted as a barrier to realising the potential benefits of remote support and assistance.

Some research suggests that early career allied health workers and nurses are at higher risk of worker turnover,[195] while stakeholders often spoke of high turnover among new Personal care and support workers, indicating the need for tailored retention strategies for younger, or early career cohorts. In this regard, attraction and retention strategies are often closely intertwined and for some providers, retention strategies begin even before recruitment. Many stakeholders spoke about ensuring that the right candidates with a passion for the job are recruited and that students are appropriately supported during training. An example of this is the Indigenous Allied Health Australia National Aboriginal and Torres Strait Islander Health Academy, which focuses on tailored training to promote a successful transition to employment and retention for Aboriginal and Torres Strait Islander health students.

Broadly, these issues are also often associated with thin markets, which are discussed in Part 4.8.

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[193] L. Brown et al., *Longitudinal Tracking of Workplace Outcomes for Undergraduate Allied Health Students Undertaking Placements in Rural Australia*, J Allied Health, vol. 46, no. 2, 2017; D. Playford, M. C. Moran, and S. Thompson, *Factors associated with rural work for nursing and allied health graduates 15-17 years after an undergraduate rural placement through the University Department of Rural Health program*, Rural Remote Health, vol. 20, no. 1, 2020; T. Smith et al., *Profile and rural exposure for nursing and allied health students at two Australian Universities: A retrospective cohort study*, Aust J Rural Health, vol. 29, no. 1, 2021; KBC Australia, *Independent Evaluation of the Rural Health Multidisciplinary Training Program*, 2020

[194] National Rural Health Commissioner, *Review of rural allied health evidence to inform policy development for addressing access, distribution and quality*, 2020

[195] M. Chisholm, D. Russell, and J. Humphreys, *Measuring rural allied health workforce turnover and retention: what are the patterns, determinants and costs?*, Aust J Rural Health, vol. 19, no. 2, 2011; Jane Mills et al., *Retaining early career registered nurses: a case study*, BMC Nursing, vol. 15, no. 1, 2016

8.2 Other factors will influence the future supply of the care and support workforce

There are a wide range of factors which influence, and will likely continue to shape, the care and support workforce into the future. The factors covered in this section draw together some of the observations made throughout this report and explore potential implications for the supply of the care and support workforce.

8.2.1 Public perception and participant views

The workforce strategies across aged care, the NDIS and mental health (Part 1.2) all cite the need to reframe negative perceptions associated with working in care and support and mental health settings.

Persistence of negative perceptions about working in care and support may drive an undervaluing of the care and support workforce and be an ongoing barrier to people:

- understanding the wide variety of opportunities, job roles and careers available
- considering and being attracted to a care and support role as a career of choice
- remaining in the care and support workforce.

The Australian Government's *A Life Changing Life,* ACWIC's *Bring Your Thing* and the Victorian Government's *Work That Matters* campaigns are perception reframing examples that highlight the variety of opportunities of working in aged, disability and veteran care and support.[196]

Internationally, campaigns have also been implemented to improve the public perception of working in care and support roles. These include the *Proud to Care* initiative in the United Kingdom, a television campaign by France's CNSA (Caisse nationale de solidarité pour l'autonomie) and the Normale Helden (translates as Normal Heroes) campaign in Belgium.[197]

Each of the workforce strategies referred to in Part 1.2 also recognise the need to incorporate feedback from recipients of care and support into workforce planning. A challenge to this, however, is the lack of data on the perspectives of care and support recipients, which would provide valuable insights into their needs and preferences and how these translate to the skills required by the care and support workforce.

8.2.2 Job design

Person-centred approaches are shaping and changing the job roles in the care and support workforce but are yet to be fully captured in articulations of job design and architecture or flow through to ANZSCO. Job design as an influence on workforce supply is multifaceted. Throughout the Study, stakeholders pointed to job design as an enabler for defining career paths, dispelling negative perceptions of working in care and support roles, ensuring training is well suited to job requirements and ongoing professional development, and underpinning better understanding of scopes of practice within and across care and support occupations.

8.2.2.1 Career paths vary across care and support occupations

A factor in workforce attraction and retention is the availability of opportunities for workers to grow, progress and advance their careers. Stakeholders consulted during the Study highlighted the importance of career paths for the care and support workforce. The term 'career path' was used in a range of different contexts, however, most can be summarised as progression through roles that lead to more pay and/or responsibility. This could be through one job or through a series of jobs.

This issue of career paths was also highlighted in the Aged Care Royal Commission's final report:

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[196] Government of Victoria, Shining a light on work in the disability sector, 2021; Aged Care Workforce Industry Council, Bring your thing to a new career in Aged Care, 2021

[197] OECD, *Who Cares? Attracting and retaining care workers for the elderly*, 2020

> "a clear understanding of what a job involves not only informs competency requirements and career paths, it fosters clarity for both workers and people receiving aged care and their families. It also enables the design of effective training and education frameworks. To be sure that education and training frameworks will create a capable workforce that can build a career in aged care, there is a need to understand, standardise and define jobs".[198]

At higher skill levels, career paths in care and support occupations are more clearly articulated with minimum qualifications, registration, placement, supervision and ongoing professional development, advancement and transition opportunities are well-established. This contrasts with career paths for Personal care and support workers where the benefits of accumulating skills and qualifications through additional training and professional development is not clearly linked to career progression, increased scope of responsibility or pay. Throughout the Study, stakeholders consistently raised the lack of career paths as a disincentive for working in care and support, noting that small increments in pay between occupations like *Nursing support and personal care workers* and *Enrolled and mothercraft nurses* negate the benefits of a more senior role and/or investment in training. Notwithstanding stakeholder views, the analysis in Part 7.2 suggests that transitions to higher skilled care and support occupations do occur, and indicates personal care and support roles can be used as 'stepping stones' to other roles even though these may not be recognised as formal career pathways.

Internationally there is recognition that career prospects and structures in the care and support sector require further development, driven by a better understanding of skills and qualifications to formalise care and support roles.[199] Yet, there are different approaches to formalising career paths. Both Canada (Ontario) and Belgium (Flanders) have regional measures that require formal training and registration to work in care and support roles, unlike Australia and many other countries where formal certification is not always required.[200]

There are actions underway to address aspects of career paths and job design. Specifically, in aged care the Aged Services Industry Reference Committee has been established and is responsible for examining new approaches to career structuring and progression and the education pathways needed to support these. Under the *NDIS National Workforce Plan*, the HSSO is progressing development of training to support skills needs and career paths across the care and support workforce, including micro-credentials. Improved career paths in mental health is also a priority area outlined in the consultation draft of the *National Mental Health Workforce Strategy*.

8.2.2.2 Access to ongoing professional development is inconsistent across care and support occupations

Ongoing professional development was consistently highlighted by stakeholders as a key enabler of the care and support workforce. This was considered especially important given the evolving and complex work context in which care and support workers are required to practice. Stakeholders noted several features of care and support work that necessitate structured ongoing professional development, including:

- high levels of regulation and compliance
- changing policy and legislative landscape
- interpersonal interactions with individuals with complex needs
- work settings which require independent application of knowledge and skills under limited supervision.

Ongoing professional development is formalised in parts of the care and support workforce but not in others. For AHPRA regulated occupations, annual registration requirements are linked to formalised continuing professional development.[201] For other care and support roles, such as the occupation group Personal care and support workers, ongoing professional development is not

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[198] Royal Commission into Aged Care Quality and Safety, *Royal Commission into Aged Care Quality and Safety final report: care, dignity and respect, Final Report - Volume 3A: The new system*, 2021

[199] OECD, *Who Cares? Attracting and retaining care workers for the elderly*, 2020

[200] OECD, *Who Cares? Attracting and retaining care workers for the elderly*, 2020

[201] AHPRA, Continuing Professional Development, 2021

formally required. Some stakeholders also noted that when professional development is offered it may be linked to compliance measures and regulatory/policy changes, rather than focused on workforce capability uplift.

8.2.2.3 A role for micro-credentials and stackable skills for improving job design, career paths and ongoing professional development?

Micro-credentials are small, certification-style courses that focus on particular areas of study and are much quicker and cheaper than formal qualifications, meaning students can upskill quickly and be recognised for it.[202] Micro-credentials may also be grouped or 'stacked' so students can build their credentials into larger and more recognisable qualifications. This could be particularly beneficial to the care and support workforce, where many workers attribute lack of time as the main barrier to training.[203] Micro-credentials could also allow care and support workers to respond more quickly to changes in participant needs and emerging industry practices by upskilling more frequently. The needs of participants can be diverse and complex, meaning there is an opportunity for care and support workers to upskill and specialise with the right training pathways. With more opportunities to specialise through training, the career development and progression of care and support workers may be further improved.

Micro-credentials have been gaining increased prominence internationally.

- The European Union and the United Kingdom have begun working towards incorporating micro-credentials into their existing qualifications frameworks.[204]
- Canada has recently established a national framework for micro-credentials.[205]
- New Zealand accredits micro-credentials in its qualifications framework.[206]

Micro-credentials were recently explored in the *Expert Review of Australia's Vocational Education and Training system* and the *Review of the Australian Qualifications Framework* (AQF Review). While the use of micro-credentials is not currently widespread in Australia, their availability is increasing as an alternative way for learners to acquire new skills. More than half of Australia's universities currently offer micro-credentials and there was a recent surge of VET micro-credentials made available through the Australian Government's COVID-19 response, including through the JobTrainer Fund.

The Australian Government is developing a National Micro-credential Marketplace, to provide a nationally consistent platform for students to compare short courses and credit point value.[207] Australian and state and territory governments are also progressing recommendations from the AQF Review, including recommendations to improve guidance for education and training providers on how micro-credentials should be recognised for credit towards other AQF qualifications

In the recent NDIS workforce plan, DSS noted it would work with the HSSO and relevant Industry Reference Committees to develop accredited micro-credentials. This initiative is intended to improve the quality of support provided in the NDIS and enhance the career paths of its workforce.[208]

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[202] RMIT Online, What are micro-credentials? And why are they important?, 2020

[203] DSS, *NDIS National Workforce Plan: 2021 - 2025*, 2021

[204] European Commission, A European approach to micro-credentials, 2021

[205] Colleges & Institutes Canada, National framework for microcredentials, 2021

[206] New Zealand Qualifications Authority, Guidelines for applying for approval of a training scheme or a micro-credential, 2021

[207] The Hon Dan Tehan MP, [former] Minister for Education and Senator the Hon Michaelia Cash, [former] Minister for Employment, Skills, Small and Family Business, Marketplace for online microcredentials, 2020

[208] DSS, *NDIS National Workforce Plan: 2021 - 2025*, 2021

8.2.3 Technology and innovation in care and support

Technology change is pervasive across all parts of society and it will continue to play a role in shaping the care and support environment, both influencing the demand for care and support as well as how it is provided. Business and process automation and technological augmentation have the potential to drive efficiencies in the sector and alter the demand for workers. Historically, technology has played an important role in driving productivity growth.

8.2.3.1 Telehealth and other technology innovations

Advances in technology will expand the range of interventions available to Australians, increasing their choices around health care as well as how they receive care and support.

Telehealth is an example of a technological trend which has emerged in health care. The demand for telehealth has dramatically increased since the beginning of the COVID-19 pandemic. As discussed in Part 6.6.2, telehealth has been identified by the NSC as one of the top 10 skills which are emerging or trending in the labour market.

Telehealth is a flexible service delivery mode which helps expand access to care and support services for those living in rural and remote regions and for those living with mobility issues and severe disabilities that often act as a barrier to accessing care and support. Although telehealth technology isn't an outright substitute for physical consultation and face-to-face service delivery, it can be a complementary tool for care and support where face-to-face contact is not essential or would otherwise not be accessible.

Telehealth technology may also improve the productivity of care and support workers by reducing time spent and costs to travel to clients. The time and cost savings may improve overall working conditions and increase the ability to provide care to more clients in less time. Telehealth and digital communication in general may also have indirect effects on other occupations in a care and support team, such as aged and disability carers, by reducing the time spent on transporting clients to medical consultations or counselling in person. These tasks can be physically demanding and labour intensive, particularly for clients with high mobility needs.

Other innovations in smart-home monitoring and integrated technology using sensors, GPS tracking and artificial intelligence may improve the overall quality of patient care, and assist care and support by better personalising individual care needs for clients. This may also have a positive impact on care and support workers as improved outcomes of clients may boost overall job satisfaction and general wellbeing. As discussed in Part 8.1.1, job satisfaction is one of the key drivers for overall retention rates in the care and support workforce.

Technology also has the potential to reduce the high labour intensity in care and support work. However, as innovation and investment in technology for care and support increases over time, the care and support workforce will require the necessary levels of digital literacy and technology skills to fully realise these benefits and productivity gains. Stakeholders indicated that the level of digital literacy in parts of the current care and support workforce is low, and small business operators and sole traders in the care and support sector may not always have the knowledge or skills to make the best use of current technology. Importantly, care and support recipients will also need digital literacy skills to access services delivered, or augmented, via technology.

Norway and Japan – strategies to introduce technology into the long-term care sector

The OECD reports that Northern European countries and Japan have been at the forefront of introducing advanced technology into long-term care, with more complex technological devices beginning to be introduced into care settings.[209]

Running from 2014 to 2020, the Norwegian government introduced the National Welfare Technology Program – aimed at increasing the integration of welfare technology in long-term care services.[210] Some of the technologies in the program include mobile social alarms, location trackers, automated pill dispensers, electronic door locks, digital supervision, updated call systems in care homes and optimised vehicle routing in home care services.[211]

The OECD also reports that from a skills perspective, Norway is training nurses on the basics of technology development and design, has introduced a national strategy to improve the digital skills of care workers during entry training, and updated the curriculum for health and social workers, which includes technology use and development.[212]

In 2013, Japan identified 8 priority areas for introduction of robotic technology into care settings. These cover a range of broad devices that incorporate robotic technology - not just what is commonly considered to be a robot. The priority areas are:

- wearable and non-wearable transfer aids providing power assistance to care givers including lifting
- toileting assistance, including adjustable position toilets
- indoor and outdoor mobility aids, such as walking aid devices to provide walking support and carrying loads and aids to provide assistance to sit, stand and use toilets
- bathing aids to support elderly people to safely get in and out of baths
- monitoring systems for care homes and private homes.

Key goals for the introduction of robotic technology into care settings are workload reduction, independent living, and enhanced quality of life, as well as promoting growth in the care robotic industry.[213]

8.2.3.2 Automation versus augmentation of care and support roles

Occupations that are particularly susceptible to automation are roles that tend to be non-cognitive, routine, highly rule-based and process driven. By contrast, occupations in the direct care and support workforce tend to inherently need human contact to listen and respond to diverse and changing client needs, making these roles more difficult to automate. However, this does not imply that these occupations are immune to task change and augmentation by disruptive technology.

Analysis by the NSC of prominent future of work models shows that there are substantial differences in automation risk of occupations across different models. The methodology used by the NSC to measure the automatability of occupations, based on the Work Task Automatability model by Duckworth et al.,[214] shows that the health and care cluster, within the Australian Skills Classification, has a weighted automation score of 2.62, which is relatively less automatable compared with other skills cluster families.

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[209] OECD, *Who Cares? Attracting and retaining care workers for the elderly*, 2020

[210] OECD, *Research and innovation in health and care in Norway: Case study – Innovation Policy Review of Norway*, 2017

[211] Kristin Standal, *Presentation on the National Program for Welfare Technology*, 2019

[212] OECD, *Who Cares? Attracting and retaining care workers for the elderly*, 2020

[213] Japanese Ministry of Economy, Trade and Industry, Revision of the Priority Areas to Which Robot Technology is to be Introduced in Nursing Care, 2017

[214] Paul Duckworth, Logan Graham, and Michael Osborne, *Inferring Work Task Automatability from AI Expert Evidence, Proceedings of the 2019 AAAI/ACM Conference on AI, Ethics, and Society*, 2019

That said, in the care and support workforce, administrative tasks in managing client records which are manual and repetitive can be streamlined through software and business automation tools as discussed in Part 6.6.2. Stakeholders consulted in the Study have suggested that technological augmentation is often in response to safety and security of care and support recipients and workers. Stakeholders also view technology as a useful tool to improve the quality of care and the data used to determine individual care and support needs.

Through innovation and investment, it is anticipated that technological augmentation of occupations will continue to occur and although care and support work is largely person-centric, it does not make it immune to this trend as most of these occupations do involve some tasks that are highly automatable. Therefore, the current and future care and support workforce will need to adapt and learn new skills in order to meet the expectations of an evolving job description which will become more technology dependent.

8.3 System settings also impact the care and support workforce

8.3.1 System setting inferences from workforce labour market characteristics

The prevalence of casualisation, underemployment and multiple jobs (Part 5) in the care and support workforce indicates that there is latent capacity to increase supply. However, system barriers may be blocking the realisation of this potential. There are a range of complex interactions, which are difficult to disentangle, that contribute to employer and worker preferences, including industrial relations, program funding models and regulation.

8.3.1.1 Industrial relations settings are complex

The interaction between collective bargaining, modern awards and the funding of government care and support programs is both complex and important. Wages and employment conditions are significant factors affecting the care and support workforce. In 2019-20, employee expenses represented 66% of total provider expenditure in residential aged care and was also a large component of the NDIS.[215] Wages can also affect the attraction, retention, utilisation and productivity of care and support workers.[216] Therefore, the setting, funding and altering of wages and employment conditions can affect the future demand and supply of the care and support workforce.

There are 3 broad categories of wage-setting methods in Australia: awards, collective agreements and individual arrangements. [217] Awards are determined by the FWC and act as the minimum terms and conditions for most national system employees in Australia. Most awards relate to particular industries or occupations. There are 5 main awards relevant to the care and support workforce:

- Aged Care Award – covers a variety of roles in residential aged care settings, including Personal care and support workers.
- Social, Community, Home Care and Disability Services (SCHADS) Award – covers multiple sectors, including home care, family day care, social and community services, and crisis assistance and supported housing. For the purpose of the Study, this award is relevant for Personal care and support workers in in-home and community settings.
- Nurses Award – covers nurses in all settings other than schools. Roles include nursing assistants, enrolled nurses, registered nurses and nurse practitioners.
- Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award – covers employees in the Aboriginal community-controlled health services industry.
- Health Professionals and Support Services Award – covers a wide range of other health and support roles, including hospital orderlies, cleaners, cooks, drivers, dental assistants, pathology technicians, counsellors and a range of allied health roles (including those in scope for the Study).[218]

Collective agreements are the most common pay setting for the care and support workforce, covering 64% of workers in May 2018 (Figure 274).[219] Across occupation groups, collective agreements are the most common setting for Personal care and support workers (75%), Health and welfare support workers (57%) and Registered nurses (53%).[220] Individual agreements[221] are more frequent in higher skill level occupations and are the most common pay setting for Allied

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[215] Australian Government Solicitor, Submission to the Work value case, 23 July 2021, 2021

[216] Royal Commission into Aged Care Quality and Safety, *Royal Commission into Aged Care Quality and Safety final report: care, dignity and respect, Final Report - Volume 2: The current system*, 2021

[217] ABS, Wage-setting methods and wage growth in Australia, 2018

[218] Fair Work Commission, Award Viewer 2021, MA000018, MA000100, MA000034, MA000115, MA000027, 2021

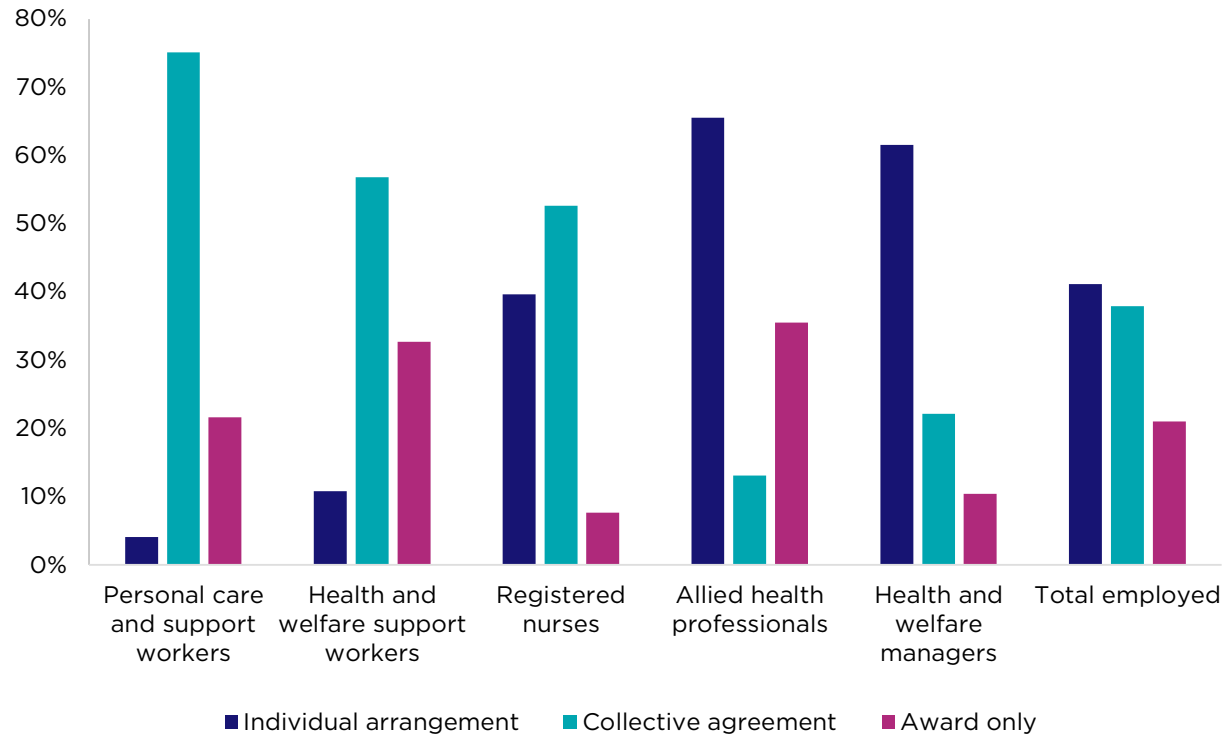
[219] ABS, Employee Earnings and Hours, Australia, May 2018 [Microdata], 2019

[220] ABS, Employee Earnings and Hours, Australia, May 2018 [Microdata], 2019

[221] Individual agreement data includes owner manager of incorporated enterprises.

health professionals (66%) and Health and welfare managers (62%).[222] In no occupation group are awards the most common pay setting.

Figure 274: Pay setting by occupation group, May 2018



Source: ABS Employee Earnings and Hours, by MOSP3 variable, May 2018 in TableBuilder. ANZSCO 4-digit (unit group) by ANZSIC 2 digit (sub-division) by method of pay setting. Due to ABS data perturbation, parts may not sum to 100%. Individual agreement data includes owner manager of incorporated enterprises.

While most care and support workers are employed on collective agreements (64% in May 2018), the award system can impact the wages and conditions of all workers in the sector. Under the FWC's *Better Off Overall Test*, employees on collective agreements must be better off than they would be under the relevant award.[223] The award system therefore acts as a safety net for care and support workers and drives the minimum wages and conditions of all workers.

Wage growth of residential aged care workers on collective agreements has been only slightly higher than the annual increase in the Aged Care Award. Between March 2016 and 2021, the average annualised wage increase for residential aged care enterprise agreements was 2.9%.[224] In comparison, the minimum pay rate in the Aged Care Award increased by an average of 2.7% per year over the same period.[225] This is unsurprising given aged care subsidies are indexed each year at a rate which is based primarily on increases to the minimum wage.[226]

In the NDIS, the Disability Support Worker Cost Model (Cost Model) is based on the SCHADS Award. [227] While the Cost Model does not establish or provide guidance on minimum wage levels, it informs the maximum price for supports funded by the NDIS. By using the SCHADS Award, which is a minimum wage, to inform the maximum level of government funding available to providers, it is unsurprising that wage growth in the sector has mostly followed annual increases in the award wage.

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[222] ABS, Employee Earnings and Hours, Australia, May 2018 [Microdata], 2019

[223] ABS, Wage-setting methods and wage growth in Australia, 2018

[224] Attorney-General's Department, Aged Care Sector Snapshot: pay setting, earnings, enterprise agreements, workforce, unpublished analysis, 2021

[225] Fair Work Commission, *Modern Award Statistics, 2015-2021*, 2021, NSC analysis

[226] Aged Care Financing Authority, *Eighth report on the Funding and Financing of the Aged Care Industry*, 2020

[227] NDIA, *Disability Support Worker Cost Model Assumptions and Methodology 2021-22*, 2021

These outcomes suggest that although most care and support workers are employed on a collective agreement, the award system is the substantial driver of wages and conditions in the sector.

The award system does not distinguish care and support from other settings

The current award system does not entirely reflect the distinct roles and responsibilities of workers in care and support settings. For example, the Aged Care Award is an industry award which covers many different occupations under a single title: 'aged care employee'.[228] This means the same minimum pay rates and conditions apply for a wide range of roles, including:

- cleaners
- maintenance workers
- pay clerks
- personal care workers
- gardeners
- drivers
- cooks.

As a result, the award does not recognise the skills or responsibilities that may be specific to personal care and support, cleaning, gardening or food services in residential aged care, nor does it take into consideration whether these roles should attract different minimum pay rates.

While most roles in residential aged care are covered by the Aged Care Award, registered nurses are covered by the Nurses Award, which is an occupation award. This means nurses in aged care are covered under the same national award and classification as those working in primary health care and general practice, with no differentiation in conditions or remuneration for the skills and responsibilities that are specific to each of these settings.

The Study notes that relevant parties are using the existing mechanisms in the Fair Work Act to seek to vary multiple care and support awards. This includes matters such as pay rates and role definitions.

Wage progression in the Aged Care Award is comparably low

Like most awards, the Aged Care Award includes a number of pay points or levels that represent the different rates of pay workers are eligible to receive. These pay points recognise gained experience, responsibility, qualification and/or workload. For personal care workers, there are only 5 pay points in the Aged Care Award, compared with 25 pay points for registered nurses in the Nurses Award.[229] While the Study does not have a view on the appropriate number of pay points (added complexity in awards may not be desirable), the room for wage progression in the Aged Care Award is comparatively limited. The difference between the lowest and highest personal care worker pay point is just 16.6%, compared with 122% for registered nurses (Figure 275). The comparatively small number of pay points in the Aged Care Award is partly owed to the lack of qualification requirements in these roles, which typically attract additional pay points in other modern awards.

The Aged Care Award is illustrative of the comparatively limited career progression available for personal care workers, who can expect little to no increase in real compensation relative to their length in the role.

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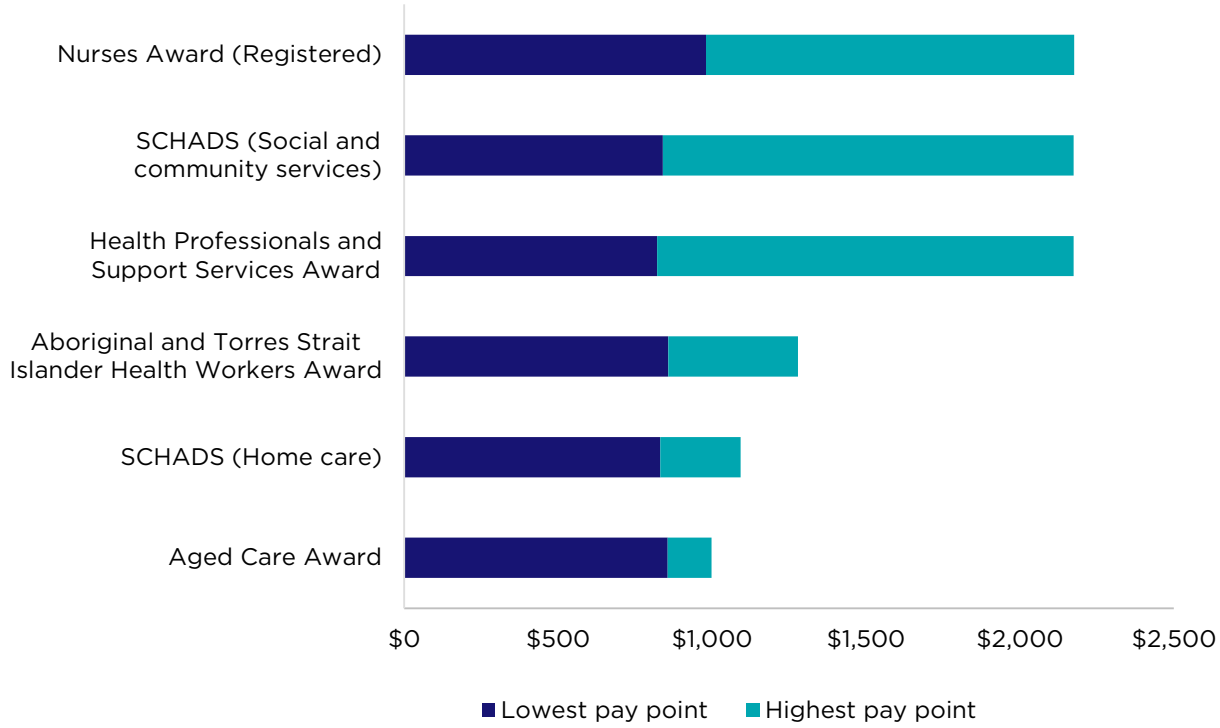
[228] Fair Work Commission, *Aged Care Award 2010 MA000018*, 2010

[229] Fair Work Commission, *Aged Care Award 2010 MA000018*, 2010; Fair Work Commission, *Nurses Award 2010 MA000034*, 2010

Figure 275: Lowest and highest pay point of care and support awards, minimum weekly wage FWC 2021-22



Source: Fair Work Commission, award statistics, 2020-21.

While there are 8 levels of social and community services employee in the SCHADS Award, each with multiple pay points, the NDIS Cost Model only includes 4 levels of disability support worker. These 4 pay points are linked to pay levels within the SCHADS Award. While the Cost Model does not set or establish minimum wage levels for the workforce, it does set the maximum levels of government funding for disability workers in the NDIS. This means the funding cap for disability workers in the NDIS ($38.34) in 2020 was lower than the highest SCHADS pay point of ($55.82) (Table 7).[230]

Table 7: Assumed SCHADS classifications and pay rates, 1 July 2020

NDIS level	Assumed SCHADS classification	Award hourly rate (1 July 2020)
Disability support worker 1	2.3	$29.56
Disability support worker 2	2.4/3.1	$30.69
Disability support worker 3	3.2	$31.92
Disability support worker 4	4.4	$38.34
SCHADS classification (social and community services workers)	8.3	$55.82

Source: NDIS Disability Support Worker Cost Model, 2020.

[230] Fair Work Ombudsman, *Pay Guide, Social, Community, Home Care and Disability Services Industry Award*, 2020, social and community services employee, level 8 pay point 3.

8.3.1.2 Conditions and the interaction with person-centred care

The various modern awards also set the minimum conditions of care and support workers. These can include conditions such as penalty and overtime rates, minimum engagements, broken and split shifts and allowances. The minimum award conditions are set by the FWC and do not necessarily reflect the environment or settings of the various care and support programs. The award system is complex, and it can be difficult for employers and employees to understand its interconnections with care and support programs.

For example, person-centred care models (such as in the NDIS) may not sit well with award arrangements which pre-date these models.

Person-centred care gives program participants greater control over the care and support services they receive. This can have implications for the workforce, with increased levels of unpredictability in the demand for services and hours of work.[231] The type, frequency, time, location and amount of care and support can be altered by the recipient, requiring flexibility by the provider and its workforce. This is sometimes at odds with the SCHADS Award, which provides little flexibility in managing when, where and how work is done and compensated. Some of the common complexities in applying the SCHADS Award to the NDIS include:

- **Minimum engagements:** some NDIS participants may only require short periods of care and support. Under the SCHADS Award, casual workers are entitled to a 2-hour minimum engagement period. In an NDIS trial site in October 2015, 78% of service requests were at or less than 2 hours.[232] This can have implications for workers, providers and participants. Workers may need to work many short shifts to accumulate enough hours of work per week, while providers may be financially disadvantaged for accepting shifts below the 2-hour minimum. Alternatively, participants may be in a situation where they must pay for the 2-hour minimum when it is above the amount of services they require.
- **Broken shifts:** Person-centred care includes peak and off-peak demand for services. For example, people with disability may choose to seek support services at the beginning and end of their day. Under the SCHADS Award, workers who have a break between shifts (other than a meal break) are entitled to additional allowances.[233] This can mean it is more cost effective for providers to employ multiple disability support workers to provide services to one participant in order to avoid paying additional allowances. Some workers may therefore miss out on additional hours, driving underemployment and multiple job holding. In this situation, providers are also having to employ more support workers than actually needed, putting additional workforce demand pressures on the sector. It can also negatively affect participants who may need to receive their services from multiple support workers, affecting the continuity of the services they receive.

Matters such as minimum engagements and broken shifts are currently before the FWC as part of the 4-yearly modern award reviews.

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[231] NDS, *A guide to employing a flexible workforce in a person-centred environment*, 2015

[232] NDS and Jobs Australia, *Submission to the 4-yearly review of modern awards*, 2016

[233] NDS, *A guide to employing a flexible workforce in a person-centred environment*, 2015

Case study: who pays for travel time?

Many care and support workers, particularly in the NDIS and in-home aged care programs, are required to travel multiple times each day for work. The cost of travelling for work can be particularly burdensome for regional participants and providers who need workers to travel long distances between locations.[234] Without reasonable reimbursement, workers may be financially disincentivised to service clients in more remote locations. However, it is not always clear who is liable for paying travel costs.

The awards: neither the SCHADS nor Aged Care Award define the time spent travelling between workplaces as paid work time. These awards include a $0.80 per kilometre allowance for workers who use their own vehicle during work hours to cover fuel and wear and tear.

The NDIS: in most instances, provider travel time can be included in the time charged to NDIS participants, including from home or between participants. However, the amount of travel a provider can claim is dependent on the area classification of the participant (between 30-60 minutes). Where a worker is travelling to provide services to more than one participant in a region, the provider should 'apportion that time (including the return journey where applicable) between participants, *with the agreement of each participant in advance'.*[235]

In-home aged care: there is no standardised reimbursement of staff travel costs in aged care. The 2016 NACWCS found that 77% of home care and support outlets provided paid time for travel between care appointments, while 48% provided a fuel/depreciation allowance for work-related transport costs. Only 16.7% of outlets paid time for travel between a worker's home and their care/support appointments.[236]

8.3.2 Regulation, pricing and funding across care and support programs

The regulatory environments for aged care, NDIS and veteran care programs are often disconnected from one another, creating different and separate requirements for workers and providers in each program. This also introduces a range of incentives and disincentives to operate in each program market. The workforce implications of this system complexity and misalignment of regulatory environments are significant and create barriers to workforce mobility across programs.

8.3.2.1 Worker screening checks

Worker screening arrangements in the care and support sector have been changing. The NDIS Worker Screening Check has replaced the different arrangements that previously operated in each state or territory, setting a minimum national standard that all workers engaged in a risk assessed role must meet. The NDIS Worker Screening Check is portable nationally and across NDIS providers. Screening checks are undertaken by the relevant Worker Screening Unit in each state and territory (Table 8), which sets their own application fees, which vary across jurisdictions. While there is a national standard, some states and territories may have additional requirements in some circumstances (for example, people who work with children may need to undertake additional screening).

[234] NDIA, *Report of Annual Pricing Review 2020-21*, 2020

[235] NDIA, *Price Guide 2020-21, Version 2.1*, 2021

[236] Mavromaras, et al., *2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce*, 2017

Table 8: NDIS Worker Screening Units differences across states and territories

State or territory, Worker Screening Unit agency	Worker screening check fee	Ability to work while screening check being processed
Australian Capital Territory, Access Canberra	$137.00	✓
New South Wales, Services NSW	$80.00	✓
Northern Territory, SAFE NT	$124.00	✓
Queensland, Disability Worker Screening	$120.00	×
South Australia, Department of Human Services Screening Unit	$117.70	×
Tasmania, Consumer, Building and Occupational Services	$115.50	✓
Victoria, Department of Justice and Community Services	$121.10	×
Western Australia, Department of Communities	$145.00	✓

Source: Individual state and territory Worker Screening Unit agencies.[237]

Depending on the laws in each state or territory, a worker may begin working in a risk assessed role once they have submitted an application for an NDIS Worker Screening Check, but before they have been granted a clearance.[238] In these circumstances, registered NDIS providers must ensure that the worker is appropriately supervised by a person with an NDIS worker screening check. In some jurisdictions, workers must wait for clearance to commence work. In this context some stakeholders raised the length of time taken to process worker screening checks can result in prospective employees finding alternate employment while checks are completed.

The NDIS workers screening check is a legislative requirement for all registered NDIS providers, but is optional for unregistered NDIS providers (Part 8.3.2.2), and it is open to self-managed NDIS participants to decide whether workers providing their supports require an NDIS worker check.[239]

The NDIS Worker Screening check is recognised under both the aged care and NDIS legislation, however the police check requirements for workers in aged care is not recognised for NDIS purposes, as police checks are point-in-time and not as comprehensive as an NDIS check.[240]

The *NDIS National Workforce Plan* recognises the need to further align worker regulation across care and support programs, and the Australian Government announced funding in the 2021-22 Budget to implement a care and support code of conduct and a nationally consistent pre-employment screening process across aged, veteran and disability care and support services. Legislative amendments to bring this into effect are currently under parliamentary consideration.

8.3.2.2 Provider registration processes and differences in provider status

A mix of provider registration requirements exist across care and support programs with different associated administrative and compliance processes. The type of provider category also varies across and within programs. This mix adds to the complexity of the system and influences the different ways the care and support workforce may be engaged across programs.

The NDIS is comprised of both registered and unregistered providers. Registered providers can demonstrate they have met the NDIS Practice Standard and specific quality and safeguards requirements for the supports they provide. A small number of NDIS services can only be

[237] ACT, Access Canberra; NSW, Services NSW; NT, SAFE NT; Queensland, Disability Worker Screening; SA, Department of Human Services Screening Unit; Tasmania, Consumer, Building and Occupational Services; Victoria, Department of Justice and Community Services; WA, Department of Communities.

[238] Department of Health, *Aged Care Worker Screening Guidelines, July 2021*, 2021

[239] NDIS Quality and Safeguards Commission, NDIS Worker Screening Check, 2021

[240] Department of Health, *Aged Care Worker Screening Guidelines, July 2021*, 2021

provided by registered providers (such as specialist disability accommodation, aspects of behaviour support and where a regulated restrictive practice is likely to be in use). However, NDIS participants whose plans are self-managed or plan-managed can use an unregistered NDIS provider in most circumstances.[241]

Becoming a registered NDIS provider requires an independent quality audit to be completed, at the provider's cost. A verification or certification quality audit is also required for registration renewal (the maximum registration is up to 3 years). Stakeholders indicated that audits range from around $1,000 to over $16,000 and can be a significant cost depending on the provider's size and financial capacity. The audit process has been highlighted as a potential disincentive for entering the registered provider NDIS market.

For most aged care programs providers are required to be approved and able to meet legislative criteria. Approved provider status is not required for the CHSP or National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Approval is also not required for private aged care providers who do not receive government funding for aged care services.[242]

To be an approved aged care provider, an organisation must be an incorporated entity. Sole traders are unable to be approved aged care providers. This, in part, explains the different provider mix across aged care and NDIS programs (Part 2.1.5). The approval and reaccreditation processes include assessment against legislated criteria by the Aged Care Quality and Safety Commission. Review audits may be undertaken, if required, but unlike in the NDIS, are not a mandatory part of accreditation processes. Accreditation fees are applied on a cost recovery basis and range from $0 (in certain circumstances) to around $22,000 depending on the number of allocated places at the service.

Although the registration and accreditation processes have similar objectives to ascertain the suitability of providers, there is no ability to recognise provider status across programs. This creates administrative inefficiencies in the care and support system.

Different approaches to codes of conduct have been adopted by the NDIS and aged care. The NDIS Code of Conduct is a legislative instrument under the *National Disability Insurance Scheme (Code of Conduct) Rules 2018*, that applies to both registered and unregistered providers, and workers. In contrast, ACWIC has developed and released in 2021 the Aged Care Voluntary Industry Code of Practice (an initiative under *A Matter of Care*). As noted in Part 8.3.2.1, implementation of a care and support code of conduct across aged, veteran and disability care and support services was announced in the Australian Government's 2021-22 Budget.

8.3.2.3 Funding and pricing settings influences provider business decisions

Stakeholders provided a range of insights into how pricing and funding models across the programs influence business decisions around staff scheduling and operating models, including whether to stay within particular program markets or invest in innovation and workforce development.

Stakeholders pointed to the shift to person-centred care and the interaction with program funding and pricing settings as incentivising providers to employ workers on short-hour casual or part-time contracts – leading to the rise of an 'on-demand' workforce and 'just-in-time' staffing. This approach ensures there is sufficient workforce coverage to meet the increasingly complex and diverse consumer needs, as well as keep operating costs low within an increasingly competitive market environment. This also enables scaling of operations in line with the incremental rollout of the NDIS. However, it is not well-understood how these labour market characteristics of the workforce are also driven by business practice inertia or lack of innovation.

Across the different programs, stakeholders indicated that similar services attract different revenue depending on the program. The Study notes that the 2021-22 Budget included the measure *Addressing existing price regulations and below market rate fees in veterans' care*, which increased DVA provider fees for certain occupational therapy and podiatry services from 1 July 2021.

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[241] NDIS Quality and Safeguards Commission, Unregistered NDIS providers, 2021

[242] Aged Care Quality and Safety Commission, Becoming an approved aged care provider, 2021

Stakeholders said that the NDIS' client-driven, fee-for-service model and variable pricing arrangements across provider types had a number of implications. For example, stakeholders said that payment for services in arrears had implications for cashflow and financial certainty, given participants' choice of provider. Stakeholders also stated that price caps may be too high or too low for many participants and providers, depending on a range of circumstances (such as an individual's complex needs and associated support requirements). Providers have flexibility around pricing, scheduling and payment terms, which can be negotiated with self-managed participants. This flexibility may incentivise operating as an unregistered NDIS provider – a view put forward by a number of stakeholders.

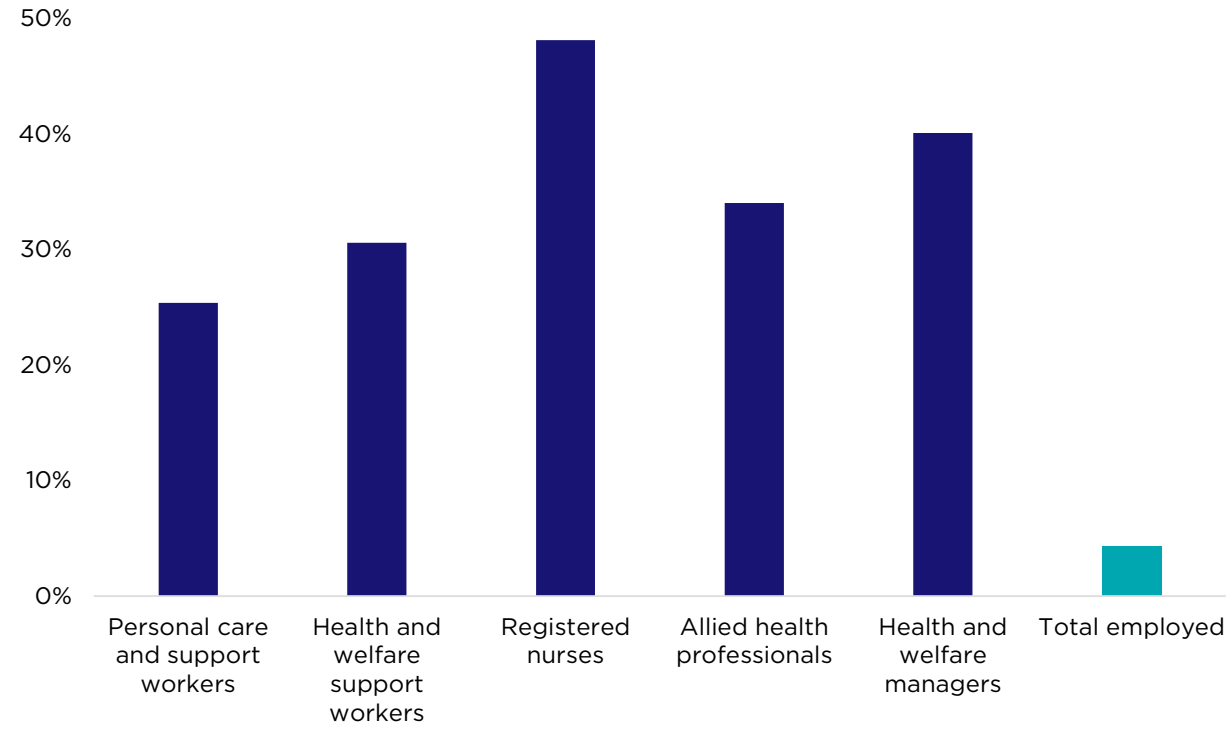
Place-based block funding applies to most aged care programs, which provides a degree of financial certainty. However, many stakeholders were critical of the adequacy of funding and limited capacity to invest in service delivery innovation and workforce capability uplift.

Tax system concessions

Fringe benefits tax (FBT) concessions can be an attractive feature of the care and support sector for some workers. Many non-profit organisations, including care and support providers, are eligible for the FBT exemption and can pass on to their employees a proportion of their wages as a reimbursement of personal expenses. Salary packaging often features in online job advertisements for Personal care and support workers, highlighting the use of non-wage benefits providers use to attract workers.

In 2018-19, care and support workers were significantly more likely to report fringe benefits (employer tax-exempt) than the Australian average (Figure 276). This suggests that salary packaging is available and actively used by many workers in the care and support sector, and can be a financial incentive in workers' decisions to work for multiple providers.

Figure 276: Proportion of workers with reportable fringe benefits 2018-19



Source: ATO Taxation Statistics 2018-19.

8.3.2.4 Impact of regulation on business practice

Regulation is an important and necessary part of the delivery of care and support services to ensure quality service and outcomes for those Australians who rely on these services. However as highlighted throughout this Part, how regulation is implemented in practice can have unintended consequences for the care and support workforce and ultimately on the quality of care provided.

Many stakeholders suggested that regulation is biased toward measuring compliance and does not incentivise innovation in client care and support. Examples included reporting compliance with prescribed 'tasks' being undertaken for clients without consideration of whether these tasks led to a better outcome for the client or could be done a different way. Aged care providers, in particular, noted more targeted approaches to care and support that take into consideration the client's needs would provide better client outcomes and improve job satisfaction for workers. Use of technology to monitor whether an aged care resident is able to move themselves independently overnight was a practical example cited by providers, where worker support could then be used to support those who require assistance rather than disturbing all residents.

A further example was the implementation of mandatory care minutes. While providers acknowledged this was intended to improve quality outcomes for aged care residents, in implementing this measure some providers noted they would take into consideration the fiscal impacts in their business decisions. For example, using registered nurses who have recently entered the workforce (and are at lower pay scale levels) over more experienced registered nurses (at higher pay scale levels).

Ensuring regulatory settings have the appropriate checks and balances, so that quality outcomes are achieved while ensuring productivity and innovation enhancements are not dampened, is a significant challenge that impacts workforce utilisation.

These illustrative examples across worker screening, provider regulation, pricing, and taxation speak to the significant complexity of operating within and across the care and support system. Given this, it is important that the workforce implications of regulatory and operating frameworks are considered both in their program-specific context, but also from a whole-of-care and support system perspective. Without this, the potential for disincentives and unintended consequences is high, and risks exacerbating service delivery and workforce gaps. A framework for workforce monitoring and ensuring workforce implications are factored into policy development and decision making is discussed in Part 11.

Part 9
Is there a workforce gap?

Part 9 examines whether there is, or isn't, a workforce gap at the current point in time; and forecasts demand and supply of the care and support workforce into the future.

A comment on the modelling in this Part and the conclusions that should be drawn

The key conclusion to draw from Part 9 is not the size of any future workforce gap, but that ultimately the care and support workforce may need to look different in the future than it does today.

The modelling in this Part contains a number of assumptions. These include assumptions around inflows into the sector, wages, average hours and migration. To the extent *any* of the many assumptions contained in the model are not realised, outcomes will of course differ. It is also important to remember that part of the reason for commissioning this modelling is to help ensure that workforce gaps are avoided.

Models also fail to fully capture the complexity and the dynamic nature of a modern economy.

As a case in point, the introduction of the NDIS created the need to recruit a large workforce over a very short period of time, with concerns about pressure being put on the care and support workforce leading to a workforce shortage. For instance, a 2011 Productivity Commission report into the disability care and support sector noted that a workforce shortage in disability care would be exacerbated after the implementation of the NDIS.

However, and as discussed earlier in this Study, the labour market was broadly able to manage the roll-out of the NDIS (including through attracting at the margin, more younger people and men into the care and support workforce – noting that they remain a relatively small share of the overall workforce).

It is therefore important that there is sufficient flexibility in the labour market to enable such adjustments to occur – both within the care and support sector and across the labour market more broadly.

A workforce 'gap' is forecast, but the outlook could change

To prevent the unusual events of 2020 and 2021 from influencing the longer-term projections, the starting point used by Deloitte Access Economics for both the baseline forecasts and sensitivities presented in this Study for workforce supply are necessarily based on the 2016 Census of Population and Housing. (This differs from other estimates contained in this Study based on ABS 2021 Labour Force Survey data.)

Based on forecasts commissioned for this Study it is expected that by 2049-50 the total demand for the care and support workforce will reach around 531,620 full-time equivalent (FTE) positions. This is an increase of around 99% relative to the workforce in FTE terms in 2020-21.

- On a headcount basis (i.e. the number of actual workers required given average hours worked by occupation), the total care and support workforce required is expected to reach 721,750 workers by 2049-50 (up from 364,120 in 2019-20).

The future demand for the care and support workforce is expected to reach approximately 3.9% of total employment by 2049-50, up from 2.9% in 2019-20.

- That is, in order to meet the future workforce demand requirements around 1 in every 25 people working in the Australian workforce will need to be employed within the care and support workforce.

While the care and support workforce has grown significantly over the past 2 decades, the baseline forecast anticipates that workforce supply will grow more slowly over the next 30 years. Total care and support workforce supply, in both FTE and headcount terms, is expected to grow at an average rate of approximately 0.6% per year over the next 30 years.

- Except for Allied health professionals, the supply of workers into the relevant care and support occupation groups is expected to grow relatively slowly (and for some occupation groups, supply is anticipated to decline over the next 3 decades).

As workforce demand is expected to exceed workforce supply, a workforce gap emerges in the short-term and continues to grow over the next 30 years for the care and support workforce. This gap is approximately 211,430 FTE positions by 2049-50.

- Looking at the broader care and support workforce, it is clear that the anticipated workforce shortages are likely to be concentrated in the skill level 4 occupations (*Aged and disabled carers* and *Nursing support and personal care workers*) – a not unexpected result given that the majority of the total care and support workforce is currently comprised of these 2 key occupations.
- Meeting workforce demand for some skill level 1 occupations could also be a significant challenge. While the supply of Allied health professionals is expected to largely meet demand at the national level (noting that there are likely to be ongoing difficulties in the recruitment of Allied health professionals in some regions of Australia), there are expected shortages by 2049-50 for *Registered nurses*, *Health and welfare services managers* and *Nurse managers*.

At the moment skill shortages and recruitment difficultly exists, but that does not mean demand exceeds supply at a national level

There is limited evidence of a significant workforce shortage in the care and support sector at the national level at the current time. That said, there are skill shortages present for care and support occupations across Australia, and instances of recruitment difficulty exist, as reflected in NSC data.

Notwithstanding the limited evidence of a workforce gap at the national level, analysis at state and regional levels adds important context to this observation.

Each region across Australia has a unique set of workforce challenges and opportunities, including for the care and support workforce. Similarly, each region has a different demand for the care and support workforce based on a number of population and socio-economic characteristics.

Therefore, there is no single ratio of workforce to participants which provides a sufficient level of care and support services within a community. As a result, caution should be used when using macro-level data and indicators to understand local markets, with skill shortages particularly difficult to identify at a regional level. A place-based needs analysis should instead be undertaken in order to incorporate localised factors.

9.1 There is limited evidence of a current gap between workforce demand and supply at the national level

There is limited evidence of a significant workforce shortage in the care and support sector at the national level at the current time. While there are pockets of shortages present for particular care and support occupations across Australia, there is not a widespread or significant gap across all care and support occupations nationally.

If there were to be a significant gap between demand and supply at the national level it would be expected that one or more of the following would be occurring:

- growth in average hours worked across the current care and support workforce
- increases in wages across the sector to attract additional workers into the sector
- falling levels of underemployment as employers utilise their existing workforce more intensely
- changes in the relationship between job advertisements and employment.

While none of the above factors are currently evident to any great extent across the care and support workforce, it is important to acknowledge that government funding and regulation of care and support may mean that these typical labour market mechanisms are less prevalent than in other differently regulated sectors. In addition, the impact of COVID-19 is likely to have impacted many of the demand and supply aspects of the care and support workforce.

> For the purposes of the forecasts presented in this part of the report**, it has been assumed that workforce demand and supply is broadly aligned at the start of the projection period**. Were there to be an identified gap based on other information, any workforce gap presented in these forecasts should be considered as *additional* to the identified gap.

Based on the forecasts presented later in this chapter, significant gaps between workforce demand and supply are anticipated to emerge in the next few years as demand for the care and support workforce significantly outpaces the growth in the anticipated supply.

9.1.1 Employer surveys identify that there are some skill shortages and recruitment issues in the care and support workforce

While no significant gaps between current supply and demand for the care and support workforce are identifiable in the current labour market data, several surveys have been conducted to investigate various aspects of skill shortages and recruitment difficulty for specific parts of the sector.

Results from NDS' 2020 survey of disability service providers in Australia, suggests that for those providers surveyed, recruitment difficulty is particularly elevated for psychologists (87% of respondents said this role was extremely or moderately difficulty to recruit competent staff for) and the allied health roles of occupational therapists (86%), speech therapists (83%) and physiotherapists (76%). While recruitment difficulty does not necessarily mean employers are unable to fill their vacancies, all of these roles were also found to be in shortage on the 2021 SPL (Part 9.1.1.1 and Part 12.7.1).

The incidence of skill shortages in the aged care sector has declined since 2012, particularly in residential care. In 2016 NACWCS, skill shortages were reported by 53% of residential care facilities and 42% of home care and home support outlets (compared to 76% and 49% respectively in 2012). Skill shortages were more prevalent in locations outside major cities across both settings. A shortage of *Registered nurses* was most common in residential aged care, while a shortage of Community care workers was noted in home care and home support outlets. A lack of suitable applicants was the primary reason for skill shortages, with slow recruitment processes also commonly cited as leading to skill shortages. Residential care facilities also reported the need for specialist knowledge contributing to skill shortages while home care and home support outlets reported their geographical location as contributing to skill shortages.

9.1.1.1 National Skills Commission's Skills Priority List

The Skills Priority List (SPL) is produced annually by the NSC and provides a detailed view of shortages as well as the future demand for occupations over the next 5 years across Australia.

Mental health occupations are not included in the analysis below, but are included in Part 12.

Table 9: Care and support workforce occupations by Skills Priority List category, 2021

In shortage; strong future demand	
● Aged or disabled carer	● Speech pathologist
● Enrolled nurse	
In shortage; moderate future demand	
● Diversional therapist	● Personal care assistant
● Nursing support worker	● Podiatrist
● Occupational therapist	● Physiotherapist
No shortage; strong future demand	
● Audiologist	● Mothercraft nurse
● Community arts worker	● Recreation officer
● Community worker	● Residential care officer
● Disabilities services officer	● Welfare worker
● Family support worker	● Youth worker
No shortage; moderate future demand	
● Aboriginal and Torres Strait Islander health worker	● Registered nurse (critical care and emergency)
● Dietitian	● Registered nurse (developmental disability)
● Hospital orderly	● Registered nurse (disability and rehabilitation)
● Medical administrator	● Registered nurse (medical)
● Nurse manager	● Registered nurse (medical practice)
● Nurse practitioner	● Registered nurse (mental health)
● Nursing clinical director	● Registered nurse (paediatrics)
● Nutritionist	● Registered nurse (perioperative)
● Primary health organisation manager	● Registered nurse (surgical)
● Registered nurse (aged care)	● Social worker
● Registered nurse (child and family health)	● Therapy aide
● Registered nurse (community health)	● Welfare centre manager

Key to occupation groups: ● Personal care and support workers, ● Health and welfare support workers, ● Registered nurses, ● Allied health professionals, ● Health and welfare managers.

Source: NSC, Skills Priority List, 2021. Note that data for the 2021 SPL were collected over the period July 2020 to April 2021 and may not reflect the situation in Australia as at September 2021 due to the recent COVID-19 outbreaks and associated lockdowns.

National shortages were identified in 21% of assessed care workforce occupations (9 occupations) compared with 19% of all occupations assessed (Table 10). However, looking from the perspective of employment share, almost half (47%) of care and support workforce employment is in an occupation rated as being in shortage. A significant contributor to this is the large employing occupations of *Aged or disabled carer*, *Nursing support worker* and *Personal care assistant* which accounted for over 70% of employment across the occupations rated as being in shortage.

All occupations in the care and support workforce are projected to have either strong or moderate future demand. A slightly lower proportion of care and support workforce occupations are projected to have strong future demand compared with the average across all occupations (30% compared with 33%). Similarly, looking from an employment perspective, occupations with high future demand account for a higher proportion (41%) of total care and support workforce employment.

Of the 2-digit ANZSCO occupation groups relating to the care and support workforce listed in the SPL, shortages were most apparent in *Carers and aides*, with 60% of occupations in shortage. *Health and welfare support workers* (78% of occupations), had the highest proportion of occupations with strong future demand, followed by *Legal, social and welfare professionals* (75% of occupations).

Table 10: Care and support workforce occupations in shortage and strong future demand, by 2-digit ANZSCO occupation group

Occupation group (2-digit ANZSCO)	Occupation group name (2-digit ANZSCO)	No. of occupations assessed	Proportion in shortage	Proportion with strong future demand
13	Specialist managers	4	0%	0%
25	Health professionals	21	19%	10%
27	Legal, social and welfare professionals	4	0%	75%
41	Health and welfare support workers	9	22%	78%
42	Carers and aides	5	60%	20%
	Care and support occupations in SPL	**43**	**21%**	**30%**

Source: NSC, Skills Priority List 2021.

9.1.1.2 Survey of Employers who have Recently Advertised (SERA)

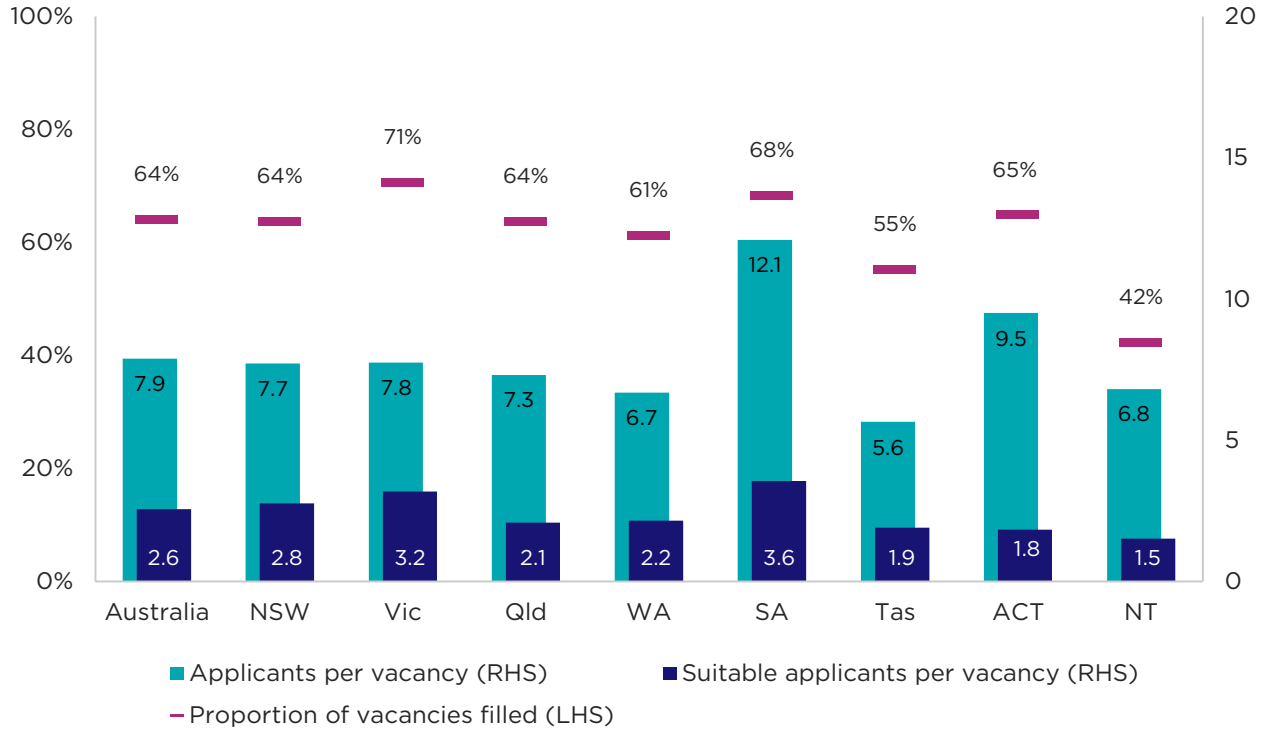
The NSC undertakes research into the labour market for selected occupations through the SERA, which forms a key part of the evidence base for the SPL.

Between February 2020 and July 2021, the NSC surveyed over 1,500 vacancies for nursing and allied health occupations. These occupations comprised: registered and enrolled nurses; occupational therapists; physiotherapists; podiatrists; psychologists; speech pathologists and audiologists.

In total, 64% of vacancies surveyed across these occupations were filled across all industries. On average, employers received 5.3 qualified applicants per vacancy and 2.6 suitable applicants per vacancy.

Looking across states and territories (Figure 277), employers in the Northern Territory filled the lowest proportion of vacancies (42%), followed by Tasmania (55%). In Tasmania, local university training is currently not available for some allied health professions (including physiotherapy, occupational therapy and speech pathology), although is expected to commence in coming years. This was raised by some stakeholders as restricting the current supply of allied health professionals in Tasmania.

Figure 277: Proportion of vacancies filled (%), average number of applicants and suitable applicants per vacancy (no.), surveyed nursing, pyschology and allied health occupations, by state and territory, February 2020 to July 2021



Source: NSC, Survey of Employers who have Recently Advertised, 2021.

Employers experienced slightly more difficulty recruiting for care and support occupations in regional areas, filling 63% of vacancies, compared with 65% of vacancies in metropolitan areas (Table 11). Employers in metropolitan areas also received more applicants per vacancy, received more qualified applicants, and considered more applicants to be suitable.

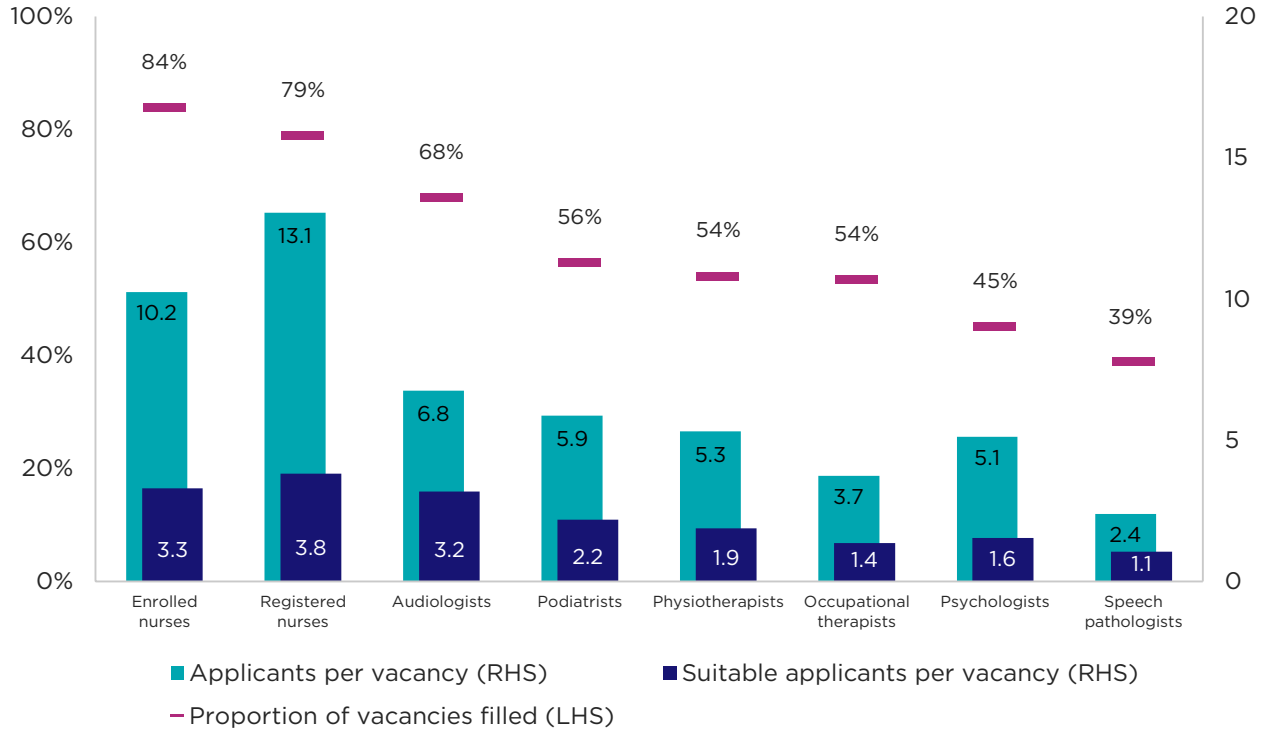
Table 11: Key indicators, nursing, psychology and allied health occupations, by metropolitan and regional, February 2020 to July 2021

Key indicators	Metropolitan	Regional	Total
% of vacancies filled	65%	63%	**64%**
Average number of applicants per vacancy	8.8	6.1	**7.9**
Average number of qualified applicants per vacancy	5.8	4.1	**5.3**
Average number of suitable applicants per vacancy	2.8	2.0	**2.6**

Source: NSC, Survey of Employers who have Recently Advertised, 2021.

Looking at results by occupation (Figure 278), employers filled vacancies for nurses with the least difficulty, while vacancies for psychologists and allied health professionals had lower proportions of vacancies filled. Employers recruiting for nurses also received more applicants overall and considered a greater number of applicants suitable compared with allied health occupations.

Figure 278: Proportion of vacancies filled (%), average number of applicants and suitable applicants per vacancy (no.), nursing, pyschology and allied health occupations, Australia, February 2020 to July 2021



Source: NSC, Survey of Employers who have Recently Advertised, 2021. Includes 4-digit and 6-digit ANZSCO occupations.

While most vacancies for enrolled and registered nurses were filled, employers in different sectors or locations had varied recruitment experiences.

Positions for enrolled nurses in aged care had lower fill rates (77%) compared with hospital or local health service positions (86%).

More difficulty was evident recruiting for registered nurses in mental health related positions (70% of vacancies filled, compared with 79% for all registered nurses). There was also slightly more difficulty filling registered nurse vacancies in regional Australia (76% filled). Vacancies for registered nurses in the aged care sector had a fill rate of 84%, slightly above the overall average for registered nurses (noting that data were collected prior to July 2021).

9.1.1.3 Recruitment Experiences and Outlook Survey (REOS)

The REOS, conducted by the NSC, is a continuous survey of employers to monitor recruitment activity in the labour market and covers a range of topics including the business impacts of COVID-19, current recruitment activity, recruitment difficulty, recruitment methods, business risks and future staffing expectations.

Reason for recruitment

Results from the REOS from 10 August 2020 to 13 August 2021 suggest that the need to replace staff is a more common reason for recruitment for employers recruiting for care and support occupations, compared with all occupations (Figure 279).

- Some 59% of employers recruiting for care and support occupations recruited for 'replacement positions only', and a further 21% recruited for 'both replacement and new positions'. This compares with 55% of employers for all occupations recruiting for 'replacement positions only', and 9% recruiting for 'both replacement and new positions'
- The results suggest that recruiting to replace staff is more common in Capital Cities compared with Rest of State areas, although differences in results are relatively minor.

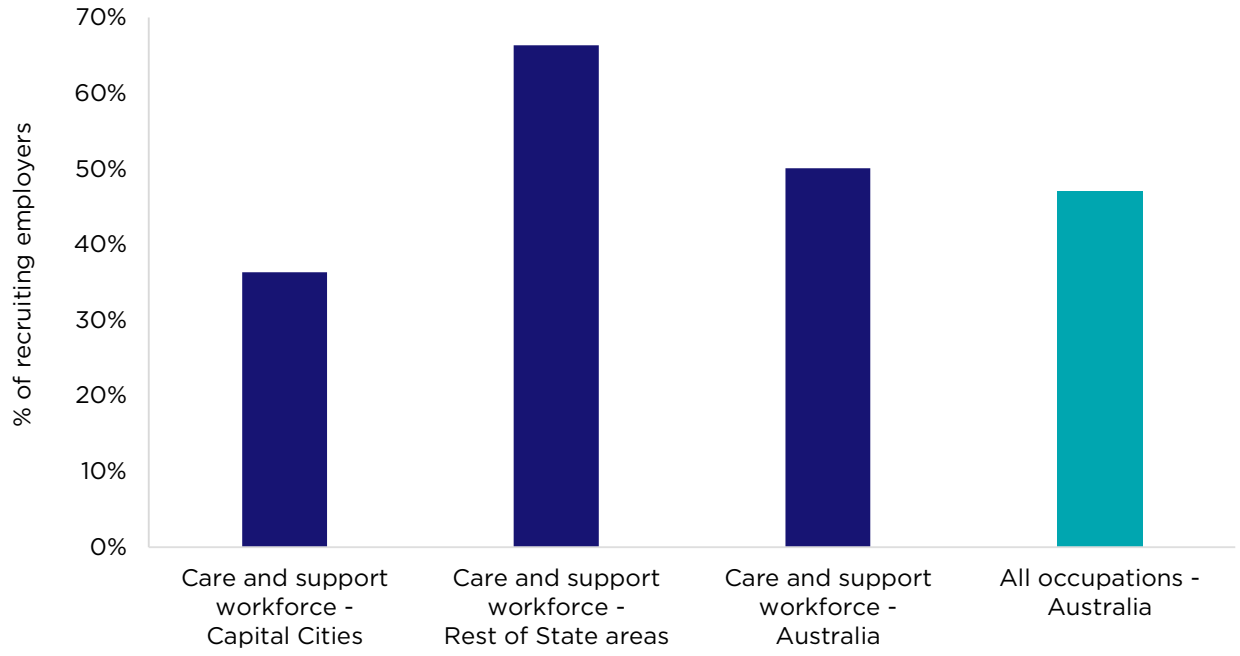
Figure 279: Reason for recruitment, by location, August 2020 to August 2021

Source: NSC REOS, 2021. Data covers the period 10 August 2020 to 13 August 2021.

Recruitment difficulty

REOS data shows that 50% of employers recruiting for care and support occupations experienced recruitment difficulty, slightly higher compared with all occupations over the same period (47%) (Figure 280). Employers in Rest of State areas (66%) recruiting for care and support occupations were far more likely to experience recruitment difficulty compared with employers in Capital Cities (36%).

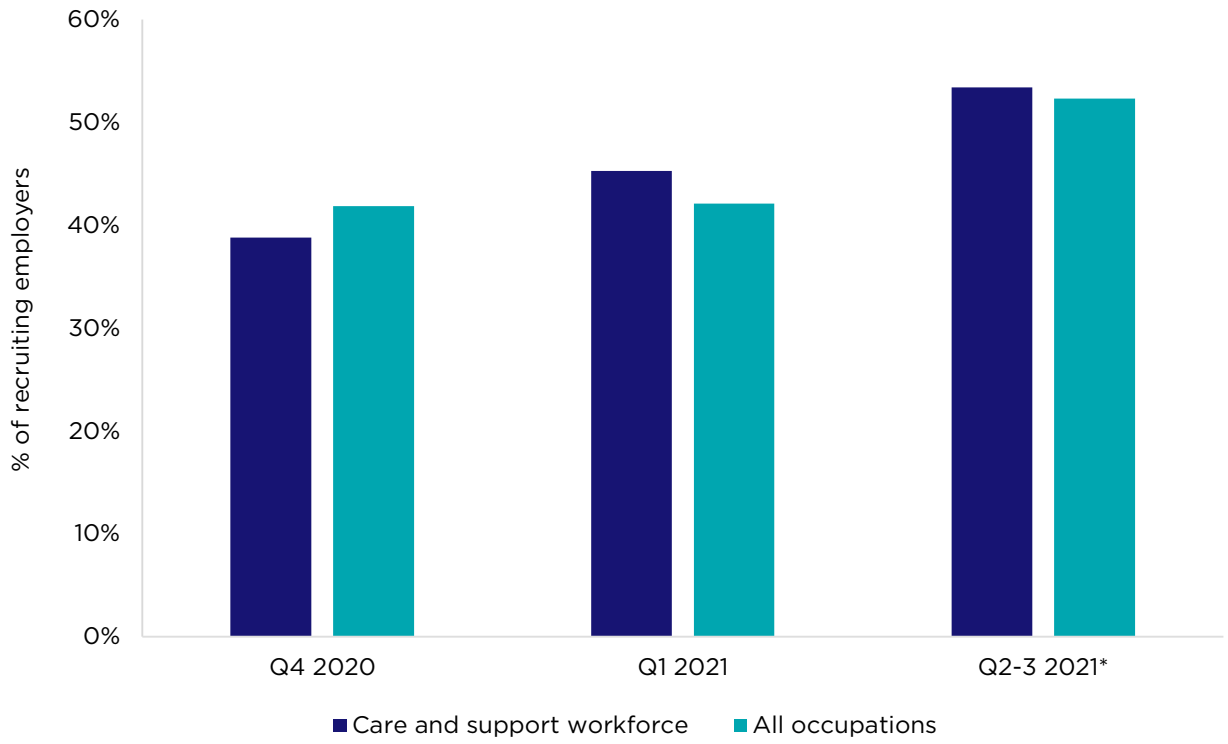
Figure 280: Incidence of recruitment difficulty, August 2020 to August 2021



Source: NSC REOS, 2021. Data covers the period 10 August 2020 to 13 August 2021.

Over time, the incidence of recruitment difficulty for care and support occupations has increased, from 39% in Quarter 4, 2020 to 53% in Quarters 2 and 3, 2021 (Figure 281). This is in line with the increase in the incidence of recruitment difficulty for all occupations, which has increased from 42% to 52% over the same period.

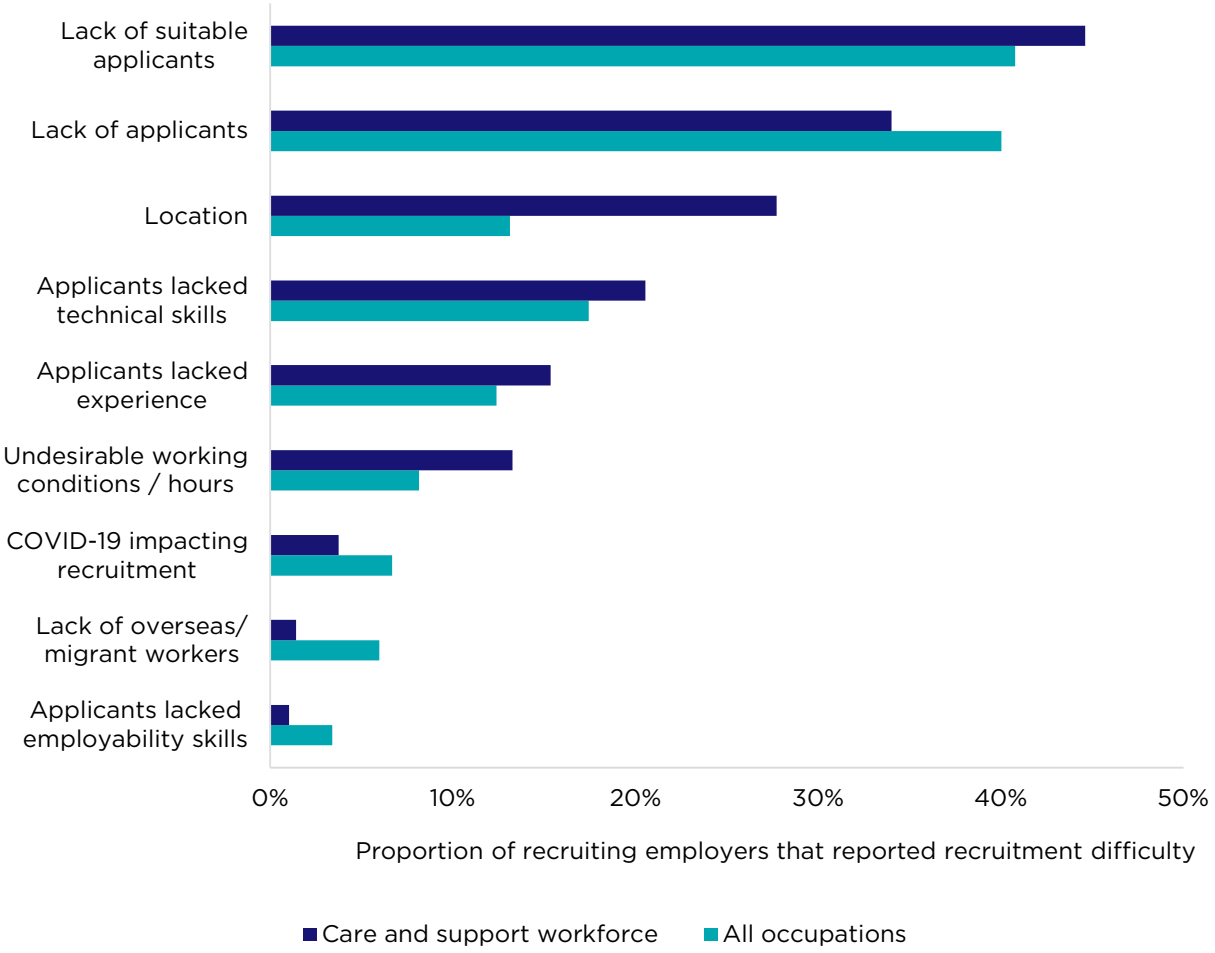
Figure 281: Incidence of recruitment difficulty over time, August 2020 to August 2021



Source: NSC REOS, 2021. *Data covers the period 10 August 2020 to 13 August 2021.

The reasons for recruitment difficulty for care and support occupations were similar to the reasons for all occupations, although the proportion of employers with difficulty recruiting for care and support occupations that said the location of their town or organisation was a reason for difficulty (28%) was notably higher compared with all occupations (13%) (Figure 282).

Figure 282: Reasons for recruitment difficulty, September 2020 to August 2020



Source: NSC REOS, 2021. Data covers the period 21 September 2020 to 13 August 2021. Employers may have provided more than one reason.

Employers recruiting for care and support workers are more likely to cite a lack of suitable applicants (45%), rather than a lack of applicants in general (34%). Results across REOS and other NSC survey programs[243] suggest that most employers attract applicants when recruiting, but lack of experience, lack of technical skills, qualifications and/or licencing are key reasons for employers regarding applicants as unsuitable. This may reflect, at least in part, that while many employers may be attracting sufficient applicants (relative to other occupations) there is a disconnect between applicants' qualifications and employers' perception of applicants' potential job effectiveness or work readiness (Part 7.3.2).

[243] NSC, Survey of Employers who Recently Advertised (SERA), unpublished data, 2021

9.2 A national perspective may overlook challenges at the regional level

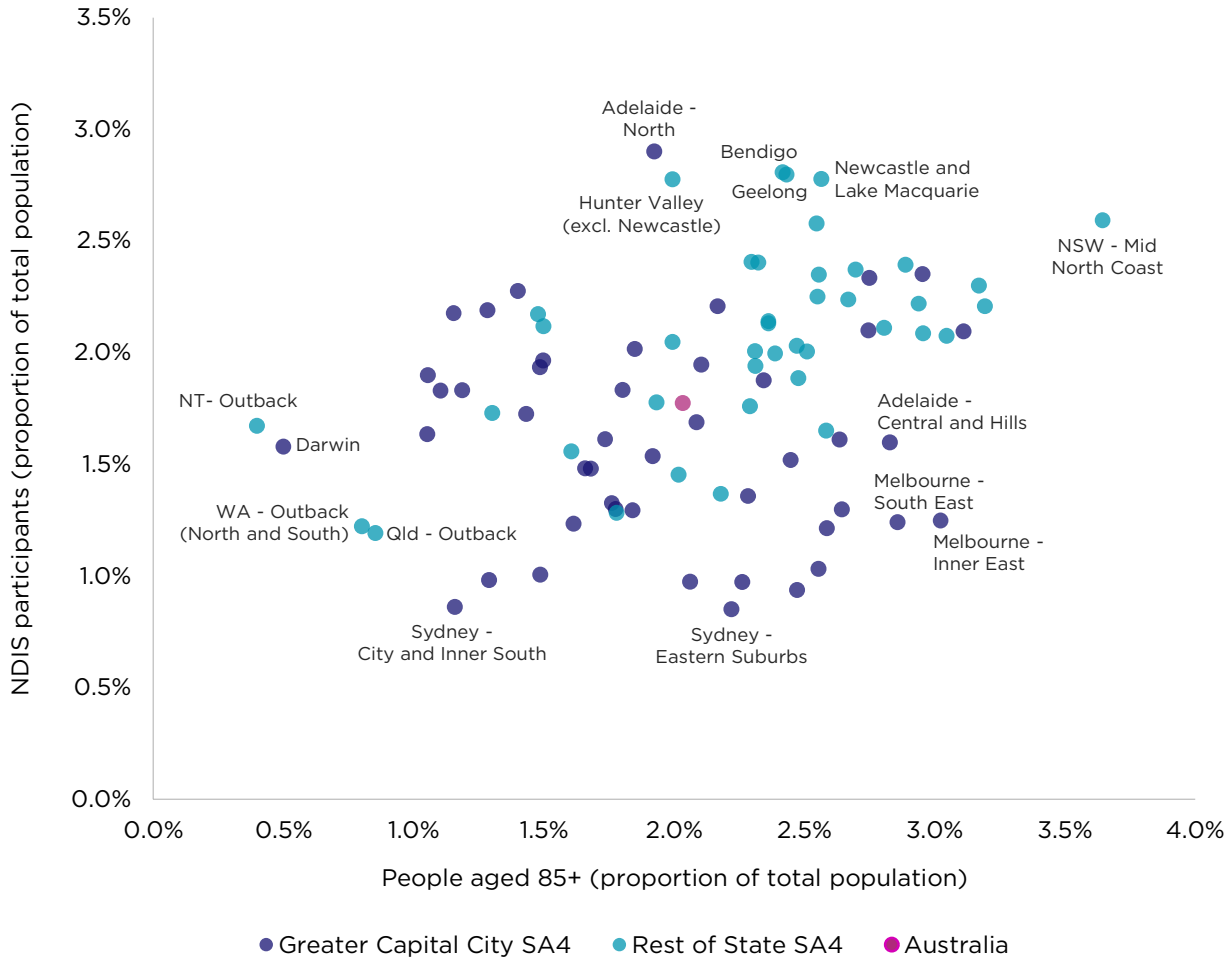
Notwithstanding the limited evidence of a workforce gap at the national level, analysis at state and regional levels adds important context to this observation.

9.2.1 There is no right balance between workforce demand and supply at the regional level

Each region across Australia has a unique set of workforce challenges and opportunities, including for the care and support workforce. Similarly, each region has a different demand for the care and support workforce based on a number of population and socio-economic characteristics such as the number of older people living in the region, the number of NDIS participants and their care and support requirements, together with the available facilities and associated health and medical functions within the area. In general, regions located outside the capital cities tend to have an older population structure (with the exception of more remote parts of Western Australia and the Northern Territory), however different rates of population ageing will drive different rates of growth for the care and support workforce demand into the future.

The distribution of Statistical Area Level 4 (SA4) regions across Australia by the proportion of population who are NDIS participants, and the proportion of the population aged 85 years and over as a proxy for the *relative* care and support demand for these 2 cohorts within a community, is shown in Figure 283.

Figure 283: Distribution of NDIS participants and people aged 85 and over (share of total population) by SA4, 2021*



Source: NDIS Participant Data March 2021. ABS Regional Population by age and sex, Australia (2019). *Regional population data is for June 2019. NDIS participant data is for March 2021 (latest published at the SA4 level). While the share of the older population is important, the number of older people requiring care may be higher in regions with a lower share of the population aged 85 years and over based on the total size of the population within each region. For example, while only 1.7% of the population in Melbourne – South East SA4 is aged 85 years and over, the region currently has the largest number of people in this age group (15,000) due to the large population of the area.

SA4 regions within Greater Capital Cities and Rest of State areas are identified separately. Regions in the top right quadrant are more likely to require a significant proportion of their workforce to be engaged in the care and support workforce to provide aged care and NDIS services due to a relatively high proportion of the population being NDIS participants and people aged 85 years and older.

The Mid North Coast SA4 in NSW has the highest share of the population aged 85 years and over (3.6% of the total population), followed by North West SA4 in Victoria and Richmond-Tweed SA4 in NSW (both 3.2%). In contrast, only 0.4% of the population living in Northern Territory - Outback SA4 are aged 85 years and over, similar to the proportion in Darwin SA4 (0.5%).

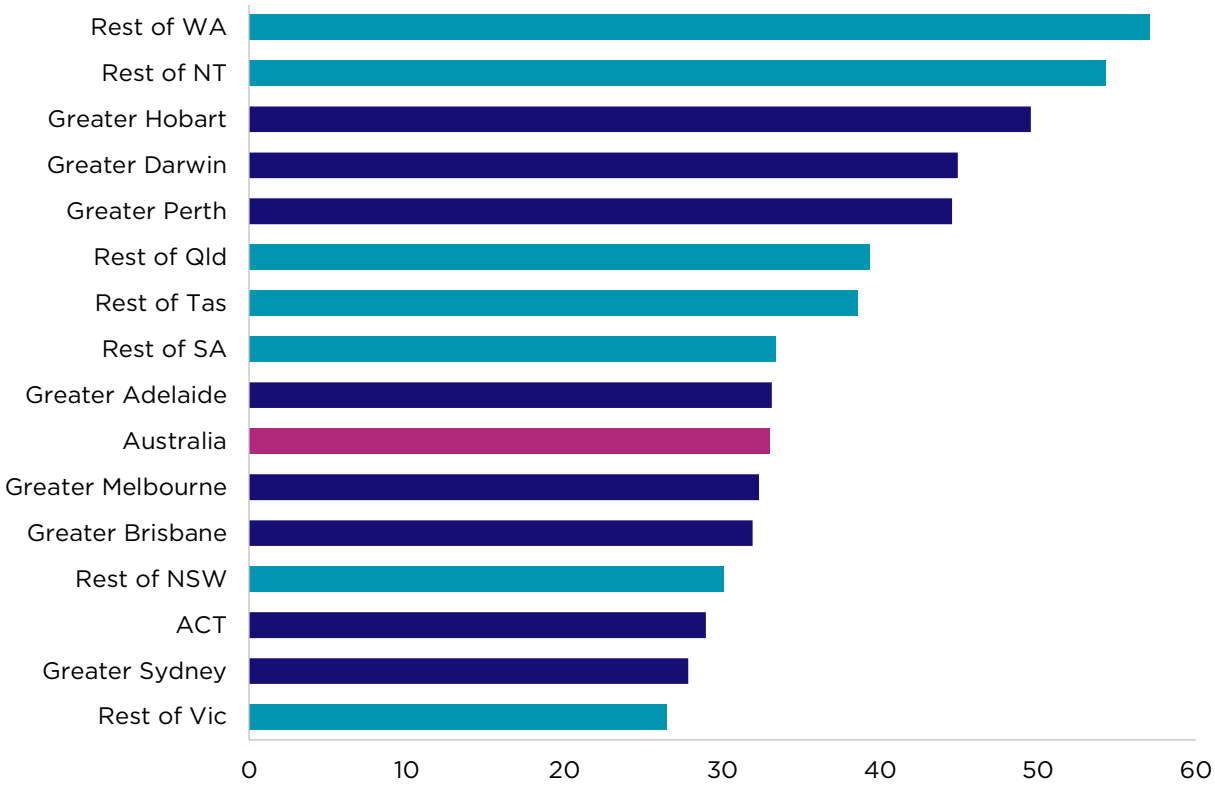
The distribution of current NDIS participants also varies across the regions, driven by a broad set of factors including the age structure of the population and disability rates across different communities, as well as the timing of the NDIS rollout across various parts of the country. Sydney – City and Inner South SA4 and Sydney – North Sydney and Hornsby SA4 had the lowest shares of the total population accessing the NDIS (both 0.9%). In contrast, 2.9% of people living in Adelaide – North SA4 are NDIS participants which may, at least partially, reflect the timetable of the initial NDIS rollout which included South Australia being among the first roll-out sites.

The age structure and share of NDIS participants within a regional population are not the only factors which determine the number of care and support workers required. The care and support requirements for each regional population differs, including the propensity to receive support from particular programs (e.g. residential aged care, NDIS) at each age. Each region has a set of characteristics which shifts the ratio between care and support recipients and the required workforce. These may include the geographical distribution of program participants (e.g. a more regionally dispersed participant population may require a larger workforce to accommodate longer travel times), the type of care and support services required, the average hours worked by the existing workforce, the rate of underemployment for the existing workforce, and the distribution of occupations within the care and support workforce.

There is no single ratio of workforce to participants which provides a sufficient level of care and support services within a community. As shown in Figure 284, at the national level there are approximately 33 people working as Personal care and support workers per 100 NDIS participants and people aged 85 years and over.

The ratio between the number of Personal care and support workers and the NDIS participants and population aged 85 years differs across Australia. It is lowest in the Rest of Victoria (26 workers per number of NDIS participants and population aged 85 years and older) and Greater Sydney (28 workers per key population) and highest in the Rest of Western Australia (57 workers per key population) and Rest of Northern Territory (54 workers per key population).

Figure 284: Personal care and support workers per 100 key participant cohorts (NDIS participants and people aged 85+), 2021



Source: NSC, Nowcast of Employment by Region and Occupation (NERO), June 2021; ABS Regional Population, June 2019; NDIS Participant Data, March 2021.

As a result, caution should be used when using macro-level data and indicators to understand local markets. A place-based needs analysis should instead be undertaken in order to incorporate localised factors.

Caution should also be exercised when analysing data at the local level due to complexities introduced by some data sources being reported on a place of work basis (e.g. job vacancies), while others are reported on a place of usual residence basis.

9.3 Workforce demand is expected to grow rapidly over the next 30 years

Future demand for the care and support workforce will be predominately driven by the growing number of Australians requiring care and support services, particularly amongst older Australians. While the rollout and growth of the NDIS in recent years has driven much of the contemporary growth across the sectors, residential aged care is expected to be the key driver of future workforce demand.

> To prevent the unusual events of 2020 and 2021 from influencing the longer-term projections, the starting point used by Deloitte Access Economics for both the baseline forecasts and sensitivities presented in this Study for workforce supply are necessarily based on the 2016 Census of Population and Housing.
>
> - That is, the February 2021 estimate of the care and support workforce of around 460,000 differs from the starting point of the baseline forecasts (363,500 at 2019-20).
>
> As recommended in Part 11 of the Study, the baseline forecasts should be updated in the next few years in order to capture both updated detailed data from the 2021 ABS Census of Population and Housing, together with labour force data from beyond the height of the COVID-19 pandemic in 2020 and 2021 (and the associated increase in staffing numbers in response to the impacts of the pandemic across the care and support sector).
>
> The forecast growth rates in workforce supply and workforce demand are essentially unaffected by the starting point estimates. Similarly, the broad conclusions presented here and the directional trends are also robust to the differences in starting point.

The workforce demand outlook contained in this section (i.e. the baseline forecast) assumes the following:

- Currently announced Australian Government policy relating to care and support programs remains unchanged.
- For both disability support and aged care, the propensity to access each program by age and gender is unchanged over time.
- There is no change in the age-specific prevalence of disability across the Australian population. That is, the health of the average 70-year-old remains the same in the coming decades as it is today.
- Funding per recipient in the NDIS moves in line with indexation rules applied in aged care programs.
- Relative wages within the care and support workforce match movements in broader economy-wide changes.
- There are no major changes to the way care and support is delivered.
- Increases in productivity flow through to higher levels of care, rather than lower government funding or higher profits for providers.
- While workforce data is included in historical counts for the COVID-19 period, assumptions are typically based on the years preceding the COVID-19 pandemic.
- The workforce demand forecasts provided in this Study are based on existing funding and eligibility criteria, together with future demographics.
- Unmet demand, not captured by the existing NDIS, aged care and veteran care programs considered by this Study, has not been incorporated in this outlook.

Each of the assumptions presented above, together with the underlying demographic outlook, funding expectations and eligibility guidelines for each program are subject to change (and many would be expected to change) over the forecast horizon, which would shift the expected outlook.

In the short-term, policy changes aimed at increasing and lifting staffing levels in aged care will increase demand over the next few years. This includes changes announced as part of the 2021-22 Budget aimed at improving access and quality in aged care, such as:

- Increases in the provision of HCPP places.
- Changes aimed at increasing staffing levels in residential aged care.
- Additional funding for residential aged care.

Over the longer-term, trends in the need for care and support will drive the number of participants in each program and the associated workforce required. This would result in:

- Aged care programs experiencing the fastest growth in participant numbers over time, as a result of the ageing population. This gains momentum from around 2030 as the Baby Boomer generation begin to age into their 80s.
- Growth in the NDIS in the long term reflecting slower population growth among those aged under 65 (noting that it is assumed that the propensity to access the NDIS remains unchanged in this forecast).
- Programs for veterans experiencing slower growth in the short-term, before the ageing of younger eligible veterans contributes to faster growth from around 2040.

In aggregate, this results in a larger share of the Australian population receiving formal care and support over time, therefore requiring a larger share of the total labour force to meet this demand.

NDIS workforce projections: then and now

The 2011 Productivity Commission report into the disability care and support sector noted that a workforce shortage in disability services would be exacerbated after the implementation of the NDIS.[244] Several workforce issues were raised in the report, including workforce capacity, increasing pressure from aged care, and potential for severe shortages, and many topics are factors also considered in this Study – attraction, wages, career paths, workforce utilisation, migration, productivity.

Several of the submissions in 2011 emphasised these concerns, including from the South Australian government who noted that there was already significant pressure on the disability care workforce at the time.[245]

As the NDIS roll out progressed, public commentary highlighted concerns within the sector of a workforce shortage – with headlines like *'NDIS: Staff shortages, lack of Government co-operation flagged as roll-out problems'* and *'NDIS: Report warns workforce understaffed in major cities, raises concerns over readiness'*.[246]

The implementation of the NDIS led to a rapid rise in recruitment over a very short period of time. While employer surveys suggested that the workforce would suffer from shortages, the sector has grown rapidly, and the workforce has adjusted. More recent data suggests there were limited workforce supply issues at a national basis in the care and support workforce pre-COVID.[247]

This illustrates that economies in real-life are more dynamic and responsive than can be reflected in forecasting models. While it is clear that matching future supply and demand presents a challenge, history illustrates that the labour market can be responsive to changing demand with forecast gaps often not eventuating as projected.

[244] Productivity Commission, *Disability Care and Support, Report no. 54*, 2011

[245] Productivity Commission, *Submission 496 to the Productivity Commission Disability Care and Support inquiry report*, 2011

[246] ABC, NDIS: Staff shortages, lack of Government co-operation flagged as roll-out problems, 2015; ABC, NDIS: Report warns workforce understaffed in major cities, raises concerns over readiness, 2017

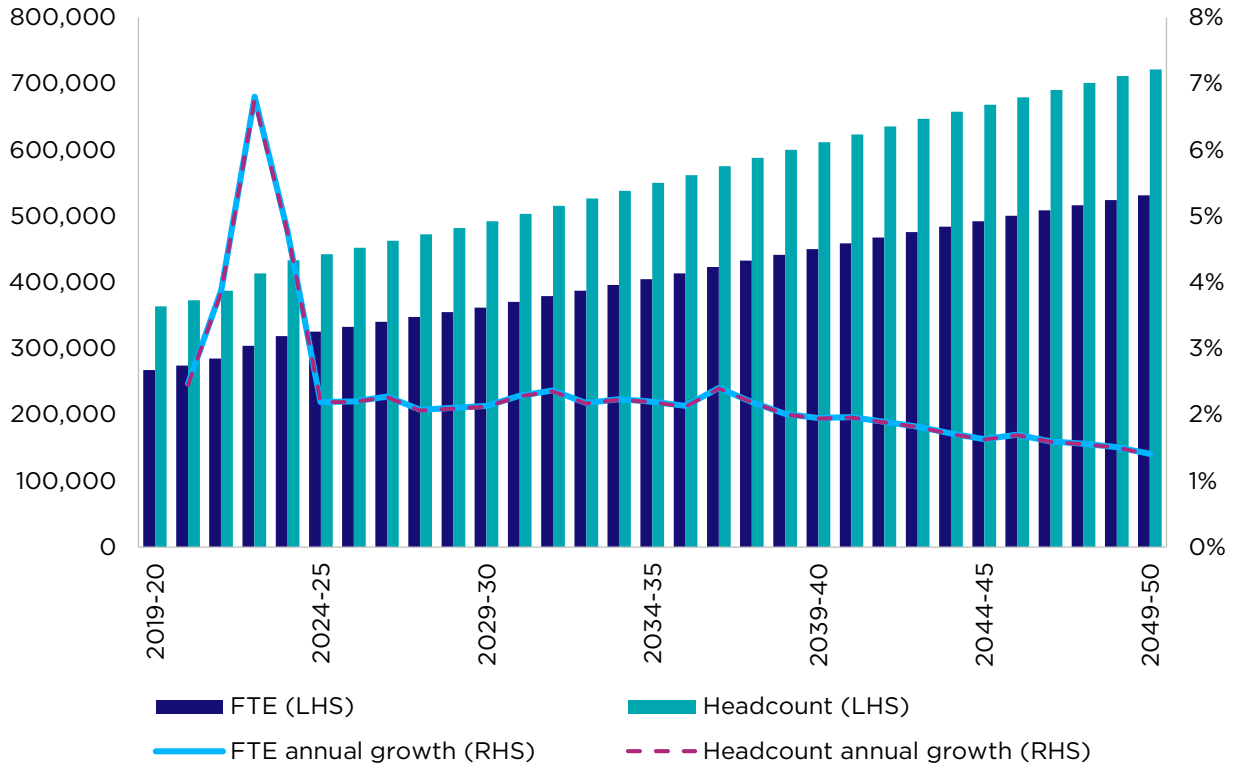
[247] Deloitte Access Economics, *Caring today, caring tomorrow - A profile of the care and support workforce (commissioned for the Care Workforce Labour Market Study)*, 2021

Further detail on the modelling methodology is presented in Appendix C. Where feasible, the forecasts below are included on both a full-time equivalent (FTE)[248] and headcount basis. This is an important distinction, given the relatively high rates of part-time employment for some care and support occupations. While headcount is largely equivalent to employment, multiple job holders (who may be counted twice in the headcount measure if they work across multiple occupations and/or industries, but only once in the employment data) mean that the measures are not identical.

Based on forecasts commissioned for this Study, it is expected that by 2049-50, the total requirements for the care and support workforce is expected to reach around 531,600 FTE positions (Figure 285), representing a total increase of around 99% relative to the workforce in FTE terms in 2020-21. On a headcount basis (i.e. the number of actual workers required given average hours worked by occupation (Figure 286), the total care and support workforce required is expected to reach around 721,800 workers by 2049-50 (up from 364,100 in 2019-20).

While there is likely to be a peak in the annual growth rate for workforce demand in the short-term – driven by the introduction of additional workforce requirements, predominately in the residential aged care program, annual growth in workforce demand will continue to remain above 2% until around 2038-39 (as Baby Boomers continue to age into the cohorts most likely to utilise aged care services and the number of NDIS participants continues to grow in line with the broader population). After that, growth is expected to mitigate somewhat, with the increase in workforce demand expected to be around 1.7% per year over the last decade of the forecast period (2039-40 to 2049-50). The rate of annual growth in workforce demand is expected to exceed projected population growth over the same time period.

Figure 285: Projected workforce demand (FTE and headcount), level and annual growth (%), 2019-20 to 2049-50



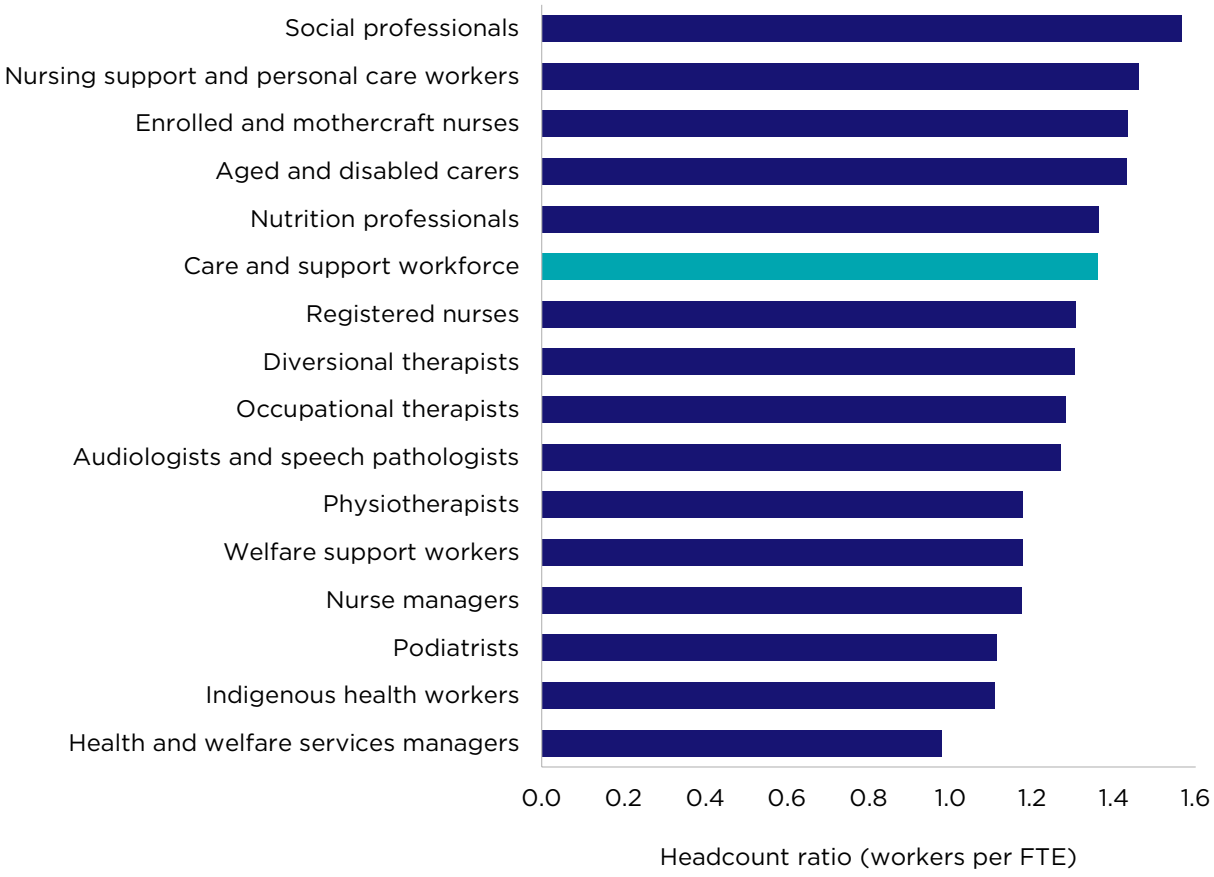
Source: Deloitte Access Economics, 2021.

Given the propensity for a significant proportion of people employed in Personal care and support worker occupations to work on a part-time basis (Part 5.1), the actual count of workers (i.e. the

[248] Full-time equivalent (FTE) is measured as 35 hours per week.

headcount) required to meet demand is significantly larger than for forecasts made on an FTE basis. For example, it is anticipated that approximately 1.46 *Nursing support and personal care workers* will be required to meet the requirement for every 1 FTE position in this occupation. The ratio is similar for *Aged and disabled carers* (1.43 workers per FTE) and *Enrolled and mothercraft nurses* (1.43 workers per FTE), while being slightly lower for *Registered nurses* (1.31 workers per FTE). The ratio of headcount to FTE is assumed to remain unchanged over the forecast period, with any shifts in the average hours worked within each occupation expected to shift the relationship between FTE and headcount requirements.

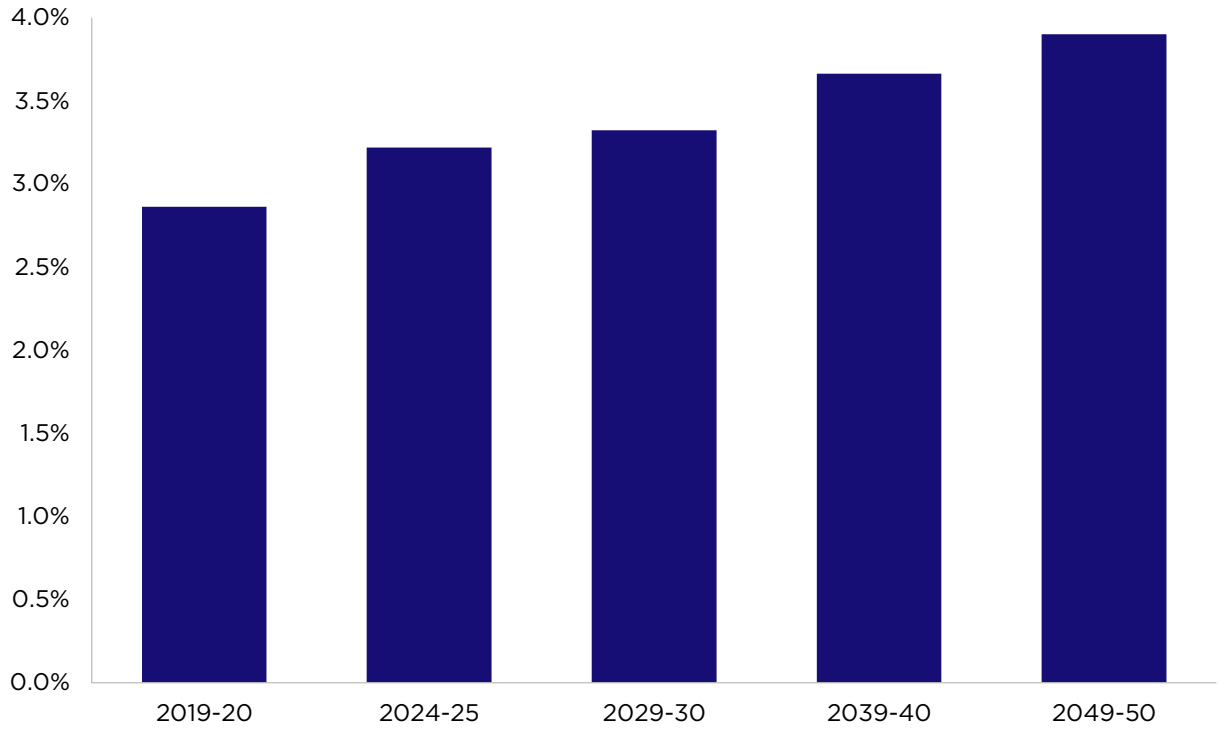
Figure 286: Headcount ratio (workers per FTE), by occupation, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021. Headcount ratios are assumed to remain constant over the forecast period.

Future demand for the care and support workforce is expected to reach approximately 3.9% of total employment by 2049-50, up from 2.9% in 2019-20 (Figure 287).That is, in order to meet the future workforce demand requirements around 1 in every 25 people working in the Australian workforce will need to be employed within the care and support workforce by 2049-50.

Figure 287: Projected workforce demand (headcount), care and support workforce as share of total employment (%), 2019-20 to 2049-50

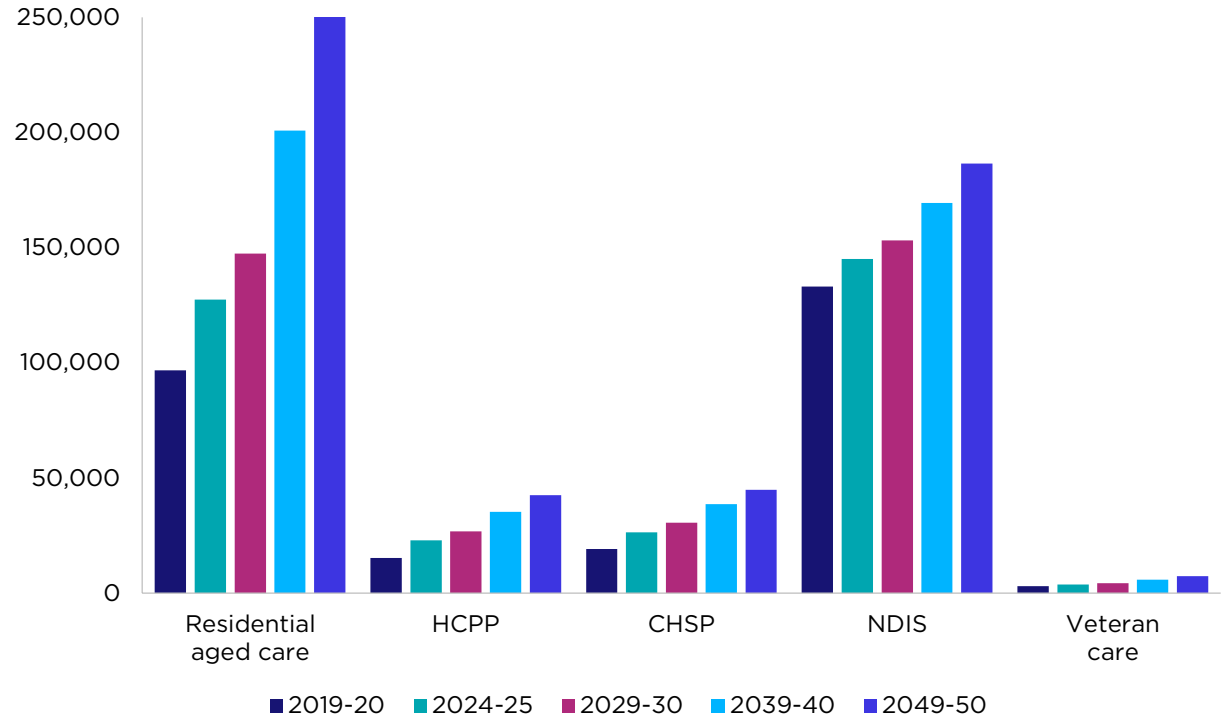


Source: Deloitte Access Economics, 2021.

While the NDIS workforce is currently estimated to be slightly larger in FTE terms (133,220 in 2020-21) than the residential aged care workforce (96,760 FTE in 2020-21) (Figure 288) the FTE workforce required for Residential Aged Care is expected to overtake the NDIS workforce in 2031-32.

Over the next 30 years to 2049-50, FTE workforce demand within the Residential Aged Care program is expected to grow at around 3.2% per year. This rate of growth is exceeded by HCPP, with anticipated growth in FTE of 3.5% per year (from 15,220 FTE in 2019-20 to 42,420 in 2049-50) which itself represents a significant increase.

Figure 288: Projected care and support workforce demand (FTE), by program 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021

The (mis)alignment between workforce demand by program and industry

While workforce demand has initially been forecast on a program-level basis, driven by the expected funding and demographic drivers within each program, workforce supply is analysed and forecast on an industry and occupation basis in order to utilise existing labour market data. As noted earlier (Part 1.3.1), the alignment between many of the care and support programs and the existing industry classification is relatively ineffective, and caution should be exercised when utilising the industry view. In particular, many of the key roles within the NDIS, CHSP and HCPP are currently aggregated into the *Other social assistance services* industry. Any future revision of the ANZSIC should therefore carefully consider the need to provide significantly more detail in this part of the classification to facilitate more effectual labour market analysis and workforce planning.

Another example of the misalignment and complexity of industry-based data relative to program-based workforce data is highlighted by the various measures available for the residential aged care workforce. Due to the way in which labour market data is collected, while each employee is allocated to an occupation based on their individual activities, the industry is determined by the main industry in which their employer operates (rather than the industry in which they perform the majority of their work). Within the aged care sector, many providers operate in residential aged care and home care, with the industry coded to *Aged care residential services* (a subdivision within *Residential care services*). As a result, many people who are coded to *Aged care residential services* would more accurately belong in *Other social assistance services* if they are providing services within a program participant's home environment. This misalignment is demonstrated by a comparison between the FTE workforce measure for the Residential Aged Care program measure in 2019-20 (96,760) and the *Aged care residential services* industry measure for the same period (145,700).[249]

[249] Deloitte Access Economics, *Caring today, caring tomorrow - A profile of the care and support workforce (commissioned for the Care Workforce Labour Market Study)*, 2021

In addition, it is important to note that there is a significant difference between the most recent FTE workforce data for the 2020 ACWC compared with both the 2016 NACWCS and the labour force, based estimates over the same period. There are a number of potential reasons underlying the differences between these datasets, including the impact of COVID-19 and potential double-counting of the workforce in some instances where a worker was employed by more than one provider. In addition, the industry count may also fail to capture agency or sub-contractor staff (as explored in Part 2.7.1) (approximately 7,350 headcount for the Residential Aged Care program in 2020).

A comparison is shown at Table 12 for the 2016 NACWCS, the 2020 ACWC and the program estimates used for this project on an FTE basis. Results from aged care censuses are presented for direct care roles only, although it should be noted that the scope of allied health occupations within the 2020 ACWC shown in this count is broader than this Study's occupation groups (for example includes pharmacists).

While there is relatively close alignment between the labour-force based measures to the 2016 NACWCS, the 2020 ACWC shows that there has been considerable growth between the 2 time periods for residential aged care (32%) compared with other care programs (5%).

While the aged care censuses are likely to provide more robust workforce measures for the relevant aged care programs, the lack of consistent data for the NDIS and veteran care, together with its relatively infrequent collection, means that labour force data has instead been used for the program estimates in this Study.

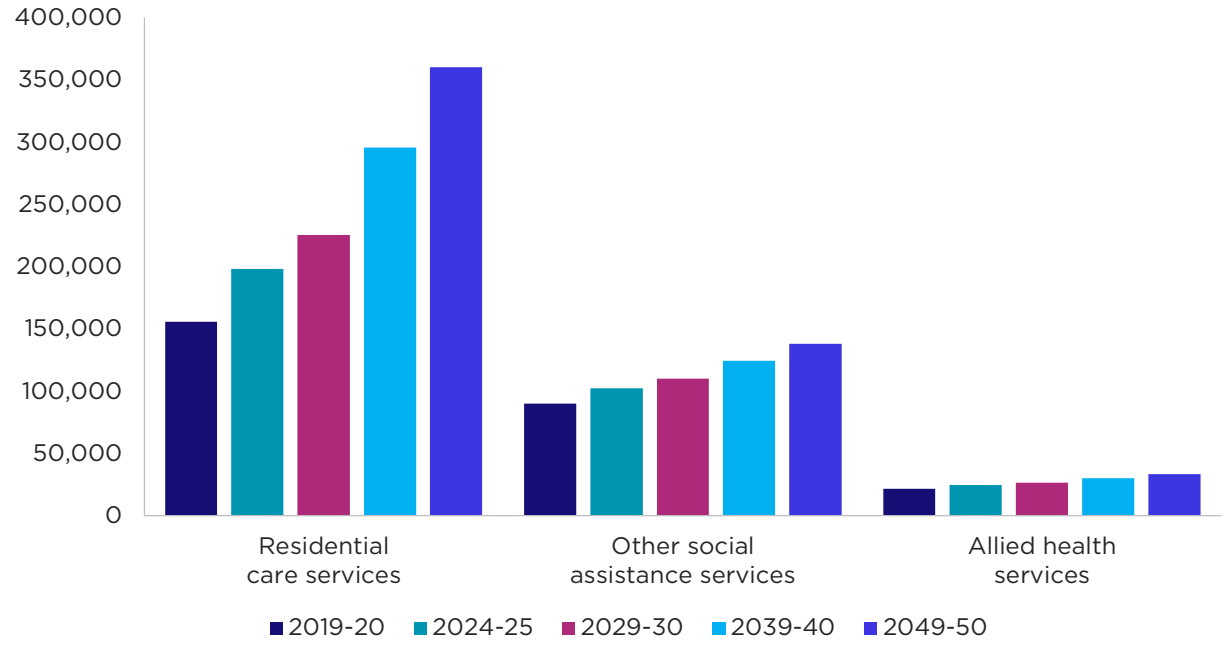
Table 12: Aged care workforce (FTE), comparison of data sources

Aged care program	2019-20 program estimate	2016 NACWCS	2020 ACWC
Residential Aged Care	96,760	97,920	129,151
HCPP	15,221	44,087	25,308
CHSP	19,192		21,141
Total	**131,173**	**142,007**	**175,600**

Source: Deloitte Access Economics (2021), Department of Health (2017), Department of Health (2020). For the 2020 ACWC, some providers did not provide data for hours worked, and this was more common for allied health professionals than for nurses and personal care workers. Therefore, in addition to potential over counting in the headcount number due to staff working in multiple jobs, the FTE totals may underrepresent the true figure due to unknown hours worked by all staff.

Industry-level forecasts (Figure 289) show that most future demand for the care and support workforce will be driven by the *Residential care services* and *Other social assistance services* industries. In total, the workforce required to support the demand within the *Residential care services* industry is expected to be approximately 359,900 FTE by 2049-50, growing from around 155,600 FTE positions in 2019-20 at a rate of 2.8% per year over the 30-year period. In comparison, workforce demand by FTE is expected to grow more slowly for *Other social assistance services* (1.4% per year) and *Allied health services* (1.4% per year).

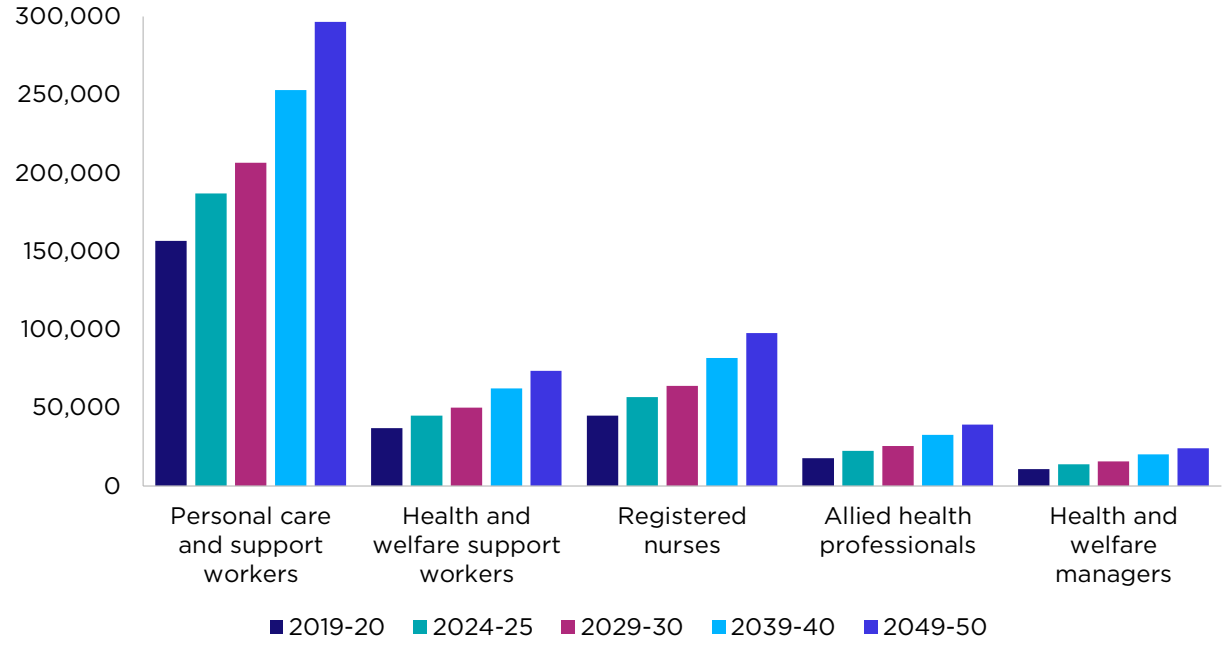
Figure 289: Projected care and support workforce demand (FTE), by industry, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

As shown in Figure 290, from an occupation perspective Personal care and support workers (comprised of *Aged and disabled carers* and *Nursing support and personal care workers*) will continue to form the majority of demand for the care and support workforce (59% of total FTE workforce demand in 2019-20 and 56% of total FTE workforce demand in 2049-50). Across the forecast period, the demand for each of the occupation groups is expected to grow at a relatively high annual rate, ranging from 2.7% per year for Allied health professionals to 2.2% per year for Personal care and support workers.

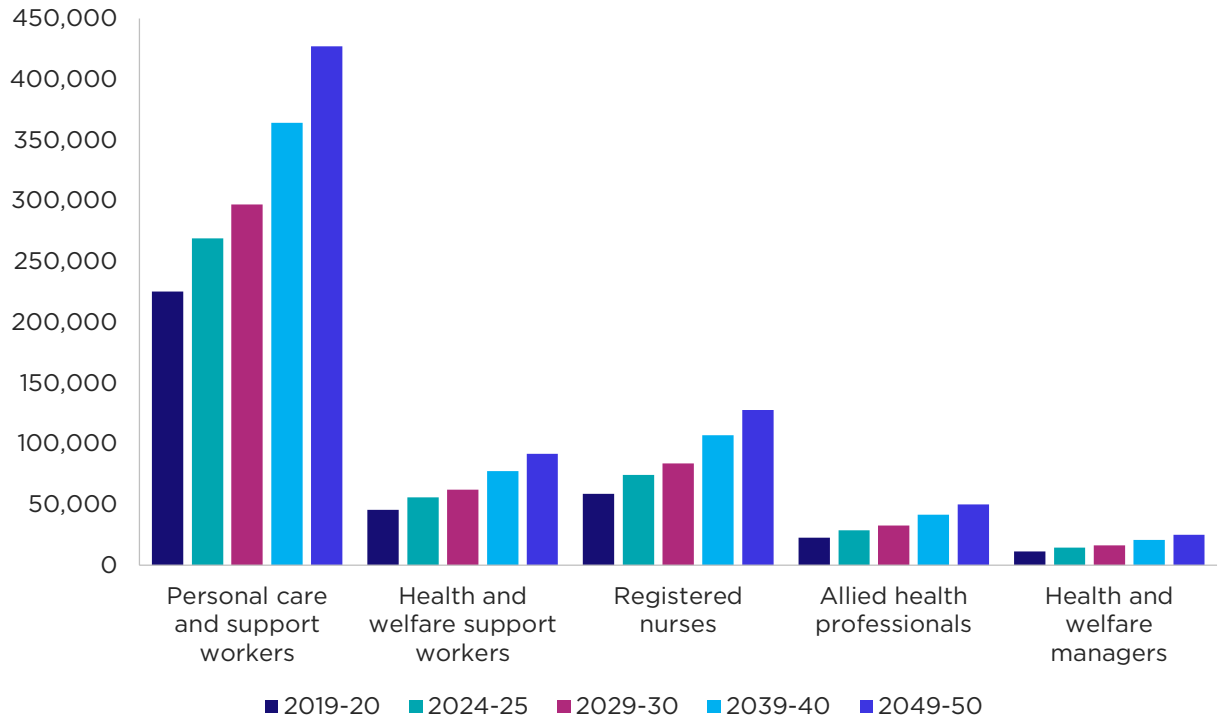
Figure 290: Projected workforce demand (FTE), care and support workforce, by occupation group, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

Given current average hours worked in each occupation and the resulting headcount ratio, the workforce demand by headcount for Personal care and support workers is expected to reach around 427,000 in 2049-50 (growing from 225,400 in 2019-20) (Figure 291). The workforce demand for *Registered nurses* is expected to increase to 127,800 headcount (from 58,800 in 2019-20), while also growing significantly for Health and welfare support workers (from 45,800 in 2019-20 to 91,700 in 2049-50).

Figure 291: Projected care and support workforce (headcount), by occupation group, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

9.4 ...while workforce supply is expected to grow more slowly...

While the care and support workforce has grown significantly over the past 2 decades (Part 3.2.2), the baseline forecast anticipates that workforce supply will grow more slowly over the next 30 years. This outlook assumes a range of existing factors will drive this outlook, including:

- The current education and training policy settings put in place by the Australian Government, states and territories remain unchanged. That is, the relative cost of obtaining qualifications relevant to the care and support workforce does not change.[250]
- There is no change in the skills (qualifications and fields of education) required to work in care and support occupations, either due to policy reform or driven by the requirements of providers.
- Migration program settings remain similar to those over the past decade, with borders assumed to re-open in 2022. This assumption is broadly consistent with the assumption presented in the 2021 IGR.[251] The impact of recent border closures has been included in the short-term projections.
- Relative wages across industries relevant to care and support occupations remain unchanged.
- Individual preferences for work hours and income evolve as they have in the recent past, so that average hours worked per person remain unchanged (and as a result, the ratio between FTE and headcount also remains unchanged).
- The propensity for people to leave the labour force is similar to what has been observed in history.
- New entrants to the sector reflect historic gender shares, which results in the care and support workforce continuing to rely heavily on attracting a significant proportion of the female workforce in order to meet future demand.

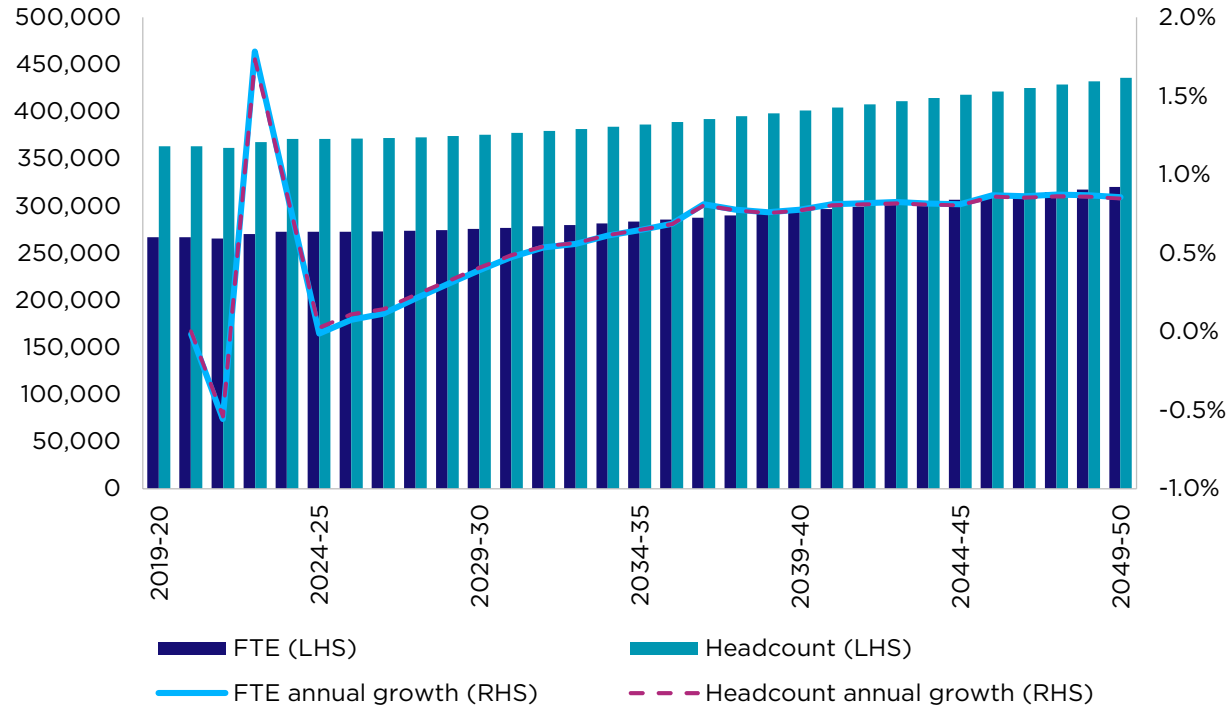
It should be noted that this is a measure of the *stock* of available workforce supply in any point in time. For example, while the difference in the 2 time periods for a particular occupation group may be forecast to be *x workers*, this is a measure of *net additional workers* supplied, with any worker who leaves this occupation group also needing to be replaced over the time period.

Total care and support workforce supply, in both FTE and headcount terms, is expected to grow at an average rate of approximately 0.6% per year over the next 30 years (Figure 292). While there is expected to be a short-term increase in workforce supply if international borders re-open as assumed in 2022, this is expected to be temporary, with future annual growth expected to remain below 1% per year for the next 30 years to 2049-50.

[250] More specifically, the model assumes that education and training is available for any person who wishes to undertake it. Were education and training to be constrained in any way, this would potentially reduce supply of the workforce in some occupations which require a qualification. Note that the Home Care Workforce Support Program has also not been explicitly included in the projection. Any new net additional personal care workers attracted by this project would add to the projected supply for the period in which they were employed in the care and support workforce.

[251] The Treasury, *2021 Intergenerational report: Australia over the next 40 years*, 2021

Figure 292: Workforce supply (FTE and headcount), baseline forecast, 2019-20 to 2049-50



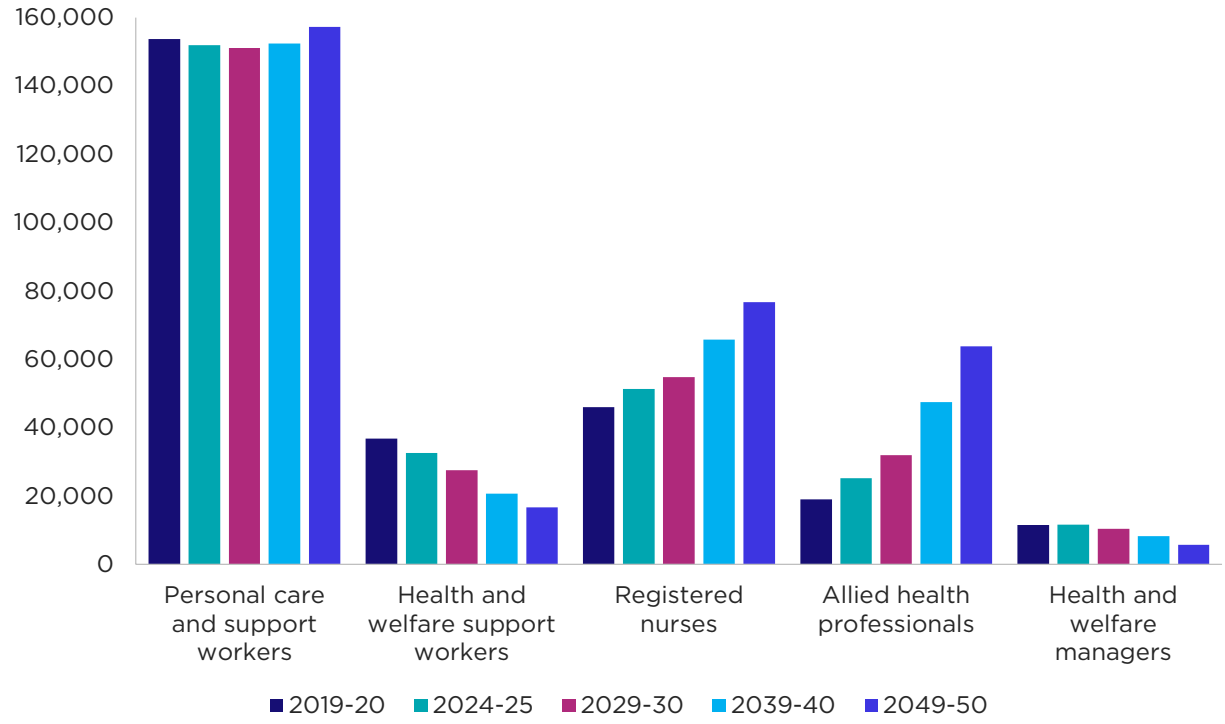
Source: Deloitte Access Economics, 2021.

Except for Allied health professionals, the supply of workers into the relevant care and support occupation groups is expected to grow relatively slowly (and for some occupation groups, supply is anticipated to decline over the next 3 decades) (Figure 293). Overall, the supply of workforce for the Personal care and support workers occupation group is expected to increase from 153,700 FTE in 2019-20 to 157,300 in 2049-50.

For some occupation groups, growth in workforce supply is expected to be negative over the period, implying that at least some of the people who leave the workforce over the forecast period are not replaced. This is not to suggest that there are no new entrants into the occupation, but rather where growth is negative, the *inflows* into the workforce are lower than the anticipated *outflows* resulting in a net loss to the total workforce supply. In FTE terms, the supply of workforce for both Health and welfare support workers (-2.6% per year) and Health and welfare services managers (-2.3% per year) is expected to be lower in 2049-50 than in 2019-20. That is, for every 1,000 workers who leave the Health and welfare support workers occupation group each year, only 974 are expected to be replaced under the assumptions outlined for this Study.

In FTE terms, the additional supply of Personal care and support workers is expected to slow to just 0.1% per year over the next 30 years (well below the expected growth rate for workforce demand of 2.2% per year). This slow growth rate for the Personal care and support worker occupation group is driven by a decline in the supply in *Nursing support and personal care workers* (-2.7% per year), while *Aged and disabled carers* grows more slowly (0.8% per year).

Figure 293: Projected care and support workforce supply (FTE), by occupation group, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

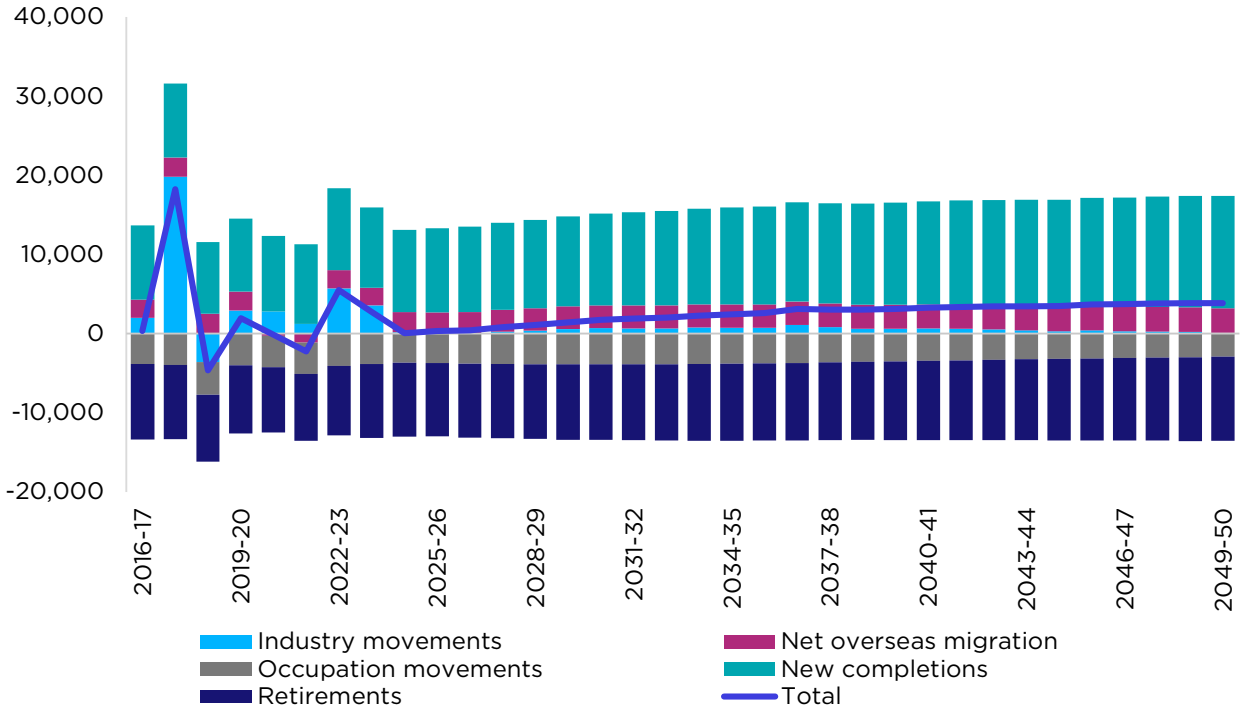
Overall, the addition of any new entrants into the care and support workforce is expected to be largely offset by a significant number of retirements each year - presenting an ongoing challenge for workforce supply (Figure 294). The relatively low rates of growth expected in the care and support workforce will primarily be driven by the people who have completed relevant qualifications and entered the care and support workforce as new employees. Growth will also be supported to a lesser extent by net overseas migration from 2022-23[252] and industry movements.

Industry movement measures the number of people who would otherwise work in the health sector and other industries but move to the care and support workforce, while remaining in the same occupation, as the relatively high demand makes it easier to find a job quickly in the care and support workforce.

Occupation movements (people changing occupations) will be an overall net detractor from the total care and support workforce over the next 30 years.

[252] This assumes international borders re-open in 2022, consistent with the assumptions contained in the 2021 Intergenerational Report.

Figure 294: Changes in projected supply of the care and support workforce (headcount), 2016-17 to 2049-50

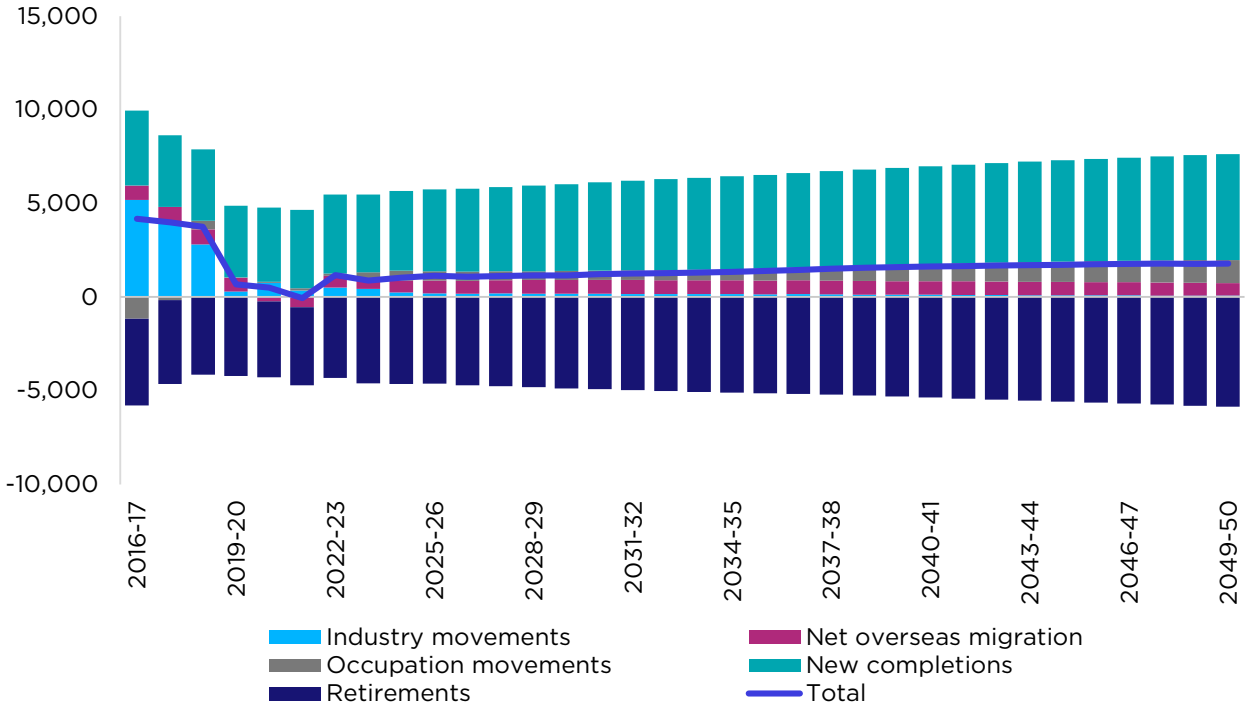


Source: Deloitte Access Economics, 2021.

For *Aged and disabled carers*, the only *net* outflow for workforce supply is retirements. These are significant with around 25 in every 1,000 people working in this occupation expected to retire in 2021 – a rate that is expected to increase each year as the workforce ages (Figure 295).

The largest contributor to additional workforce is expected to be new completions, followed by occupation movements (with movements into the occupation expected to exceed movements to other occupation) and net overseas migration. Industry movements are expected to be relatively neutral – with outflows and inflows across industries for these occupations relatively small (and balanced).

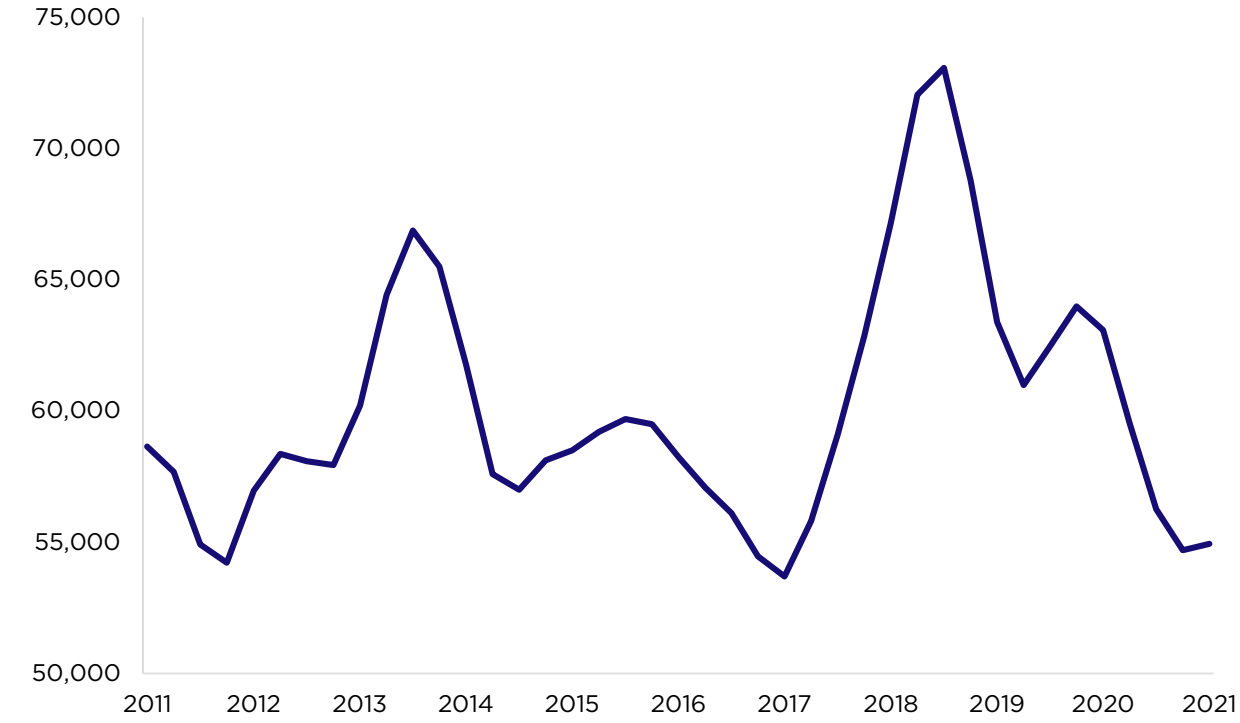
Figure 295: Projected changes in workforce supply (headcount), *Aged and disabled carers*, 2016-17 to 2049-50



Source: Deloitte Access Economics, 2021.

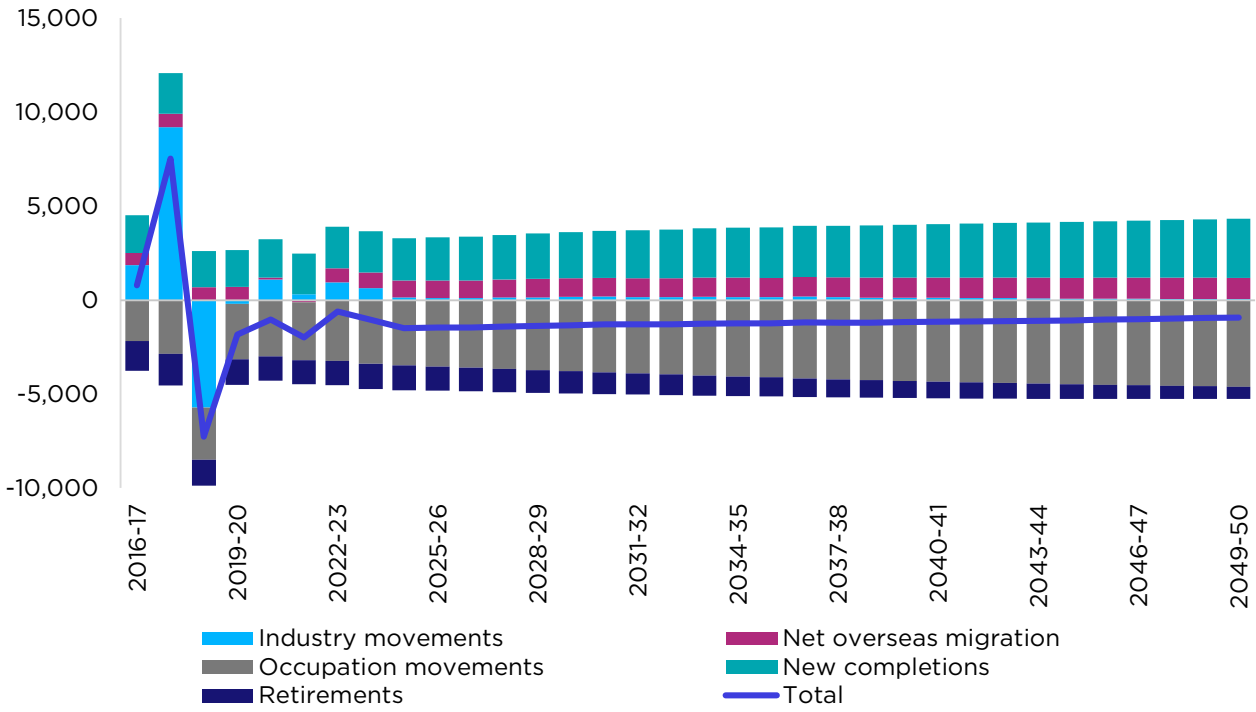
In contrast, supply of workers into the *Nursing and personal care workers* occupation is expected to decline over the period, following a recent period of employment volatility (Figure 296) as measured by the ABS Labour Force Survey. While there are some anticipated retirements out of the occupation, the key driver is occupation movements, which measures the (net) number of people moving industries but working within the same occupation (Figure 297). New completions are the main driver of new additions to the supply of *Nursing support and personal care workers*, while net overseas migration also makes a positive contribution. Overall, the workforce supply for this occupation is expected to fall by -2.5% per year as outflows from the occupation outweigh inflows.

Figure 296: Employment, *Nursing support and personal care workers* in care and support industries (quarterly, trend)



Source: ABS Longitudinal Labour Force Survey, 2021.

Figure 297: Projected changes in workforce supply (headcount), *Nursing support and personal care workers,* 2016-17 to 2049-50

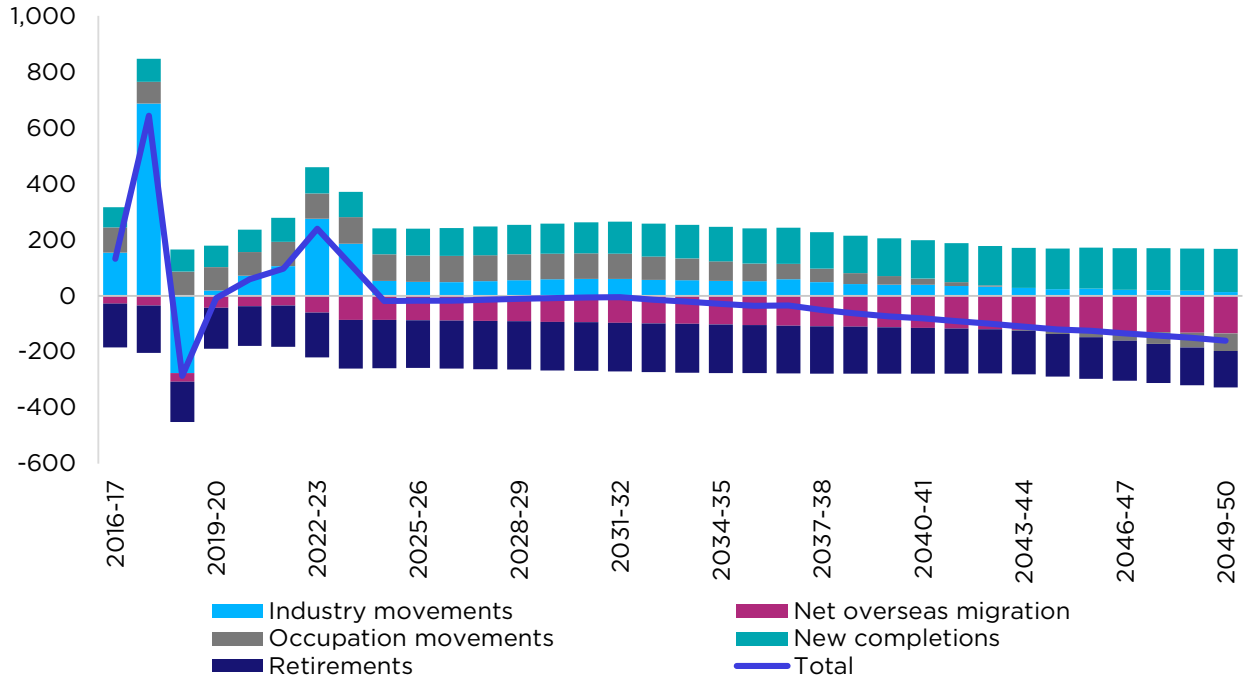


Source: Deloitte Access Economics, 2021.

There is also negative growth in workforce supply expected for some of the higher skilled occupations, including *Nurse managers* (-0.8% per year). *Nurse managers* had an average age of

47 years in 2016, and almost 30% of those employed as *Nurse managers* were aged 55 years and over, at least partially reflecting the general seniority of the role. The inflow of new qualification holders into *Nurse managers* is expected to fall short of replacing those who are retiring each year, while net overseas migration is also expected to be negative (with the number of *Nurse managers* leaving Australia expected to outweigh those arriving (noting that these numbers are relatively small at fewer than 180 per year). As *Registered nurses* is a pathway occupation to becoming a *Nurse manager*, it is important to note that any slowdown in the growth in the supply of *Registered nurses* will also flow through to the outlook for *Nurse managers*.

Figure 298: Changes in workforce supply (headcount), *Nurse managers*, 2016-17 to 2049-50

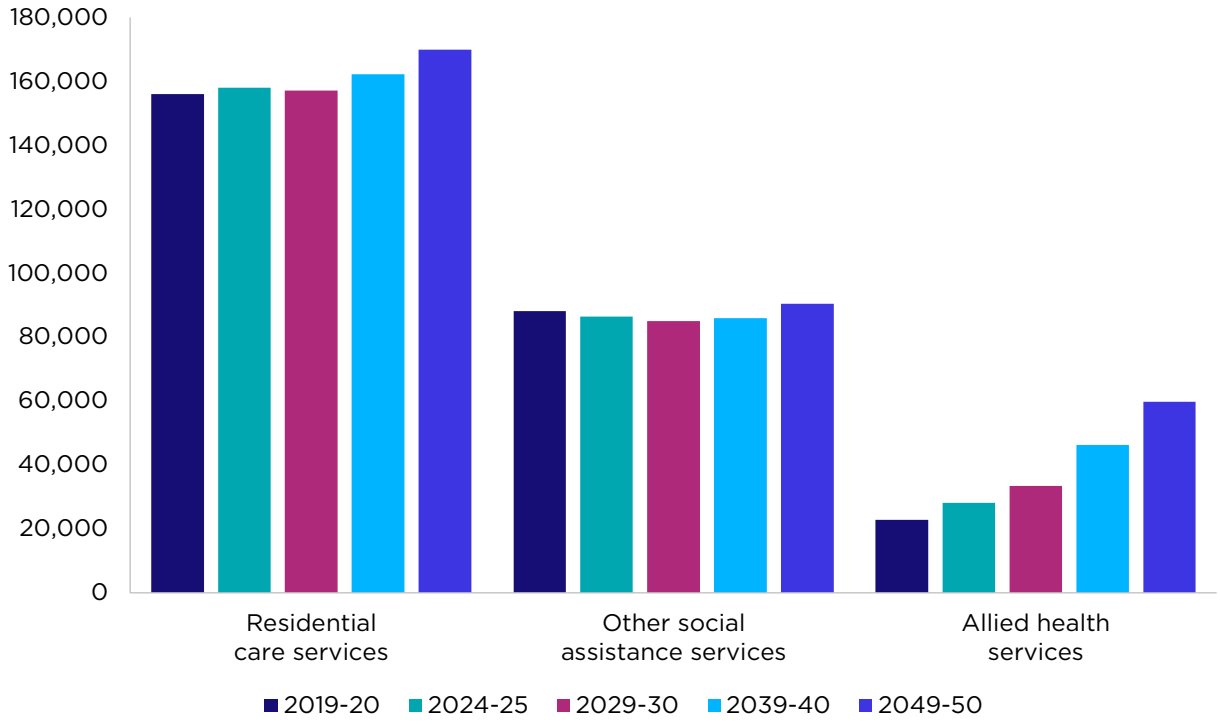


Source: Deloitte Access Economics, 2021.

On an industry basis, workforce supply is expected to grow for all industries (Figure 299), albeit slowly for the *Other social assistance services* industry at 0.1% per year, and *Residential care services* industry at 0.3% per year.

(As noted in Part 9.3, the alignment between the existing industry structure and the relevant care and support programs, together with the difficulties associated in capturing the main industry of the employer rather than the employee, mean that results presented by industry should be interpreted with caution.)

Figure 299: Projected workforce supply (FTE), by industry, 2019-20 to 2049-50



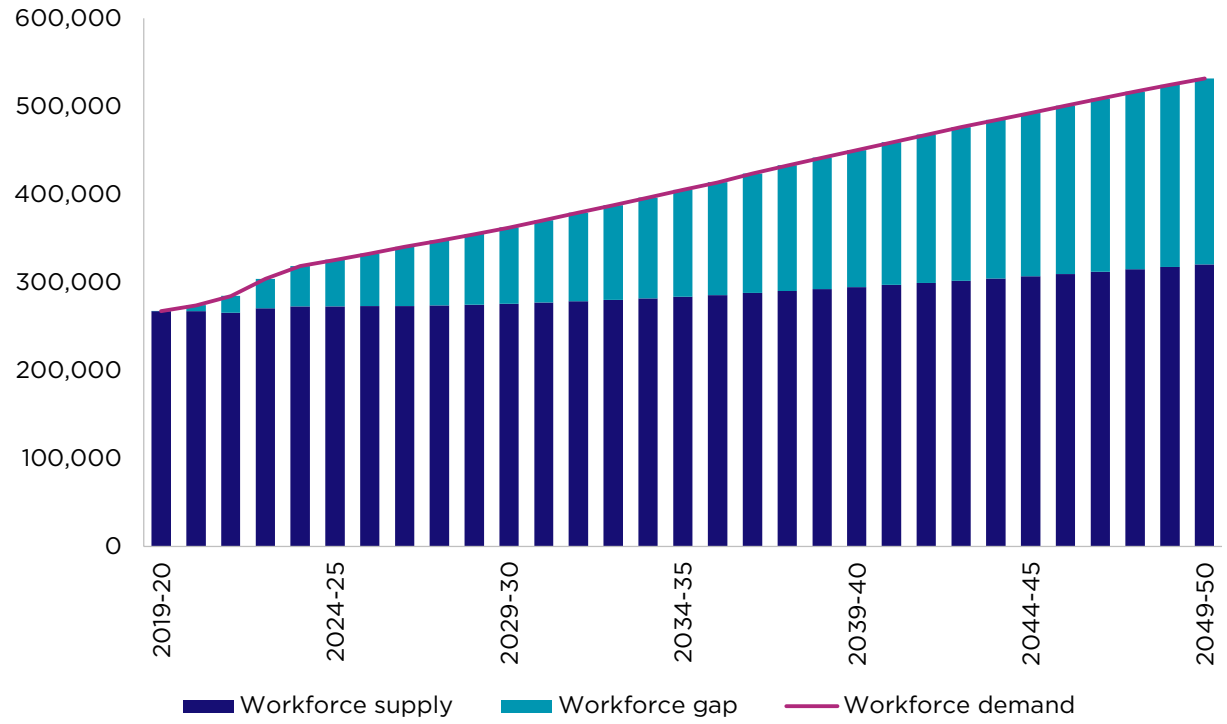
Source: Deloitte Access Economics, 2021.

9.5 ...resulting in a significant gap across the care and support workforce

As workforce demand is expected to exceed workforce supply, a workforce gap emerges in the short-term and continues to grow over the next 30 years (Figure 300).

Over the forecast period (to 2049-50), the workforce required to meet demand is expected to grow to around 531,600 FTE, significantly outpacing workforce supply which is only expected to increase to 320,200 FTE (based on recent historical workforce trends). This results in a workforce gap of approximately 211,400 FTE positions by 2049-50.

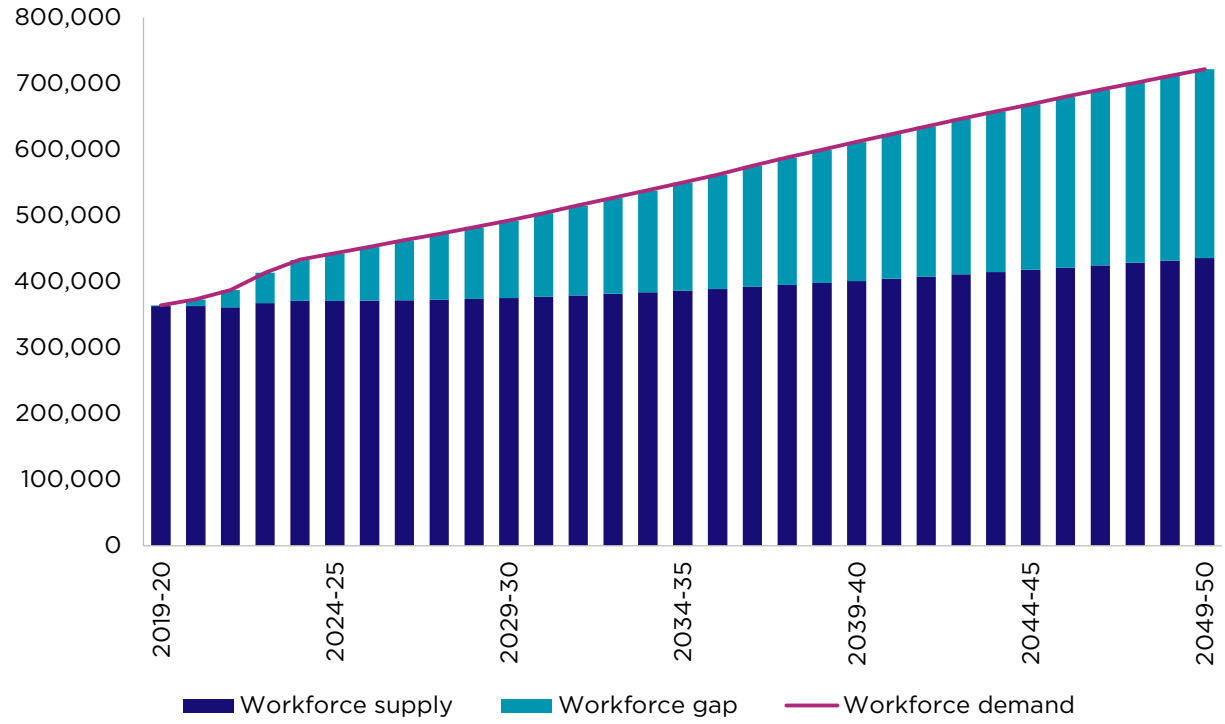
Figure 300: Projected workforce supply, demand and gap (FTE), care and support workforce, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

On a headcount basis, which accounts for the average hours worked across each occupation, the workforce gap is even larger, reaching an expected 285,800 workers by 2049-50 (Figure 301). It is also important to note that an anticipated workforce gap emerges from the first year of the forecast (2020-21) and is expected to reach almost 100,000 workers (99,400) by 2027-28.

Figure 301: Projected workforce demand, supply and gap (headcount), care and support workforce, 2019-20 to 2049-50

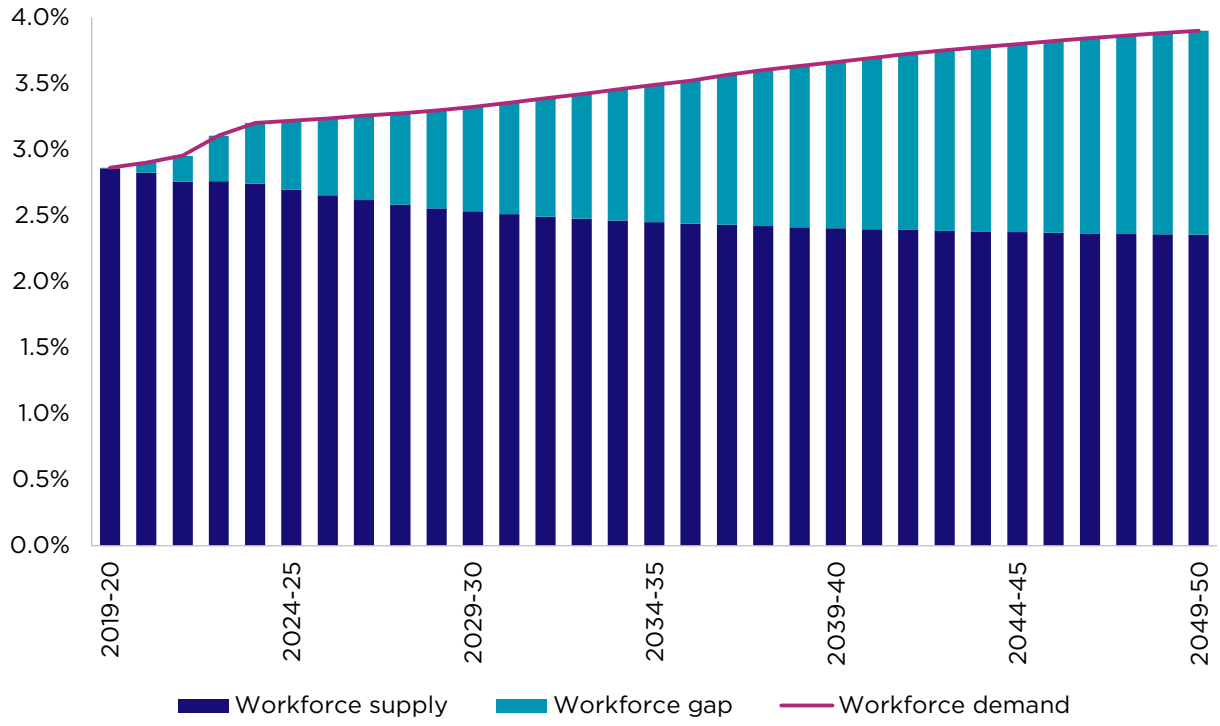


Source: Deloitte Access Economics, 2021.

The gap between workforce demand and workforce supply is expected to reach 1.5% of total employment in Australia by 2049-50 (Figure 302).

Attracting an additional 1.5% of total employed (or 285,800 workers/headcount) presents a challenge to the sector, particularly if other occupations and industries are also expected to experience shortfalls in workforce. While some factors, such as the automation of some sectors, may provide additional capacity within the labour market, the distribution of labour across occupations will need to shift significantly to meet forecast demand in the care and support workforce.

Figure 302: Projected workforce demand, supply and gap (headcount), care and support workforce as share of total employment (%), 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

A note on Allied health professionals

- All workforce supply forecasts for Allied health professionals should be interpreted with care, noting the caveats outlined below.
- While the NDIS, aged care and veteran care systems all utilise Allied health professionals, it is difficult to identify the Allied health professionals engaged in the delivery of services to these cohorts of participants. In addition, it is likely that a significant proportion of Allied health professionals deliver services to both participants within care and support programs, as well as the broader community.
- In 2021, the vast majority of Allied health professionals were employed in the *Allied health services* industry. While it is expected that a significant proportion of Allied health professionals are engaged in the provision of care and support services in some capacity, there is no labour market data available to determine either the proportion of the workforce providing care and support services to the participants in scope for this Study, nor the proportion of total hours worked spent in delivering these services.
- As a result, the workforce supply forecast for Allied health professionals captures the **total future workforce supply of the occupations captured as part of this Study** – *Nutrition professionals, Occupational therapists, Physiotherapists, Podiatrists* and *Audiologists and speech pathologists/therapists*, which is likely to significantly overstate the delivery of allied health services to the care and support workforce.
- Finally, the baseline forecasts presented in this report assume that there is no significant national shortage at the current time. It has been noted, through both stakeholder feedback and employer surveys, that many allied health services remain difficult to recruit (noting that the number of Allied health professionals required within a service is typically lower than occupations such as *Aged and disabled carers* and *Nursing support and personal care workers*). Where there is an existing shortage, this would be additional to the forecasts presented in this Study.

While workforce gaps are expected to emerge across almost all care and support occupations, it is the lower skill level roles that are expected to face the highest future workforce gaps. Overall, future workforce gaps across the sector are expected to be due to shortages across most occupations (Figure 303). While the difference in the annual growth rates for workforce supply and demand are highest for Health and welfare support workers and Health and welfare managers, given the relative size of the occupation groups, the largest gap in headcount is expected for Personal care and support workers.

The supply of Allied health professionals is expected to exceed the demand requirements over the next 30 years, noting the caveats stated above. The relatively strong growth in the expected supply of Allied health professionals has been driven by the expansion of these occupations over the past decade. This rapid growth, particularly in the younger age groups within the workforce (Figure 81 and Figure 82) will result in lower retirements over the short-term (with new entrants via qualification completions significantly outweighing retirements over the forecast period). In addition, Allied health professions tend to require the completion of specialised undergraduate degrees, which suggests there will be a greater attachment to these occupations than lower skill level occupations, with fewer outflows to other occupations (relative to lower skilled care and support occupations). For Allied health professionals, the key risk to this outlook is industry movements, with any increase in the relative attraction of sectors outside the care and support workforce (e.g. health sector) likely to put downward pressure on the supply of workers for this occupation group.

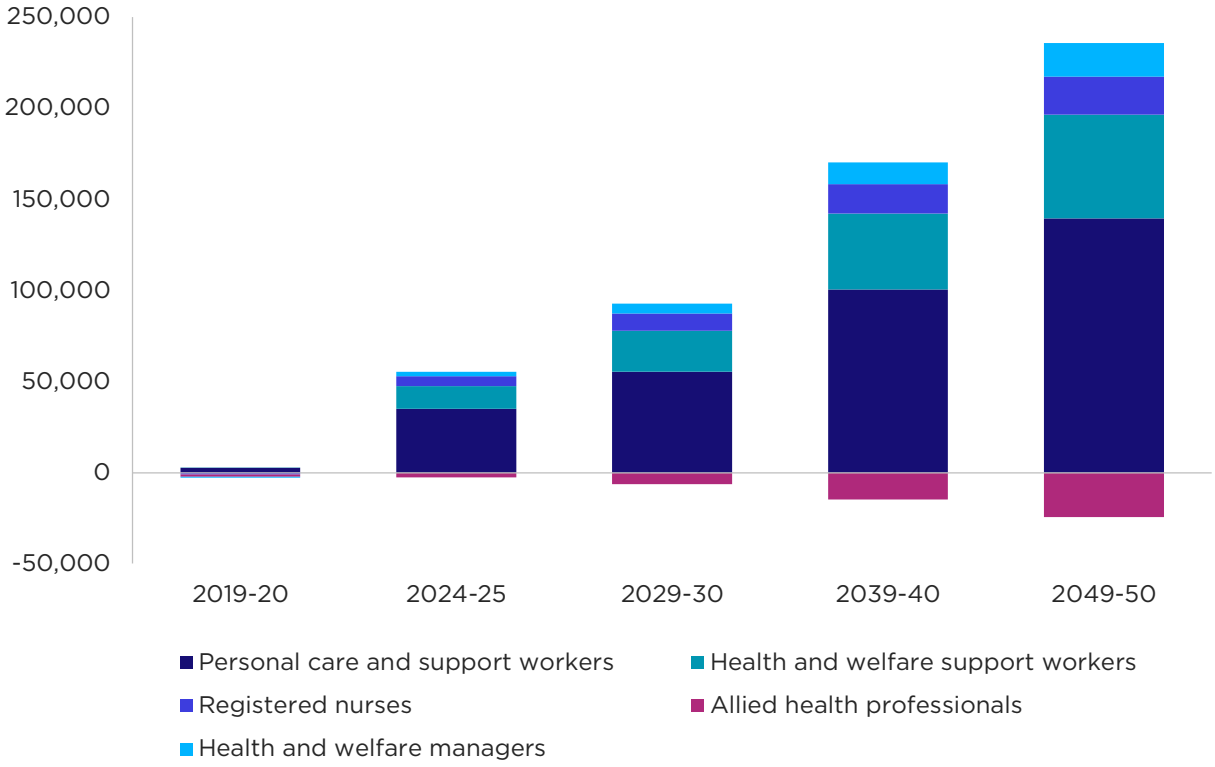
Figure 303: Projected supply and demand of the care and support workforce, annual growth rate (%), by occupation group, 2019-20 to 2049-50

Source: Deloitte Access Economics, 2021. Results for Allied health professionals should be interpreted with caution as the occupation growth captures broader workforce supply of these occupations beyond the provision of services to the care and support workforce.

The total workforce gap for the care and support workforce (assuming supply and demand are currently in balance) is expected to grow to 52,900 FTE in 2024-25, 86,600 FTE in 2029-30 and 211,400 FTE by 2049-50 (Figure 304). In 2049-50, around two-thirds (66%) of the workforce gap is due to an anticipated undersupply of Personal care and support workers, with a further quarter (27%) due to an undersupply of Health and welfare support workers. There is an expected shortage of around 139,300 FTE for Personal care and support workers, 57,000 FTE for Health and welfare support workers, 21,000 FTE for Registered nurses and 18,500 for Health and welfare

managers. As noted above, the expected available supply of Allied health professionals is sufficient to meet demand at the national level.

Figure 304: Projected workforce gap (FTE), by occupation group, 2019-20 to 2049-50



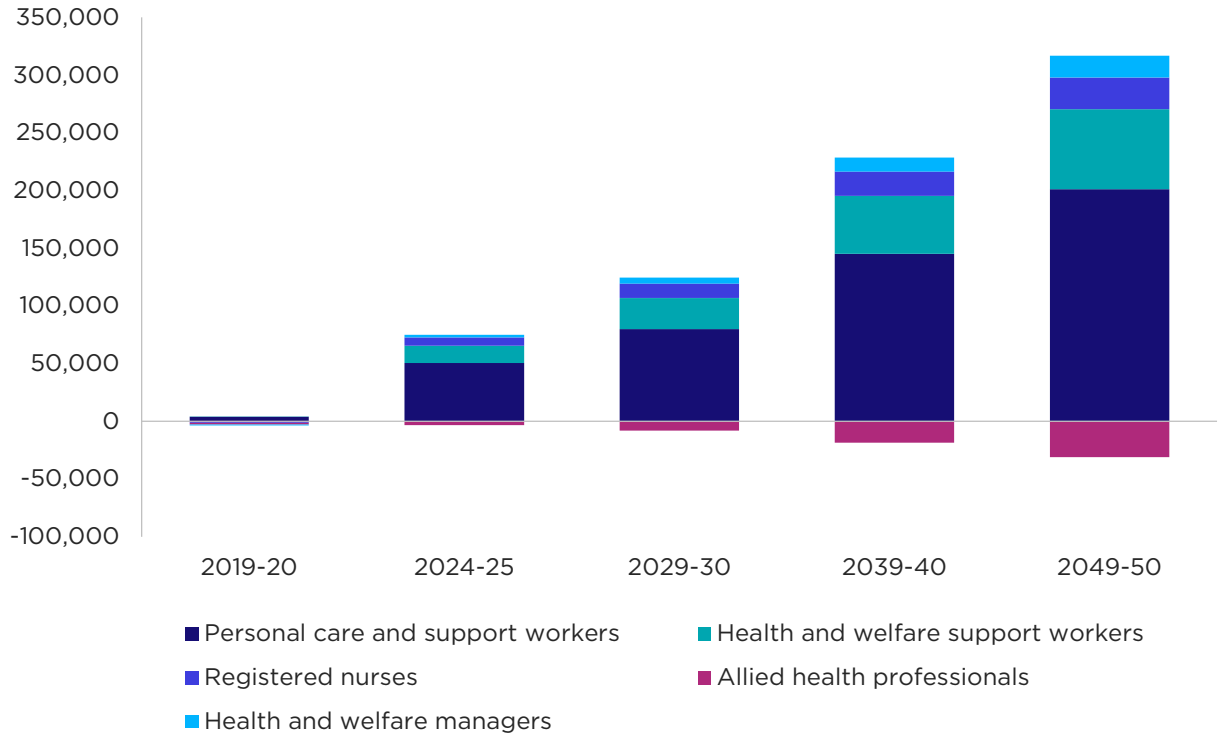
Source: Deloitte Access Economics, 2021. Results for Allied health professionals should be interpreted with caution as the occupation growth captures broader workforce supply of these occupations beyond the provision of services to the care and support workforce.

Given the propensity for a relatively high proportion of the care and support workforce to work part-time, the future workforce gap is significantly larger when measured by headcount. In 2024-25 there is expected to be a shortfall of 35,000 Personal care and support workers (comprising 33,200 *Aged and disabled carers* and 17,330 *Nursing support and personal care workers*) (Figure 305).

The shortage for this occupation group is expected to increase significantly over time, reaching 201,300 workers (headcount) by 2049-50. That is, to meet the anticipated workforce demand, the care and support workforce will need to attract 201,300 workers *in addition to those replacing outflows from the occupations*.

In total, the total workforce gap for the care and support workforce, as measured by the number of workers (headcount) is expected to reach 285,800.

Figure 305: Projected gap between workforce demand and supply (headcount), by occupation group, 2019-20 to 2049-50

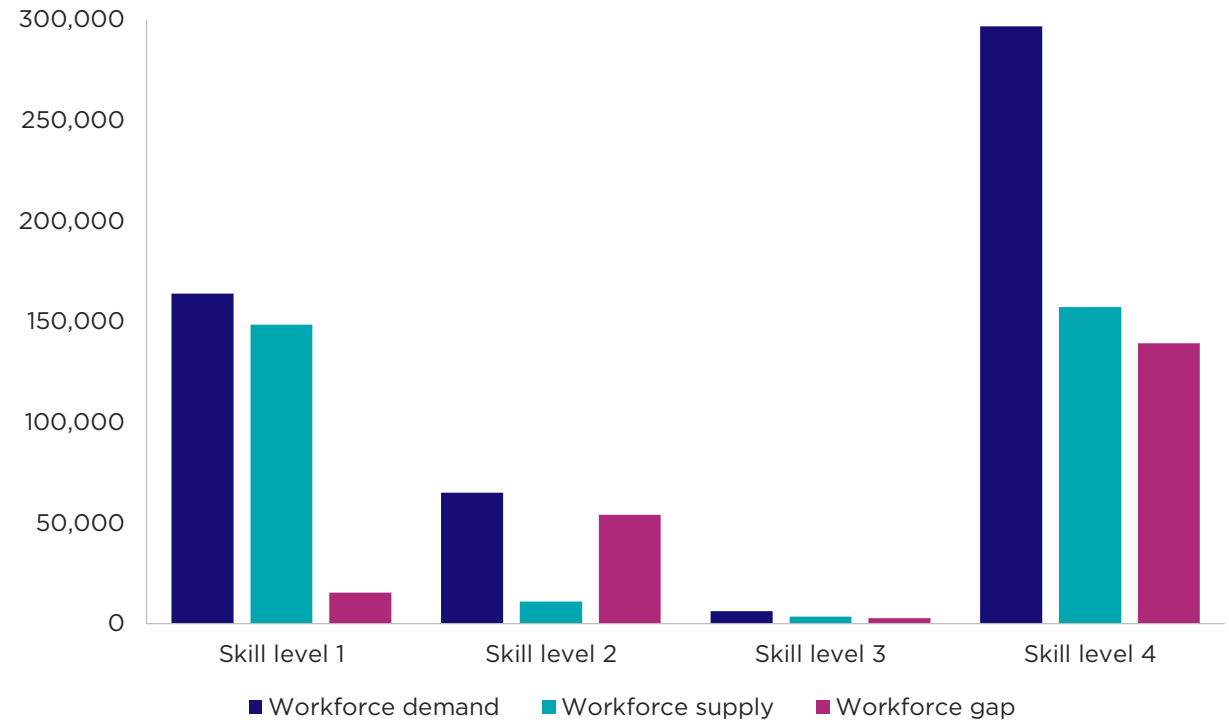


Source: Deloitte Access Economics, 2021. Results for Allied health professionals should be interpreted with caution as the occupation growth captures broader workforce supply of these occupations.

9.5.1 Occupations with skill levels 3 and 4 will be in the greatest shortage, but meeting demand for skill level 1 will also be a challenge

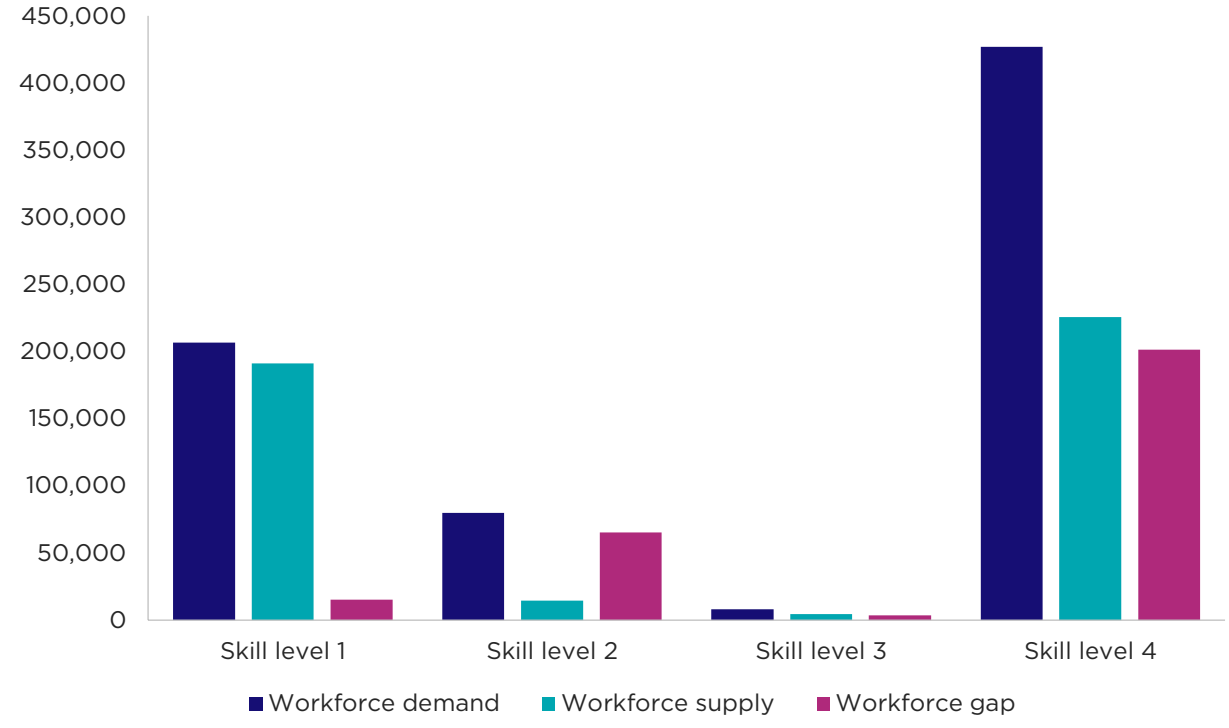
Workforce gaps (measured as the difference between workforce demand and workforce supply) will emerge at every skill level across the care and support workforce (Figure 306 and Figure 307).

Figure 306: Projected workforce demand and supply (FTE), care and support workforce, by skill level, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

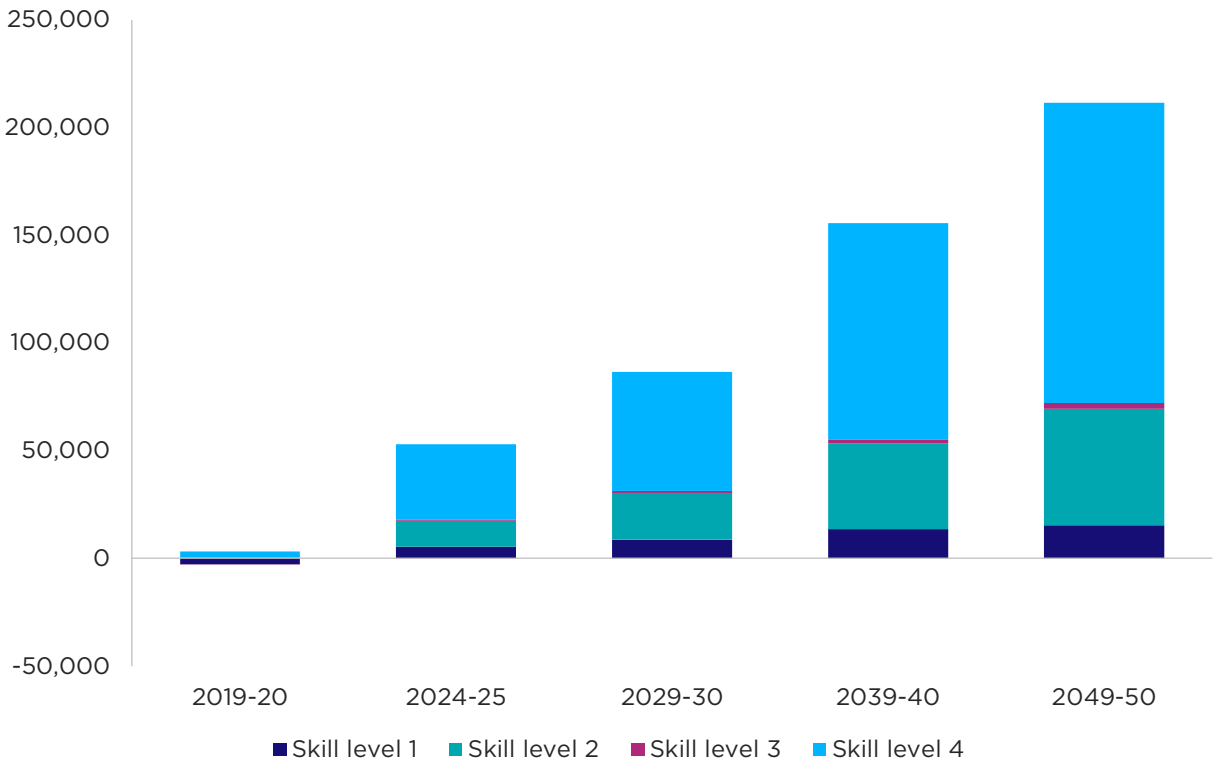
Figure 307: Projected workforce demand and supply (headcount), Care and support workforce, by skill level, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

Looking at the broader care and support workforce, it is clear that the anticipated workforce shortages are likely to be concentrated in the skill level 4 occupations (*Aged and disabled carers* and *Nursing support and personal care workers*), with 66% of the total FTE workforce gap in 2049-50 (Figure 308). While this is not unexpected, given that the majority of the total care and support workforce is currently comprised of these 2 key occupations (Table 1), attracting an *additional* 139,300 FTE skill level 4 workers (i.e. in addition to the new entrants required to balance any exits from the occupations) is likely to present a challenge.

Figure 308: Projected workforce gap (FTE), care and support workforce, by skill level, 2019-20 to 2049-50

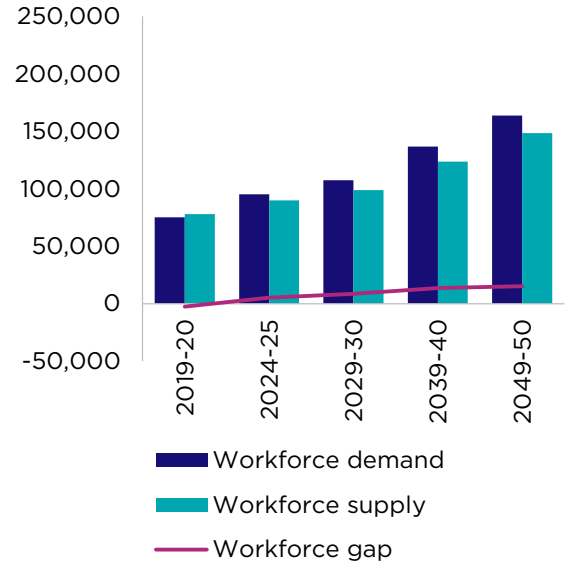


Source: Deloitte Access Economics, 2021.

While skill levels are not a reflection of the competencies and capabilities of individuals working in these occupations, they do provide a guide to the training and education requirements typically required for relevant occupations. In the context of a potential workforce shortage, the skill requirements of the occupations in undersupply are important, as they provide information about the training and education requirements, together with potential timelines to develop the required skills, in order to meet workforce demand.

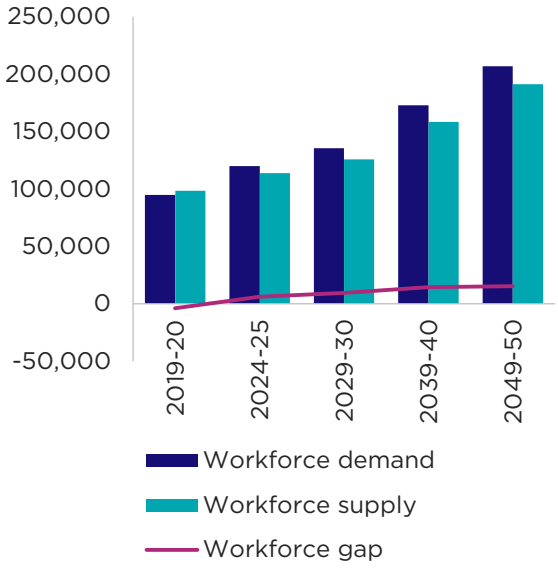
Meeting workforce demand for some skill level 1 occupations will also be a challenge. While the supply of Allied health professionals is expected to largely meet demand at the national level (noting that there are likely to be ongoing difficulties in the recruitment of Allied health professionals in some regions of Australia), the expected shortage by 2049-50 for *Health and welfare services managers* (14,900 FTE), *Nurse managers* (3,600 FTE) and *Registered nurses* (21,000 FTE) is likely to have a significant impact on residential aged care in particular. Sustained competition in attracting people with these skills will continue to come from the broader health and medical sectors, with relative wage differentials likely to play a key role in the capability of the care and support workforce to attract and retain people within skill level 1 occupations.

Figure 309: Projected workforce demand, supply and gap (FTE), care and support workforce, skill level 1 occupations, 2019-20 to 2049-50



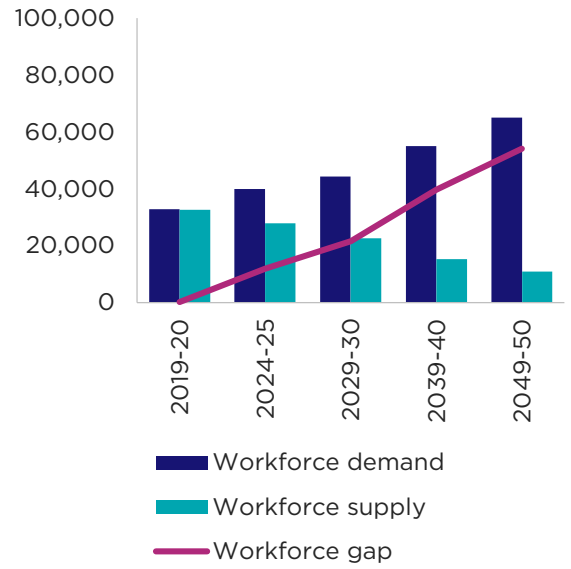
Source: Deloitte Access Economics, 2021.

Figure 310: Projected workforce demand, supply and gap (headcount), care and support workforce, skill level 1 occupations, 2019-20 to 2049-50



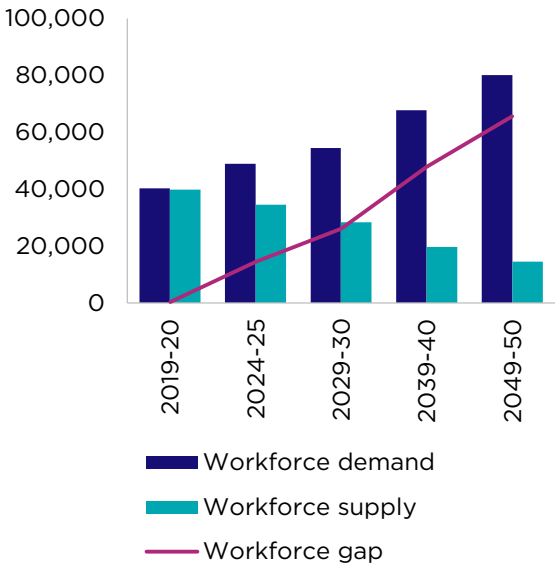
Source: Deloitte Access Economics, 2021.

Figure 311: Projected workforce demand, supply and gap (FTE), care and support workforce, skill level 2 occupations, 2019-20 to 2049-50



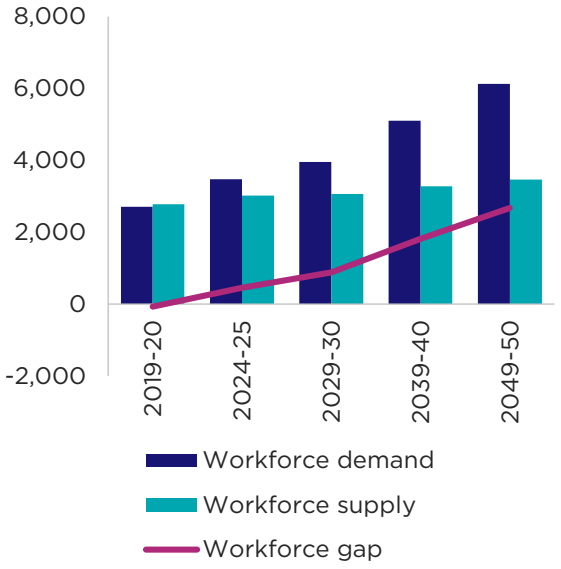
Source: Deloitte Access Economics, 2021.

Figure 312: Projected workforce demand, supply and gap (headcount), care and support workforce, skill level 2 occupations, 2019-20 to 2049-50



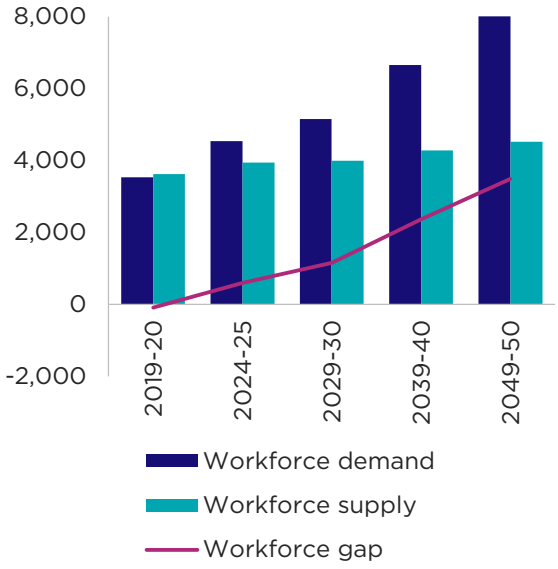
Source: Deloitte Access Economics, 2021.

Figure 313: Projected workforce demand, supply and gap (FTE), care and support workforce, skill level 3 occupations, 2019-20 to 2049-50



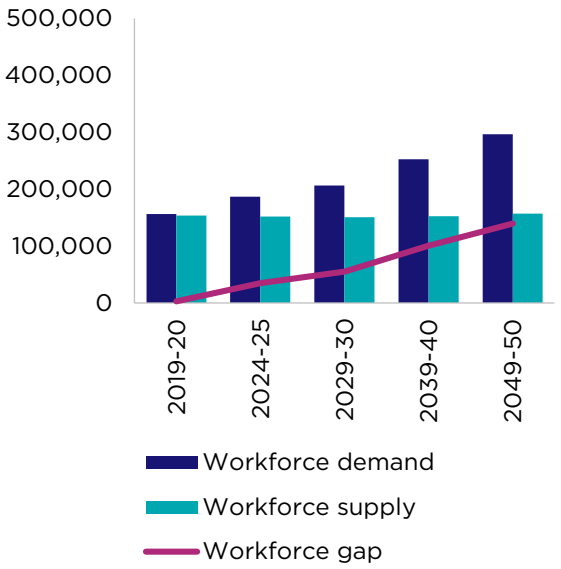
Source: Deloitte Access Economics, 2021.

Figure 314: Projected workforce demand, supply and gap (headcount), care and support workforce, skill level 3 occupations, 2019-20 to 2049-50



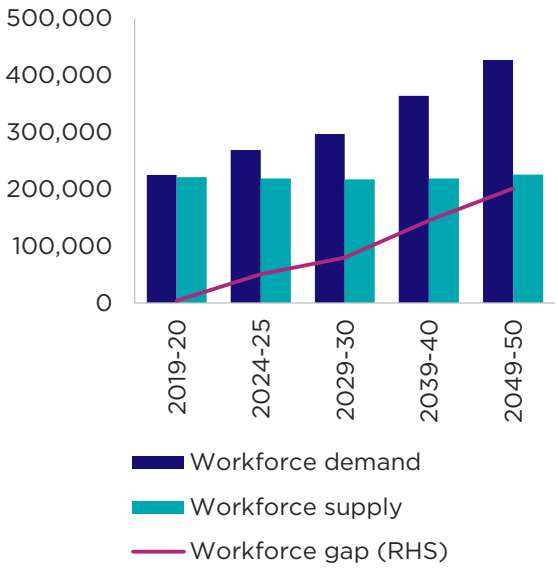
Source: Deloitte Access Economics, 2021.

Figure 315: Projected workforce demand, supply and gap (FTE), care and support workforce, skill level 4 occupations, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

Figure 316: Projected workforce demand, supply and gap (headcount), care and support workforce, skill level 4 occupations, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

In considering the forecasts presented in this Study, it is important to note that the care and support workforce operates somewhat differently to other labour markets within the economy. That is, the demand for workforce is largely driven by the requirements of the population – a combination of the size, structure, characteristics and preferences of that population.

The implications of a workforce shortage is also therefore different in the care and support sector than they would be for, say, the mining or financial sector. In addition, the role of technology (and broader capital) operates differently in a sector which is labour-intensive and non-tradeable. A workforce shortage in the care and support sector could result in the undersupply of care and support services to a population that has been deemed eligible – under existing government policy – to receive these services.

Part 10
Opportunities and risks in addressing workforce challenges

Part 10 explores a series of alternate assumptions for several of the key assumptions used in the forecasting process.

The sensitivities presented are not designed to model alternate policies or government decisions. Instead, they provide insight into the workforce implications, should alternate assumptions be incorporated for any of the key variables.

As the sensitivities demonstrate, there is no single solution to closing the forecast gap between workforce supply and workforce demand.

Across the sensitivities:

- A reduction in the rate of assumed productivity growth (lower productivity sensitivity) sees higher demand for care and support workers. That increase in demand drives a larger workforce gap than in the baseline forecasts. Lower productivity growth could have a significant impact on any future workforce gap.
- A permanent increase in wages for specific occupations relative to other comparable occupations (permanent wage increase sensitivity) lowers demand for the care and support workforce and increases the supply. That said, a gap nonetheless remains.
- While a permanent relative wage increase sensitivity has been considered (above), it is much more likely that other industries and occupations would adjust their own wages to retain workers. Hence the Study also modelled a temporary increase in relative wages for specific occupations. Again, demand is reduced and supply increased, but to a lesser extent than in the permanent relative wage increase scenario.
- Increases in the average hours worked by those employed in the care and support workforce (increased average hours sensitivity) reduces the number of people required to meet workforce demand, while increasing workforce supply on an FTE basis. Overall, the workforce gap is lower relative to the baseline forecast.
- Increased workforce retention (improved workforce retention sensitivity) has no impact on workforce demand but reduces the outflows of workers from the care and support workforce. This sensitivity results in a modest long-term reduction in the projected workforce gap.
- Higher levels of total net overseas migration (increased net overseas migration sensitivity) increases the supply of workers into the care and support workforce. If the share of migrants entering the care and support workforce were to increase, this would further increase the supply of care and support workers relative to the baseline projections and reduce the workforce gap. That is, this scenario models an increase in migration generally, not an increase in migration targeted solely toward the care and support workforce.
- Extending the number of 'care minutes' delivered within residential aged care (extended care minutes sensitivity) has a modest impact on workforce demand. While the increase in the workforce gap is relatively small, it emerges immediately.

While the sensitivities reflect some levers that influence the workforce projections, this Study has also highlighted a range of other supply and demand factors which present future opportunities and risks for the care and support workforce which are not able to be modelled.

Less tangible, but not less important, are factors like public perception, new articulations of job design and architecture, technology adoption and innovation rates. These all reflect opportunities to influence the care and support workforce gap.

Beyond these factors, the role of the wider economy and its capacity to contribute to the supply of the care and support workforce is a relevant consideration. While outside the terms of reference for this Study, opportunities may exist in other parts of the economy to improve productivity and hence increase the potential flows of workers to the care and support workforce from other sectors.

10.1 A change in key assumptions will alter the projections of future workforce gaps

The 7 different sensitivities considered, each highlighting important assumptions about the future, are:

- a reduction in the rate of assumed productivity growth (**lower productivity sensitivity**)
- a temporary increase in wages for specific low-paid occupations relative to other comparable occupations (**temporary wage increase sensitivity**)
- a permanent increase in wages for specific low-paid occupations relative to other comparable occupations (**permanent wage increase sensitivity**)
- increases in the average hours worked by those employed in the care and support workforce (**increased average hours sensitivity**)
- increased workforce retention in the care and support workforce (**improved workforce retention sensitivity**)
- higher levels of total net overseas migration (**increased net overseas migration sensitivity**)
- extending the number of 'care minutes' delivered within residential aged care (**extended care minutes sensitivity).**

Each sensitivity assumes that only the specific variables of interest change, and that all other aspects of the baseline remain constant.

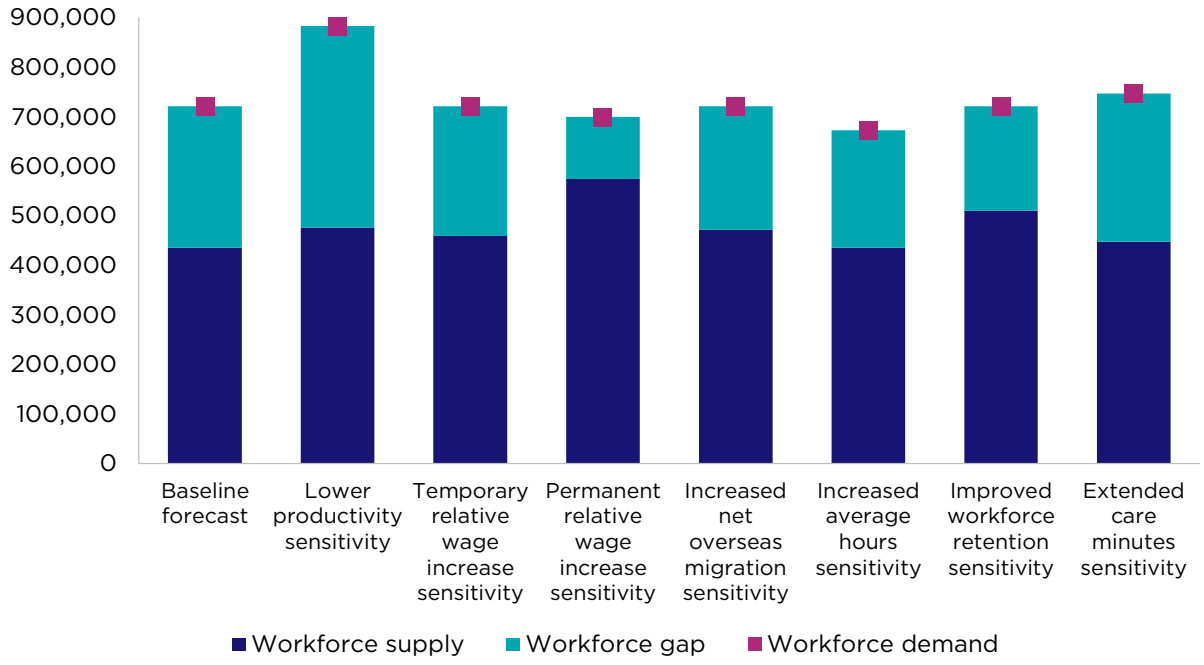
> These sensitivities are not intended to reflect designed or intended outcomes, but rather to outline the importance of various assumptions within the forecasting process. They should not be taken as recommendations of the Study.

Each sensitivity results in a different impact to the anticipated gap for the future care and support workforce. With the exception of the lower productivity and extended care minutes sensitivities, all other sensitivities contribute to reducing the overall workforce gap. As the sensitivities demonstrate, there is no single solution to closing the forecast gap between workforce supply and workforce demand.

The workforce gap under each sensitivity is summarised in Figure 317. Overall, the lower productivity sensitivity (a reduction of annual productivity from 1.5% to 0.5%) has the largest net impact, increasing the total workforce gap to 299,600 FTE (or 406,800 workers) by 2049-50 compared with the baseline forecast workforce gap of 211,430 FTE (or 285,800 workers).

The largest reduction to the future workforce gap is seen in the permanent wage increase sensitivity (a *permanent* relative increase in wages for the lowest paid occupations within the care and support workforce), reducing the total workforce gap to 97,300 FTE (or 125,100 workers) by 2049-50. Note that this sensitivity assumes that the relative wage increase is maintained across the entire forecast period, with any increases in wages for related sectors matched by an additional wage increase in the care and support occupations.

Figure 317: Projected workforce demand, supply and gap (headcount), care and support workforce, baseline forecast and sensitivities, 2049-50



Source: Deloitte Access Economics, 2021.

Total demand by headcount for the care and support workforce as a share of the total workforce is highest under the lower productivity sensitivity (4.8%), and lowest under the increased hours worked sensitivity (3.6%) (Table 13). Overall, the permanent relative wage increase sensitivity has the greatest impact on reducing the workforce gap, lowering the workforce gap by around 160,700 workers (headcount) relative to the baseline forecast.

Table 13: Projected workforce demand, supply and gap (headcount) and share of total employment (%), care and support workforce, baseline forecast and sensitivities, 2049-50

Sensitivity	Workforce demand	Workforce supply	Workforce gap	Workforce gap (relative to baseline)	Workforce demand (share of total employment)
Baseline forecast	721,800	436,000	285,800		3.9%
Lower productivity	883,300	476,500	406,800	121,100	4.8%
Temporary relative wage increase	721,800	459,800	262,000	-23,800	3.9%
Permanent relative wage increase	699,500	574,400	125,100	-160,700	3.8%
Higher net overseas migration	721,800	472,000	249,800	-36,000	3.9%
Increase in average hours worked	672,700	436,000	236,700	-49,100	3.6%
Improved workforce retention	721,800	510,600	211,200	-74,600	3.9%
Extended minutes of care delivered	747,000	447,800	299,200	13,500	4.0%

Source: Deloitte Access Economics, 2021.

10.2 Lower productivity sensitivity

Within the baseline forecast, productivity is assumed to be 1.5%, consistent with the total productivity assumption in the 2021 IGR.[253] As noted in the 2021 IGR, achieving this assumption would require an improvement over recent performance, with productivity growth averaging 1.2% over the last complete productivity cycle in the 2010s.

Given the traditionally strong links between the number of care and support workers and the delivery of care and support services, achieving productivity growth in the care and support sector can be more challenging than in other sectors where automation and other technological advances have been relatively rapid (for example, the manufacturing and mining sectors).

10.2.1 Lower productivity sensitivity: lower productivity requires a larger workforce to deliver the same level of care

Productivity growth in the care and support sector is not guaranteed. If productivity growth were to fall short of the baseline assumption, this would have implications for labour demand, wages, and the supply of care and support workers.

For this sensitivity, productivity is expected to be 0.5% per year, a reduction of one percentage point from the baseline assumption of 1.5% per year. It is assumed that there is no change in government funding relative to the baseline, in order to isolate the impact of the productivity assumption within the context of fixed government funding.

As a result of lower productivity, providers would need to hire more workers to deliver the same amount of care and support services as in the baseline forecast. This results in an increase in the number of workers required per program recipient, with the level of care delivered to recipients remaining unchanged.

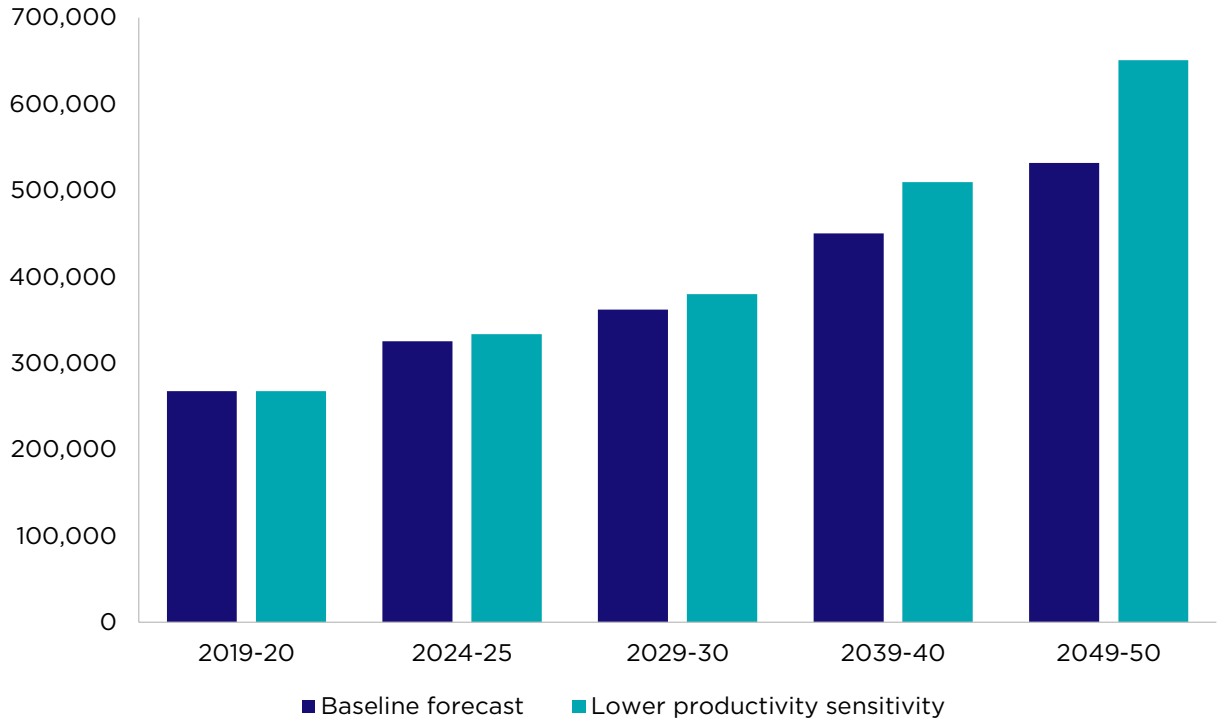
It is assumed that the reductions in productivity are matched by reduced wages in the care and support workforce, reflecting changes in the value of work performed over time, rather than placing increased labour costs on providers. At the same time, lower wages mean that additional labour is affordable given government funding remains unchanged (i.e. providers can afford to hire more people for the same total wages bill).

10.2.2 Lower productivity sensitivity: impact on future workforce demand

Under the lower productivity sensitivity, total demand for the care and support workforce is expected to increase to 650,700 FTE by 2049-50, around 22% higher than the workforce demand under the baseline forecast (531,600 FTE) (Figure 318). Over the forecast period (to 2049-50), workforce demand in FTE is expected to increase at an average of 3.0% per year under this sensitivity, compared with 2.3% per year under the baseline forecast.

[253] The Treasury, *2021 Intergenerational report: Australia over the next 40 years*, 2021

Figure 318: Projected workforce demand (FTE), care and support workforce, baseline forecast and lower productivity sensitivity, 2019-20 to 2049-50

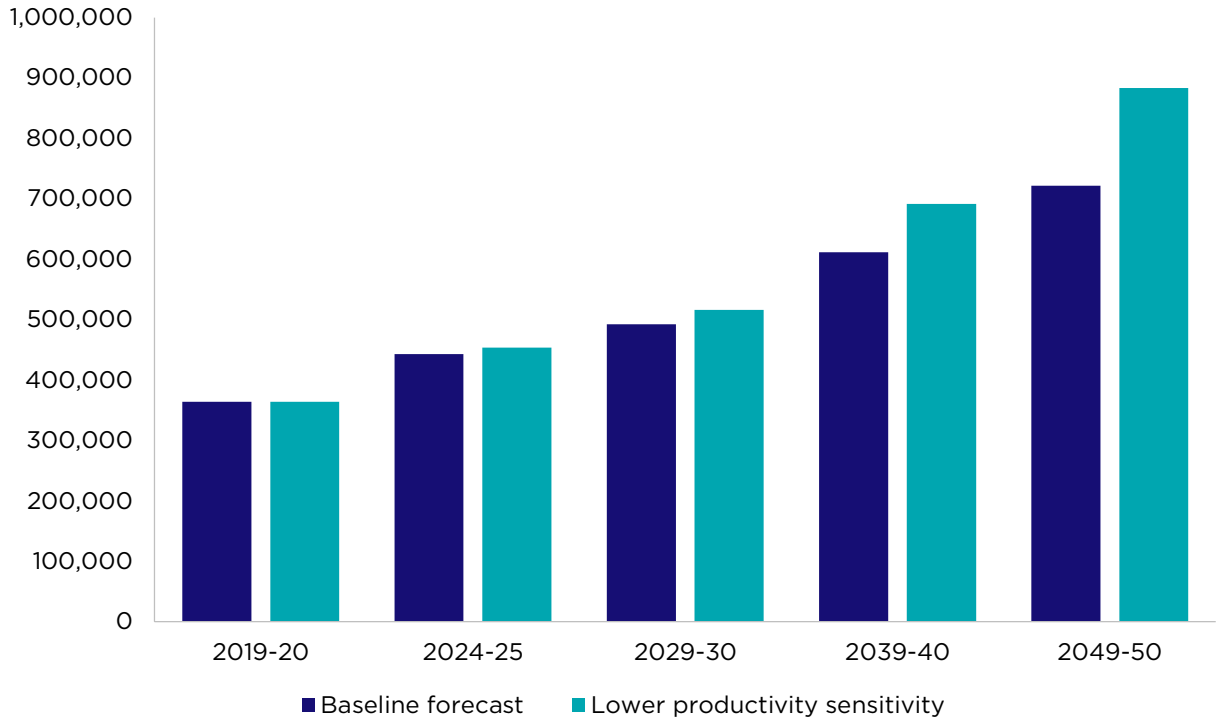


Source: Deloitte Access Economics, 2021.

On a headcount basis, this lower productivity assumption sees total workforce demand increase to 883,300 workers in 2049-50, compared with 721,800 under the baseline assumption (Figure 319). To meet this level of workforce demand under a lower productivity assumption, the total care and support workforce would need to increase by around 519,200 workers (or 143%) over the next 30 years. Overall, the average annual rate of growth in demand for the total care and support workforce on a headcount basis (3.0% per year) significantly exceeds the rate of growth forecast for the total Australian workforce (1.3% per year).[254]

[254] Deloitte Access Economics, *Caring today, caring tomorrow - A profile of the care and support workforce (commissioned for the Care Workforce Labour Market Study)*, 2021

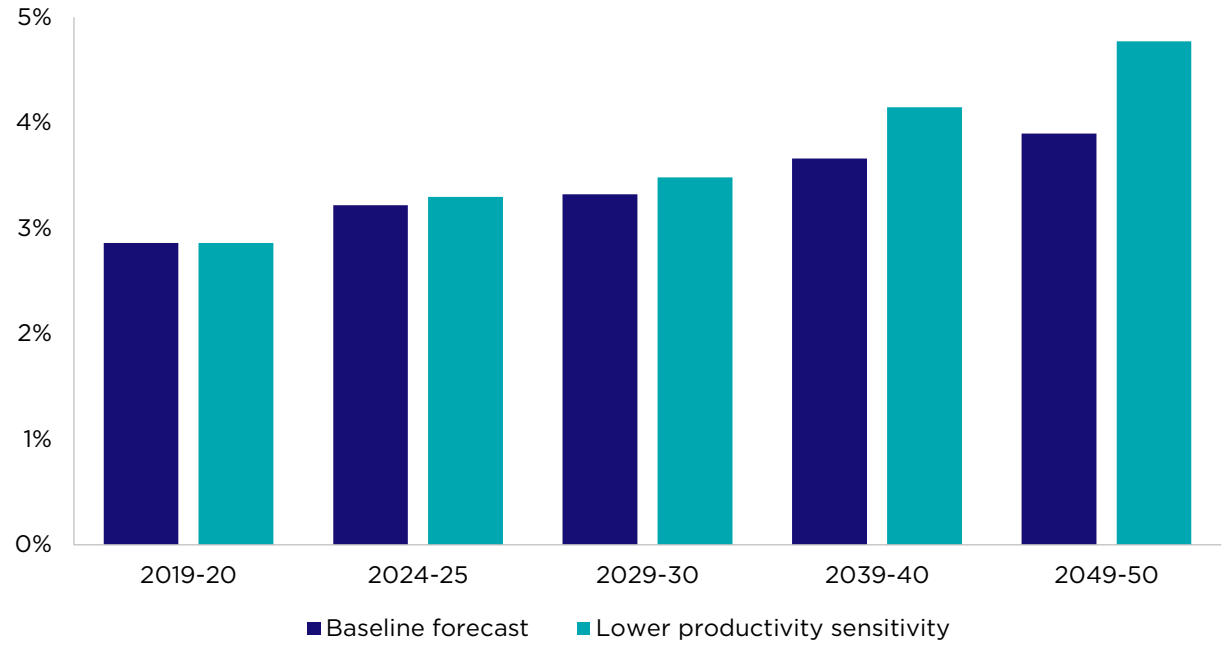
Figure 319: Projected workforce demand (headcount), care and support workforce, baseline forecast and lower productivity sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

A lower productivity assumption significantly increases the share of the total workforce required to meet future workforce demand. Under a lower productivity sensitivity, demand for the care and support workforce reaches 4.8% of the total Australia workforce by 2049-50 (Figure 320). That is, all other things being equal, if productivity increases by only 0.5% per year for the care and support workforce over the projection period, almost 1 in 20 people in the total Australian workforce (4.8%) would be required to work in the care and support workforce in order to meet workforce demand. More specifically, 2.8% of people in the Australia workforce would need to be working as Personal care and support workers (compared with 2.3% under the baseline forecast), up from approximately 1.8% of the Australian workforce in 2019-20.

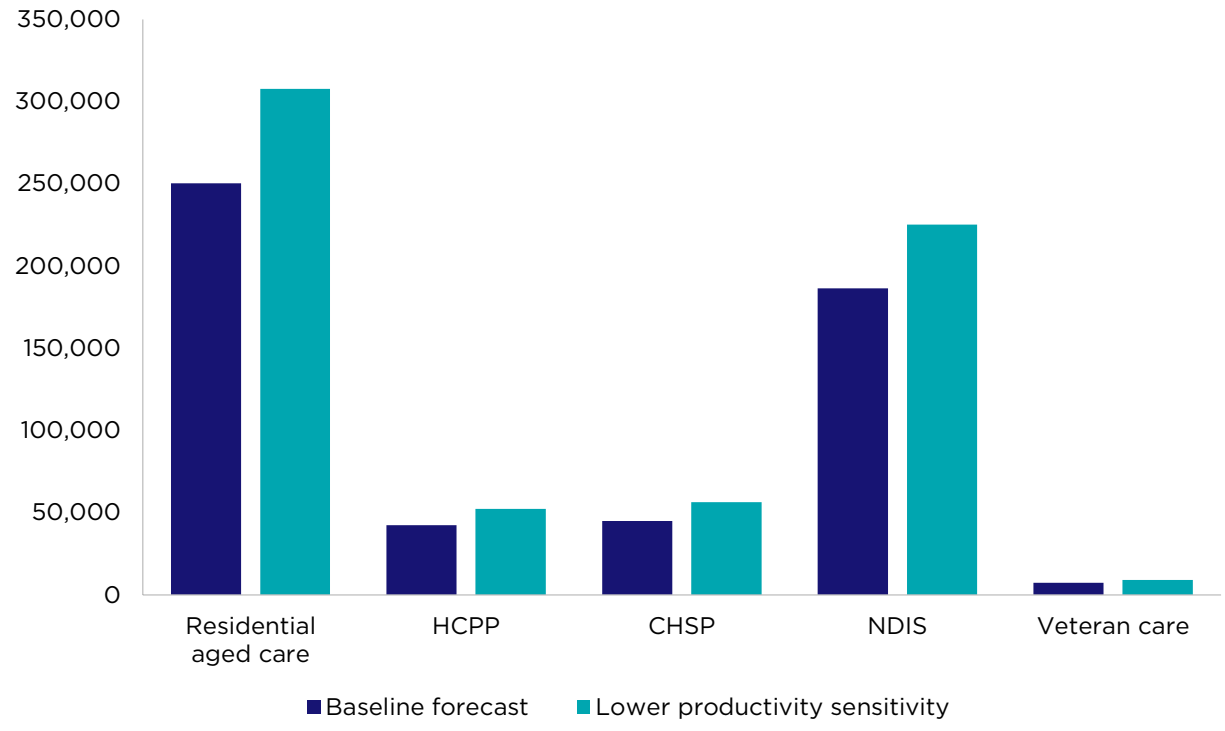
Figure 320: Projected workforce demand (headcount), care and support workforce, baseline forecast and lower productivity sensitivity, share of total employment (%), 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

Under the lower productivity assumption, the residential aged care program continues to be the key driver of future workforce demand, followed by the NDIS. With lower productivity, workforce demand within residential aged care is expected to grow to 307,700 FTE by 2049-50 (compared with 250,400 FTE under the baseline forecast) (Figure 321).

Figure 321: Projected workforce demand (FTE), care and support workforce, by program, baseline forecast and lower productivity sensitivity, 2049-50



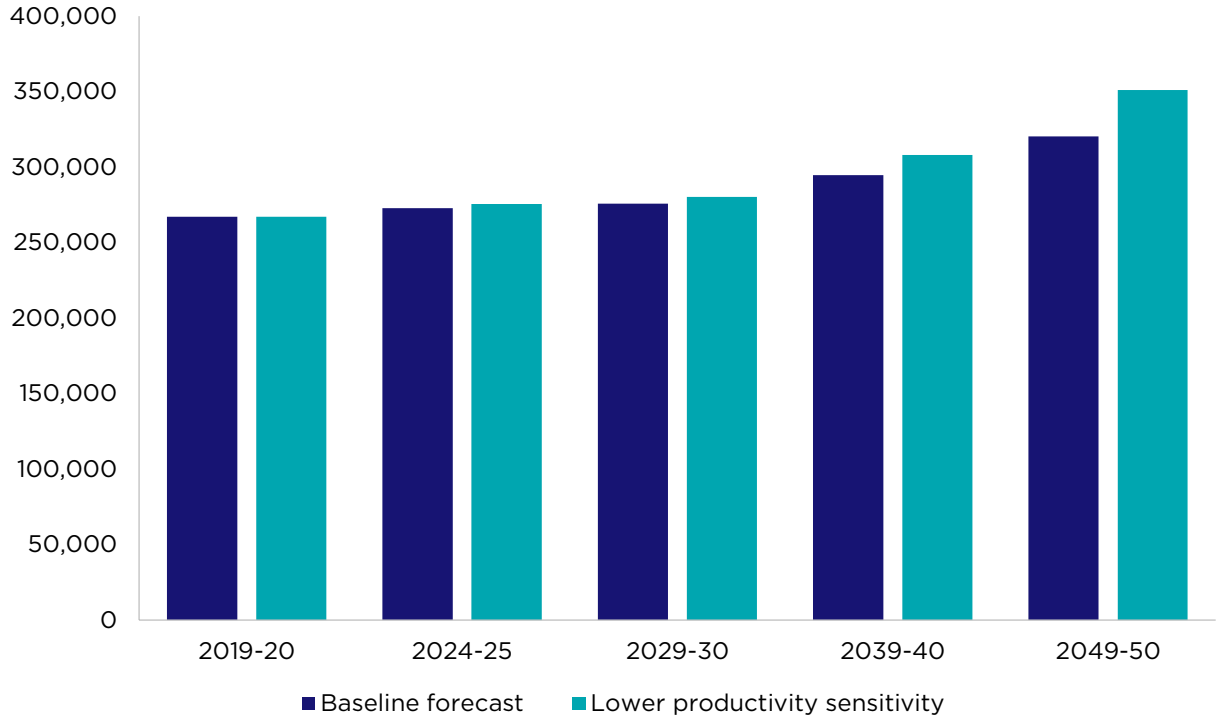
Source: Deloitte Access Economics, 2021.

10.2.3 Lower productivity sensitivity: impact on future workforce supply

On the workforce supply side, a lower productivity assumption has a modest impact on the size of future workforce supply. While lower wages mean that potential workers are less likely to choose to join the relevant occupations, at the same time the significantly higher level of demand attracts additional workers to the industry as workers look to join the 'shortest queue' when looking for a job. There are also shifts expected across retirements, occupation movements and industry movements commensurate with changes in demand and the size of the care and support workforce. For example, while retirement rates are unchanged, a higher number of workers means more workers are retiring in future years under this sensitivity.

The result of a lower productivity assumption for the care and support workforce is an increase of expected total care and support workforce supply to 351,100 FTE in 2049-50, compared with 320,200 FTE under the baseline forecast (Figure 322).

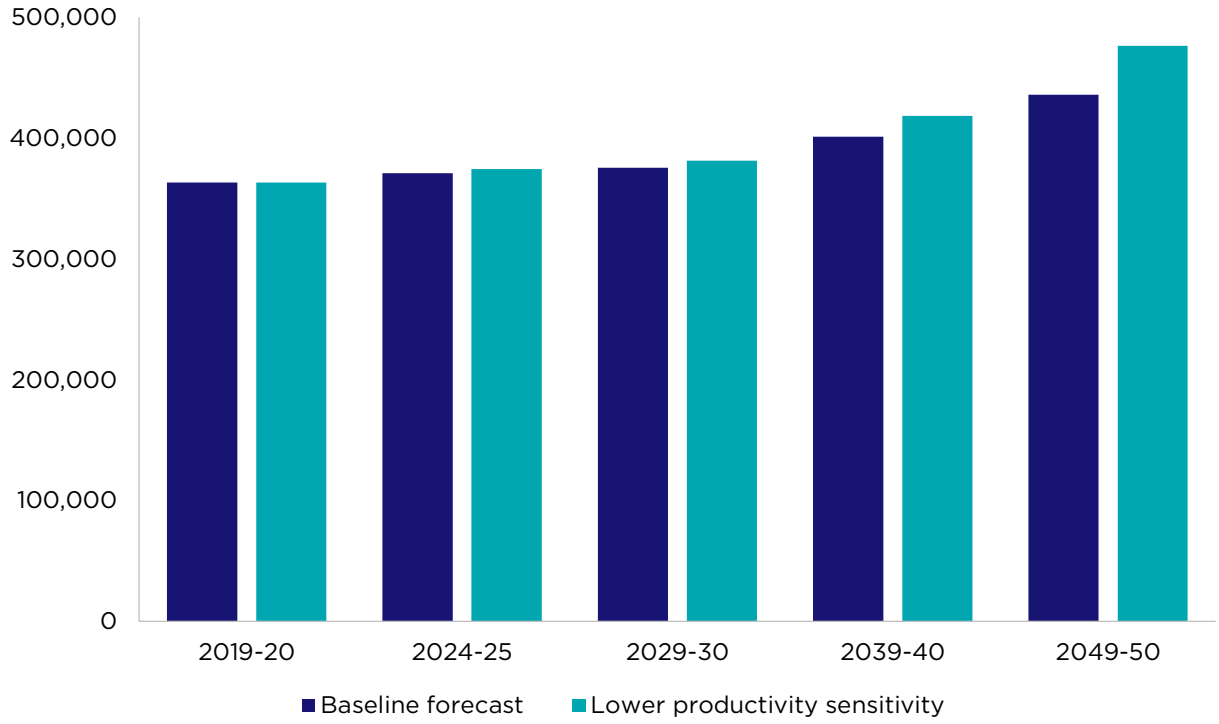
Figure 322: Projected workforce supply (FTE), care and support workforce, baseline forecast and lower productivity sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

On a headcount basis, workforce supply is expected to increase to 476,500 by 2049-50 under the lower productivity sensitivity, compared with 436,000 for the baseline forecast (Figure 323). The average hours worked per person employed in each occupation has been assumed to remain constant under each sensitivity, although this would be subject to change in practice as individuals respond to changing workforce conditions (Figure 286).

Figure 323: Projected workforce supply (headcount), care and support workforce, baseline forecast and lower productivity sensitivity, 2019-20 to 2049-50

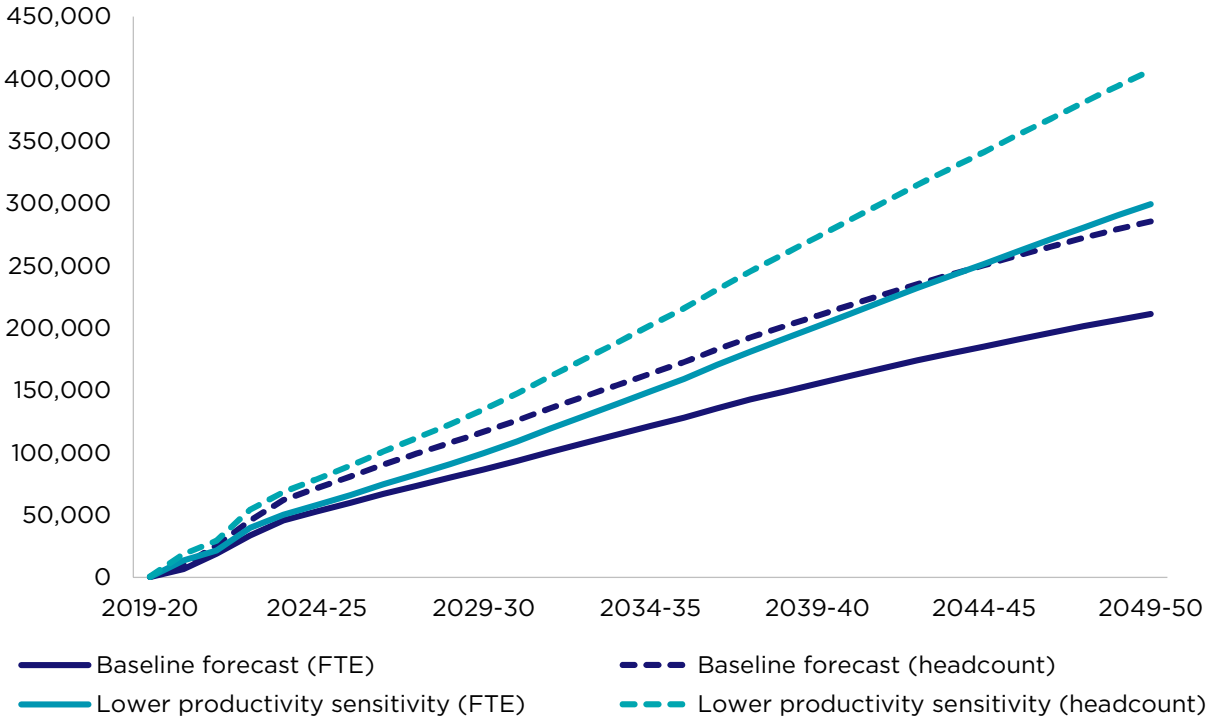


Source: Deloitte Access Economics, 2021.

10.2.4 Lower productivity sensitivity: impact on future workforce gap

While both demand and supply of the total care and support workforce is expected to be higher under the lower productivity sensitivity, the change in workforce demand relative to the baseline forecast is expected to significantly exceed the change in workforce supply. As a result, the projected workforce gap on both an FTE and headcount basis is significantly greater under the lower productivity sensitivity than the baseline forecast. By 2049-50, the workforce gap for the total care and support workforce under the lower productivity sensitivity is expected to reach 299,600 FTE (406,800 workers) – 42% higher in FTE terms than under the baseline forecast (211,400 FTE or 285,800 workers) (Figure 324).

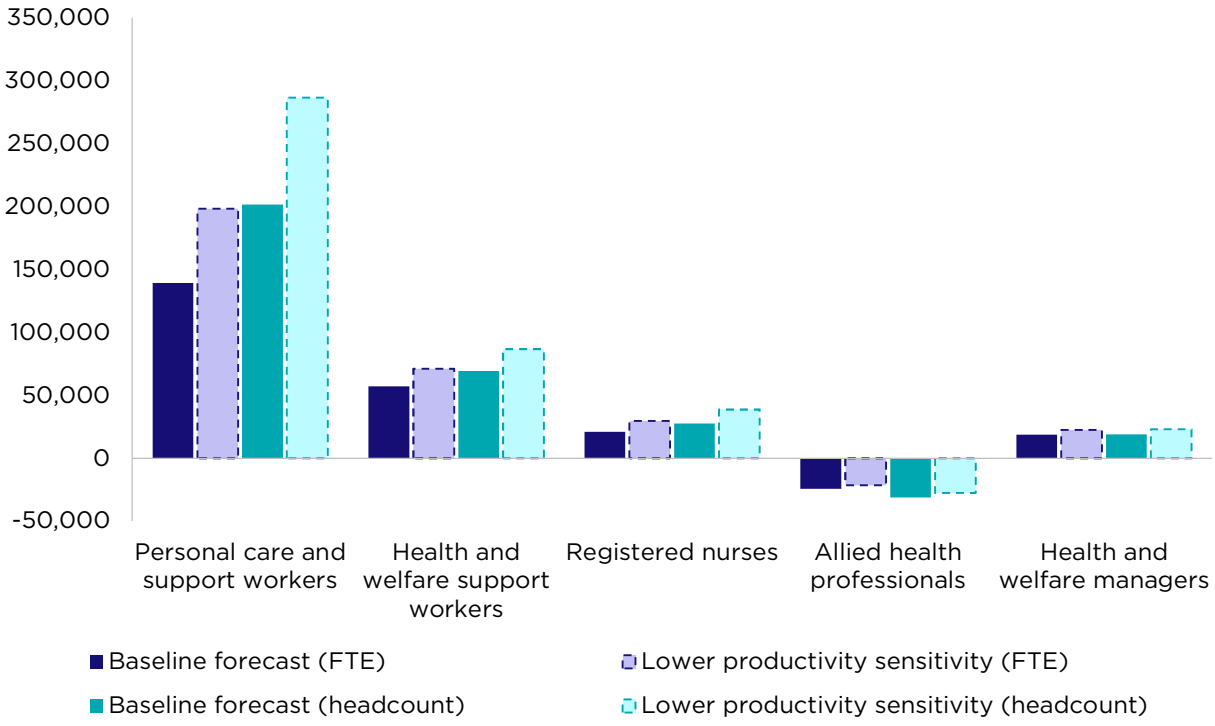
Figure 324: Projected workforce gap (FTE and headcount), care and support workforce, baseline forecast and lower productivity sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

As per the baseline forecast, the workforce gap for Personal care and support workers (skill level 4) continues to form the majority of the workforce shortage under the lower productivity sensitivity, with larger workforce gaps also evident for Health and welfare support workers (skill levels 1 and 3) and Health and welfare managers (skill level 1), together with Registered nurses (skill level 1) (Figure 325). Noting the complexities in interpreting forecast data for Allied health professionals (Part 9.5), workforce availability is largely unchanged relative to the baseline forecast.

Figure 325: Projected workforce gap (FTE and headcount), care and support workforce, by occupation group, baseline forecast and lower productivity sensitivity, 2049-50

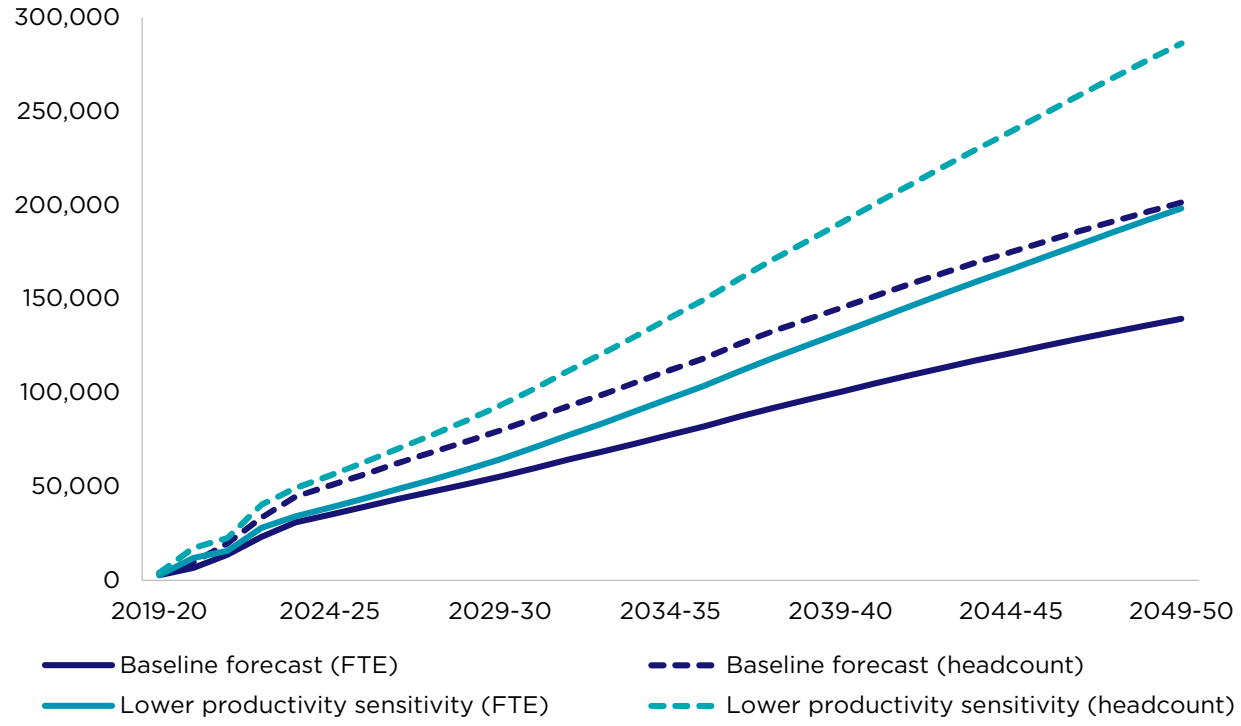


Source: Deloitte Access Economics, 2021.

Within this sensitivity, there are different impacts for individual occupation groups:

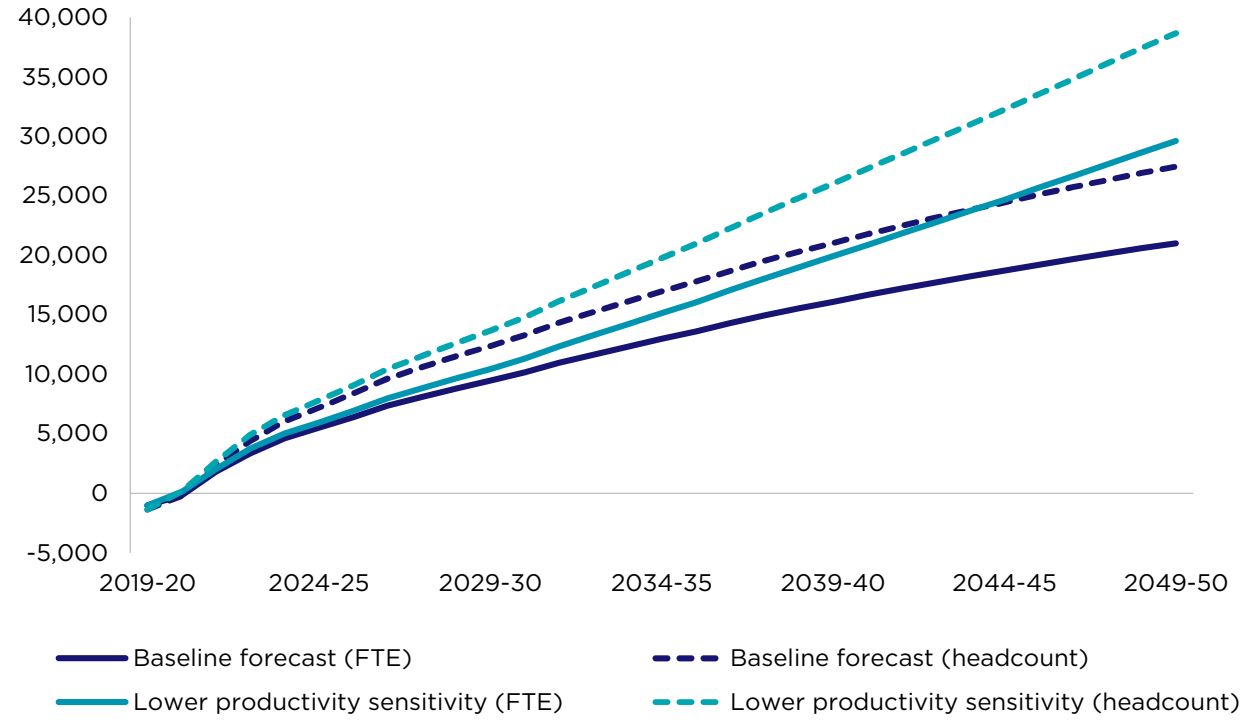
- Personal care and support workers continue to make up the majority of both the workforce demand and workforce gap, with lower productivity having a significant impact on demand for workers in these occupations (Figure 326).
- The workforce gap for Registered nurses is also higher under the lower productivity sensitivity, with the workforce gap growing quickly over the first years of the forecast period to reach an expected shortage of 11,300 FTE (14,800 workers) by 2030-31 (Figure 327).
- Health and welfare support workers also see a higher workforce gap under a lower productivity sensitivity, reaching 71,100 FTE (86,700 workers) by 2049-50 (Figure 328).

Figure 326: Projected workforce gap (FTE and headcount), Personal care and support workers, baseline forecast and lower productivity sensitivity, 2019-20 to 2049-50



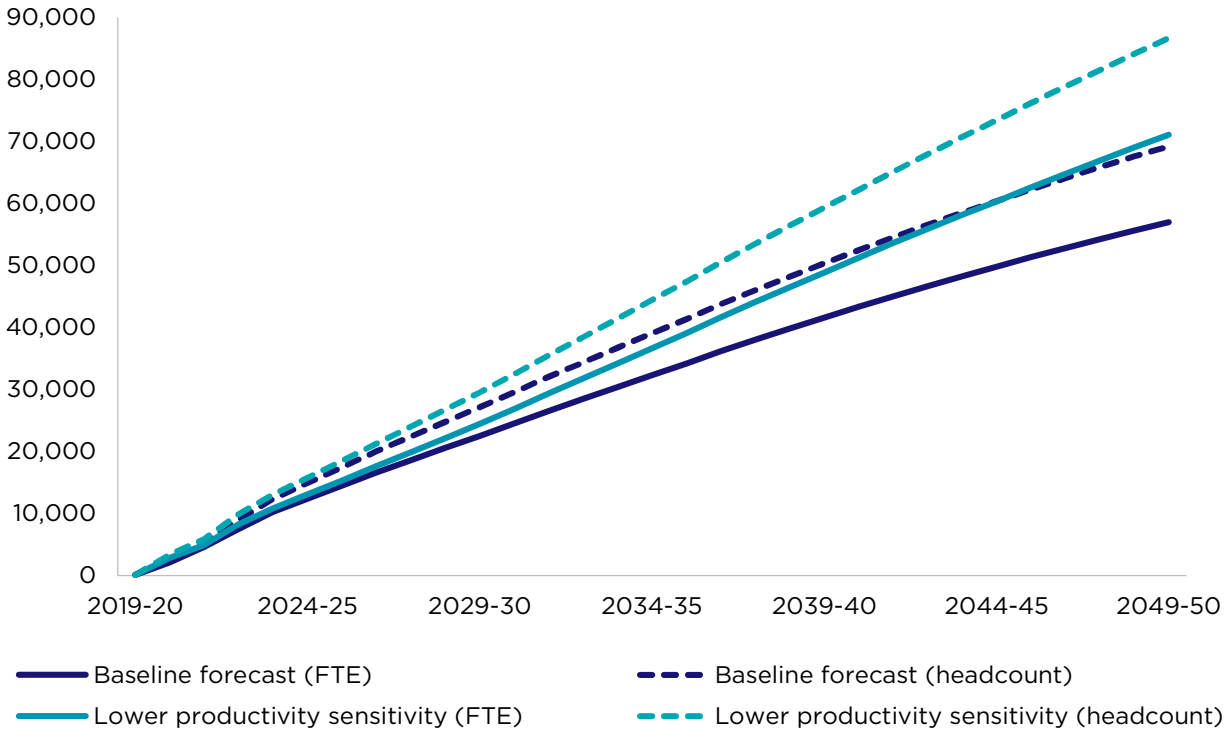
Source: Deloitte Access Economics, 2021.

Figure 327: Projected workforce gap (FTE and headcount), Registered nurses, baseline forecast and lower productivity sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

Figure 328: Projected workforce gap (FTE and headcount), Health and welfare support workers, baseline forecast and lower productivity sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

10.3 Relative wage increase sensitivities

Wages are an important factor in the decisions made by care and support providers and existing care and support workers, as well as those considering joining the care and support workforce. Changes in wages can influence both the demand for care and support workers, and the supply of those workers over time.

To illustrate the effect of higher wages on the baseline forecasts, a wage increase has been included for 3 specific occupations within the care and support sector:

- *Aged and disabled carers*
- *Nursing support and personal care workers*
- *Welfare support workers*

Together, these 3 occupations currently make up approximately two-thirds (67%) of the total care and support workforce.

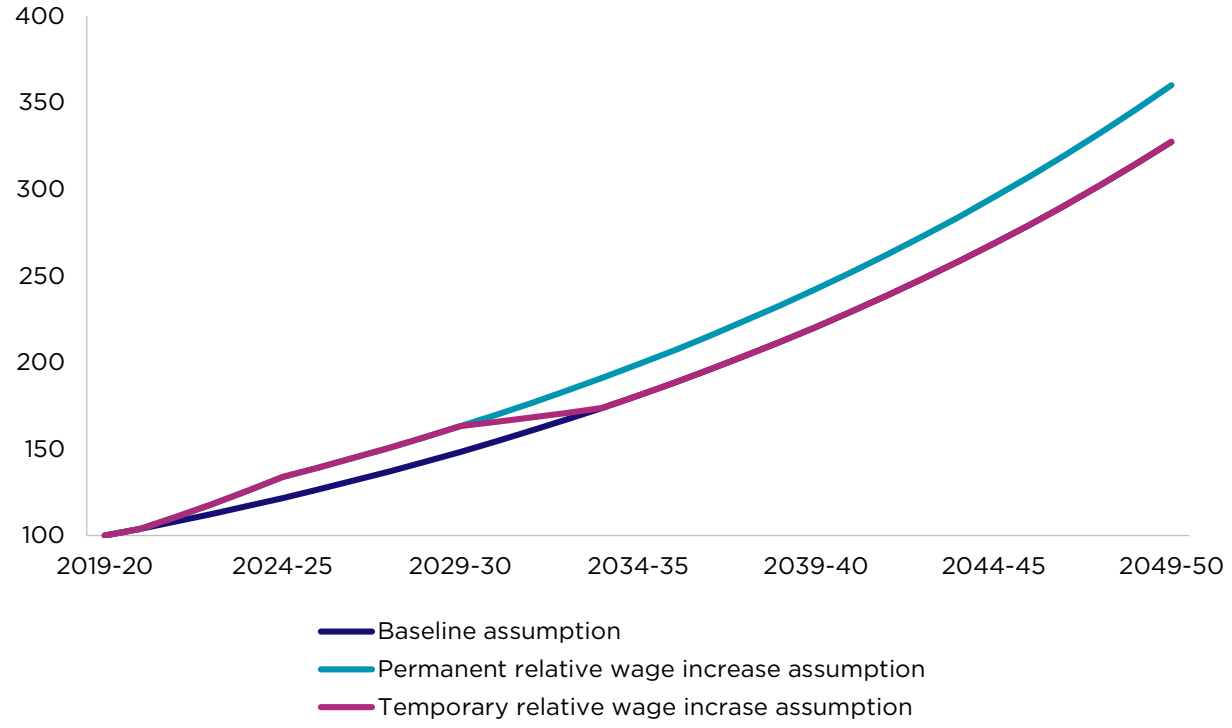
Each of these occupations is assumed to experience a 10% increase in wages relative to the baseline forecasts (and to other relevant occupations), phased in over 5 years to 2024-25. Wages for all other occupations within the care and support workforce remain unchanged from the baseline assumption. From here, 2 different wage sensitivities have been modelled.

The first wage sensitivity assumes that this relative wage increase *remains* over time (i.e. a permanent increase) (Part 10.3.1). That is, should there be any wage increases in other occupations or industries relative to the baseline, then wages for the 3 selected occupations would need to increase further in order to maintain the 10% relative difference.

The second wage sensitivity assumes that this relative wage increase *reduces* over time (i.e. a temporary increase). That is, wages in other occupations or industries are expected to adjust over time to close the relative gap over a number of years, with this adjustment expected to be complete by 2033-34, after which relative wages are aligned with the baseline assumption.

The wage growth assumption for each wage sensitivity, together with the baseline forecast assumption, indexed to 2019-20 = 100 is shown in Figure 329 below.

Figure 329: Wage growth assumption - wage sensitivities (index, 2019-20 = 100)



Source: Deloitte Access Economics, 2021.

For both wage sensitivities, in order to maintain the level of service provided to participants in the care and support sector, the government increases care funding based on the increase in wage costs in each program. That sees funding increase in line with wage rates, adjusted for the share of total costs accounted for by these occupations in each care program.

By increasing the cost of employing workers in the 3 selected occupations, 2 direct effects on workforce demand are observed:

- care and support providers look to employ fewer workers in these occupations and instead increase their demand for other, higher skilled occupations instead. This shift reflects that higher skill level labour has now become cheaper in relative terms after the change in wages, and workers in these higher skill level occupations are thought to be highly trained in delivering quality care productively.
- care and support providers look to reduce the overall amount of labour they use to deliver care and support services in favour of more labour-saving technology and equipment.

There is also a third, indirect effect on labour demand that occurs due to the increase in government funding assumed under this sensitivity. With additional funding, providers are able to deliver more care and support services than they otherwise would. This increases demand for both capital and labour across all care and support occupations.

While there are also likely to be impacts on the hours worked by the care and support workforce, this sensitivity assumes these are held constant.

10.3.1 Wage sensitivity: permanent relative increase in wages for selected occupations

Importantly, this sensitivity holds a number of assumptions constant which are likely to move in practice. Under this sensitivity, there is no response for wages in other occupations, and employers of workers moving into the care and support workforce do not attempt to try and retain their staff. Including such changes – such as incorporated in the *temporary* relative wage increase sensitivity (Part 10.3.2) – would reduce the supply response.

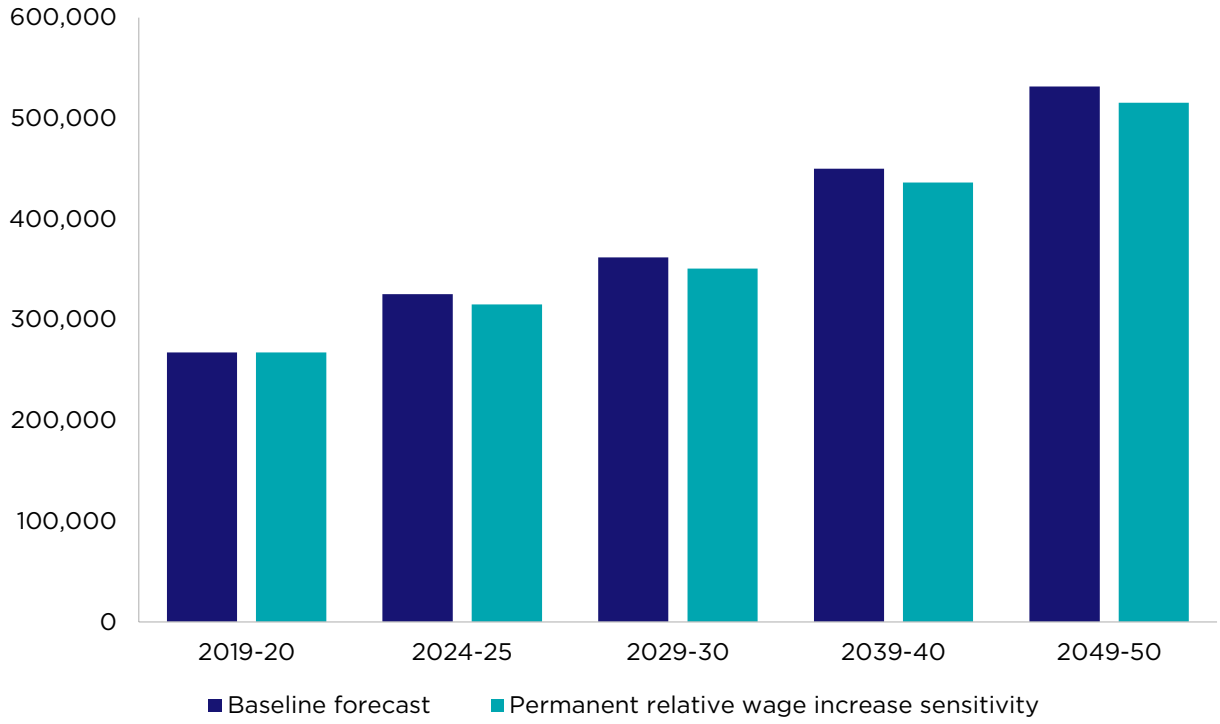
10.3.1.1 Permanent relative wage increase sensitivity: impact on future workforce demand

Overall, a permanent increase in the relative wages of *Aged and disabled carers, Nursing support and personal care workers* and *Welfare support workers* sees the following outcomes for workforce demand relative to the baseline forecast:

- a reduction in the demand for care and support workers in the occupations which experience a relative wage increase
- increased demand for workers in higher skilled occupations, particularly *Registered nurses*
- minimal change in demand for workers in other care and support occupations
- a small reduction in the overall level of care and support workforce demand.

Under the permanent relative wage increase for selected occupations sensitivity, total demand for the care and support workforce is expected to decrease to 515,700 by 2049-50, around 3% lower than the workforce demand under the baseline forecast (531,600 FTE) (Figure 330). Over the forecast period (to 2049-50), workforce demand in FTE is expected to increase at an average of 2.2% per year under this permanent relative wage increase sensitivity, compared with 2.3% per year under the baseline forecast.

Figure 330: Projected workforce demand (FTE), care and support workforce, baseline forecast and permanent relative wage increase sensitivity, 2019-20 to 2049-50

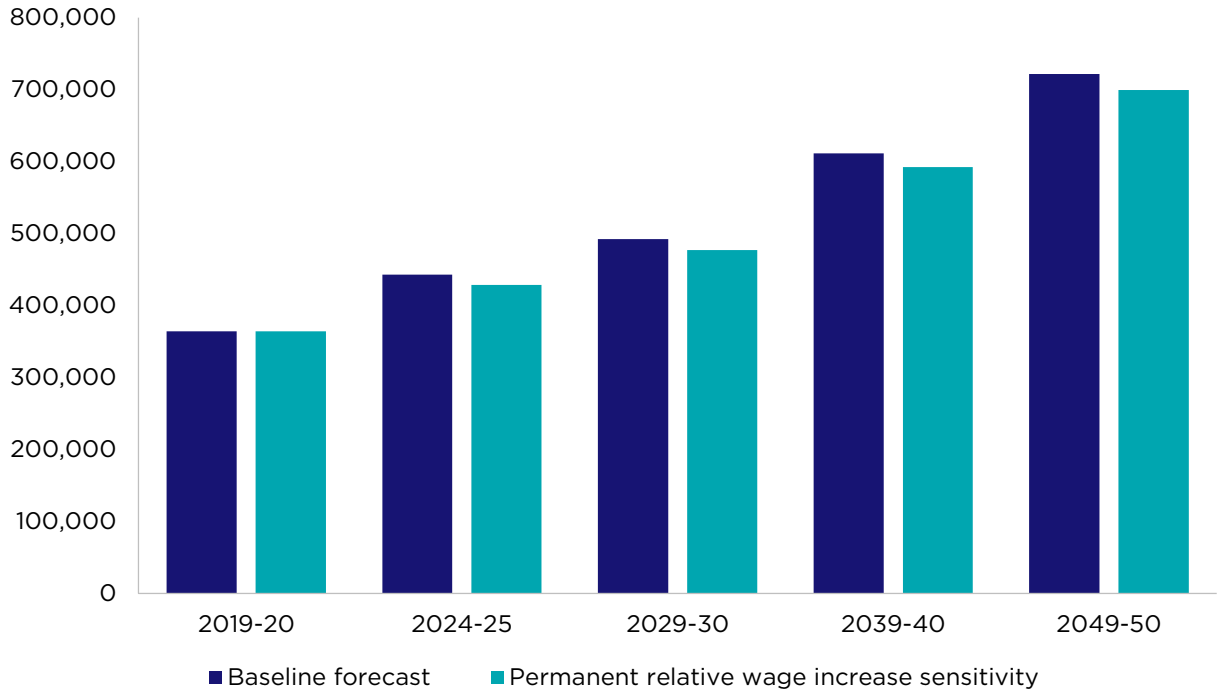


Source: Deloitte Access Economics, 2021.

On a headcount basis, increased relative wages for selected occupations, maintained over the forecast period, sees total workforce demand at 699,500 workers in 2049-50, compared with 721,800 under the baseline assumption (Figure 331). To meet this level of workforce demand under an increased permanent relative wage, the total care and support workforce would need to increase by around 335,400 workers (or 92%) over the next 30 years. Overall, the average annual rate of growth in demand for the total care and support workforce on a headcount basis (2.2% per year) significantly exceeds the rate of growth forecast for the total Australian workforce (1.3% per year).[255]

[255] Deloitte Access Economics, *Caring today, caring tomorrow - A profile of the care and support workforce (commissioned for the Care Workforce Labour Market Study)*, 2021

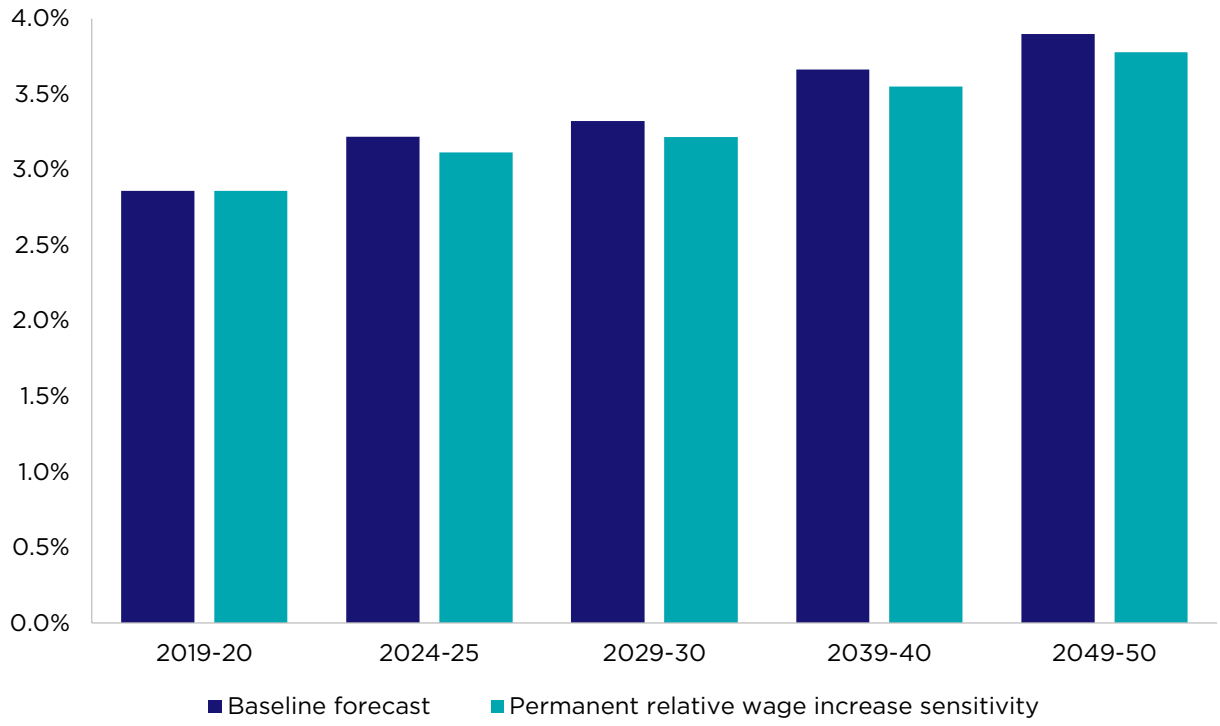
Figure 331: Projected workforce demand (headcount), care and support workforce, baseline forecast and permanent relative wage increase sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

A permanent increase in relative wages for selected occupations marginally decreases the share of the total workforce required to meet future workforce demand relative to the baseline forecast. Under this permanent relative wage increase sensitivity, demand for the care and support workforce reaches 3.8% of the total Australia workforce by 2049-50 (compared with 3.9% under the baseline forecast) (Figure 332).

Figure 332: Projected workforce demand (headcount), care and support workforce, baseline forecast and permanent relative wage increase sensitivity, share of total employment (%), 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

10.3.1.2 Permanent relative wage increase sensitivity: impact on future workforce supply

On the supply side of the model, potential workers respond to the increase in wages by increasing net movements into the 3 affected occupations.

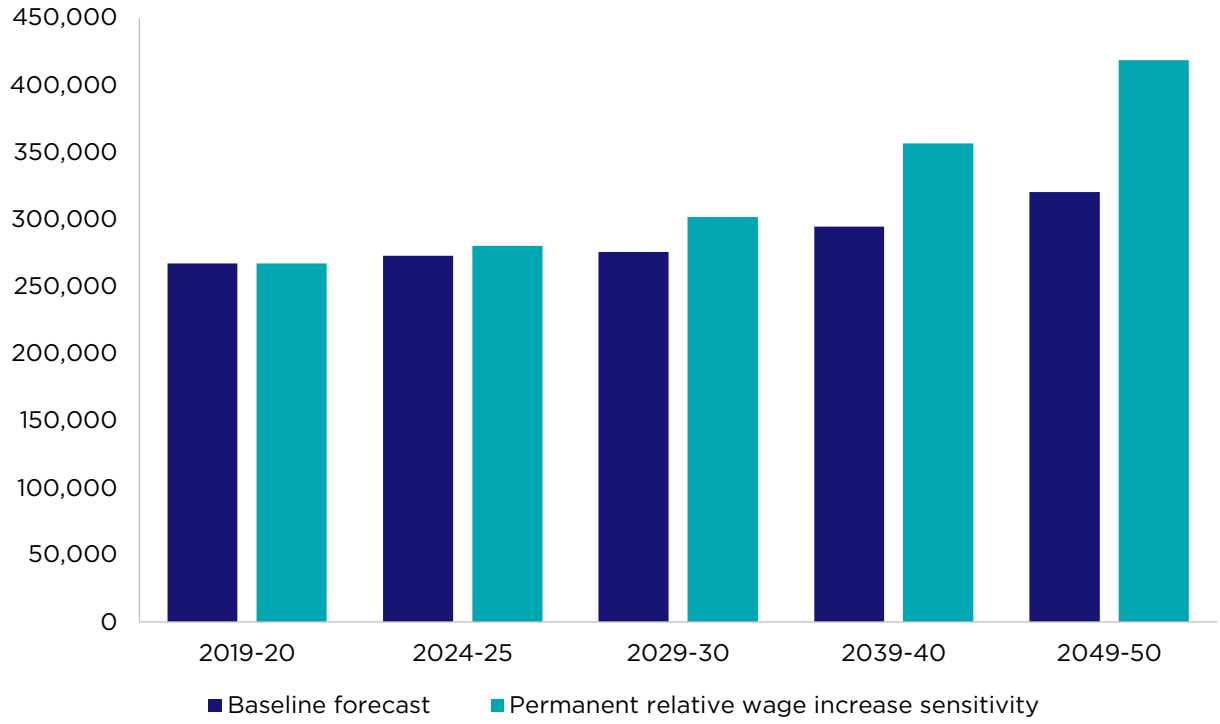
With wages permanently higher in this sensitivity, workers in other occupations can choose each year to switch to the care and support workforce occupations for which wages have increased, earning the higher wages that are available relative to the baseline.

Additional qualified workers are attracted to these 3 occupations by higher wages, resulting in faster growth in workforce supply over time. This increase in supply comes at the expense of other industries and occupations, which see an outflow of workers joining the care and support workforce.

In 2029-30, approximately 4,000 additional workers choose to enter the *Aged and disabled carers* occupation from a source pool of workers including more than 1.3 million employed people (the source pool includes workers from occupations such as *Child carers* and *Commercial cleaners*). The set of occupations in the source pool also includes other care and support workforce occupations that did not receive a wage increase.

The result of a permanent increased relative wage sensitivity for the care and support workforce is an increase of expected total care and support workforce supply to 418,300 FTE in 2049-50, compared with 320,200 FTE under the baseline forecast (Figure 333).

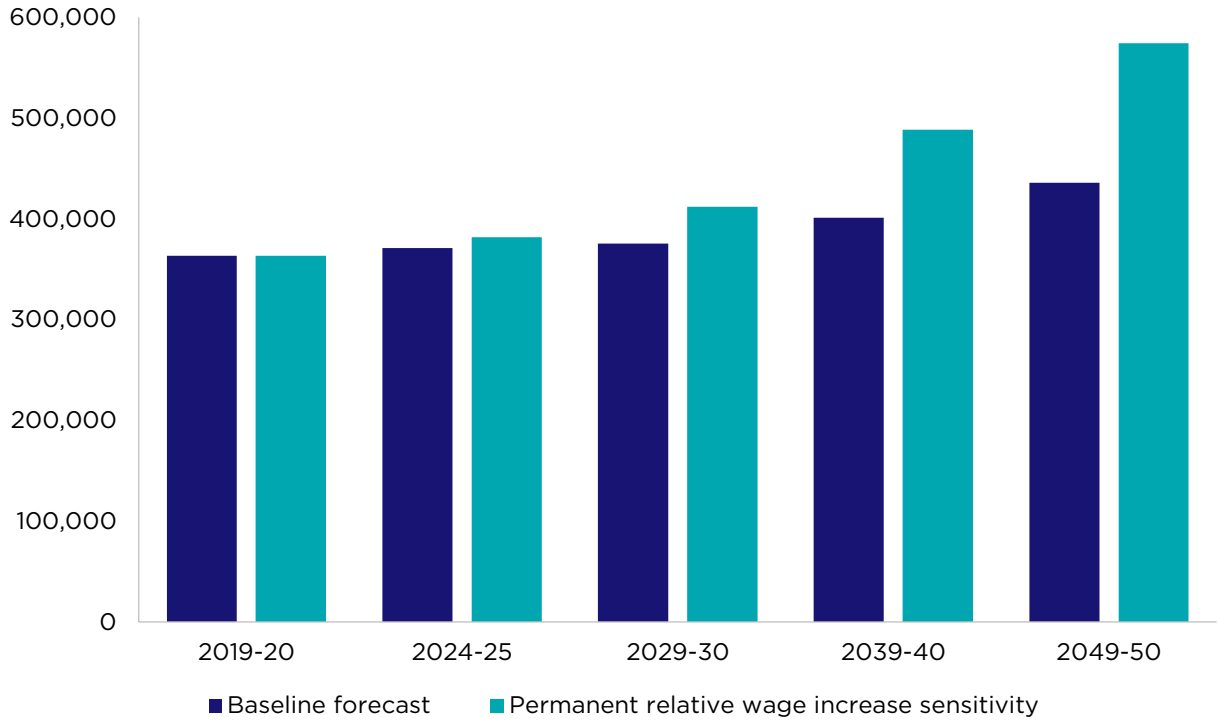
Figure 333: Projected workforce supply (FTE), care and support workforce, baseline forecast and permanent relative wage increase sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

On a headcount basis, workforce supply is expected to increase to 574,400 by 2049-50 under the permanent relative wage increase sensitivity, compared with 436,000 for the baseline forecast (Figure 334). The average hours worked per person employed in each occupation has been assumed to remain constant under each sensitivity, although this would be subject to change in practice as individuals responded to changing workforce conditions (Figure 286).

Figure 334: Projected workforce supply (headcount), care and support workforce, baseline forecast and permanent relative wage increase sensitivity, 2019-20 to 2049-50

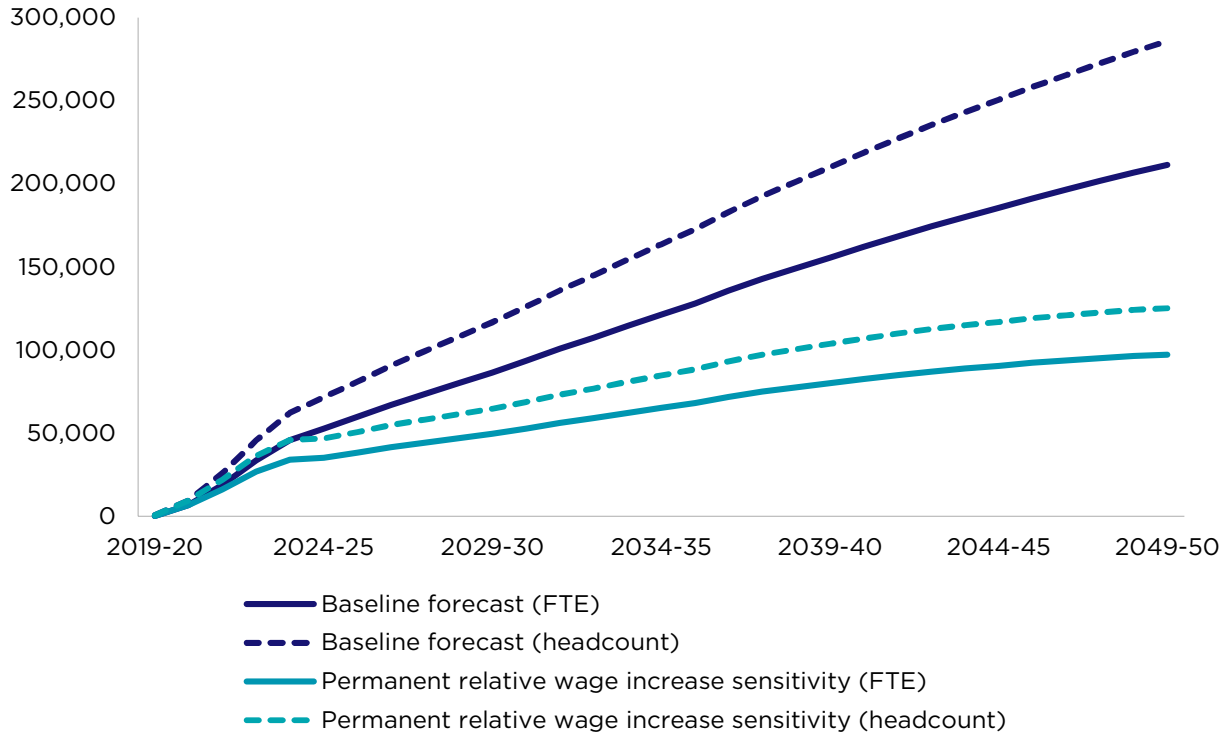


Source: Deloitte Access Economics, 2021.

10.3.1.3 Permanent relative wage increase sensitivity: impact on future workforce gap

Overall, the care and support workforce gap is reduced over time relative to the baseline forecast, with higher levels of workforce supply the driving force behind that improvement. Workforce demand is also expected to be lower under this sensitivity. By 2049-50, the workforce gap for the total care and support under the permanent relative wage increase sensitivity is expected to reach 97,300 FTE (125,100 workers) – 54% lower in FTE terms than under the baseline forecast (211,400 FTE or 285,800 workers) (Figure 335).

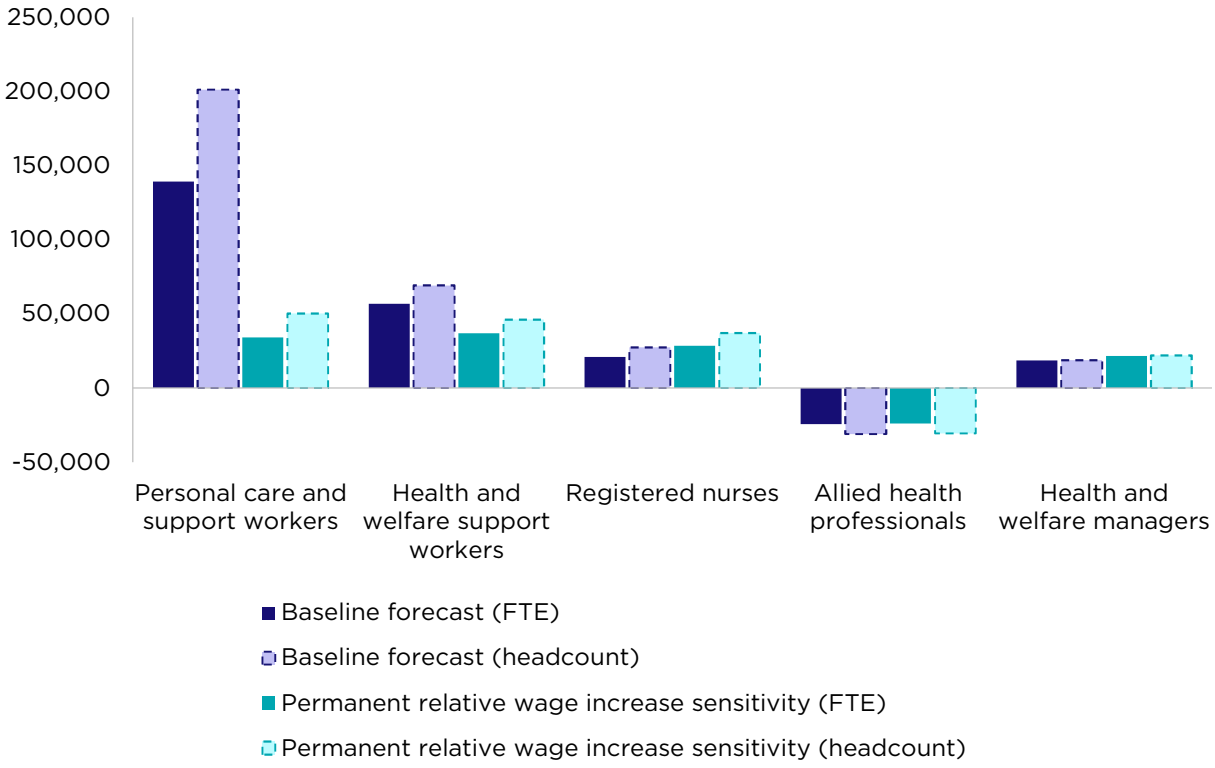
Figure 335: Projected workforce gap (FTE and headcount), care and support workforce, baseline forecast and permanent relative wage increase sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

As per the baseline forecast, the workforce gap for Personal care and support workers (skill level 4) continues to form the majority of the workforce shortage under the permanent relative wage increase sensitivity although they are significantly reduced (Figure 336). There are also noticeable reductions in the workforce gaps also evident for Health and welfare support workers (skill levels 1 and 2). The workforce gaps for Health and welfare managers (skill level 1) is largely unchanged, while the gap for Registered nurses (skill level 1) is higher under this sensitivity due to the substitution of workforce demand towards this occupation. Noting the complexities in interpreting forecast data for Allied health professionals (Part 9.5), the workforce availability is largely unchanged relative to the baseline forecast.

Figure 336: Projected workforce gap (FTE and headcount), care and support workforce, by occupation group, baseline forecast and permanent relative wage increase sensitivity, 2049-50

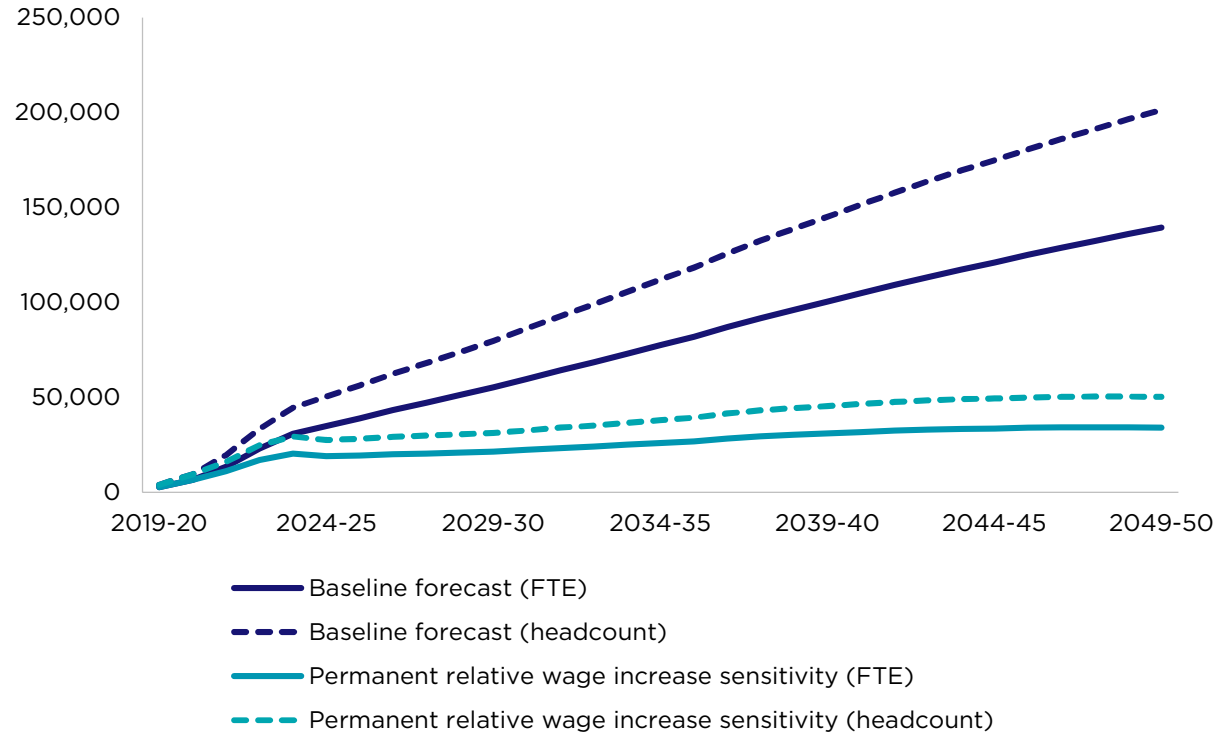


Source: Deloitte Access Economics, 2021.

Within this sensitivity, there are important differences in the impact of the change across the different occupations within the care and support workforce.

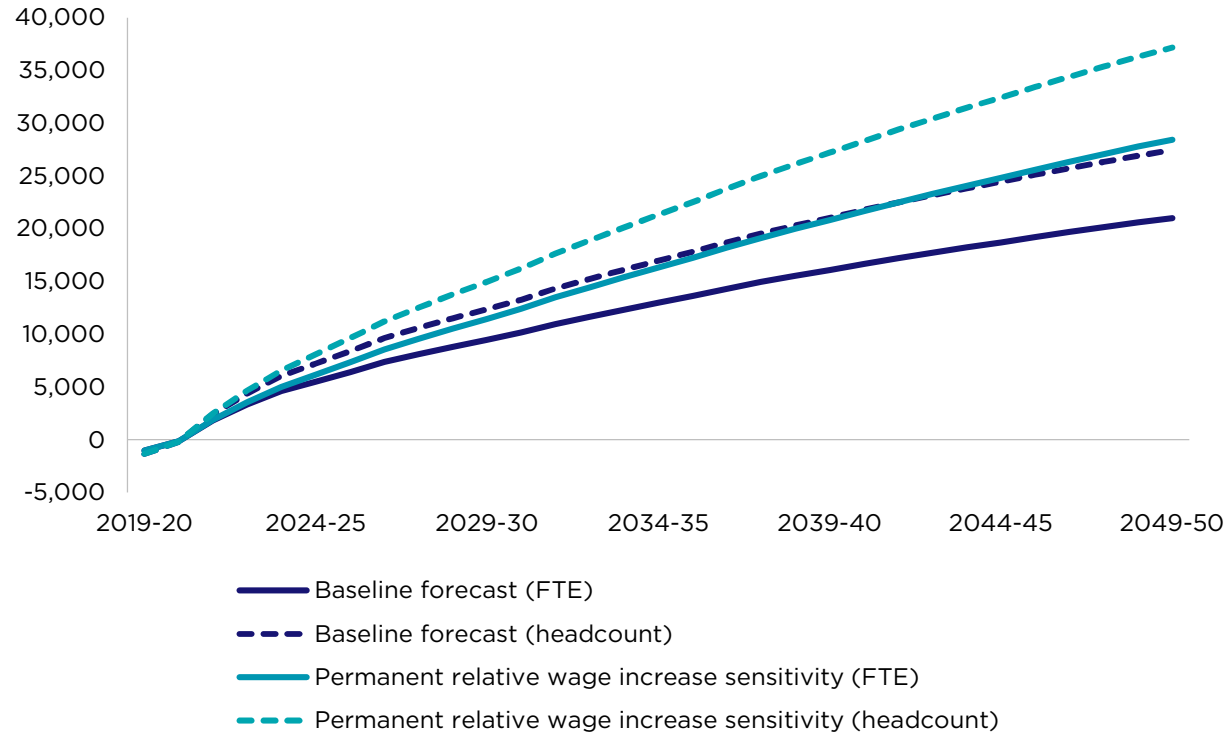
- Personal care and support workers and Health and welfare support workers see a reduction in future workforce gaps as increased workforce supply responds to higher wages (Figure 337 and Figure 338).
- Higher skilled occupations, including *Registered nurses* see increased workforce pressures (Figure 339).

Figure 337: Projected workforce gap (FTE and headcount), Personal care and support workers, baseline forecast and permanent relative wage increase sensitivity, 2019-20 to 2049-50



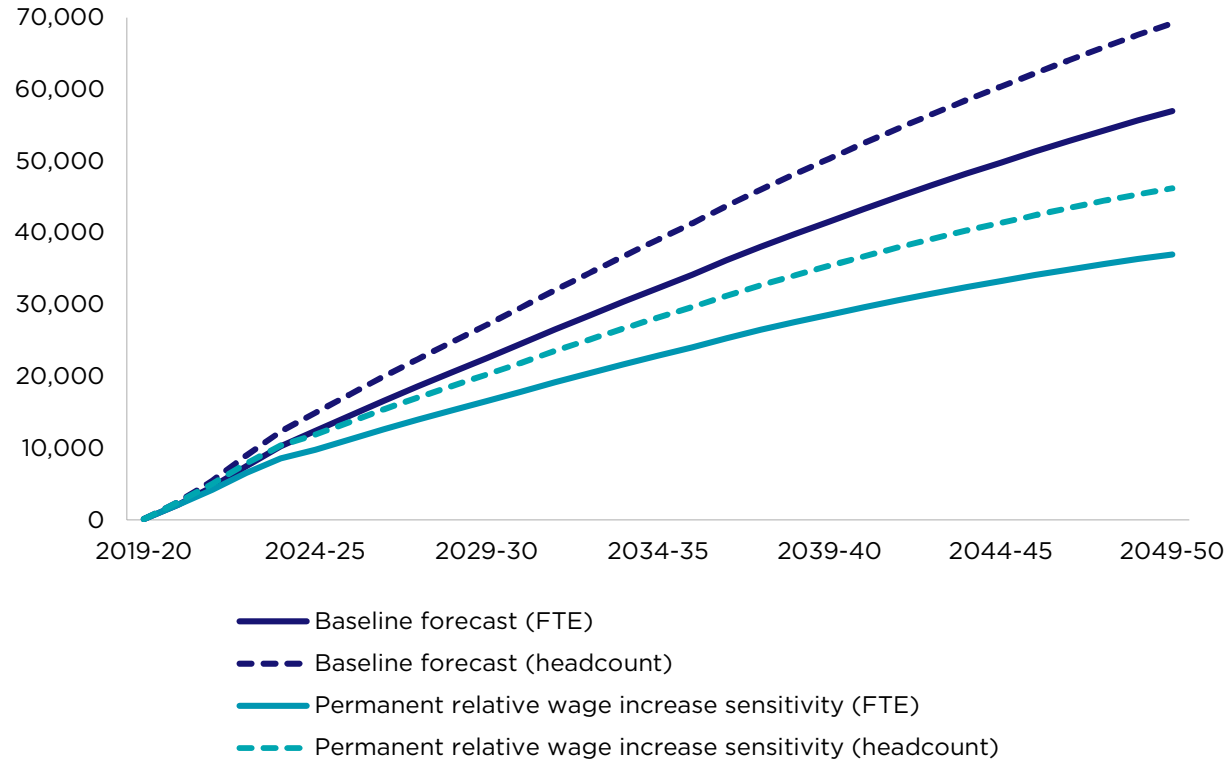
Source: Deloitte Access Economics, 2021.

Figure 338: Projected workforce gap (FTE and headcount), Registered nurses, baseline forecast and permanent relative wage increase, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

Figure 339: Projected workforce gap (FTE and headcount), Health and welfare support workers, baseline forecast and permanent relative wage increase sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

10.3.2 Wage sensitivity: temporary relative increase

While a permanent relative wage increase sensitivity has been considered in Part 10.3.1, sustaining a relative difference over a significant period of time would be a challenge. Instead, it is likely that other industries and occupations would adjust their own wages to retain workers, eroding the relative wage gains for the selected occupations within the care and support workforce.

As with the permanent relative wage increase sensitivity, this sensitivity incorporates a 10% relative wage increase for *Aged and disabled carers*, *Nursing support and personal care workers* and *Welfare support workers*, phased in over the 4 years to 2024-25. Under this sensitivity however, the relative wage increase dissipates over the next few years, with wages equal to the baseline outlook by 2033-34.

In order to maintain the level of service provided to recipients of care and support programs, under this sensitivity, government funding is increased by the same amount as the increase in wage costs in each program. That results in funding increasing in line with wage rates, adjusted for the share of total costs accounted for by these occupations in each care and support program.

All other assumptions remain consistent with the baseline forecast, including hours worked by workers in each occupation in the care and support workforce.

10.3.2.1 Temporary relative wage increase sensitivity: impact on future workforce demand

Overall, a temporary increase in the relative wages of *Aged and disabled carers, Nursing support and personal care workers* and *Welfare support workers* sees the following outcomes for workforce demand relative to the baseline forecast:

- A temporary reduction in workforce demand as care and support providers seek to employ fewer workers in the affected occupations, and instead lift demand for other, higher skilled occupations instead.
- Care and support providers look to reduce the overall amount of labour they use to produce care and support services in favour of more labour-saving technology and equipment.

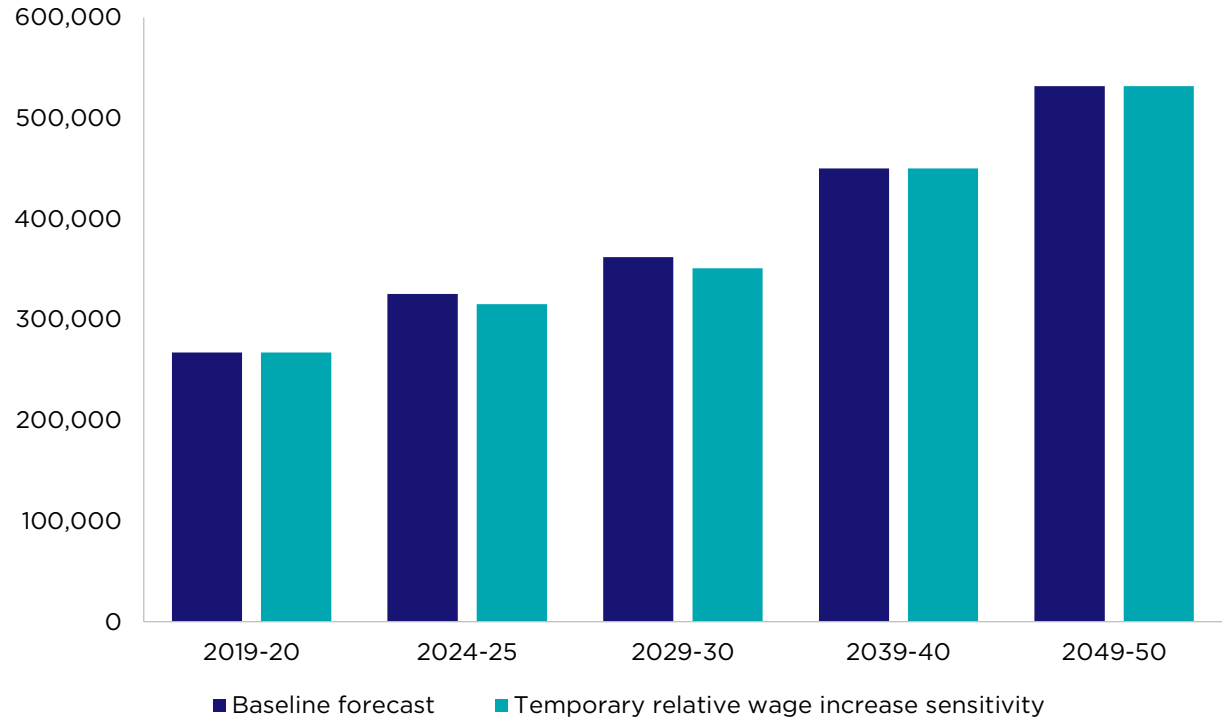
- Additional government funding allows providers to deliver more care and support services than they otherwise would. This increases demand for both capital and labour across all care and support occupations.

On balance, the temporary resulting impact on workforce demand relative to the baseline forecast includes:

- reduced demand for care workers in the occupations which experience the wage increase.
- increased demand for workers in higher skilled occupations, particularly *Registered nurses*.
- little change in demand for workers in other care and support occupations.
- a slight reduction in the overall level of care and support workforce demand through the short and medium-term, before reaching the same level as under the baseline forecast by 2049-2050.

Under the temporary relative wage increase for selected occupations sensitivity, total demand for the care and support workforce is expected to be equivalent with the baseline forecast by 2049-50 (531,600 FTE), with slightly lower workforce demand up to 2039-40 (Figure 340).

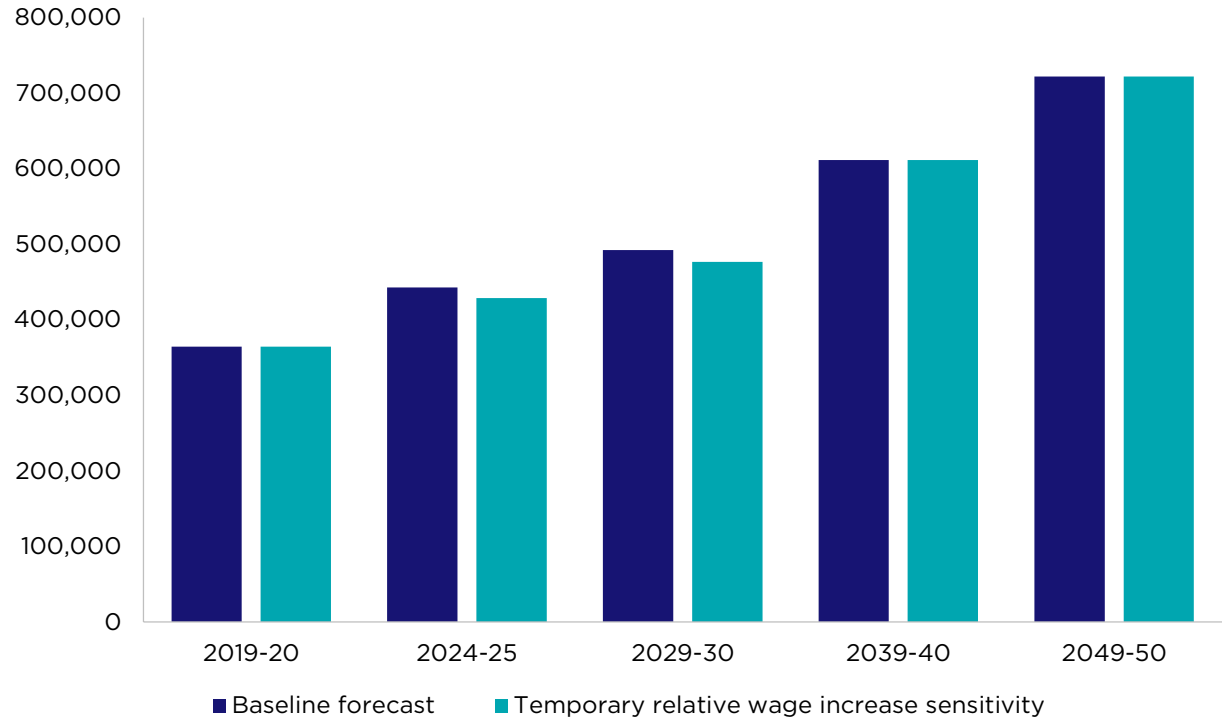
Figure 340: Projected workforce demand (FTE), care and support workforce, baseline forecast and temporary relative wage increase sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

On a headcount basis, increased relative wages for selected occupations, temporarily introduced over the forecast period, sees total workforce demand increase to 476,900 workers in 2029-30, compared with 492,400 under the baseline assumption, before reaching parity with the baseline forecast in 2039-40 (Figure 341).

Figure 341: Projected workforce demand (headcount), care and support workforce, baseline and temporary relative wage increase sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

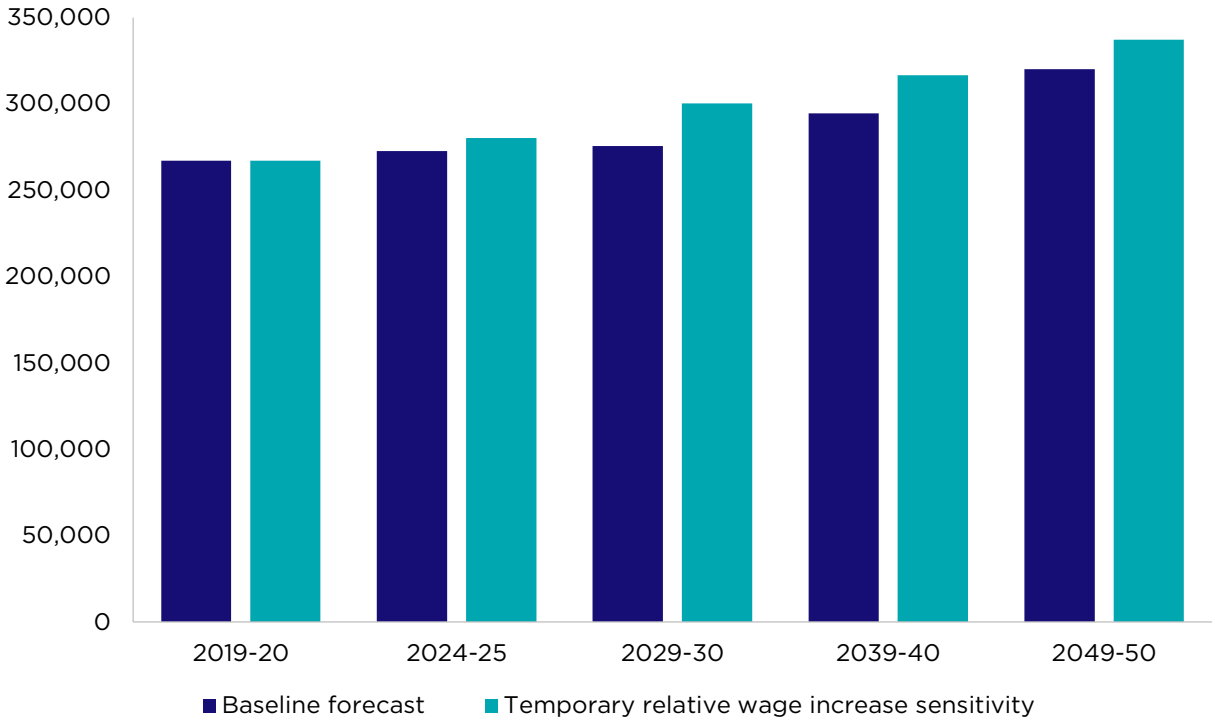
10.3.2.2 Temporary relative wage increase sensitivity: impact on future workforce supply

On the supply side of the model, potential workers respond to the increase in wages by temporarily increasing net movements into the 3 affected occupations.

More qualified workers are attracted to these 3 occupations by higher wages, resulting in faster growth in workforce supply over time.

The result of a temporary increase relative wage sensitivity for the care and support workforce is an increase of expected total care and support workforce supply to 337,100 FTE in 2049-50, compared with 320,200 FTE under the baseline forecast (Figure 342).

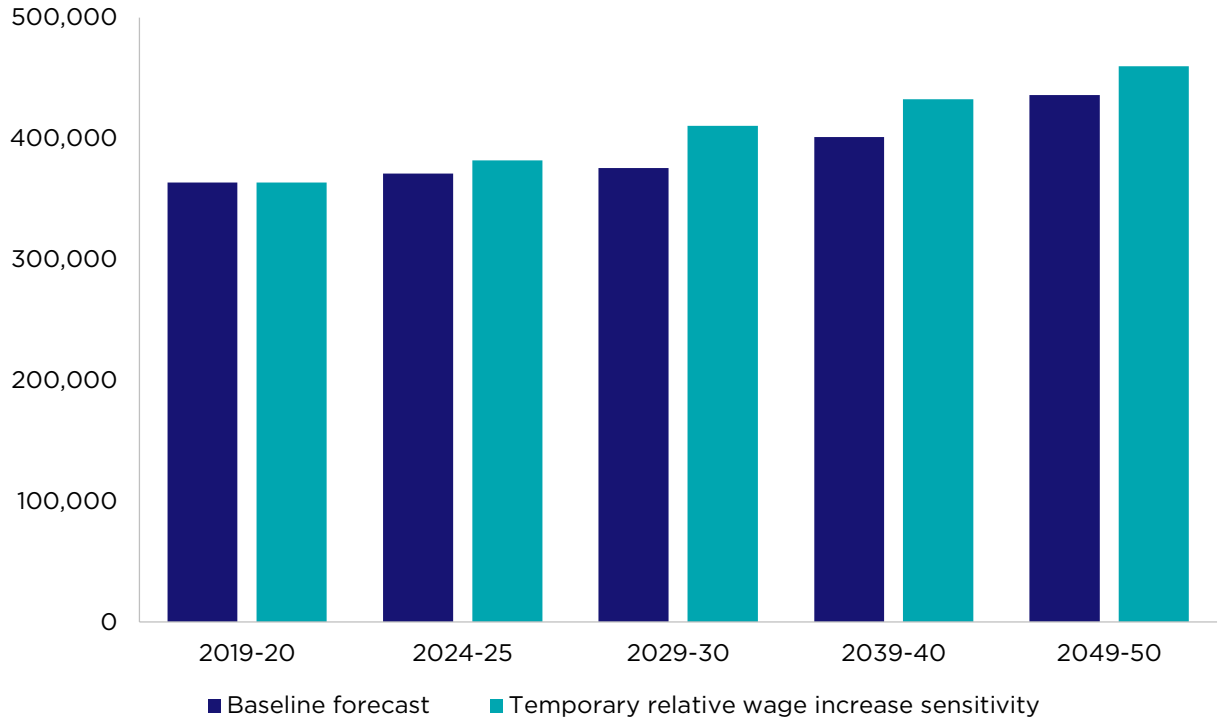
Figure 342: Projected workforce supply (FTE), care and support workforce, baseline forecast and temporary relative wage increase sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

On a headcount basis, workforce supply is expected to increase to 459,800 workers by 2049-50 under the temporary relative wage increase sensitivity, compared with 436,000 for the baseline forecast (Figure 343). The average hours worked per person employed in each occupation has been assumed to remain constant under each sensitivity, although this would be subject to change in practice as individuals responded to changing workforce conditions (Figure 286).

Figure 343: Projected workforce supply (headcount), care and support workforce, baseline forecast and temporary relative wage increase sensitivity, 2019-20 to 2049-50

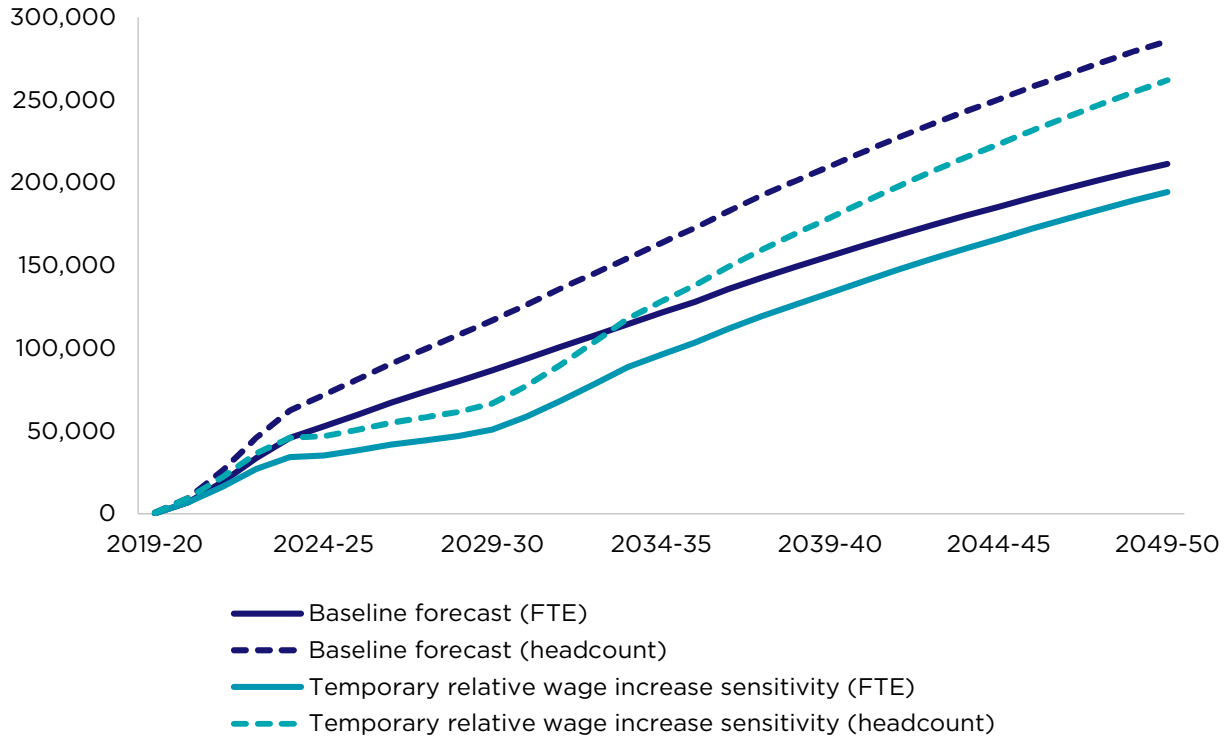


Source: Deloitte Access Economics, 2021.

10.3.2.3 Temporary relative wage increase sensitivity: impact on future workforce gap

Overall, the workforce gap for the care and support workforce is temporarily reduced over time relative to the baseline forecast, with higher levels of workforce supply the key factor in that improvement. By 2049-50, the workforce gap for the total care and support workforce under the temporary relative wage increase sensitivity is expected to reach 194,500 FTE (262,000 workers) – 8% lower in FTE terms than under the baseline forecast (211,400 FTE or 285,800 workers) (Figure 344).

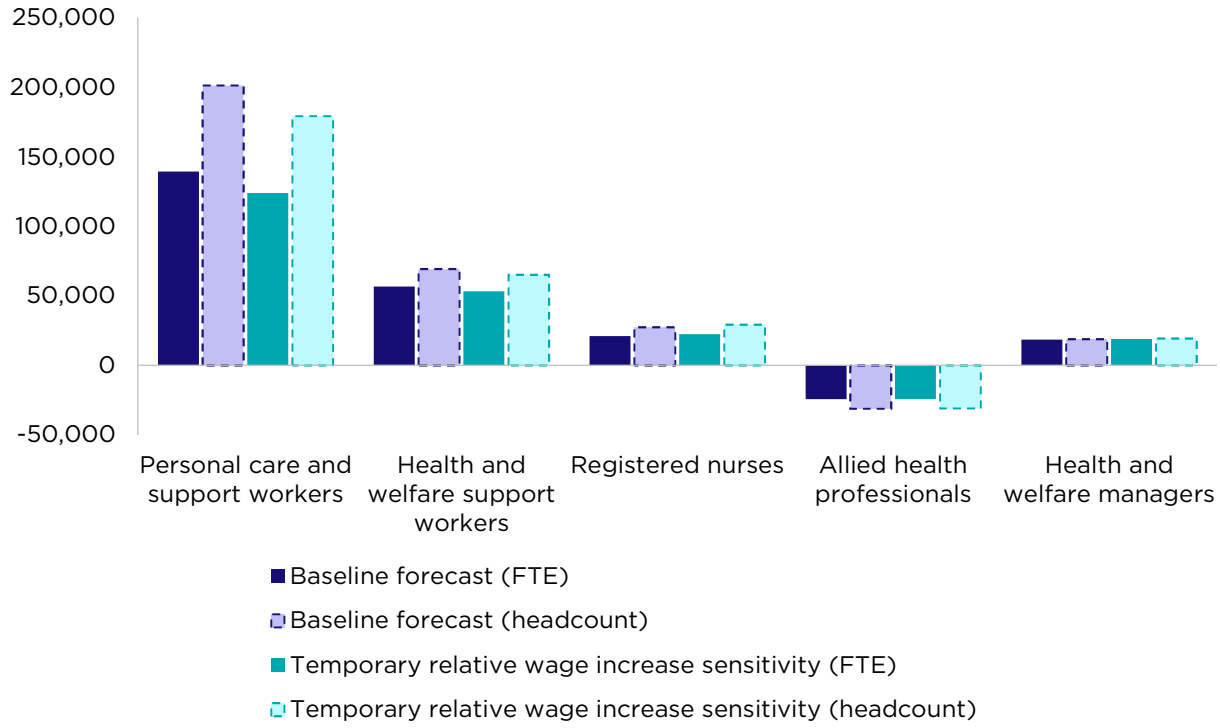
Figure 344: Projected workforce gap (FTE and headcount), care and support workforce, baseline forecast and temporary relative wage increase sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

As per the baseline forecast, the workforce gap for Personal care and support workers (skill level 4) continues to form the majority of the workforce shortage under the temporary relative wage increase sensitivity, with notable workforce gaps also evident for Health and welfare support workers (skill levels 1 and 3) (Figure 345).The workforce gaps for Registered nurses (skill level 1) and Health and welfare managers (skill level 1), are largely unchanged from the baseline forecast. Noting the complexities in interpreting forecast data for Allied health professionals (also skill level 1) (Part 9.5), the workforce availability is largely unchanged relative to the baseline forecast.

Figure 345: Projected workforce gap (FTE and headcount), care and support workforce, by occupation group, baseline forecast and temporary relative wage increase sensitivity, 2049-50

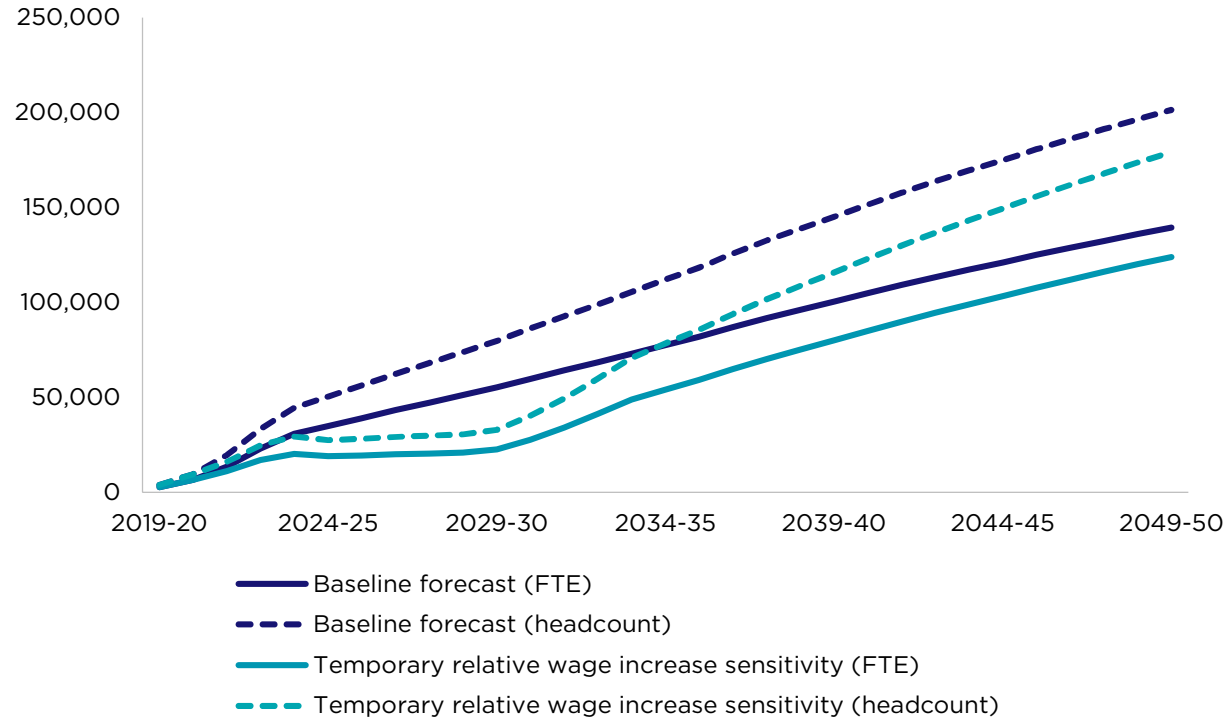


Source: Deloitte Access Economics, 2021.

Within this sensitivity, there are important differences in the impact of the change across the different occupations within the care and support workforce.

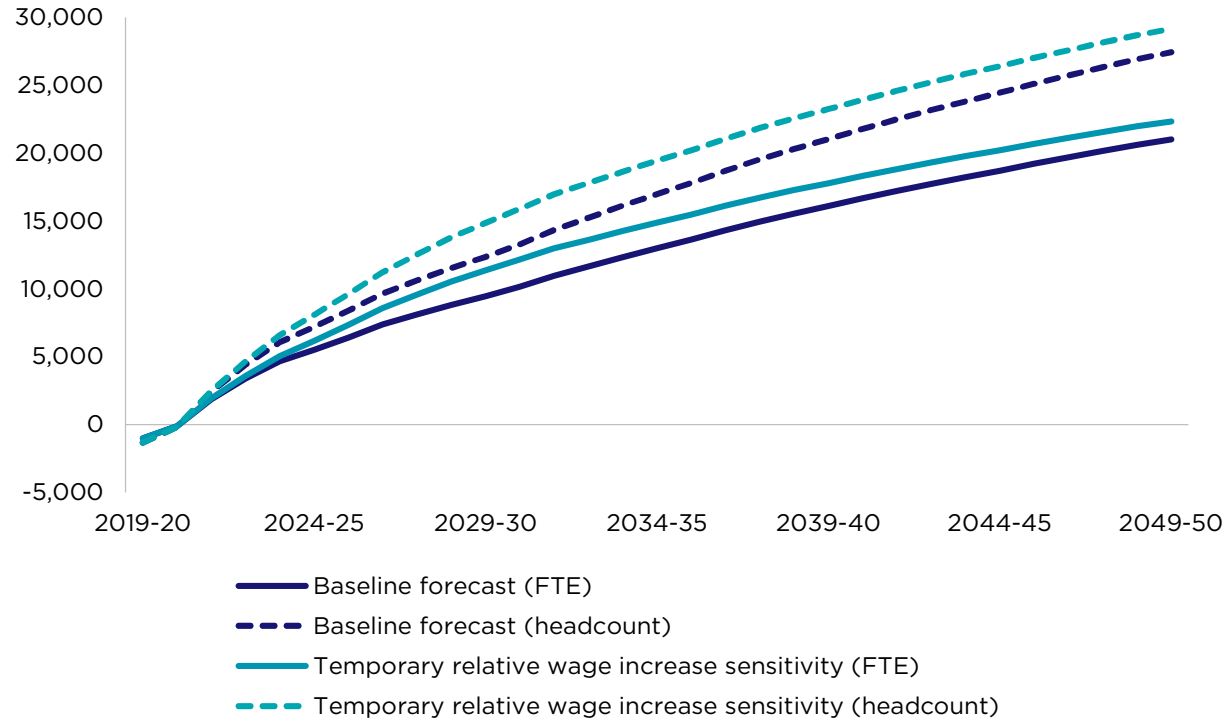
- Personal care and support workers and Health and welfare support workers see a reduction in future workforce gaps as increased workforce supply responds to higher wages (Figure 346 and Figure 347). For Personal care and support workers, the reduction in workforce gap is most prominent in the years to 2029-30, after which the relative wages gap starts to close.
- Higher skilled occupations, including *Registered nurses* see increased workforce pressures as demand impacts are muted and supply is reduced (Figure 348).

Figure 346: Projected workforce gap (FTE and headcount), Personal care and support workers, baseline forecast and temporary relative wage increase sensitivity, 2019-20 to 2049-50



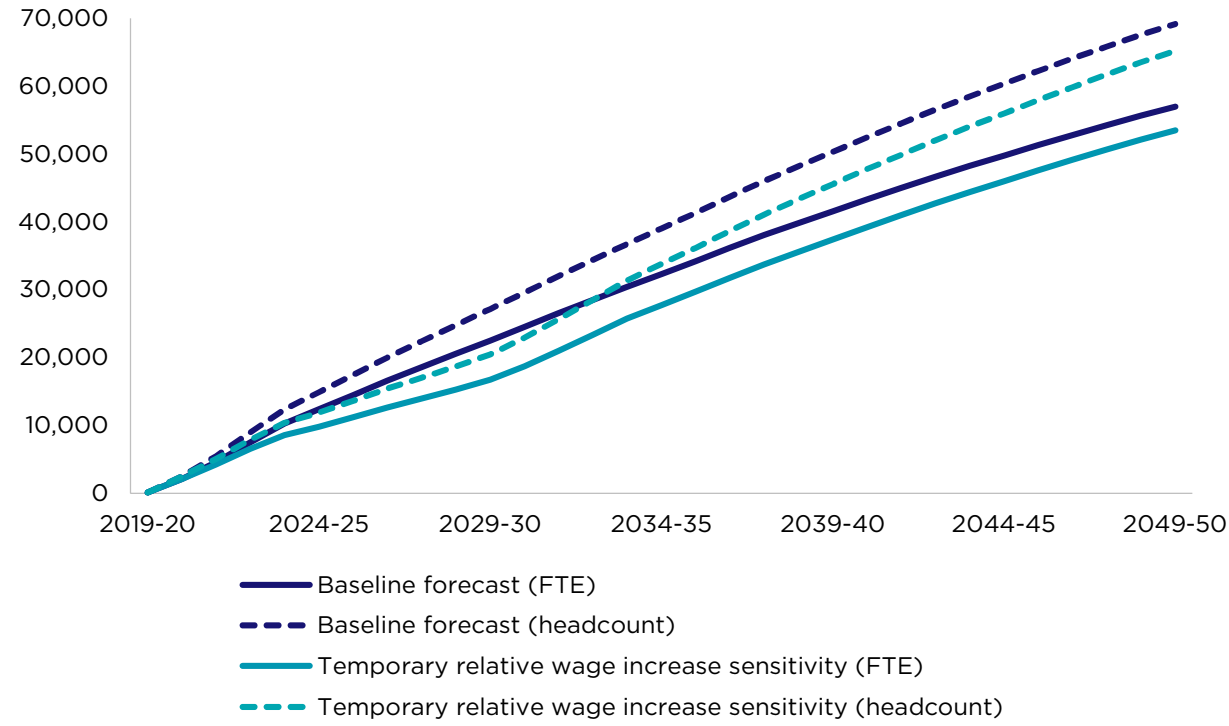
Source: Deloitte Access Economics, 2021.

Figure 347: Projected workforce gap (FTE and headcount), Registered nurses, baseline forecast and temporary relative wage increase sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

Figure 348: Projected workforce gap (FTE and headcount), Health and welfare support workers, baseline forecast and temporary relative wage increase sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

10.4 Improved workforce retention sensitivity

Improved retention within care and support occupations would reduce the outflow of workers and ease workforce pressure over time. Retention varies significantly by occupation group, with lower skill level care and support occupations having the lowest retention.

Opportunities to improve workforce retention could include improved job satisfaction, working conditions, management practices and professional and career development. While it is not possible to model each of these individual factors, it is possible to model the impact of an overall improvement in retention on the workforce.

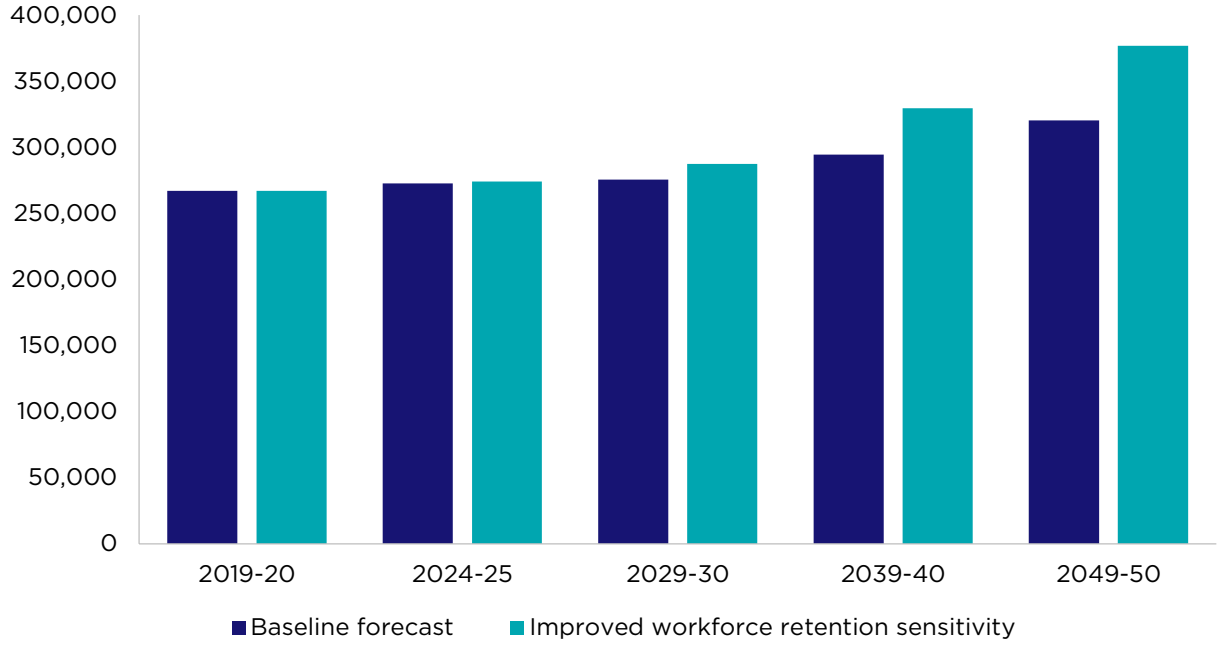
In this sensitivity, outflows of workers from the care and support workforce into other occupations are reduced by 4% per year over 5 years, beginning in 2022-23 and remain 20% lower over the remainder of the project period.

The effect of reduced outflows is most prominent on the occupations with lowest retention rates, such as *Nursing Support and personal care workers* and *Aged and disabled carers*. Occupations that already have high retention rates see little change in this sensitivity. Some occupations within the care and support workforce also have very few outflows into other sectors, such as *Audiologists and speech pathologists,* meaning improved retention makes little difference to the supply of these workers. Other occupations, such as *Indigenous health workers,* draw most of their workers from other roles within the care and support workforce, meaning improved retention also makes little difference to the supply of these workers. In this sensitivity, flows between roles in the care and support workforce such as *Registered nurses* becoming *Nurse managers*, continue even as retention increases.

10.4.1 Improved workforce retention sensitivity: impact on future workforce supply

The overall impact of this sensitivity is an increase in the total projected workforce supply of care and support workers (Figure 349). However, the impact of this sensitivity occurs slowly over time, with a minimal change in workforce supply from the baseline until 2029-30. By 2039-40, there is an additional supply of 34,900 FTE workers than the baseline (12%), increasing to 56,500 FTE additional workers by 2049-50 (18%). In this sensitivity, the total projected supply of workers (FTE) reaches 376,700 by 2049-50, with an average annual growth rate of 1.2% between 2019-20 and 2049-50 (compared with 0.6% per year in the baseline).

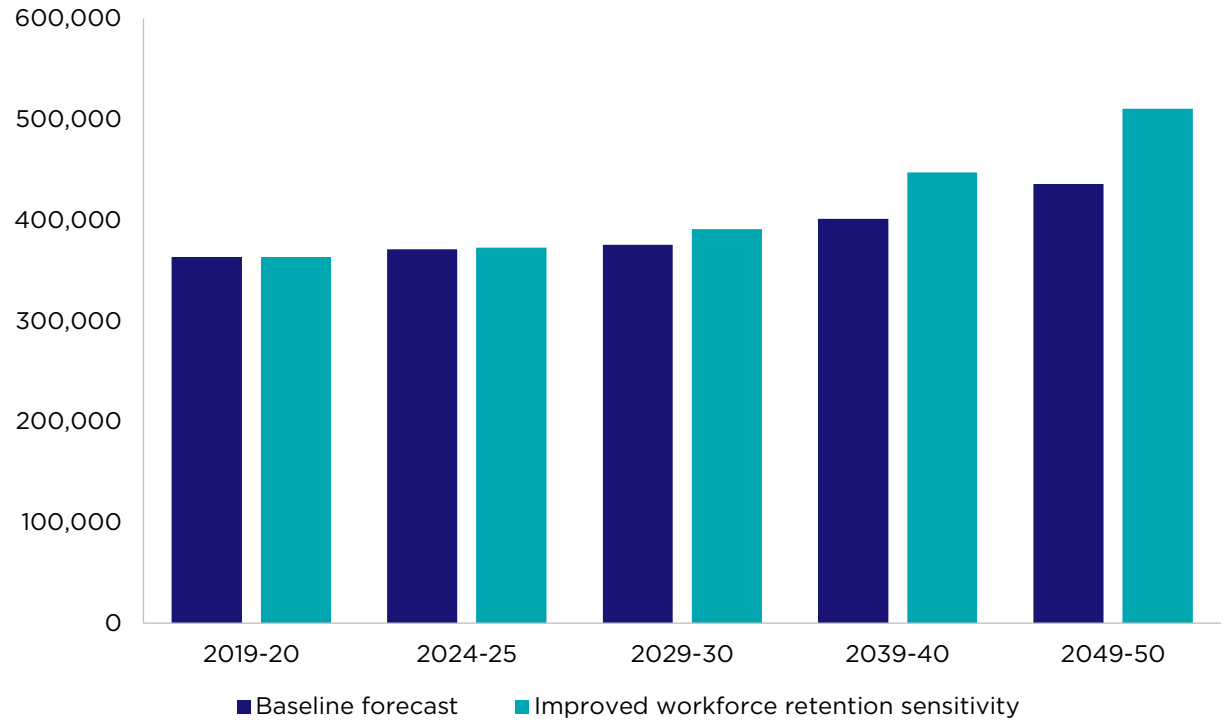
Figure 349: Projected workforce supply (FTE), care and support workforce, baseline forecast and improved workforce retention sensitivity, 2019-20 and 2049-50



Source: Deloitte Access Economics, 2021.

On a headcount basis, the impact of improved retention sensitivity sees total workforce supply increase to 510,600 by 2049-50, compared with 436,000 under the baseline assumption (Figure 350). This is a 17% increase in total supply over the baseline by 2049-50. As with FTE, the impact of this sensitivity on workforce supply is felt gradually, with the biggest increase not occurring until 2049-50. The average annual growth in supply (headcount) between 2019-20 and 2049-50 is 1.1% in the retention sensitivity, compared with 0.6% in the baseline.

Figure 350: Projected workforce supply (headcount), care and support workforce, baseline forecast and improved workforce retention sensitivity, 2019-20 to 2049-50

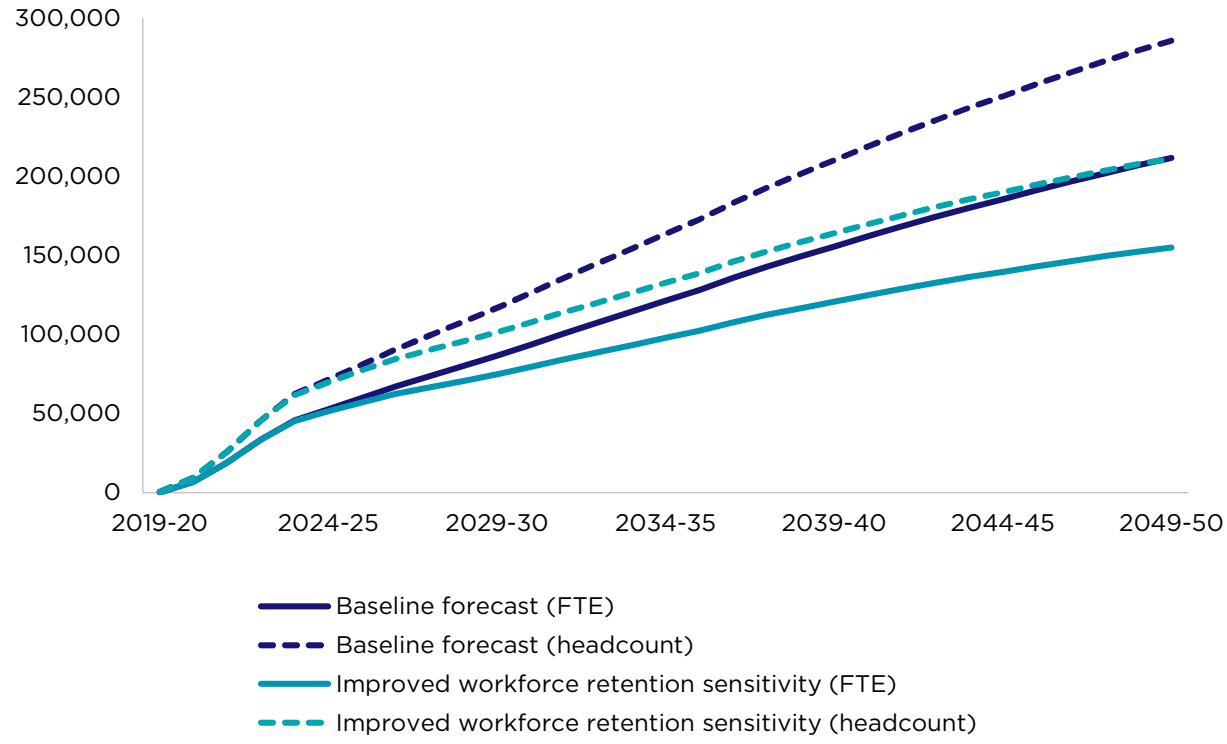


Source: Deloitte Access Economics, 2021.

10.4.2 Improved workforce retention sensitivity: impact on future workforce gap

With greater workforce supply and no change to demand, this retention sensitivity results in a long-term reduction in the projected workforce gap. While the workforce gap still exists under this sensitivity and grows each year, it grows at a slower rate than the baseline sensitivity (Figure 351). By 2049-50, the workforce gap for the total care and support workforce under the improved retention sensitivity is 154,900 (FTE), compared with 211,400 in the baseline. In headcount, the workforce gap in 2049-50 is 211,200 under the improved retention sensitivity, compared with 285,800 in the baseline.

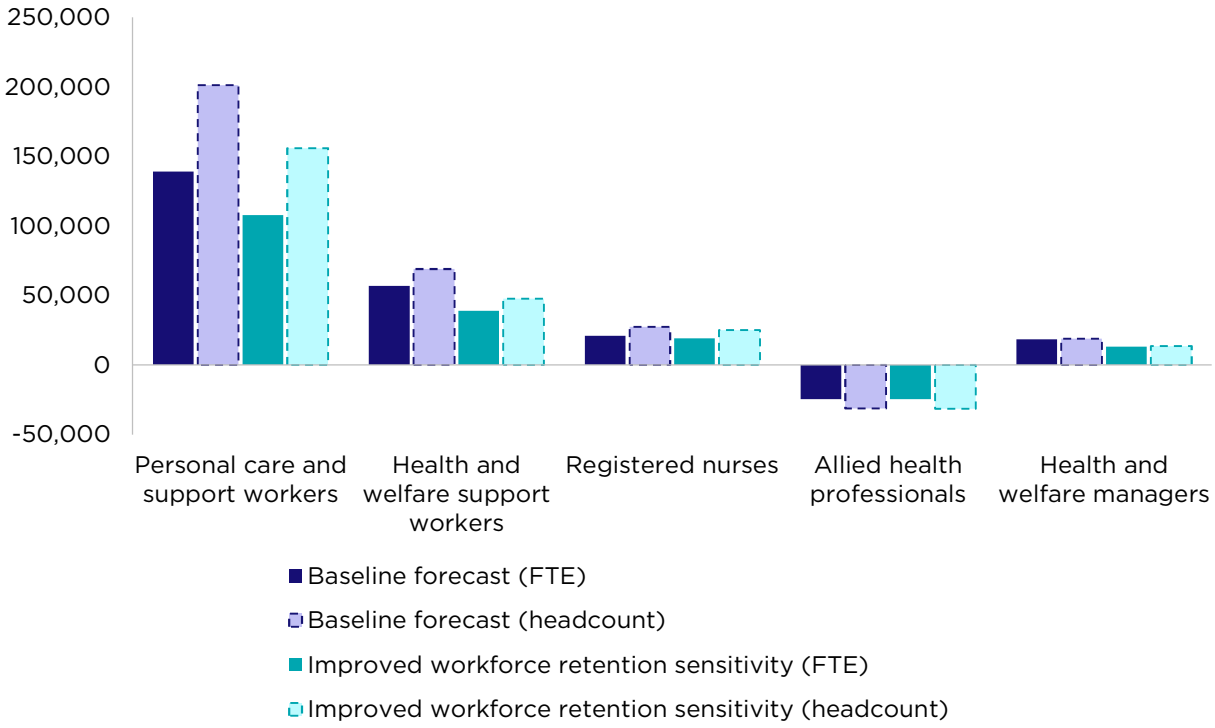
Figure 351: Projected workforce gap (FTE and headcount), care and support workforce, baseline forecast and improved workforce retention sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

As per the baseline sensitivity, the workforce gap for Personal care and support workers (Skill level 4) continues to form the majority of the workforce shortage under the improved retention sensitivity (Figure 352). However, the gap for this occupation is comparably lower in FTE and headcount than in the baseline forecast. Health and welfare support workers, Registered nurses and Health and welfare managers also retain a gap in this sensitivity, albeit smaller than in the baseline forecast. Noting the complexities in interpreting forecast data for Allied health professionals (Part 9.5), workforce availability is slightly higher for this occupation group under the improved retention sensitivity.

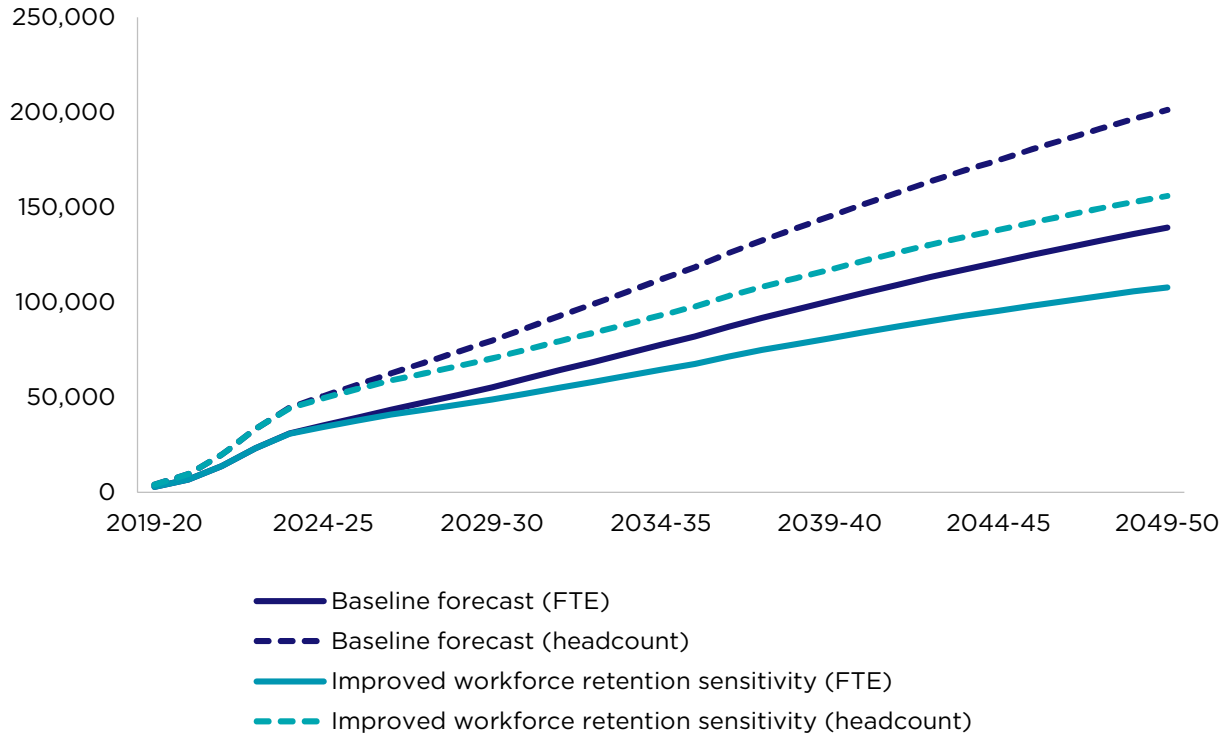
Figure 352: Projected workforce gap (FTE and headcount), care and support workforce, by occupation group, baseline forecast and improved workforce retention sensitivity, 2049-50



Source: Deloitte Access Economics, 2021.

The impact of improved retention is significant for Personal care and support workers, where by 2049-50 the gap is 45,300 workers (31,400 FTE) smaller than the baseline forecast (Figure 353). This is a reduction in the projected workforce gap of 23%. In this sensitivity, the total projected workforce gap for Personal care and support workers reaches 107,900 FTE and 156,000 headcount in 2049-50. Improved retention has a gradual long-term impact on the gap of Personal care and support workers, with minimal impact in the short-term.

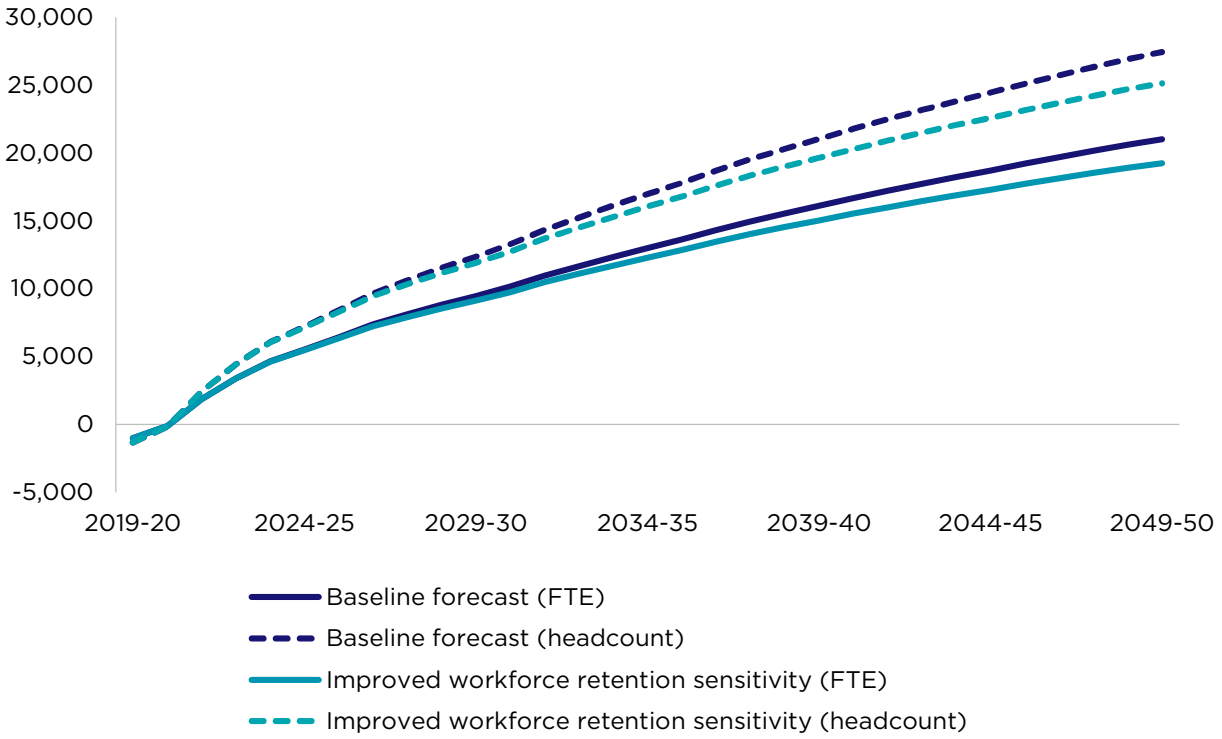
Figure 353: Projected workforce gap (FTE and headcount), Personal care and support workers, baseline forecast and improved workforce retention sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

The impact of the improved retention sensitivity is less significant on the workforce gap of Registered nurses (Figure 354). In this sensitivity, the workforce gap is 2,300 workers (1,800 FTE) smaller than the baseline forecast in 2049-50. This is a reduction in the projected workforce gap of 8%. The total projected workforce gap for Registered nurses in this sensitivity reaches 25,100 (19,200 FTE) in 2049-50, compared with 27,400 (21,000 FTE) in the baseline forecast.

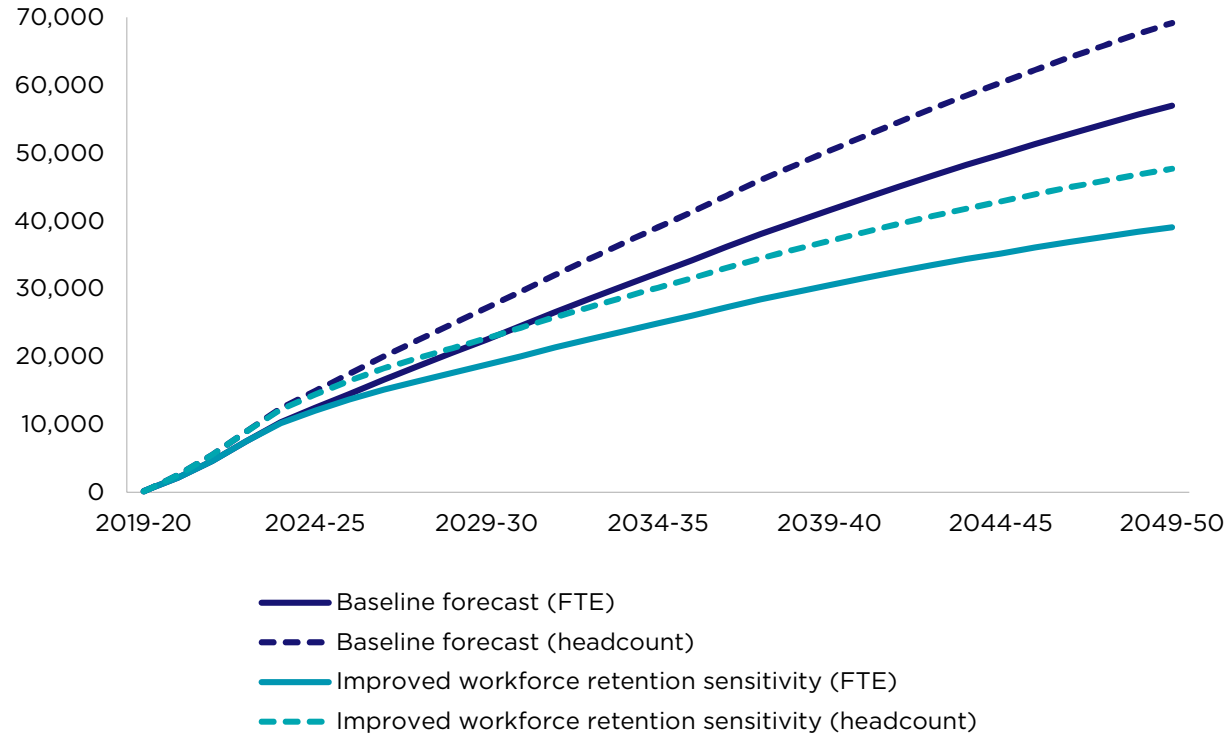
Figure 354: Projected workforce gap (FTE and headcount), Registered nurses, baseline forecast and improved workforce retention sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

Under the improved retention sensitivity, the workforce gap for Health and welfare support workers is moderately lower than the baseline (Figure 355). In this sensitivity, the workforce gap is 21,500 workers (17,900 FTE) smaller than the baseline forecast in 2049-50. This is an improvement of 31%. The total projected workforce gap for Health and welfare support workers in this sensitivity reaches 47,700 (39,100 FTE) in 2049-50, compared with 69,200 (57,000 FTE) in the baseline forecast.

Figure 355: Projected workforce gap (FTE and headcount), Health and welfare support workers, baseline forecast and improved workforce retention sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

10.5 Increased average hours sensitivity

As discussed in Part 5.6 of the Study, there is evidence of excess labour market capacity within the care and support workforce – indicated by the lower average weekly hours worked by the care and support workforce, and the higher share of underemployment when compared with the rest of the labour market.

This sensitivity models the impact of increasing the average weekly hours worked for all care and support occupations by 2 hours, commencing in 2022-23. This increase is approximately equivalent to a 20% decrease in the underemployment ratio for the care and support workforce.

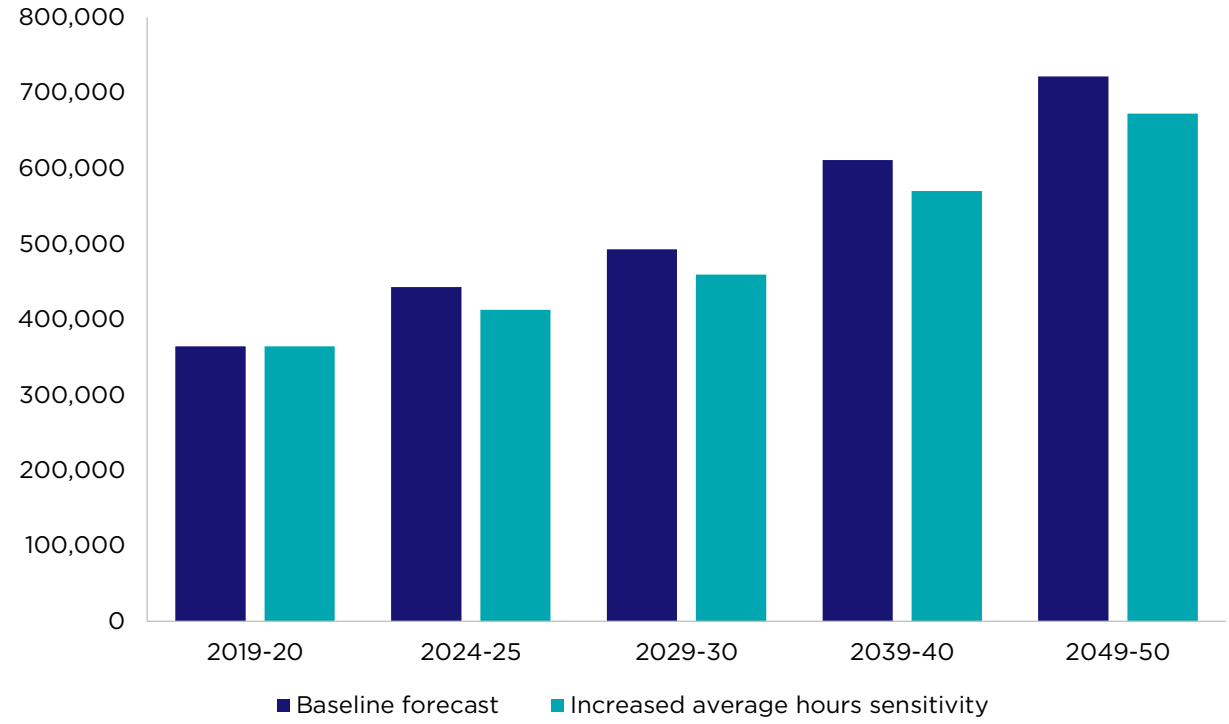
Under this sensitivity, workforce demand in FTE terms is unchanged.

10.5.1 Increased average hours sensitivity: impact on future workforce demand

Average hours worked is a key driver for the difference between the number of FTE staff demanded and the number of care workers required to meet that demand.

Under this sensitivity, workforce demand is unchanged from the baseline forecast in FTE terms. On a headcount basis, workforce demand is projected to fall by 7% across the total care and support workforce (from 721,700 to 672,700 workers) by 2049-50 (Figure 356).

Figure 356: Projected workforce demand, care and support workforce (headcount), baseline forecast and increased average hours sensitivity, 2019-20 to 2049-50



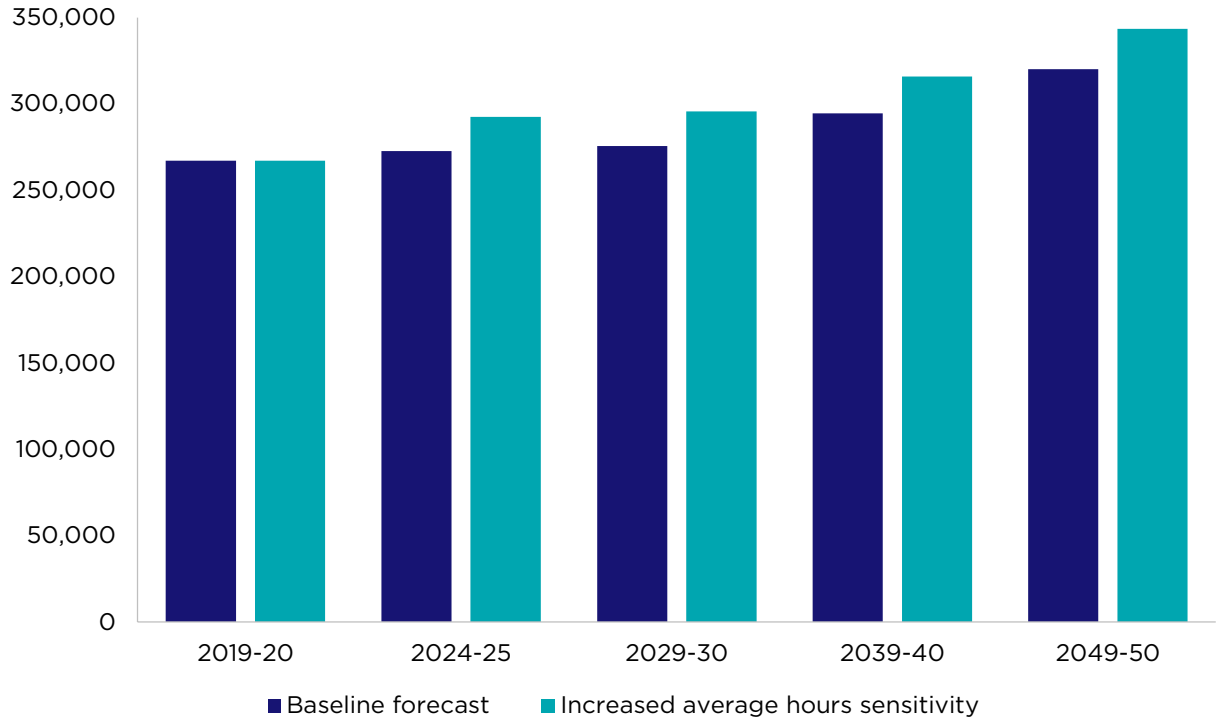
Source: Deloitte Access Economics, 2021.

10.5.2 Increased average hours sensitivity: impact on future workforce supply

This assumption has shifted the relationship between workers and total hours worked, rather than changing the number of workers in the sector. This means, the weekly number of hours supplied by each worker is expected to increase, which in turn increases workforce supply on an FTE basis.

Under this sensitivity, workforce supply is projected to increase by 7% from 320,200 to 343,400 FTE workers by 2049-50 (Figure 357).

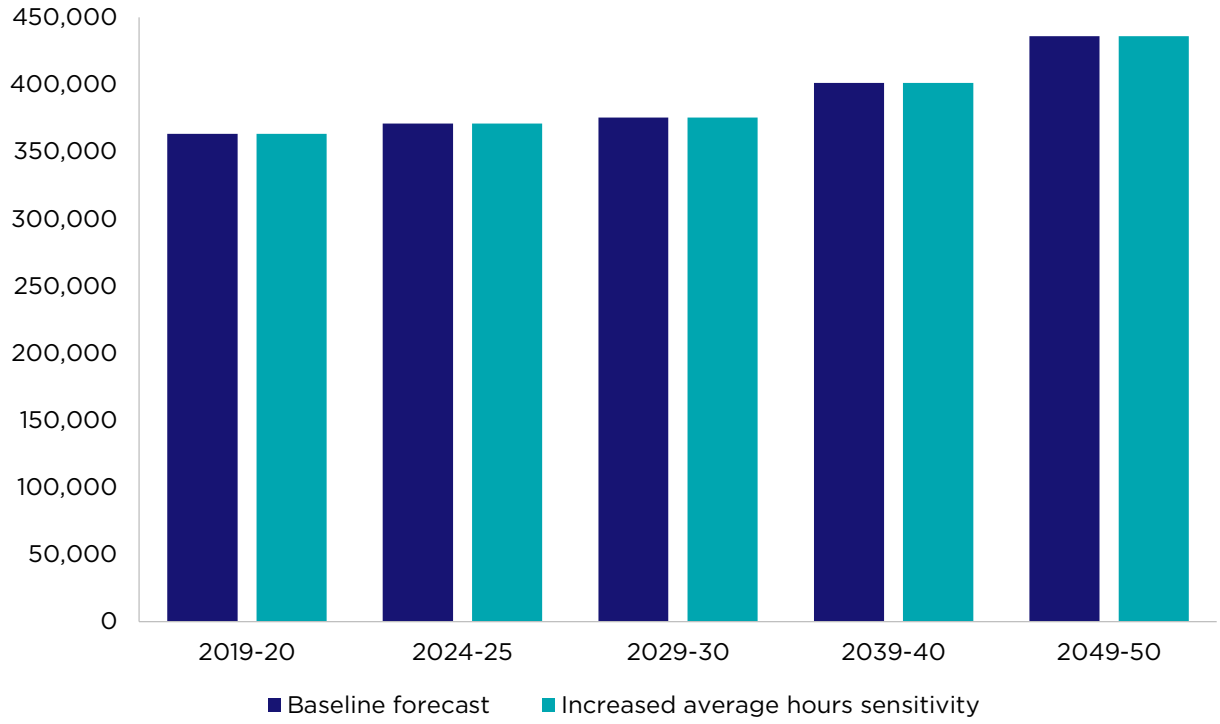
Figure 357: Projected workforce supply (FTE), care and support workforce, baseline forecast and increased average hours sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

On a headcount basis, workforce supply is projected to remain unchanged from the baseline as the same number of workers are assumed to be willing to supply their labour to the care and support workforce (Figure 358), albeit at a higher number of average hours for each person employed.

Figure 358: Projected workforce supply (headcount), care and support workforce, baseline forecast and increased average hours sensitivity, 2019-20 to 2049-50



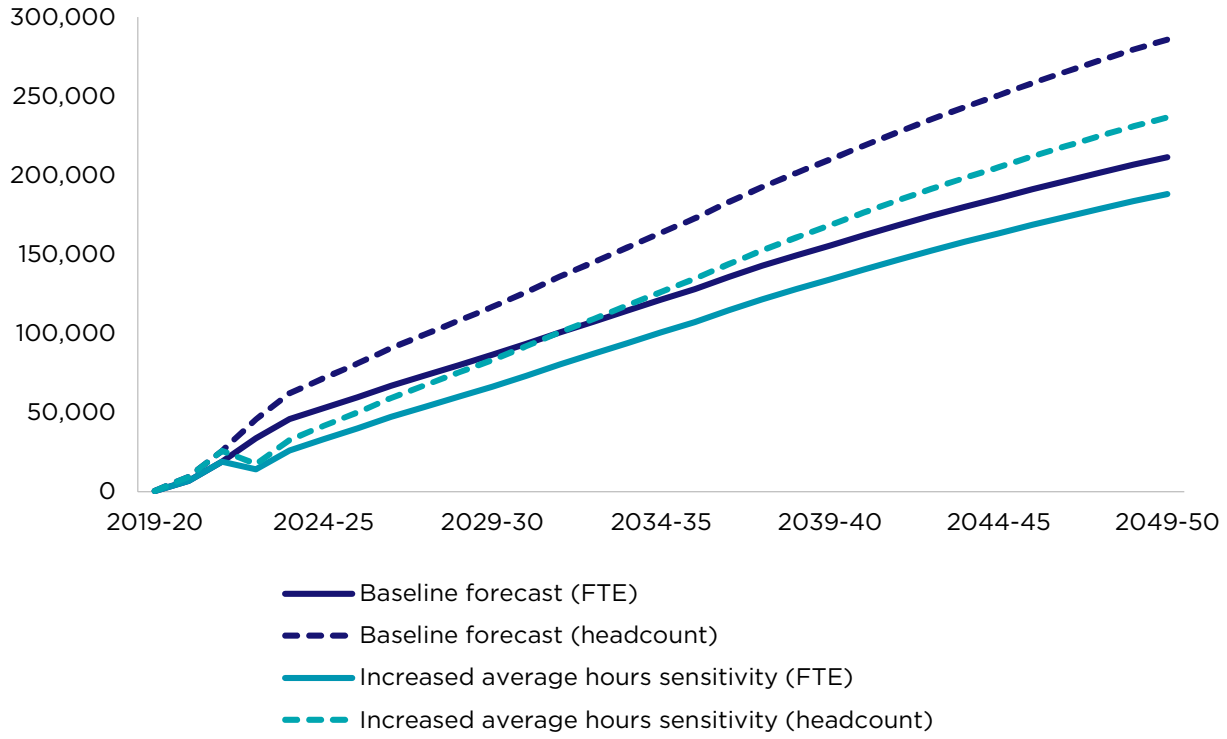
Source: Deloitte Access Economics

10.5.3 Increased average hours sensitivity: impact on future workforce gap

Overall, the increased average hours sensitivity reduces workforce demand on a headcount basis, while increasing workforce supply on an FTE basis (while workforce demand on an FTE basis, and workforce supply on a headcount basis remains unchanged).

As a result, the total workforce gap projected to fall by around 49,100 (23,300 FTE) care and support workers by 2049-50 (Figure 359), relative to the baseline forecast.

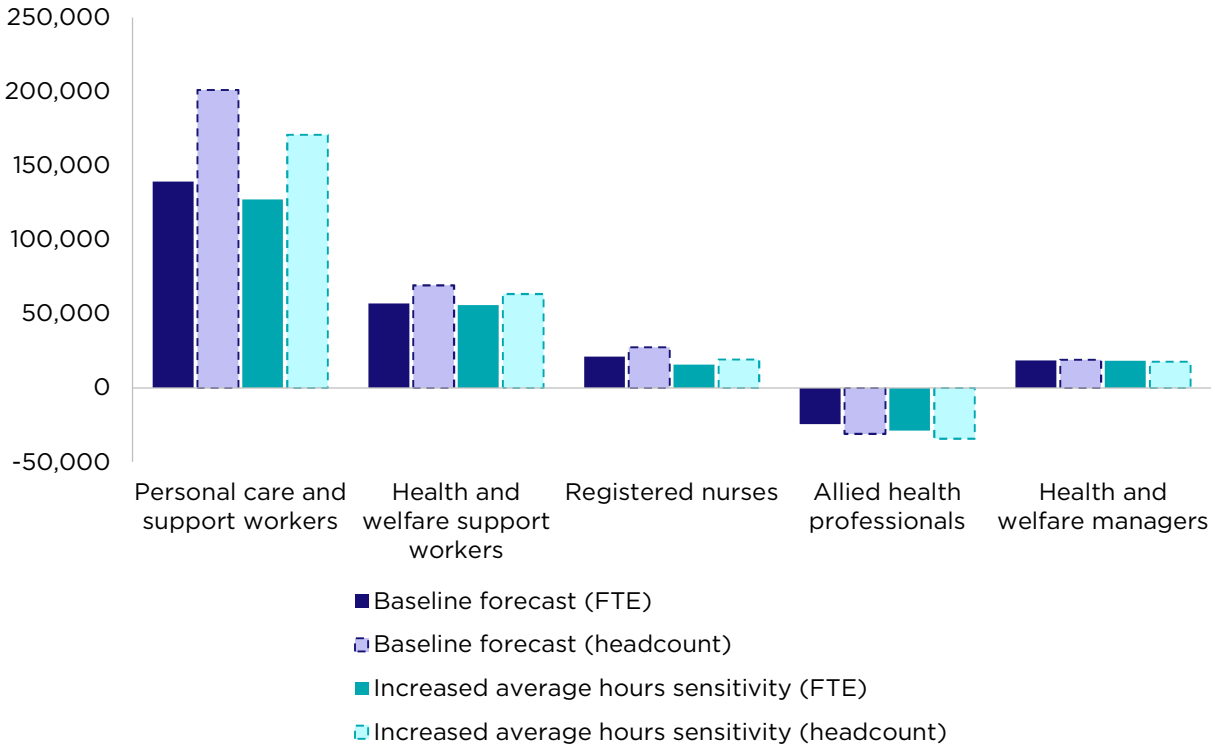
Figure 359: Projected workforce gap (FTE and headcount), care and support workforce, baseline forecast and increased average hours sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

Even after accounting for higher FTE workforce supply and lower demand for workers, as per the baseline forecast, the workforce gap for Personal care and support workers (skill level 4) still accounts for most of the workforce shortage under the increased average hours sensitivity (Figure 360). Other than Allied health professionals, which see an increased workforce surplus, the workforce gaps are reduced across all occupation groups in this sensitivity.

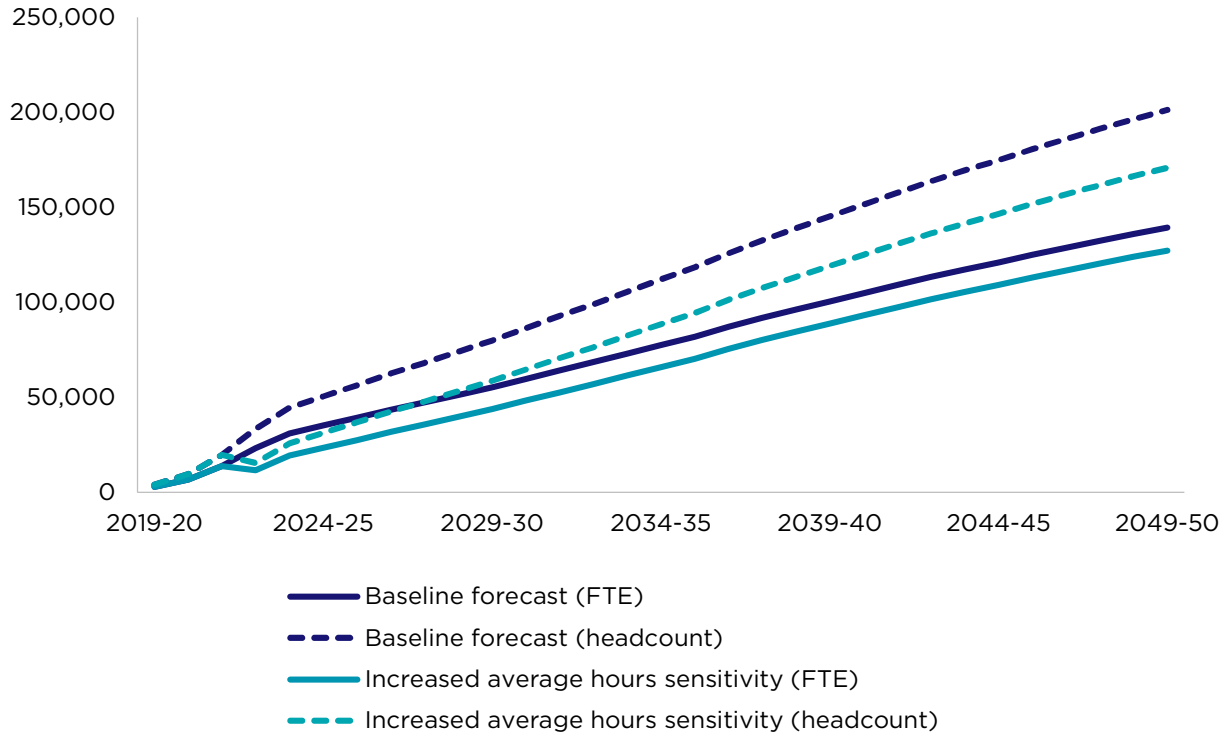
Figure 360: Projected workforce gap (FTE and headcount), care and support workforce, by occupation group, baseline forecast and increased average hours sensitivity, 2049-50



Source: Deloitte Access Economics, 2021.

Under this sensitivity, the number of Personal care and support workers is projected to increase by 8% from a baseline of 157,300 to 169,300 FTE workers in 2050 (Figure 361). At the same time, employers' demand for workers is projected to fall by 7% from 427,000 to 396,600 workers on a headcount basis. As a result, the workforce gap for Personal care and support workers is projected to narrow to 170,900 workers (127,300 FTE) – down from 201,300 workers (139,300 FTE) in the baseline forecast.

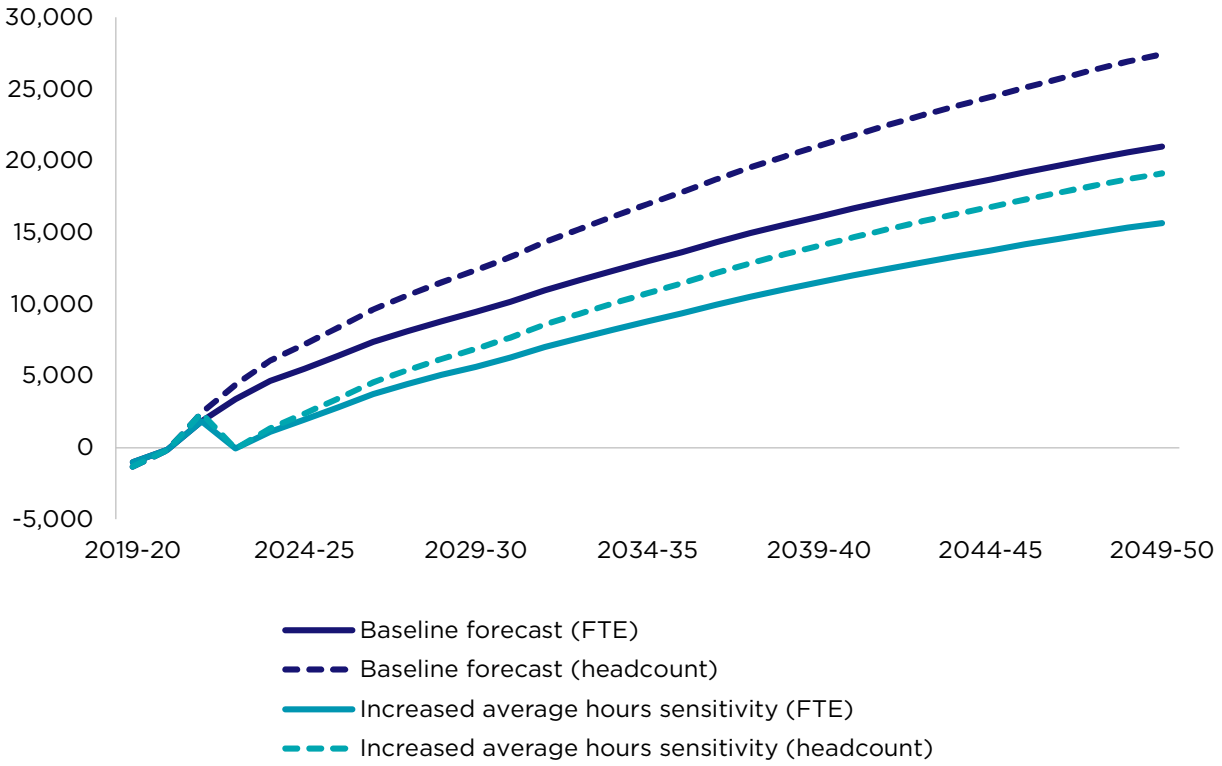
Figure 361: Projected workforce gap (FTE and headcount), Personal care and support workers, baseline forecast and increased average hours sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

Similarly, the workforce gap for Registered nurses is projected to reach approximately 19,100 workers (15,700 FTE) under the increased average hours sensitivity – less than the projected gap of 27,400 workers (21,000 FTE) under the baseline forecast (Figure 362). Increased average hours worked is also expected to have a large impact on short-term workforce shortages for Registered nurses – almost halving the projected gap in 2028–29 from 11,500 (8,800 FTE) to 6,200 (5,100 FTE) nurses.

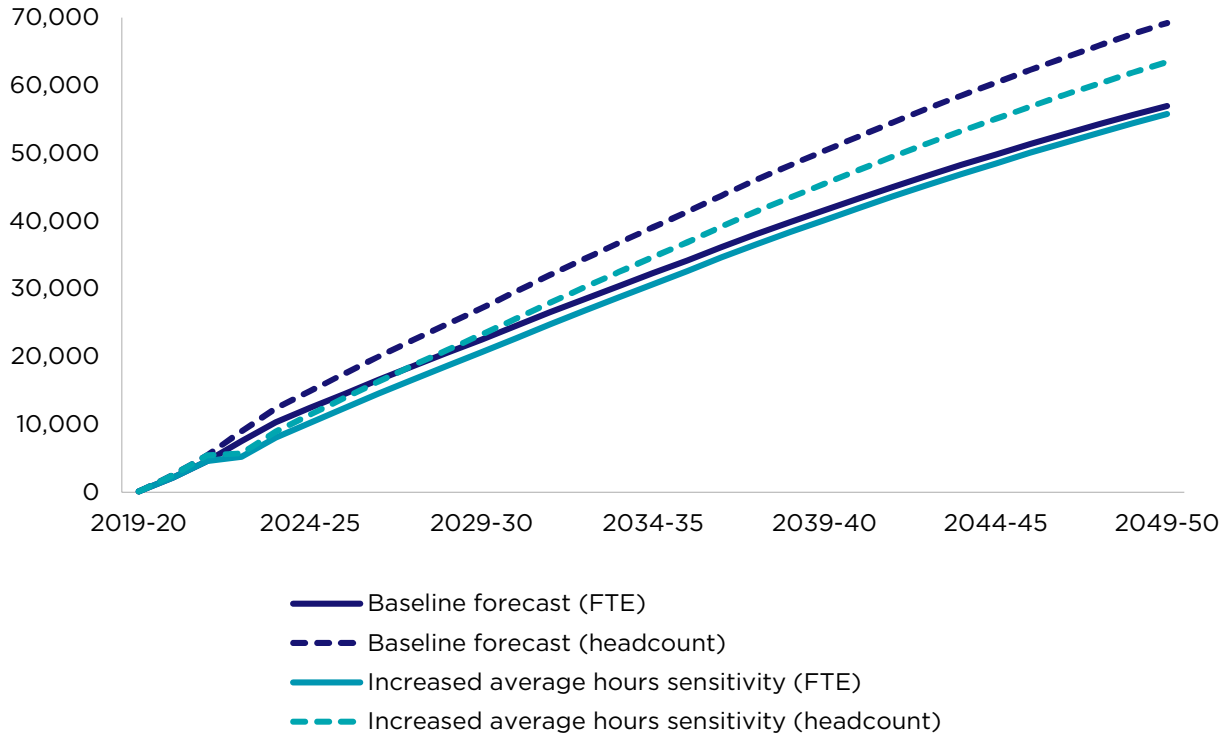
Figure 362: Projected workforce gap (FTE and headcount), Registered nurses, baseline forecast and increased average hours sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

A higher average hours worked assumption also lowers the projected workforce gap for Health and welfare support workers from around 69,200 (57,000 FTE) workers under the baseline forecast to around 63,500 (55,800 FTE) workers under this sensitivity (Figure 363).

Figure 363: Projected workforce gap (FTE and headcount), Health and welfare support workers, baseline forecast and increased average hours sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

10.6 Increased net overseas migration sensitivity

Under the higher migration sensitivity, workforce demand is unchanged from the baseline forecast. There are no changes to wages or government funding.

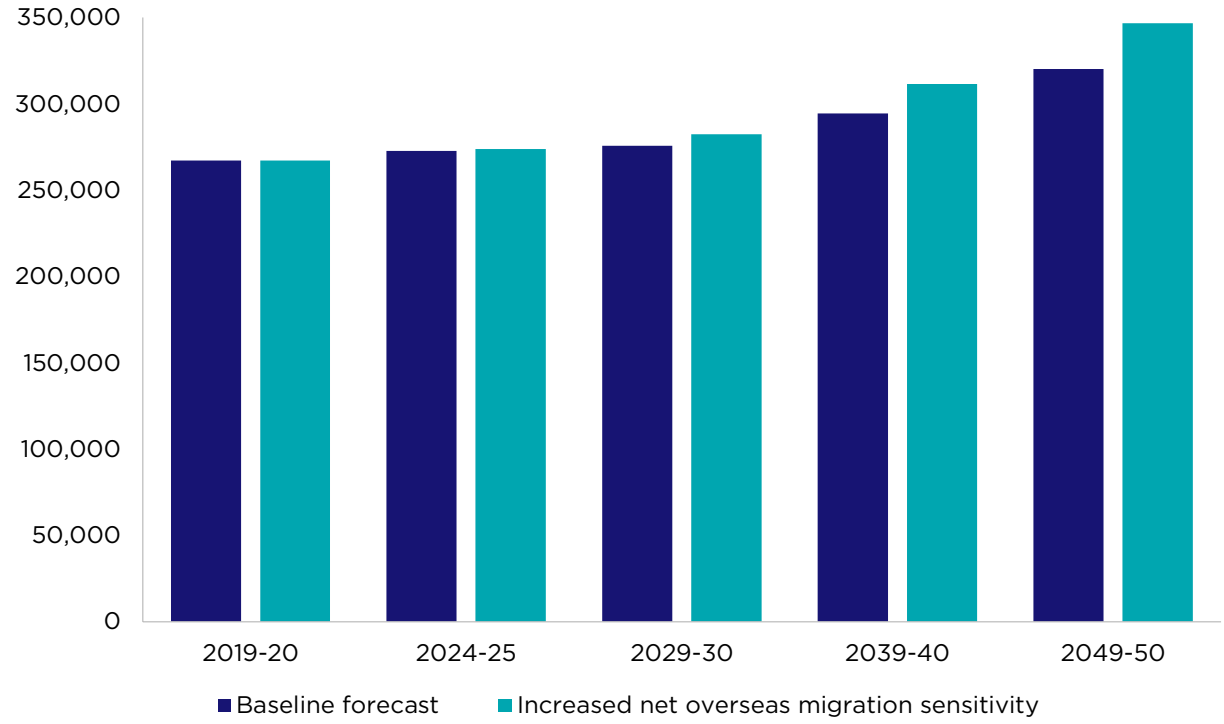
The effect of an increase in net overseas migration into Australia is explored where immigration is increased by 5% relative to the baseline (pre-COVID-19) level in each year from 2023-24 to 2025-26, for a total change of 15% in 2025-26 relative to the baseline projections.

Under the baseline projections, net overseas migration of working age individuals is around 123,000 in 2025-26 and this increases to around 179,000 under the higher migration projection. This change is then maintained throughout the remainder of the projection period.

10.6.1 Increased net overseas migration sensitivity: impact on future workforce supply

Under the increased net overseas migration sensitivity, workforce supply is expected to increase to 346,700 FTE in 2049-50, compared with 320,200 FTE under the baseline forecast (Figure 364).

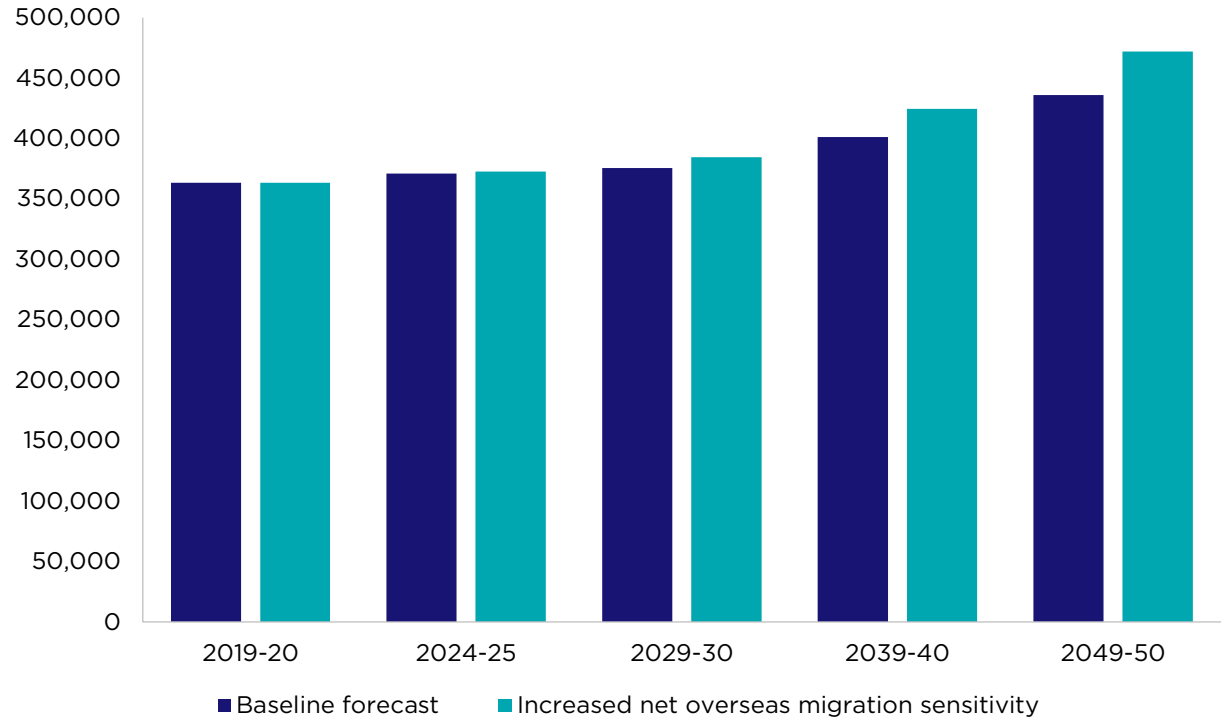
Figure 364: Projected workforce supply (FTE), care and support workforce, baseline forecast and increased net overseas migration sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

On a headcount basis, workforce supply is expected to increase to 472,000 by 2049-50 under the increased migration sensitivity, compared with 436,000 for the baseline forecast (Figure 365). The average hours worked per person employed in each occupation has been assumed to remain constant under each sensitivity, although this would be subject to change in practice as individuals respond to changing workforce conditions (Figure 286).

Figure 365: Projected workforce supply (headcount), care and support workforce, baseline forecast and increased net overseas migration sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

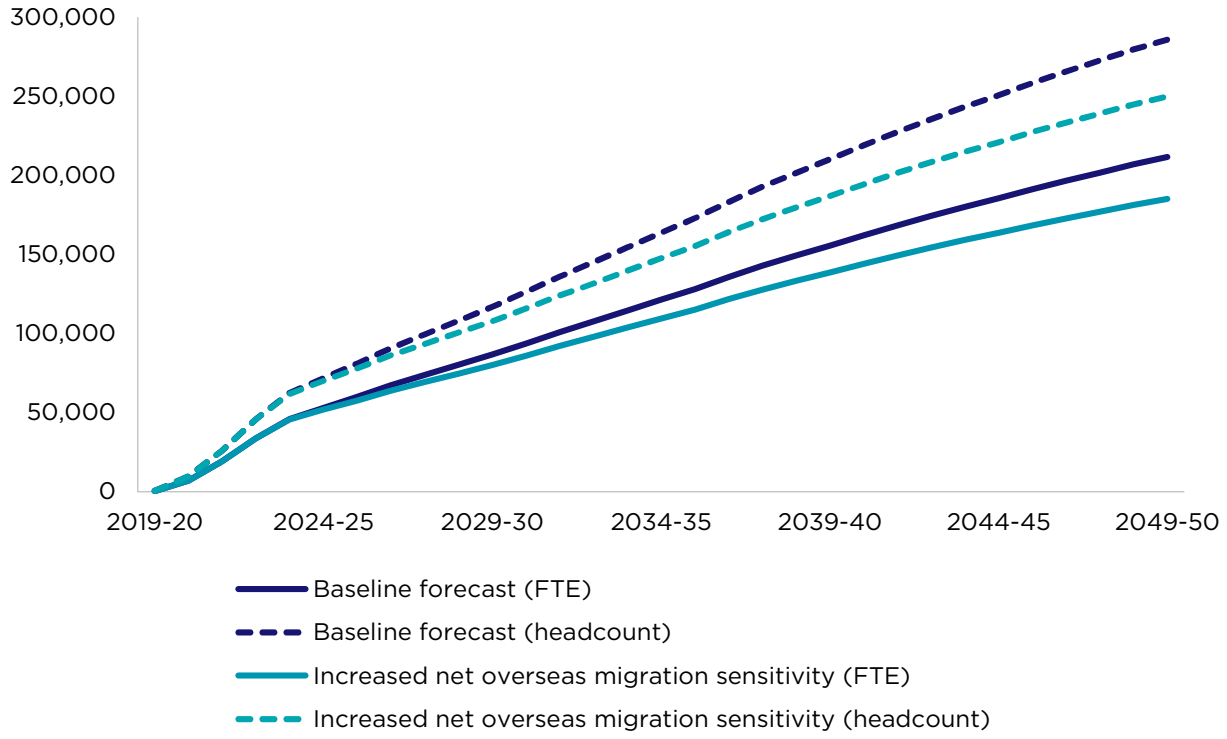
10.6.2 Increased net overseas migration sensitivity: impact on future workforce gap

As there are no changes to workforce demand in this sensitivity, the result of an increased supply of workers from increased migration is a reduction in the care workforce gap over time.

With a larger total workforce comes a greater ability to draw in workers from other industries. This provides a minor additional boost to workforce supply. The larger workforce also means that there will be an increase in retirements every year.

By 2049-50, the workforce gap for the total care and support workforce under the increased migration sensitivity is expected to reach 184,900 FTE (249,800 workers) – 13% lower in FTE terms than under the baseline forecast (211,400 FTE or 285,800 workers) (Figure 366).

Figure 366: Projected workforce gap (FTE and headcount), care and support workforce, baseline forecast and increased net overseas migration sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

Overall, workforce supply is increased with the projected care and support workforce gap reduced by around 36,000 workers (13% reduction) compared with the baseline (Figure 366).

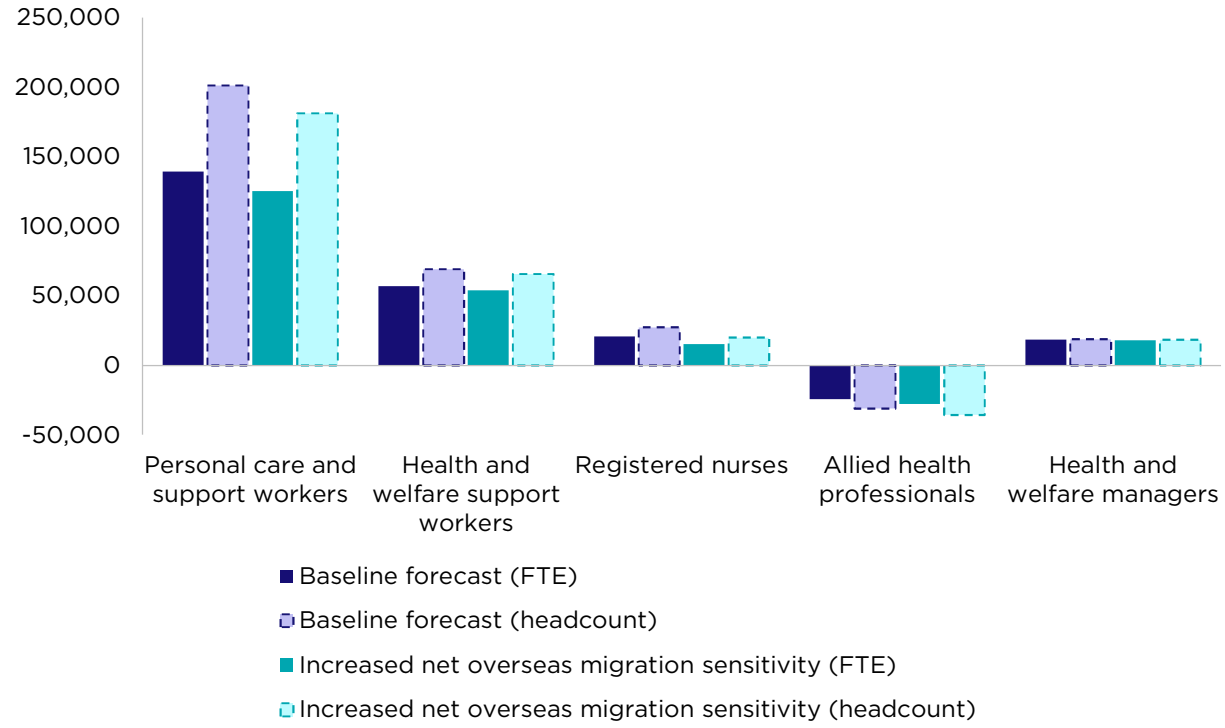
If the share of migrants flowing into the care and support workforce were to increase, that would further increase the supply of care and support workers relative to the baseline projections and reduce the workforce gap further.

As per the baseline forecast, Personal care and support workers continue to comprise the majority of the workforce shortage with the greatest workforce gaps. Health and welfare support workers and Registered nurses and Health and welfare managers also experience workforce gaps in the period to 2049-50.

This increased net overseas migration sensitivity sees a greater reduction in workforce gaps (Figure 367) for these occupations: Personal care and support workers (reduction of gap by 20,100 workers) followed by Registered nurses (7,400), Health and welfare support workers (3,600) and Health and welfare managers (500).

As with other sensitivities, noting the complexities in interpreting forecast data for Allied health professionals, workforce availability is also higher for this occupation group under the increased net overseas migration sensitivity.

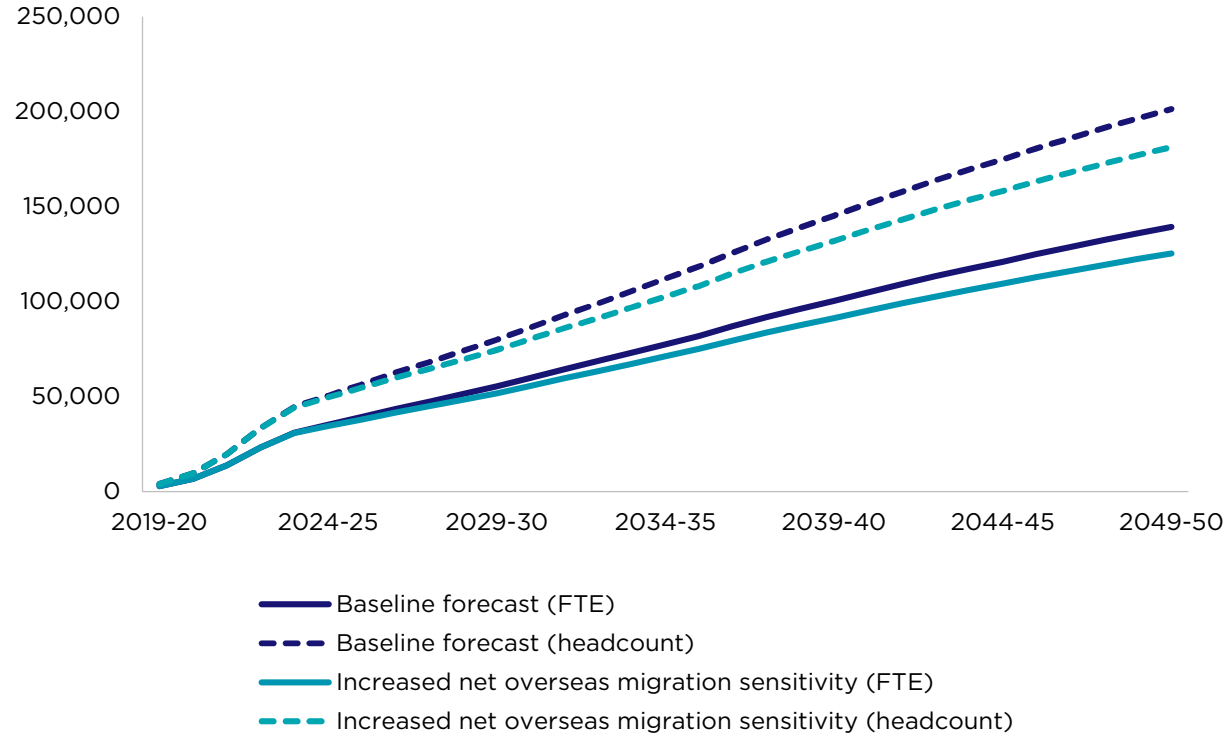
Figure 367: Projected workforce gap (FTE and headcount), care and support workforce, by occupation group, baseline forecast and increased net overseas migration sensitivity, 2049-50



Source: Deloitte Access Economics, 2021.

Personal care and support workers see the biggest reduction in the workforce gap (Figure 368).

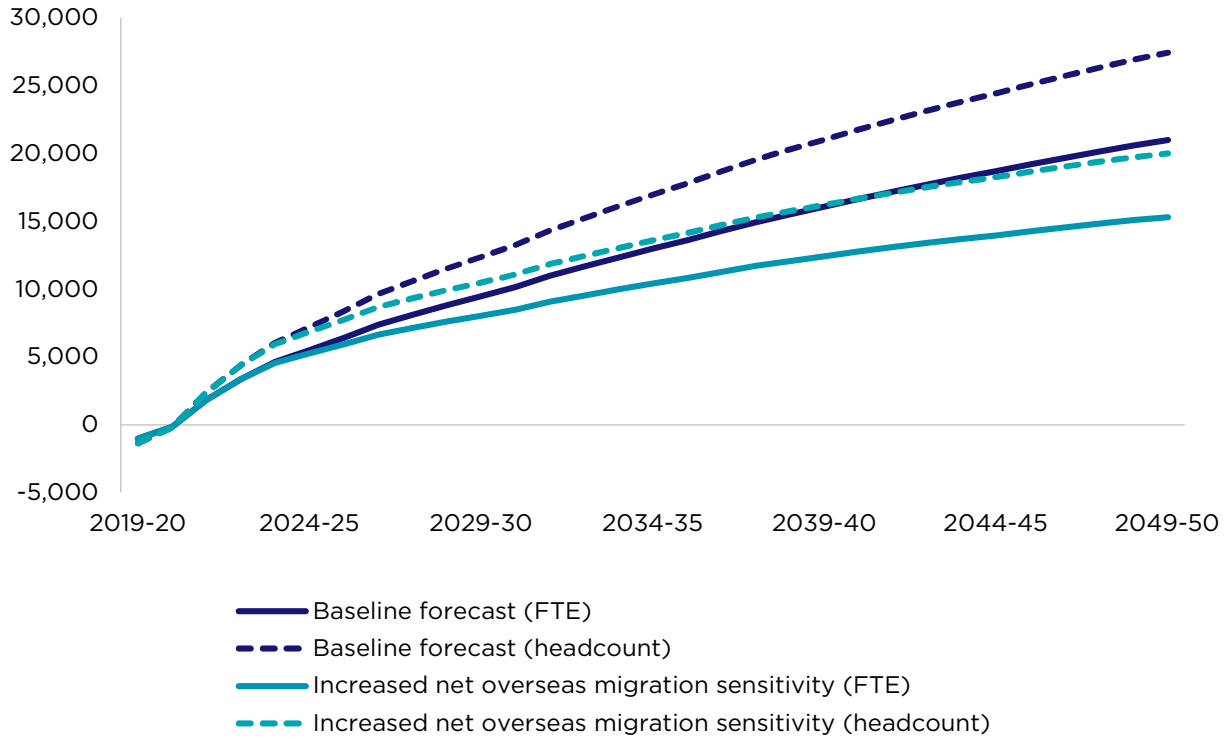
Figure 368: Projected workforce gap (FTE and headcount), Personal care and support workers, baseline forecast and increased net overseas migration sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

As shown in Figure 369, with increased net overseas migration, Registered nurses also see an increase in supply and a reduction in workforce gap of 7,400 workers (27% reduction) by 2049-50.

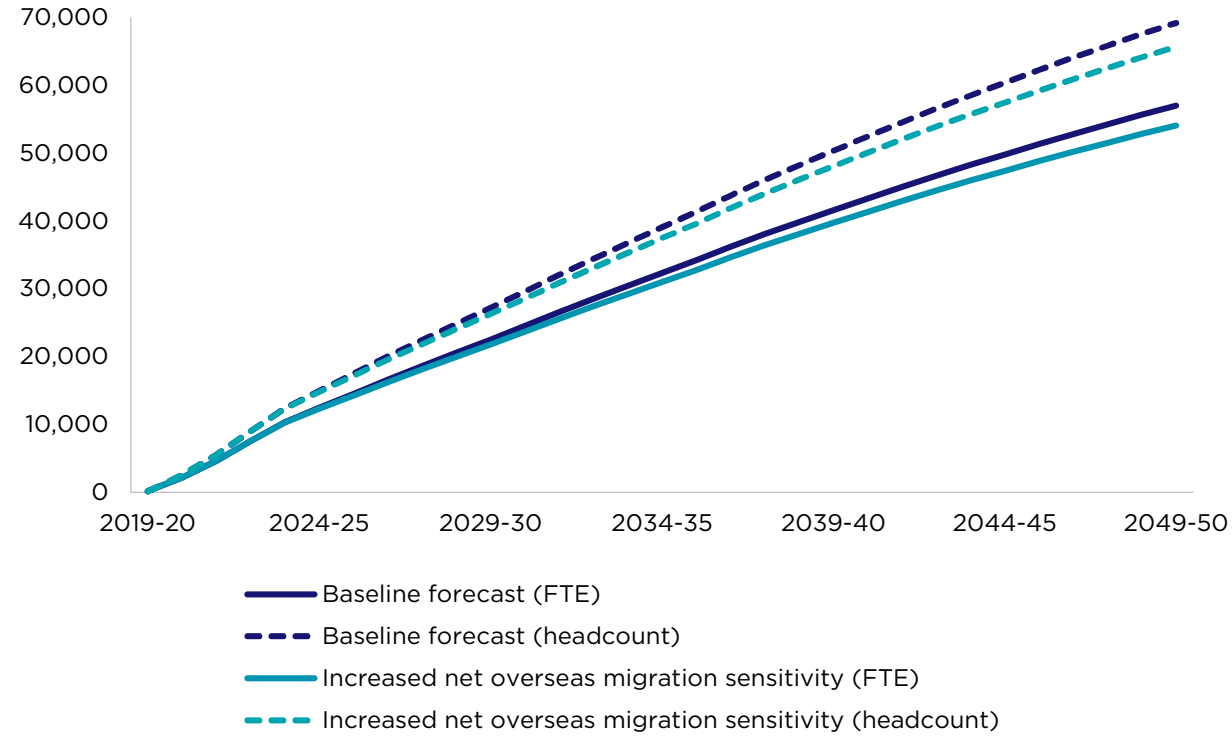
Figure 369: Projected workforce gap (FTE and headcount), Registered nurses, baseline forecast and increased net overseas migration sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

Compared with the baseline, the workforce gap for health and welfare support workers is reduced by 3,500 workers (5% reduction) by 2049-50 under increased net overseas migration (Figure 370).

Figure 370: Projected workforce gap, Health and welfare support workers, baseline forecast and increased net overseas migration sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

10.7 Extended care minutes sensitivity

Regulations around care quality are a key determinant of labour intensity in the care and support sector in general, and in residential aged care in particular.

In the 2021-22 Federal Budget, the Australian Government committed to increasing the number of minutes of direct care labour per residential care recipient to 200 minutes per day (with 40 minutes of that staff time provided by a registered nurse). An increase to 200 care minutes per resident per day has been included in the baseline forecast.

Further, the Royal Commission also recommended that:

> "From 1 July 2024, the minimum staff time standard should increase to require approved providers to engage registered nurses, enrolled nurses and personal care workers for the average resident for at least 215 minutes per resident per day for the average resident with at least 44 minutes of that staff time provided by a registered nurse.
>
> In addition, from 1 July 2024, the minimum staff time standard should require at least one registered nurse on site per residential aged care facility at all times."

This sensitivity models the impact on the workforce of the adoption of the extended care minutes recommendation (i.e. to 215 minutes per resident) and has been included in order to fully address the Study's Terms of Reference.

As the objective of implementing a minimum level of care minutes is to increase the quality of care provided to recipients, it has been assumed that providers are not able to reduce costs elsewhere as more workers are added. That is, the amount of capital and non-labour care used by providers is the same as in the baseline.

There are no changes to wages, and no other assumptions change as part of this sensitivity.

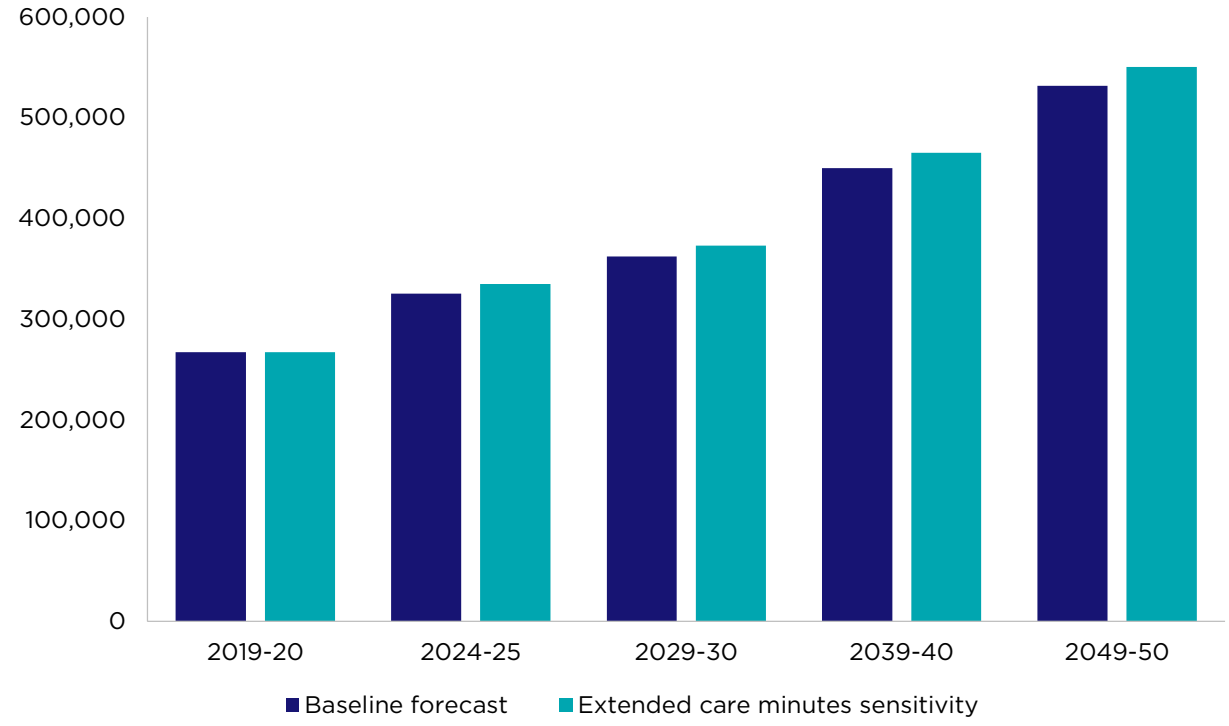
By mandating an increase in the labour intensity of residential aged care, this sensitivity directly increases workforce demand.

There are no direct impacts on workforce supply, however changes to workforce demand have some minor impacts as workers in other industries respond to a greater number of available jobs.

10.7.1 Extended care minutes sensitivity: impact on future workforce demand

Under the extended care minutes sensitivity, total demand for the care and support workforce is expected to increase to 550,400 FTE by 2049-50, around 3.5% higher than the workforce demand under the baseline forecast (531,600 FTE) (Figure 371). Over the forecast period (to 2049-50), workforce demand in FTE is expected to increase at an average of 2.4% per year under this sensitivity, compared with 2.3% per year under the baseline forecast.

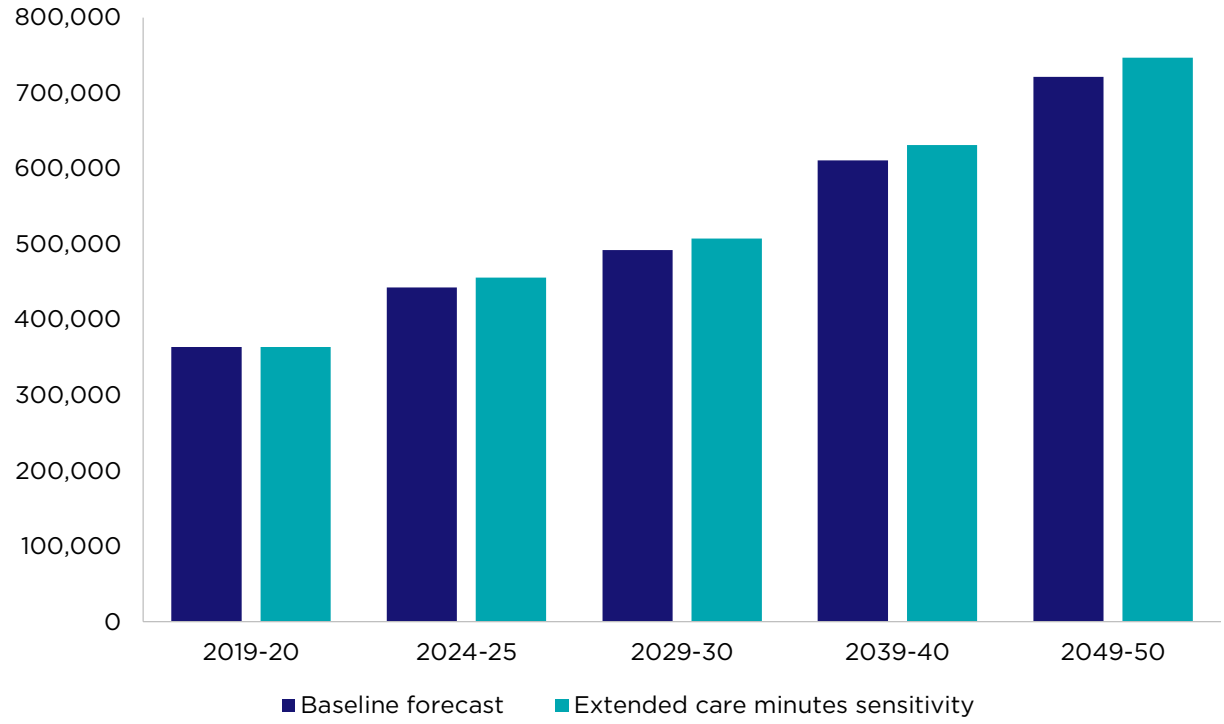
Figure 371: Projected workforce demand (FTE), care and support workforce, baseline forecast and extended care minutes sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

On a headcount basis, this extended care minutes assumption sees total workforce demand increase to 747,000 workers in 2049-50, compared with 721,800 under the baseline assumption (Figure 372).

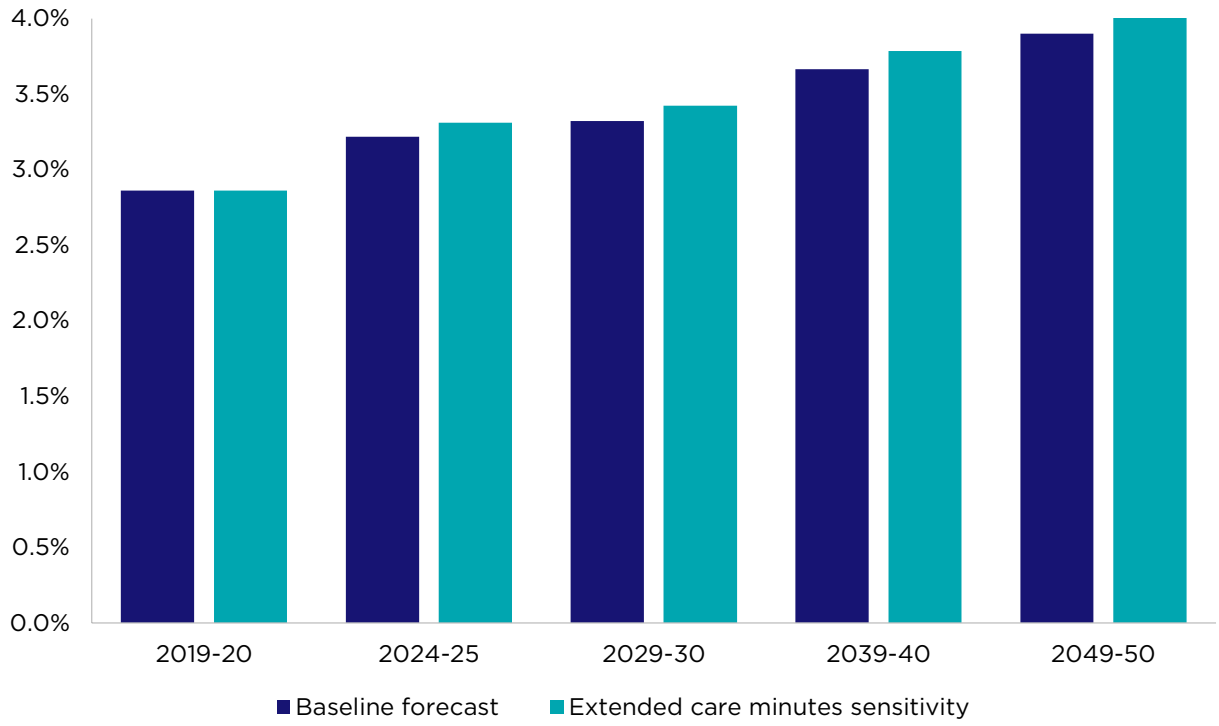
Figure 372: Projected workforce demand (headcount), care and support workforce, baseline forecast and extended care minutes sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021

An extended care minutes assumption slightly increases the share of the total workforce required to meet future workforce demand. Under an extended care minutes sensitivity, demand for the care and support workforce reaches 4.0% of the total Australia workforce by 2049-50 (Figure 373).

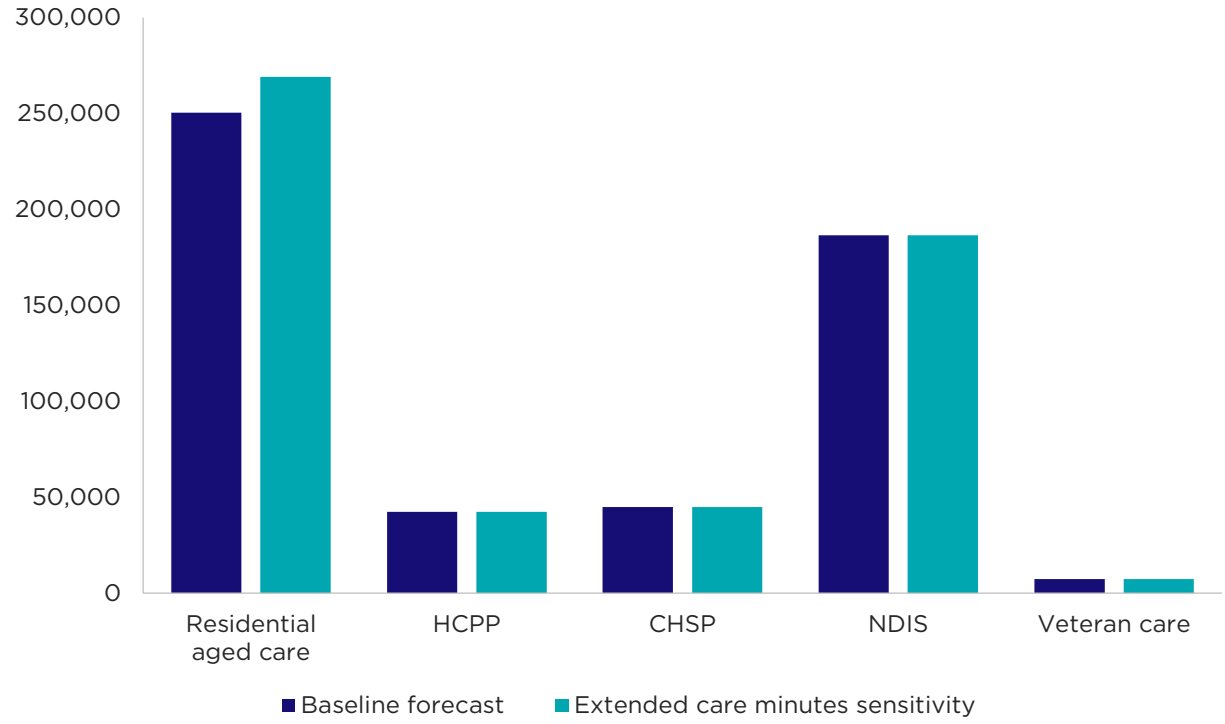
Figure 373: Projected workforce demand (headcount), care and support workforce, baseline forecast and extended care minutes sensitivity, share of total employment (%), 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

Under the extended care minutes sensitivity, the residential aged care program continues to be the key driver of future workforce demand. This is not unexpected given that the extension in care minutes is assumed to have been implemented within this environment under this sensitivity. With extended care minutes required to be delivered, workforce demand within residential aged care is expected to grow to 269,200 FTE by 2049-50 (compared with 250,400 FTE under the baseline forecast) (Figure 374).

Figure 374: Projected workforce demand (FTE), care and support workforce, by program, baseline forecast and extended care minutes sensitivity, 2049-50

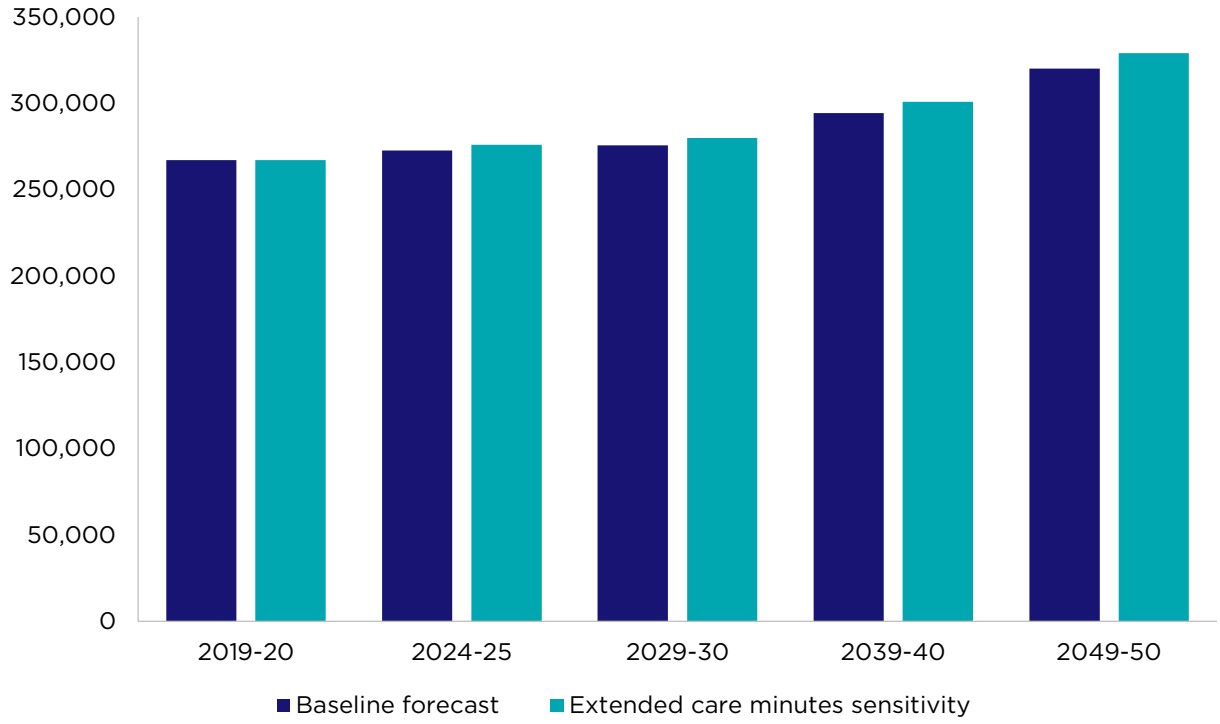


Source: Deloitte Access Economics, 2021.

10.7.2 Extended care minutes sensitivity: impact on future workforce supply

On the workforce supply side, an extended care minutes assumption has a modest impact on the size of future workforce supply. The result of the extended care minutes assumption for the care and support workforce is an increase of expected total care and support workforce supply to 329,100 FTE in 2049-50, compared with 320,200 FTE under the baseline forecast (Figure 375).

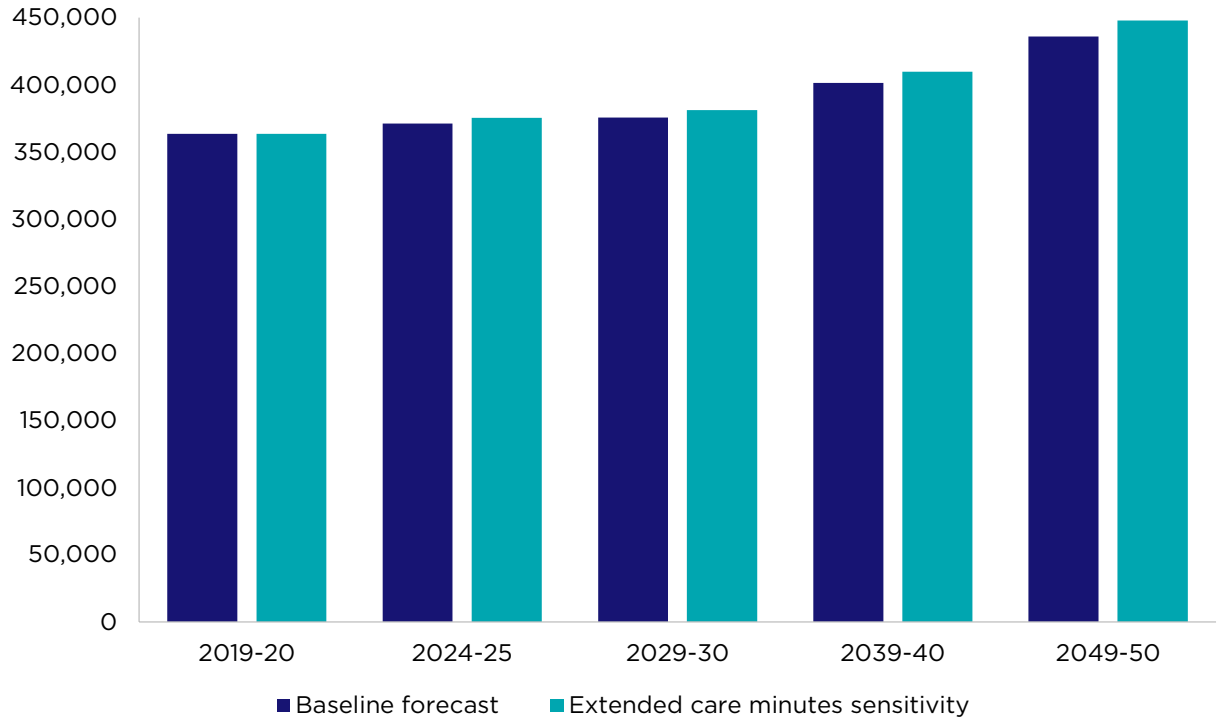
Figure 375: Projected workforce supply (FTE), care and support workforce, baseline forecast and extended care minutes sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

On a headcount basis, workforce supply is expected to increase to 447,800 workers by 2049-50 under the extended care minutes sensitivity, compared with 436,000 for the baseline forecast (Figure 376). The average hours worked per person employed in each occupation has been assumed to remain constant under each sensitivity, although this would be subject to change in practice as individuals respond to changing workforce conditions (Figure 286).

Figure 376: Projected workforce supply (headcount), care and support workforce, baseline forecast and extended care minutes sensitivity, 2019-20 to 2049-50



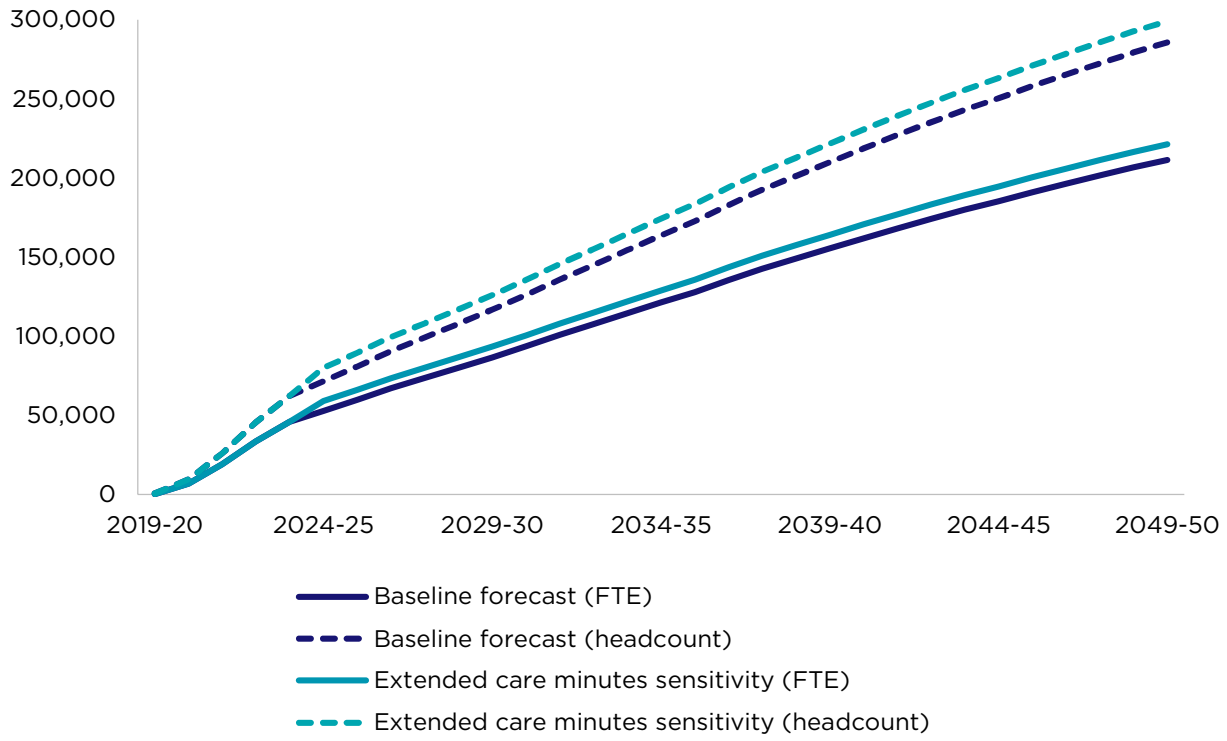
Source: Deloitte Access Economics

10.7.3 Extended care minutes sensitivity: impact on future workforce gap

While both demand and supply of the total care and support workforce is expected to be higher under the extended care minutes sensitivity, the change in workforce demand relative to the baseline forecast is expected to exceed the change in workforce supply. As a result, the projected workforce gap on both an FTE and headcount basis is larger under this sensitivity compared with the baseline forecast. By 2049-50, the workforce gap for the total care and support workforce under the extended care minutes sensitivity is expected to reach 222,300 FTE (299,200 workers) – 5% higher in FTE terms than under the baseline forecast (211,400 FTE or 285,800 workers) (Figure 377).

While the increase in the workforce gap is relatively small, it emerges immediately. It is then retained over time, as workforce demand increases in line with the demand for care.

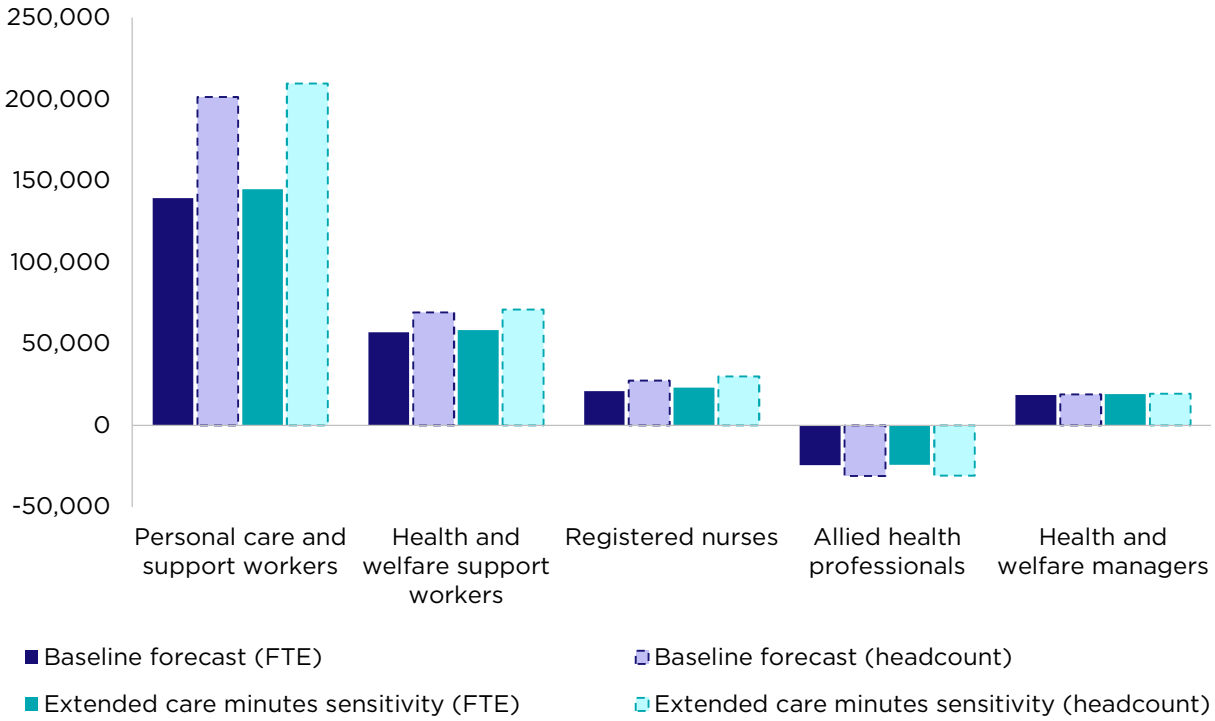
Figure 377: Projected workforce gap (FTE and headcount), care and support workforce, baseline forecast and extended care minutes sensitivity, 2019-20 and 2049-50



Source: Deloitte Access Economics, 2021.

As per the baseline forecast, the workforce gap for Personal care and support workers (skill level 4) continues to form the majority of the workforce shortage under the extended care minutes sensitivity, with larger workforce gaps also evident for Health and welfare support workers (skill levels 1 and 3) and Health and welfare managers (skill level 1), together with Registered nurses (skill level 1) (Figure 378). Noting the complexities in interpreting forecast data for Allied health professionals (Part 9.5), workforce availability is largely unchanged relative to the baseline forecast.

Figure 378: Projected workforce gap (FTE and headcount), care and support workforce, by occupation group, baseline forecast and extended care minutes sensitivity, 2049-50

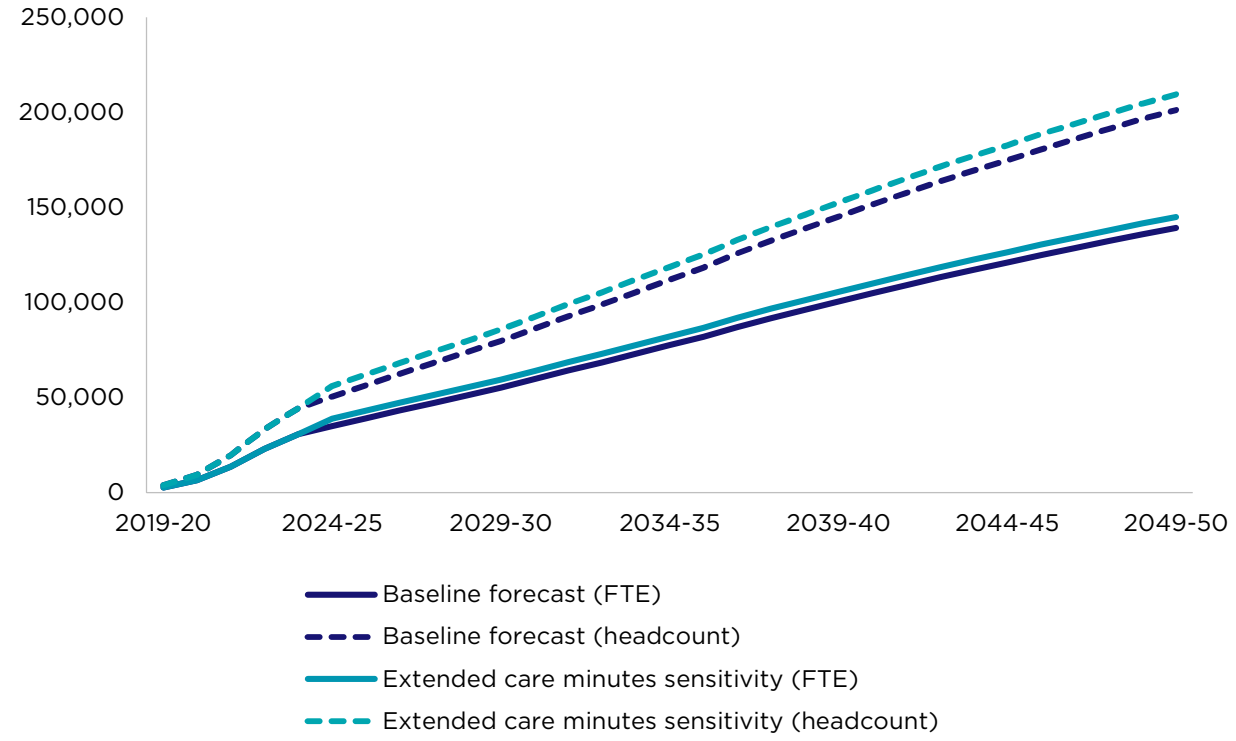


Source: Deloitte Access Economics, 2021.

Within this sensitivity, there are different impacts for individual occupation groups:

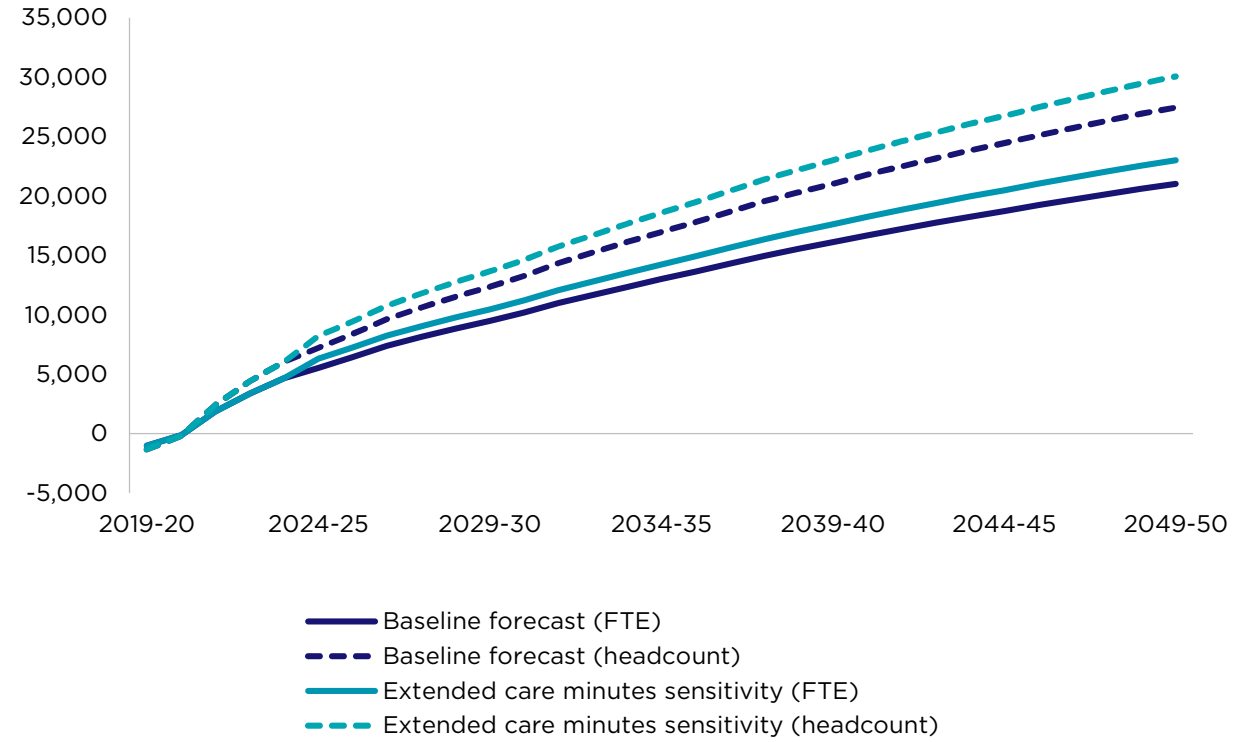
- Personal care and support workers continue to make up the majority of both the workforce demand and workforce gap, with extended care minutes increasing demand for workers in these occupations (Figure 379).
- the workforce gap for Registered nurses is also higher under the extended care minutes sensitivity, with the workforce gap growing quickly over the first years of the forecast period to reach an expected shortage of 10,400 FTE (13,700 workers) by 2029-30 (Figure 380).
- Health and welfare support workers also see a higher workforce gap under an extended care minutes sensitivity, reaching 58,300 FTE (70,900 workers) by 2049-50 (Figure 381).

Figure 379: Projected workforce gap (FTE and headcount), Personal care and support workers, baseline forecast and extended care minutes sensitivity, 2019-20 to 2049-50



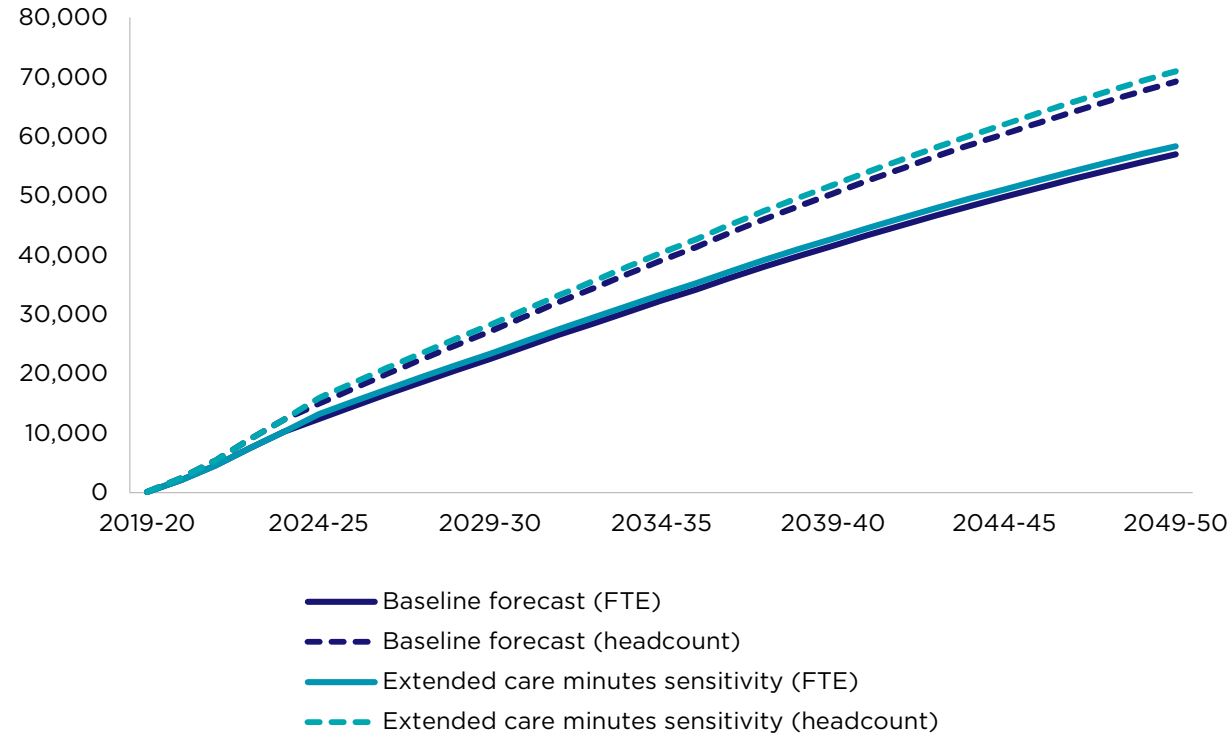
Source: Deloitte Access Economics, 2021.

Figure 380: Projected workforce gap (FTE and headcount), Registered nurses, baseline forecast and extended care minutes sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

Figure 381: Projected workforce gap (FTE and headcount), Health and welfare support workers, baseline forecast and extended care minutes sensitivity, 2019-20 to 2049-50



Source: Deloitte Access Economics, 2021.

10.8 Other opportunities and risks

The sensitivity analyses show that no single solution is able to fully close the care and support workforce gap – a combination of factors will likely be required. While the sensitivities reflect a selection of levers and settings that influence the workforce projections, this Study has also highlighted a range of other supply and demand factors which present future opportunities and risks for the care and support workforce which are not able to be modelled.

As highlighted in Part 2, demographic characteristics and program eligibility are the key drivers of demand for the care and support workforce. Should the demographic profile of Australia's population materially shift and/or care and support program parameters change in the future, this will have consequential impacts on the demand for the care and support workforce.

Further, the policy environment continues to evolve. As well as policy changes which are yet to be conceived, there are a range of policies currently under review and consideration that could potentially impact the workforce gap to varying degrees.

Less tangible, but not less important, factors like public perception (Part 8.2.1), new articulations of job design and architecture (Part 8.2.2), technology adoption and innovation rates (Part 8.2.3) all reflect opportunities, and risks, to influence the care and support workforce gap.

Beyond these factors, the role of the wider economy and its capacity to contribute to the supply of the care and support workforce is a relevant consideration. While outside the terms of reference for this Study, opportunities may exist in other parts of the economy to improve productivity and consequently increase the potential flows of workers to the care and support workforce from other sectors.

Recognising the many and complex factors which influence the demand and supply of the care and support workforce, a continuous focus on workforce implications is increasingly important. A framework to support this is outlined in Part 11.

Part 11
A framework for monitoring the care and support workforce

Part 11 of the Study proposes a framework to monitor pressures in the care and support workforce on an ongoing basis. For such a framework to be successful it will need to consider the workforce from a cross-program perspective.

Workforce implications need to be central and given active consideration in policy development and decision making across all care and support programs in light of the risk that workforce gaps could emerge in coming years.

Program-specific views, while important and necessary, also need to take account of how policy implementation is likely to influence other care and support programs, and consequently the broader workforce providing these services.

The following monitoring framework could be adopted to examine and understand the pressures in the care and support workforce. The framework has 3 components:

- regular snapshots which provide point-in-time assessments of the care and support workforce
- re-baselining the demand and supply models to revise future forecasts
- regular assessment of the impacts of new policy on the demand for and supply of the workforce.

Together, these elements provide an assessment of the here and now; the likely future profile of the workforce (that is, are future gaps increasing or decreasing); and provide a structured way for workforce implications of policy decisions to be considered across the broader care and support landscape.

11.1 Workforce monitoring framework

The objective of a care and support workforce monitoring framework (the framework) is to provide insight into workforce supply relative to workforce demand (i.e. the workforce gap) over time.

The framework has been designed to inform policy and decision making and is intended to be applied in 2 main contexts for monitoring the care and support workforce – regular snapshots and re-baselining the model projections.

As noted throughout this Study, Australia's care and support environment is evolving. Part 10 demonstrated the utility of the demand and supply model to illustrate the workforce implications of varying the underlying assumptions in the model. This points to a supplementary application of the framework for considering potential future policy changes.

The framework focuses on understanding the balance of workforce demand and supply to inform holistic assessments of whether the gap is closing or widening across care and support occupations, and how the economy is responding to demand and supply pressures on the care and support workforce.

A variety of data sources are necessary to understand the complex factors influencing workforce dynamics. From occupation and industry projections, recruitment difficulty and job vacancy data, to labour market statistics, each can contribute a perspective on the care and support workforce. Figure 382 outlines illustrative data inputs to the framework and how these could be brought together in a conceptual dashboard.

Figure 382: Framework inputs and conceptual dashboard

Regular snapshots (current state dashboard)

Timing: frequent (every 6 to 12 months)

Indicators of demand for the care and support workforce

Many variables contribute to assessing the demand for and pressure within the workforce, these include:

- recruitment activity, job vacancies, and recruitment difficulty
- skill shortages (national and regional)
- labour market characteristics and their trends
- changes in the size of the workforce
- relative wage growth.

Drivers of supply

Other variables contribute to assessing supply into the workforce, these include:

- enrolments and completions in training and education
- migration levels
- job movement and transitions
- workforce utilisation and hours worked.

Other considerations

- Direction of recent trends (balance getting better or worse?)
- Recent policy changes and impact on demand and supply
- Worker sentiment.

Re-baselining and forecast modelling

Timing: every few years (or as required)

How does the current size of the workforce differ from past projections and expectations for this point in time?

- Demand differences:
  - changes in care and support program parameters and settings
  - demographic shifts.
- Supply differences:
  - participation rates
  - productivity levels
  - migration settings.

What is driving those differences?

- Policy decisions?
- Macroeconomic environment?

What interventions might be needed?

Inform future policy making

Timing: as required

What are the workforce implications of policy options?

- Does the change increase/lower workforce demand?
- Does the change increase/lower workforce supply (including indirectly)?

Source: NSC analysis.

The framework is designed to complement agencies' existing workforce monitoring, planning and development activities and inform workforce strategy review points.

11.1.1 Regular snapshots of the care and support workforce

Conducting regular snapshots is intended to help inform timely assessments of the care and support workforce and how the balance of demand and supply is tracking at a particular point in time – where are we at right now?

Snapshots should be undertaken as part of respective workforce strategy review points, and as otherwise required, to:

- Assess the current estimated size and characteristics of the care and support workforce to understand whether the gap is closing, widening or stable.
- Examine relevant demand and supply indicators which may be driving movements and trends across care and support occupations, noting that it is an understanding of the drivers and trends which is more important than the quantification of the workforce gap itself.
- Form a view of workforce pressure and an assessment of the balance of demand and supply, having regard to the modelled projections and trends across previous snapshots.

- Consider at a regional level data sources such as the NSC's Nowcast of Employment by Region and Occupation (NERO) and internet vacancies which can provide timely insights on workforce trends.

An estimate of the current size of the care and support workforce is an important and necessary component of any snapshot. However, it is the analysis and assessment of a range of indicators, including recruitment activity, job vacancies, recruitment difficulty, skill shortages, changes in labour market characteristics which provide the intelligence about workforce demand and pressure. Careful consideration should be given to each indicator used within the framework, including frequency, reliability, volatility and relative importance among other indicators.

The training pipeline, regulatory environment, migration and other factors outlined throughout this report influence workforce supply. As such, the framework should leverage the existing reporting outputs from relevant agencies in relation to these supply side factors as part of the analysis of trends in the workforce gap and assessment of supply side pressure.

Each snapshot should also take account of other considerations which may influence the balance of supply and demand, such as relevant policy changes.

11.1.2 Re-baselining and forecast modelling

As noted in Part 9.3, over time many of the assumptions, together with the underlying demographic outlook, funding expectations and eligibility guidelines for each program are subject to change (and many would be expected to change) over the forecast horizon, which would shift the expected outlook. Accordingly, it is important that workforce demand and supply forecasts are re-baselined as required.

The objective of a care and support workforce monitoring framework (the framework) is to provide insight into workforce supply relative to workforce demand (i.e. the workforce gap) over time. Estimates of the care and support workforce can be compared over time to make an informed and holistic assessment of whether the gap is closing or widening (and how the workforce and economy is responding to demand and supply pressures).

Triggers for re-baselining the workforce projections would include, but are not limited to:

- release of new demographic data, such as the ABS Census of Population and Housing or the next IGR
- significant changes to care and support program parameters that drive workforce demand
- significant changes in Australia's economic and fiscal outlook parameters impacting supply side sensitivities, such as productivity or migration.

Re-baselining the demand and supply forecasts would also provide more precise assessments of the balance of workforce supply and demand, given that the models are informed by a more comprehensive set of data inputs than those used to inform the regular snapshot view of the care and support workforce.

Further, it also provides the opportunity to assess whether policy interventions may be required to address any significant changes in the workforce gap and/or increasing workforce pressure.

11.1.3 Inform future policy making

The care and support workforce represents a significant and growing share of the labour market. Policy changes across care and support programs have the potential to ease or exacerbate workforce pressures, directly or indirectly.

An additional benefit of the care and support demand and supply models is the ability to explore the workforce implications of policy options in greater detail. By varying the underlying assumptions in the model relevant to the policy option being explored, revised workforce estimates can be analysed and evaluated for the projected impact on the balance of workforce demand and supply.

11.1.4 Illustrative data inputs to the framework

As previously noted, it will be important to curate and leverage the wide range of relevant and available data to inform the framework, noting different data inputs may be more or less relevant to the 3 different framework applications. In this context, there are various traditional and emerging data inputs which could be used to monitor the care and support workforce.

This Study has drawn on a wide of range of data sources to better understand the factors affecting supply and demand. These data sources have ongoing applicability in the framework and provide the necessary context to inform assessments of the balance of workforce demand and supply, and what is influencing and driving workforce trends. Some of the indicators and analytic products used by this Study include:

- Census of Population and Housing (ABS) – when available in 2022 and 2023, the 2021 Census will provide more contemporary and detailed data on the occupation and industry distribution of the care and support workforce (however, COVID-19 may impact some aspects of the Census and careful application may be required).
- Labour Force Survey (ABS) – a monthly and quarterly survey providing headline estimates of employment, unemployment, underemployment, participation and hours worked (however, robust estimates for the care and support workforce across all these variables can be problematic due to data limitations, particularly for smaller care and support occupations).
- Longitudinal Labour Force Survey (ABS) – an experimental time-series that enables in-depth analysis of labour market engagement over time.
- Participation, Job Search and Mobility Australia (ABS) which this Study used to explore a range of workforce issues including underemployment and hours worked.
- Linked data assets such as the Multi-Agency Data Integration Project (MADIP) and Business Longitudinal Analysis Data Environment (BLADE) (ABS).
- Recruitment Experience and Outlook Survey (REOS) (NSC) which assists in understanding of employer's recruitment activity and difficulty across different occupations and locations.
- Internet Vacancy Index (NSC) which provides detailed information on online job advertisements at the national, state and territory and 37 regions.
- Skills Priority List (NSC) which provides a current labour market rating and future demand rating for occupations. A range of labour market indicators are used to inform the SPL, along with qualitative analysis and stakeholder input, which assists in understanding skill shortages across Australia.
- Skilled migration lists (Department of Home Affairs) identify occupations where skills gaps and productivity capacity has been identified as required in the Australian economy
- NERO (NSC) – an experimental data set which provides nowcast estimates of the occupational employment (ANZSCO 4-digit) by region (SA4) using traditional and real-time data – can assist in providing more timely estimates of employment size.

Additionally, a satellite account for care and support may improve the availability of reliable labour market data on the composition and size of the care and support workforce. Should a satellite account be established this would be an important input to the monitoring framework (Part 1).

The framework is not intended to be static and should evolve to incorporate the widest range of relevant information, from traditional and emerging sources, and progressively address data gaps over time. Noting that there are a range of projects underway across government to improve data quality and availability to inform workforce planning and development.

Finally, other considerations in the analysis of data relevant to the care and support workforce include:

- Worker sentiment – as noted in Part 8.1 there is currently no data collection which provides cross-cutting analysis of workforce sentiment, recipients views or provider perspectives, yet insight from these sources would provide an important qualitative supplement for understanding the pressures in the care and support workforce. Supplementing the

framework assessment with a range of industry and stakeholder intelligence would bring a richer set of insights from which agencies can review and refine workforce strategies.

- Different interpretations for data variables – as noted in Part 9.2, the same data variable can mean different things in different contexts and locations, which underscores the importance of calibrating data with regional, place-based and cohort specific intelligence. The models have been developed at the national level, in line with this Study's focus. However, a state or regional view could also be explored, incorporating other measures such as labour mobility (noting that this is currently challenging due to data gaps and data quality issues that exist in relation to geographically disaggregated data).
- International comparisons – as noted throughout this Study, international perspectives across demand and supply factors provide important points of comparison. The consideration of global trends in the care and support workforce alongside the framework will also be relevant moving forward.

11.2 Connecting the framework to workforce planning activities and policy design

As illustrated in Part 9 and Part 10, the demand and supply models underpinning this Study's care and support workforce forecasts reflect the interplay of care and support programs on workforce demand. Accordingly, while the framework is not intended for program-specific purposes it could be used to complement program-based considerations as the model illustrates how program changes flow through to demand and supply projections. Re-baselining and exploring potential policy design options using the model will require coordination across care programs, particularly for the demand side assumptions.

Further, the framework is not intended to replace workforce planning and development activities that exist across care and support programs. Rather, it is intended to augment and complement these activities by providing a whole-of-care and support workforce view and a detailed understanding of the workforce implications of implementing policy.

Ultimately it is the combination of more detailed data on the care and support workforce, use of the monitoring framework, as well as rigorous evaluation of strategies and policies designed to address workforce issues, which will contribute to building the skilled and capable workforce needed to deliver Australia's essential care and support services, now and into the future.

Part 12
Care and support in mental health

While the mental health workforce shares many similarities with the care and support workforce, as highlighted through this Study, there are several differences and increased complexity which are significant and warrant separate consideration.

Like the care and support system the mental health landscape is complex. Policy responsibility for mental health is shared across Australian, state and territory governments and a range of different departments and agencies. There are also a broad range of non-government organisations that operate across community mental health services.

Informal care and support also makes a substantial contribution to the provision of mental health services, with the Productivity Commission estimating the value of care and support provided by family and friends to be worth around $15 billion per year in 2018-19.

Data gaps are an even greater issue across the mental health landscape

Data availability is a major challenge in estimating the demand for mental health services and programs. Data collections focused on mental health in Australia's population are infrequent and based on self-reported observations.

Further, administrative and service level data varies in availability and has a number of limitations, making it difficult to establish a comprehensive picture of demand and usage of mental health services. The 2020 Productivity Commission's Mental Health Inquiry identified a range of data gaps across the mental health system.

Prevention and early intervention initiatives can take place in a range of settings, and again, there is no way to accurately assess demand or identify the range of occupations which may contribute to the delivery of preventive and early intervention supports.

Defining the mental health workforce is also challenging. In part this is due to the continuum of mental health and the scope of activities and services that are linked to this, as well as the absence of agreed definitions and data limitations. Notwithstanding these challenges, the mental health workforce is growing and new roles are emerging.

Which has meant the Study has adopted a different approach

Given these complexities, the Study has provided an illustrative analysis of the mental health workforce, with a focus on 7 key occupations (across 2 occupation groups – Medical mental health workers and Non-medical mental health workers) that have a direct connection to delivery of mental health services as part of their role.

The 4 Non-medical mental health occupations are of similar size, with *Welfare, recreation and community arts workers* being the largest, followed by *Psychologists*, *Social workers* and *Counsellors*. *Registered nurses* and *General practitioners and resident medical officers* are the largest Medical mental health occupations, which is unsurprising given their role in the broader health sector. *Psychiatrists* is the smallest occupation.

- The 4 Non-medical mental health occupations considered in the Study have grown considerably since 2005. Among Medical mental health occupations, *Registered nurses* and

General practitioners and resident medical officers have consistently grown since 2005. *Psychiatrists* was the only occupation to decline in size over the same period, which may be due, in part, to a combination of higher average age and retirements.

The demographic profile of the mental health workforce has some similarities with the care and support workforce

Like the care and support workforce, the mental health workforce has a much higher concentration of employed females (82%) than the overall workforce (48%) – primarily driven by a high prevalence of females in Non-medical mental health occupations.

- This share is slightly higher than the care and support workforce (79%), but also includes *Registered nurses* across all industries, the majority of whom are female. If *Registered nurses* are excluded from the analysis (as many nurses do not specialise in mental health services), the share of female employment in the mental health workforce falls.

The mental health workforce is culturally and linguistically diverse with around 40% of the workforce born overseas (similar to the care and support workforce).

- Within that there is a greater share of overseas-born workers among Medical mental health roles, compared with non-medical roles where a higher proportion of the workforce are born in Australia.

Mental health workers, similar to care and support workers, are typically older than other Australian workers. The average age of the mental health workforce has also been increasing over time, in contrast to the care and support workforce, which has a declining average age.

- The age profile varies considerably across occupations with *Psychiatrists* more likely to be older (with an average age of 49 years) and *Welfare, recreation and community arts workers* more likely to be younger (average age of 42 years).

Labour market characteristics are different, though

Mental health workers are less likely to work part-time than those employed in the care and support workforce. In February 2021, around 45% of the mental health workforce (or 35% not including *Registered nurses*) were employed on a part-time basis, compared with 52% of the care and support workforce.

Mental health workers also typically work more hours per week than the care and support workforce but less than the total workforce. Medical mental health workers (other than *Registered nurses*) work more hours than non-medical staff.

The overall underemployment ratio (share of employed) for the mental health workforce, which stood at around 6% in February 2021, is much lower than for the total workforce (9%) or the care and support workforce (13%).

Incomes vary significantly by occupation, with the workforce highly qualified

The wage income of mental health workers varies significantly by occupation, with medical occupations mostly earning more than non-medical occupations. Only 2 occupations earned less than the Australian average: *Counsellors* and *Welfare, recreation and community arts workers*.

The mental health workforce is highly qualified, with education pathways predominantly associated with higher education.

All mental health occupations considered in this Study are skill level 1 – commensurate with a bachelor degree or higher. This distinguishes the mental health workforce from the care and support workforce where the skill level profile is mixed, with the majority of the workers employed in skill level 4 roles.

- That said, other skill levels are likely represented in the broader range of mental health occupations that sit in the areas of prevention, early intervention and mental health care and support.

Enrolments for higher education qualifications for mental health occupations have increased by almost 160% between 2001 and 2019, higher than the growth in all higher education enrolments which increased by 90% over the same period.

The mental health care and support landscape is changing, and may overlap more with the broader care and support sector in the future

Throughout the Study a range of job titles have also been used by stakeholders to identify the occupations within the mental health workforce that do not align precisely with occupation titles in ANZSCO, including lived experience (peer) workers, psychosocial support workers and allied health assistants.

With the exception of allied health professionals providing care and support within a mental health setting, it is notable that the skill and qualification level of workers in these emerging (lived experience (peer) workers) and potentially emerging (psychosocial support workers) mental health roles is comparable to that of the general care and support workforce.

This suggests that, in the event of increased demand for care and support, these systems will be drawing from similar pools of workers which could further increase workforce pressure in both the care and support and mental health workforces.

Mental health skills are also growing in importance across a range of different occupations, which will add to broader demand

Online job advertisements suggest employers are increasingly looking for workers with mental health skills across a range of occupations. Between 2014 and 2020, the percentage of online job vacancies mentioning mental health skills grew across a number of health and welfare occupations, including *Social workers*, *Enrolled and mothercraft nurses* and *Welfare support workers*. Mental health skills are also becoming more prevalent in advertisements for *Aged and disabled carers*, the largest care and support occupation. This reflects the growing need for, and importance of, mental health skills in the delivery of health and welfare services.

- The draft *National Mental Health Workforce Strategy* also recognises the broader workforce has a role in supporting people experiencing suicidality, mental distress and/or ill health, and includes training initiatives to support the development of basic mental health skills across a range of care and support occupations (including aged care, disability services and allied health workers).

Mental health skills are also becoming more common in job advertisements for roles outside of health and welfare occupations and settings (for example, job vacancies for *Student counsellors*, who work predominantly in education settings) reflected by an increase in mentions of mental health skills.

As awareness of mental health issues increases, it may be expected that skills in these areas will increasingly be required for a wide range of jobs, particularly in service-based industries, including care and support and to support early intervention and prevention.

As with the care and support workforce, a range of factors impact supply

Similar to the care and support workforce, there are a range of factors influencing the supply of the mental health workforce. Indeed, there is a considerable degree of overlap between the issues identified for the care and support workforce, and those facing the mental health workforce.

Strategies to address these workforce challenges are reflected in the draft *National Mental Health Workforce Strategy.* The following outlines some additional issues identified during the Study specific to mental health, including defining scopes of practice, use of technology and system fragmentation.

Delivery of mental health care and support services is complicated by shared roles and responsibilities across governments and the non-government sector. Stakeholders cited fragmentation of the mental health system and a range of factors that may be contributing to this complex environment, including: variable policy settings and governance across jurisdictions and programs multiple service delivery models which are not well-integrated, and various funding approaches.

The workforce and service delivery implications of fragmentation can impact the remuneration and conditions of mental health workers differently across occupations and settings.

- With many different funding sources, such as the NDIS, state and territory health systems, and the community sector, the pay settings and entitlements of workers can differ widely based on the context and setting in which they work.

Estimating demand and supply is more challenging across mental health, although there may be unmet demand

The Productivity Commission estimates that around one million people with mental illness are receiving no clinical care and noted many people do not receive the treatment and supports that they need, or at the level that they need them.

Further, on the supply side there are indications of workforce shortages in some mental health occupations:

- The Productivity Commission found that there was a shortage of psychiatrists in Australia, particularly those specialising in the treatment of children, adolescents, and older people.
- *Psychiatrists, General practitioners and resident medical officers* and *Psychologists* are identified as being in shortage on the NSC's Skills Priority List.
- Analysis undertaken to inform the draft *National Mental Health Workforce Strategy* also estimated that the current mental health workforce is significantly below the national target levels in the 2019 National Mental Health Service Planning Framework.

Combined, these insights support a view that there is a degree of pressure in the mental health workforce.

Mental health occupations are likely to see ongoing growth, and workforce gaps could emerge

As noted earlier, mental health occupations have experienced employment growth in recent years, and this is expected to continue over time.

- Projections derived from Deloitte Access Economics' broader macroeconomic forecasts see that *Registered nurses* will experience the largest growth over the 10 years to 2031, followed by *General practitioners and resident medical officers* and *Psychiatrists*.
- Continuing growth is also expected across all Non-medical mental health roles, with *Social workers* expected to be the largest Non-medical mental health occupation by 2031, followed by *Psychologists* and *Counsellors*. The lowest growth rate is anticipated for *Welfare, recreation and community arts workers*.

Given the unclear starting point for demand and supply across mental health, it is difficult to quantify whether there is currently a gap between workforce demand and supply for mental health, or the magnitude of any such gap into the future. That said, a number of indicators suggest a degree of pressure on the workforce.

While the many data constraints present in mental health make workforce planning and development much more challenging, the conclusions from the care and support workforce modelling are likely to also prove salient in the mental health context.

To the extent that a workforce gap and pressure currently exists for mental health occupations, any increase in demand will exacerbate any underlying workforce shortage and will be cumulative over time. Shifts in societal attitudes, particularly increased awareness of the importance of mental health, are also likely to lead to increased demand for mental health services.

For mental health occupations at skill level 1, the supply of workers will be both a function of enrolments and completions in higher education and skilled migration levels. Negative trends in either of these supply changes will exacerbate any gap, noting that the education and training for some occupations takes many years to complete.

- The age profile of *Psychiatrists* presents some future risk to this occupation.

Acknowledging the demand for mental health workers at lower skill levels is not yet well understood, it is possible that the emerging mental health occupations and those providing early intervention, prevention, and mental health care and support may have similar skill level characteristics to the majority of the care and support workforce.

As the gap is most acute at these skill levels for the care and support workforce, this may also be where the largest workforce gap may emerge, particularly if all programs and services across aged, disability, veteran and mental health care and support are competing for the same pool of potential workers.

12.1 The demand for mental health care and support

Mental health is a positive state of wellbeing in which individuals can manage their thoughts and feelings. In this way a person can cope with the normal stress of life and reach their potential in work and community life in the context of family, community, culture and broader society.[256]

The continuum of mental health and wellbeing comprises a complex and diverse range of conditions and experiences, varying in severity and duration.

Around 1 in 5 Australians had a mental health or behavioural condition in 2017-18, and this has been increasing over time (Figure 27).[257] A higher share of people 16-25 years reported suffering from a mental health or behavioural disorder relative to older age groups. Further, a higher proportion of females reported a long-term mental health or behavioural condition than males for most age groups, with the exception being the 0-14 years age group (Figure 28).[258]

The 2007 National Survey of Mental Health and Wellbeing data found a higher proportion of males had experienced a mental health disorder in their lifetime (48% compared with 43% for females). However, a higher proportion of females reported symptoms in the 12 months prior to the survey.

Almost 1 in 3 Aboriginal and Torres Strait Islander adults (31% or 149,400) had high to very high levels of psychological distress in 2018-19, compared to 13% of non-Indigenous adults who had high levels of psychological distress.[259]

In 2020, the Productivity Commission estimated that while the majority of Australia's population are mentally well (15.3 million, 60%), mild to severe mental illness affects around 4.3 million people (17%) and a further 5.9 million people (23%) are at risk of developing mental ill-health (Figure 383).[260] Some people are at increased risk of experiencing mental health problems, including young people, the unemployed, single parents, and Aboriginal and Torres Strait Islander people.

[256] Department of the Prime Minister and Cabinet, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing: 2017-2023*, 2017

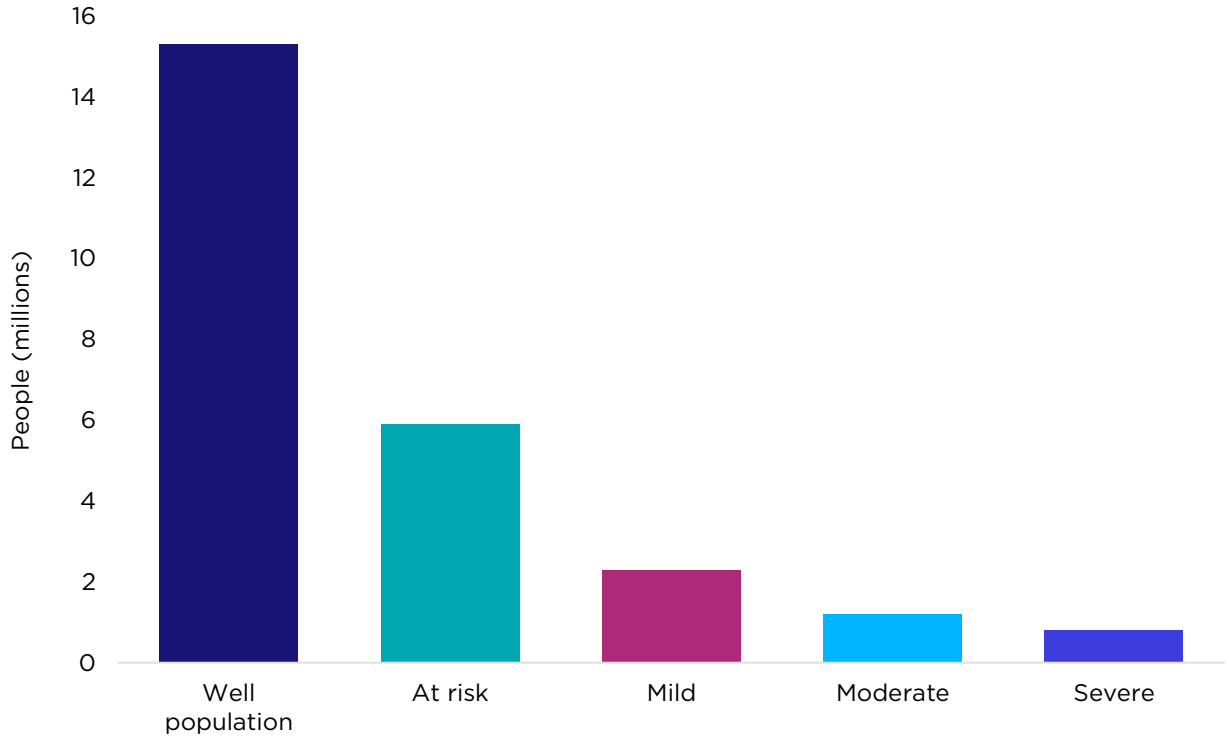
[257] ABS, National Health Survey, 2017-18 financial year, 2018

[258] ABS, Mental health, 2017-18 financial year, 2018

[259] ABS, National Aboriginal and Torres Strait Islander Health Survey, 2018-19 financial year, 2019; ABS, Mental health, 2017-18 financial year, 2018

[260] Productivity Commission, *Mental Health, Inquiry Report*, 2020

Figure 383: Distribution of mental health among Australian population (millions)



Source: Productivity Commission, Mental Health Inquiry, June 2020.

12.1.1 A range of mental health programs

As outlined in Part 2.1.4, there are a range of services provided or funded by Australian, state and territory governments that are specifically designed to meet the needs of people with mental health issues. The key services are:

- MBS subsidised mental health specific services that are partially or fully funded under Medicare on a fee-for-service basis and are provided by general practitioners, psychiatrists, psychologists, or other allied health professionals under specific mental health items.
- State and territory government specialised mental health services (including treatment for severe mental illness and suicidal distress) which includes admitted patient care in public hospitals (specialised services provided to inpatients in stand-alone psychiatric hospitals or psychiatric units in general acute hospitals).
- Community-based public mental health services, comprising:
  - ambulatory care services and other services dedicated to assessment, treatment, rehabilitation and care
  - residential services that provide beds in the community, staffed onsite by mental health professionals.
- Not-for-profit, NGO services, funded by governments focused on providing wellbeing, support and assistance to people who live with a mental illness.
- The NDIS, which supports eligible people with a psychosocial disability arising from mental health conditions to access mental health services and supports if required.[261]
- Low intensity services, such as the Head to Health website, which is funded by the Australian Government and provides information, advice, and free or low-cost phone and online mental health services and support (use of technology in mental health service is discussed in Part 12.6.2.2).

[261] Productivity Commission, Report on Government Services: Section 13, Services for mental health, 2021

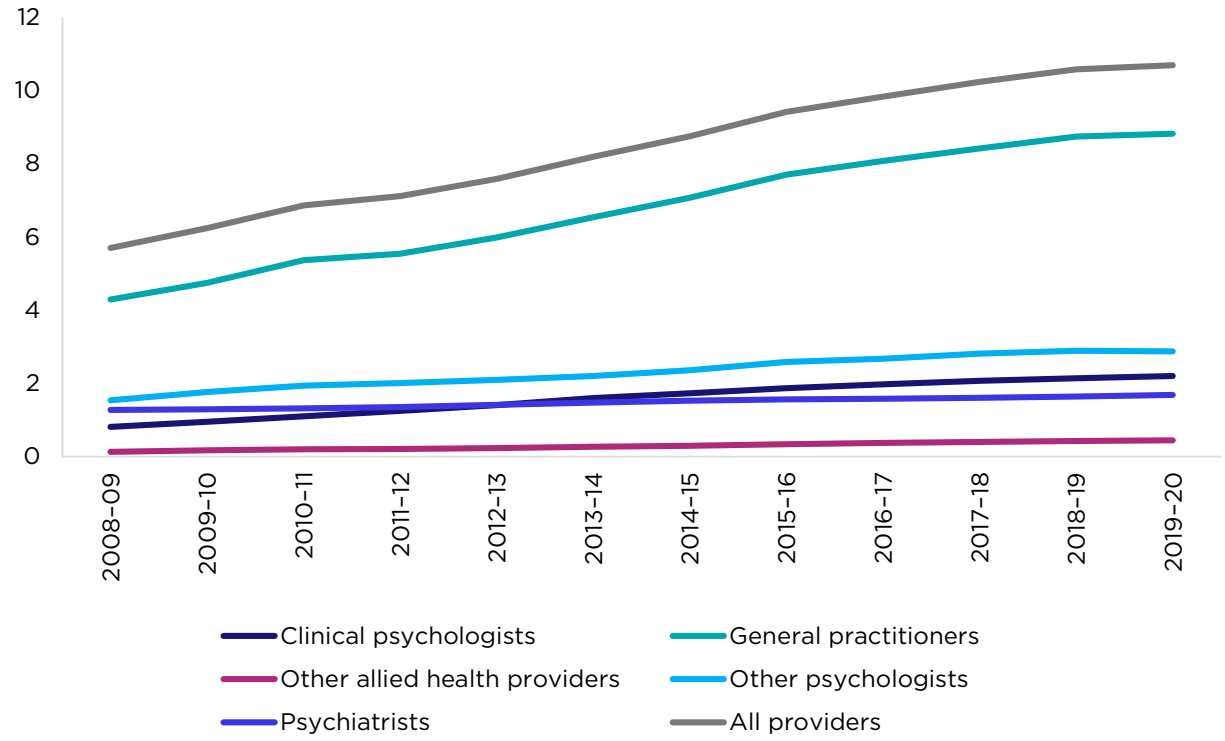
Further, as part of the *National Mental Health and Suicide Prevention Plan* a range of other measures have been announced by the Australian Government focused on prevention and early intervention. There is also significant investment at the state and territory level in mental health. For example, New South Wales, Victoria, Tasmania, and South Australia announced investments as part of their 2021-22 budgets, including for community-based mental health care.

The shift towards person-centred care approaches for mental health is consistent with the shifts seen in aged, disability and veteran care and support. Greater community awareness of mental health issues, along with investments from governments, will continue to drive demand for mental health services and contribute to workforce demand.

12.1.2 Mental health programs have been growing over time

While it is difficult to estimate the actual demand for mental health services within Australia's population, data shows that there is growing demand across a range of services and supports. For example, over the past decade, demand for Medicare-subsidised mental health-specific services has increased from 1.4 million people in 2009-10 (6.2% of the population) to 2.7 million people (10.7% of the population) in 2019-20 (Figure 384). General practitioners recorded the largest increase, providing these services to 4.8% of population in 2009-10, rising to 8.8% of population in 2019-20.

Figure 384: Proportion of Australian population receiving Medicare-subsidised mental health-specific services, 2008-09 to 2019-20



Source: AIHW, Mental health services in Australia, 2021.

People aged under 35 are more likely to seek out specialised mental health services. In 2019-20, a greater proportion of people aged 18-24 accessed Medicare-subsidised services (15.3%) than those aged 25-34 (14.5%) and 35-44 (14.1%).[262] Recognising the important role of subsidised clinical services in mental health care and support, the Australian Government recently doubled the number of Medicare-subsidised psychologist visits from 10 to 20 as part of its mental health response to the impacts of COVID-19.[263]

[262] AIHW, Mental health services in Australia, 2021

[263] Department of Health, *National Mental Health and Suicide Prevention Plan*, 2021

Further, in 2018-19, people aged 12-17 years accounted for the highest rate of community mental health care (33.6 per 1,000 population) and community mental health contacts (652.4 per 1,000 population) – that is, interactions with these services. Overall, in 2018-19, there were 9.7 million service contacts provided to approximately 453,000 patients across Australia.[264] Both the number of community mental health care service contacts and patients are increasing over time – in 2005-06 almost 5.7 million community mental health care service contracts took place across Australia. However jurisdictional differences and data quality challenges prevent robust time series analysis (Part 12.1.4).

12.1.3 Events can drive additional demand for mental health support

Events, such as the 2019-20 'Black Summer' bushfires, and the ongoing COVID-19 pandemic, can have a significant impact on people's mental health, leading to increased anxiety and panic, depression, anger, confusion and uncertainty, and financial stress.[265] This has been reflected by recent reporting from Lifeline Australia (August 2021) of a 20% growth in demand for crisis services since 2019.[266]

That such events drive demand for mental health services means that forecasting demand is therefore difficult. At the same time, the somewhat unpredictable nature of these events makes it difficult for the system to adequately respond.

There are indications that Australians' mental health has worsened since the COVID-19 pandemic began, with increased exposure to mental health risk factors including increased social isolation, unemployment, and financial insecurity.[267] The pandemic has also limited access to the services and supports people use for positive mental health and wellbeing, such as sport, physical activity, and community-based social groups.[268]

In addition, the pandemic has affected some groups more than others. The 2021 ABS Household Impacts of COVID-19 Survey found that those most likely to report high and very high rates of psychological distress included people with a mental health condition (48.0%), people who were renting (35.6%), people aged 18-34 years (29.9%), and people with disability (28.8%) (Figure 385).[269] Overall, around 20.1% of all people surveyed in June 2021 reported high or very high levels of psychological distress.

[264] AIHW, Mental health services in Australia, 2021

[265] Black Dog Institute, *Mental Health Ramifications of COVID-19: The Australian context*, 2020

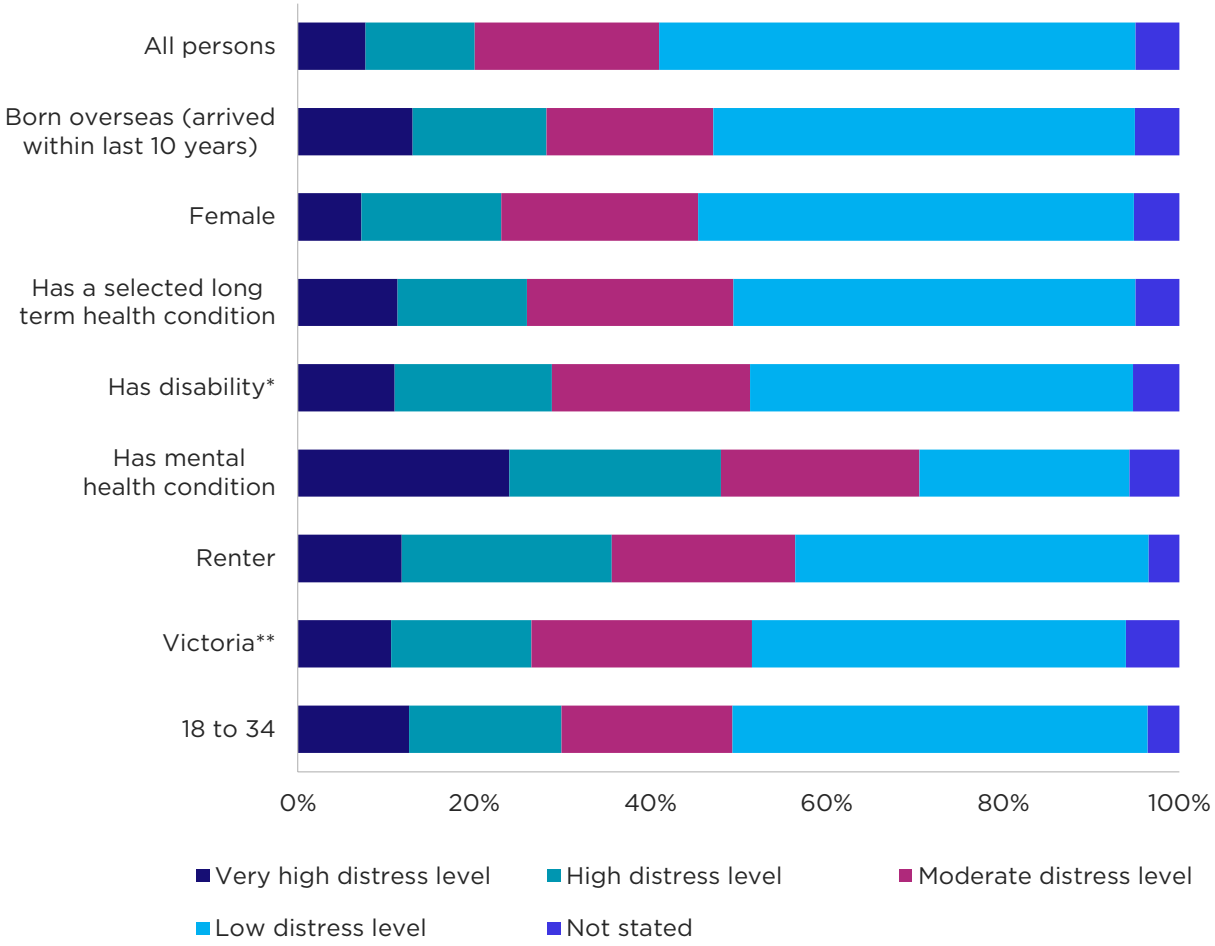
[266] Lifeline, Australians reaching out for help in record numbers (Media release 20 August 2021), 2021

[267] J. M. Newby et al., *Acute mental health responses during the COVID-19 pandemic in Australia*, PLoS One, vol. 15, no. 7, 2020

[268] Headspace, *Coping with COVID: the mental health impact on young people accessing headspace services*, 2020

[269] ABS, Household Impacts of COVID-19 Survey, April 2021, 2021

Figure 385: Psychological distress (%), by selected characteristics, June 2021



Source: ABS, Household impacts of COVID-19 survey, June 2021. Psychological distress of people aged 18 years and over was collected using the Kessler Psychological Distress Scale (K10). A very high level of psychological distress shown by the K10 may indicate a need for professional help. *Has disability includes profound core activity restriction, severe core activity restriction, moderate core activity restriction, mild core activity restriction, schooling/employment restriction, and no specific restriction. **Victoria has been included to reflect the extended lockdown in parts of the state during 2020.

Mental health crisis, support and information services for people experiencing mental distress and/or ill-health also recorded substantial increases in demand during the pandemic.[270] This situation was not confined to Australia. The OECD found that, over the course of the pandemic to date, surveys of OECD populations showed that mental health had worsened compared with pre-COVID levels, with young people's mental health worsening at a faster rate than that of general populations.[271]

Table 14 shows that after experiencing sharp increases in demand at the beginning of the pandemic, demand had started to taper for some services in the period to April 2021; however, since the COVID-19 Delta outbreaks, crisis support services such as Lifeline have once again reported increases in demand, with its "busiest days on record"[272] recorded in August 2021. This is reflected in media reports about extended lockdowns, which report both increased use of these support services, as well as mental health services accessed through Medicare.[273] While the full impact of these outbreaks and associated lockdowns on mental health is not yet known, there is

[270] AIHW, Mental health services in Australia, 2021

[271] OECD, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, 2021

[272] Lifeline, Australians reaching out for help in record numbers (Media release 20 August 2021), 2021

[273] The Guardian, Is there a mental health crisis? What Australian data reveals about impact of Covid lockdowns, 2021

potential for an increase in psychological distress, consistent with previous experiences, which will likely increase the demand for services.[274]

Table 14: Crisis and support organisations, contacts and answered contacts, 29 March 2021 to 25 April 2021

Organisation	Contacts			Answered contacts		
	Count	Change from the same 4 weeks 2020	Change from the same 4 weeks 2019	Count	Change from the same 4 weeks 2020	Change from the same 4 weeks 2019
Lifeline	81,521	-2%	+18%	71,915	-4%	+32%
Kids Helpline	25,903	-27%	+10%	13,670	0%	+16%
Beyond Blue	22,229	-15%	+31%	20,811	-15%	+57%

Source: AIHW, Mental health services in Australia, 2021.

12.1.4 Insufficient data exists to form an accurate or comprehensive picture of mental health services

Data availability is a major challenge in estimating the demand for mental health services and programs. Data collections focused on mental health in Australia's population are infrequent and based on self-reported observations. The most relevant and comprehensive are the 2007 ABS National Survey of Mental Health and Wellbeing and the 2018 ABS National Health Survey.

Further, administrative and service level data varies in availability and has a number of limitations, making it difficult to establish a comprehensive picture of demand and usage of mental health services. The 2020 Productivity Commission's Mental Health Inquiry identified a range of data gaps across the mental health system (Table 15). These gaps are most pronounced for community mental health services provided by NGOs.

[274] Biddle, N & Gray, M, *Tracking wellbeing outcomes during the COVID-19 pandemic (April 2021): Continued social and economic recovery and resilience*, 2021

Table 15: Data gaps in mental health service provision

	Who receives (Consumer information)	What services (Interventions)	From whom (Workforce)	At what cost (Government expenditure)	To what effect (Outcomes or experiences)
NGOs	● No data	● Data in initial development	● No data	● Partial data available	● No data
General practitioners	● Partial data available	● No data	● Nationally consistent data	● Nationally consistent data	● No data
MBS-rebated providers	● Partial data available	● No data	● Data available but needs improvement	● Data available but needs improvement	● No data
Primary health networks	● Data available but needs improvement	● Partial data available	● Data available but needs improvement	● Nationally consistent data	● Partial data available
Specialised community care	● Nationally consistent data	● No data	● Nationally consistent data	● Nationally consistent data	● Partial data available
Public hospital care	● Nationally consistent data	● Data available but needs improvement	● Nationally consistent data	● Nationally consistent data	● Nationally consistent data
Private hospital care	● Nationally consistent data	● Data available but needs improvement	● Nationally consistent data	● Partial data available	● Data available but needs improvement

Source: Productivity Commission, Mental Health, Inquiry Report 2020.

The NGO sector has experienced strong growth and delivers a range of community support services to people with mental illness, including psychosocial supports. Expenditure on specialised mental health services grants to NGOs increased ten-fold over the past 25 years: from $43 million in 1992-93 to $438 million in 2017-18, at the state and territory level.[275] While this may be considered a proxy for demand, it provides inadequate information on the scope and nature of the community mental health services being delivered and the workforce required to deliver them.

Of relevance to this Study, is the extent to which the community mental health services might provide the equivalent of care and support services in the mental health context and any overlap or intersections in the relevant workforces. It is possible that these areas represent the greatest demand for the mental health care and support, but also where the least information is available.

There is also a significant gap in understanding of the mental health services and supports provided through other health services and interventions, including for MBS-rebated services.[276]

Further, prevention and early intervention initiatives can take place in a range of settings, and again, there is no way to accurately assess demand or identify the range of occupations which may contribute to the delivery of preventive and early intervention supports.

12.1.5 Contributors to mental health and support

Like the care and support system (Part 2.6), the mental health landscape is complex. Policy responsibility for mental health is shared across Australian, state and territory governments. At the national level, policy leadership for mental health is shared across several Australian Government departments including the Department of Health. The National Mental Health Commission, and the recently established National Office for Suicide Prevention, provide independent policy advice on ways to improve Australia's mental health and suicide prevention system. Across each state and

[275] Productivity Commission, *Mental Health, Inquiry Report*, 2020
[276] Productivity Commission, *Mental Health, Inquiry Report*, 2020

territory there is an office holder or agency with responsibility for mental health policy and/or service delivery, including the Mental Health Commissions in New South Wales, South Australia, Queensland and Western Australia and departments of health in each jurisdiction. DSS has oversight for the psychosocial supports available under the NDIS, with psychosocial support for Australians with severe mental health needs outside of the NDIS jointly funded by the Australian, state and territory governments.

Funded by the Australian Government, Primary Health Networks (PHNs) manage and coordinate primary health care services in their regions. While they are independent organisations, PHNs tailor services to meet community needs, in line with Australian Government priorities, with one of these being mental health.

Aboriginal Community Controlled Health Organisations (ACCHOs) are also an important contributor to mental health service delivery. ACCHOs are funded by the Australian Government to provide flexible and responsive primary health care services, including mental health care, tailored to the needs of local Aboriginal and Torres Strait Islander communities.

There are also a broad range of non-government organisations that operate across community mental health services.

In relation to worker registration, AHPRA is responsible for the registration of several mental health professionals (Part 9.3.3).

12.2 The mental health workforce

Defining the mental health workforce is challenging. In part this is due to the continuum of mental health and the scope of activities and services that are linked to this, as well as the absence of agreed definitions and data limitations. Notwithstanding these challenges, the mental health workforce is growing and new roles are emerging. Informal care and volunteers also play an invaluable role in mental health care and support.

12.2.1 Identifying the mental health care and support workforce is challenging

As highlighted in Part 1.3.3, identifying the mental health workforce, and more specifically the care and support mental health workforce, is challenging. Like the care and support workforce, there is no consistent definition of the occupations comprising the mental health workforce, which may include (but are not limited to):

- Specialists: psychiatrists, psychologists, mental health nurses and social workers
- Generalists: general practitioners, allied health professionals, Indigenous health workers, and nurses
- Non-clinical: counsellors and lived experience (peer) workers.

This is complicated by the absence of an industry lens within ANZSIC (as noted in Part 1.3.3). Currently, ANZSIC does not allow differentiation of mental health-related occupations operating across multiple industries including: *Hospitals*, *Medical and other health care services*, *Social assistance services, Allied health services*, and *Residential care services*.

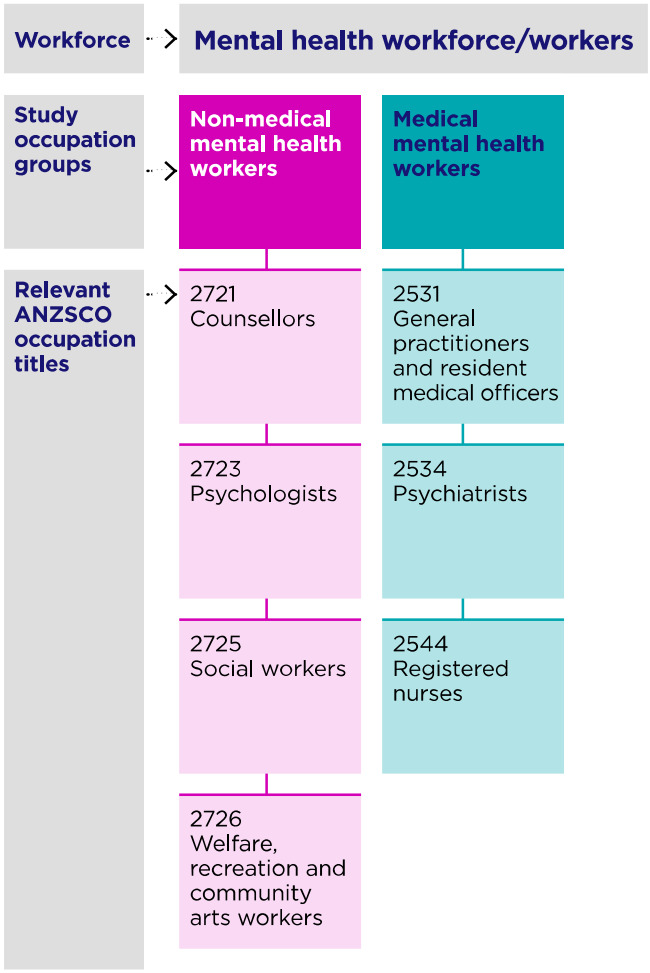
For example, stakeholders noted increased demand across a number of allied health professions, including speech pathology and occupational therapy, to provide mental health care and support services. However, a data gap exists, with stakeholders noting that it is difficult to know the number of these professionals currently working in mental health roles. This consequently impacts governments' and industries' capacity to understand the extent and nature of the demand for services, and to estimate the share of Allied health professionals working in mental health settings (Part 2.4.4). Further, there is no singular, consistent definition of what constitutes mental health services, as these encompass a continuum of services, from those designed to support prevention and early intervention, through to acute mental illness.

Similarly, there is not a consistent, agreed understanding of what constitutes the mental health workforce. Individual entities may adopt different approaches to defining the mental health workforce, including some professions and excluding others, and not having a consistent understanding of the scope of individual roles.

This lack of clarity blurs the boundaries not only within the *Health and social assistance* industries, but also outside of these industries. For example, *Student counsellors* (also referred to as school counsellors) deliver mental health care and support in an education setting. Data also shows that mental health skills and capabilities are increasingly in demand across a range of occupation and settings outside of *Health and social assistance* industries (Part 12.5.3.4). As a result, it is challenging to articulate a precise and comprehensive definition of the mental health workforce.

Given these complexities, the Study has provided an illustrative analysis of the mental health workforce, with a focus on the occupations identified in Figure 386 which have a direct connection to delivery of mental health services as part of their role. However, it is acknowledged that a wide range of other occupations are involved in the delivery of mental health services.

Figure 386: Mental health occupations analysed in this Study



Source: ABS, ANZSCO (Version 1.3), 2013. Throughout this document, ANZSCO occupations are denoted with an initial capital and italics (e.g. *Psychologists*) and the Study's occupation groups are denoted with an initial capital but no italics (e.g. Non-medical mental health workers).

In contrast to the wide range of skill levels in the care and support workforce, mental health occupations are all ANZSCO skill level 1 (Table 16). Other skill levels are likely represented in the broader range of mental health occupations that sit in the areas of prevention, early intervention and mental health care and support. However, occupation mapping to reflect this is not yet available.

The 4 Non-medical mental health occupations are of similar size, with *Welfare, recreation and community arts workers* being the largest, followed by *Psychologists, Social workers* and *Counsellors* (Table 16). *Registered nurses* and *General practitioners and resident medical officers* are the largest mental health occupations, which is unsurprising given their role in the broader health sector. *Psychiatrists* is the smallest occupation, with 2,100 workers in May 2021.

Table 16: In-scope mental health occupations by occupation group, skill level and employment size May 2021

ANZSCO code	Occupation	Skill level	Employment size
Non-medical mental health occupations			
2721	Counsellors	1	26,800
2723	Psychologists	1	29,400
2725	Social workers	1	39,200
2726	Welfare, recreation and community arts workers	1	36,800
Medical mental health occupations			
2531	General practitioners and resident medical officers	1	70,100
2534	Psychiatrists	1	2,100
2544	Registered nurses	1	307,700

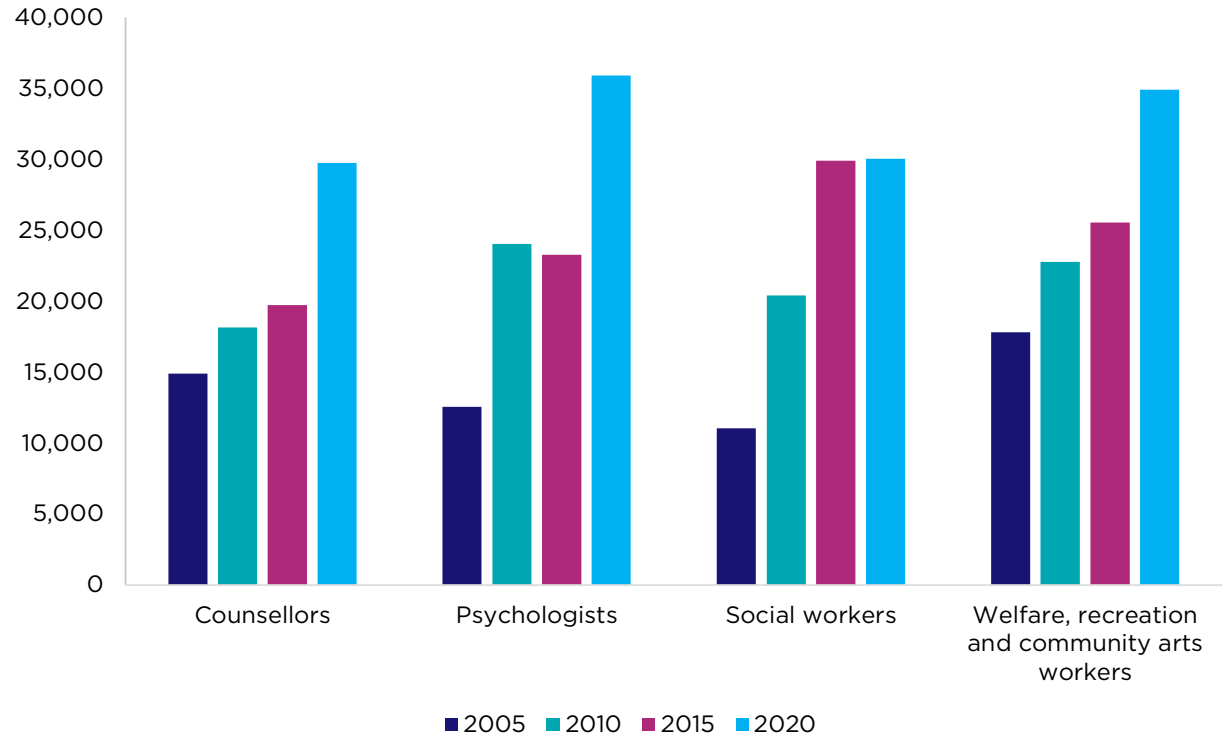
Source: ABS Labour Force Survey Detailed, May 2021. Employed across all industries.

12.2.2 Growth in the mental health workforce

All Non-medical mental health occupations have grown considerably since 2005 (Figure 387).

Between November 2005 and 2020, *Psychologists* grew the most (by 23,300 workers, 186%), followed by *Social workers* (by 19,000 workers, 172%), *Welfare, recreation and community arts workers* (by 17,100 workers, 96%) and *Counsellors* (by 14,800 workers, 100%).

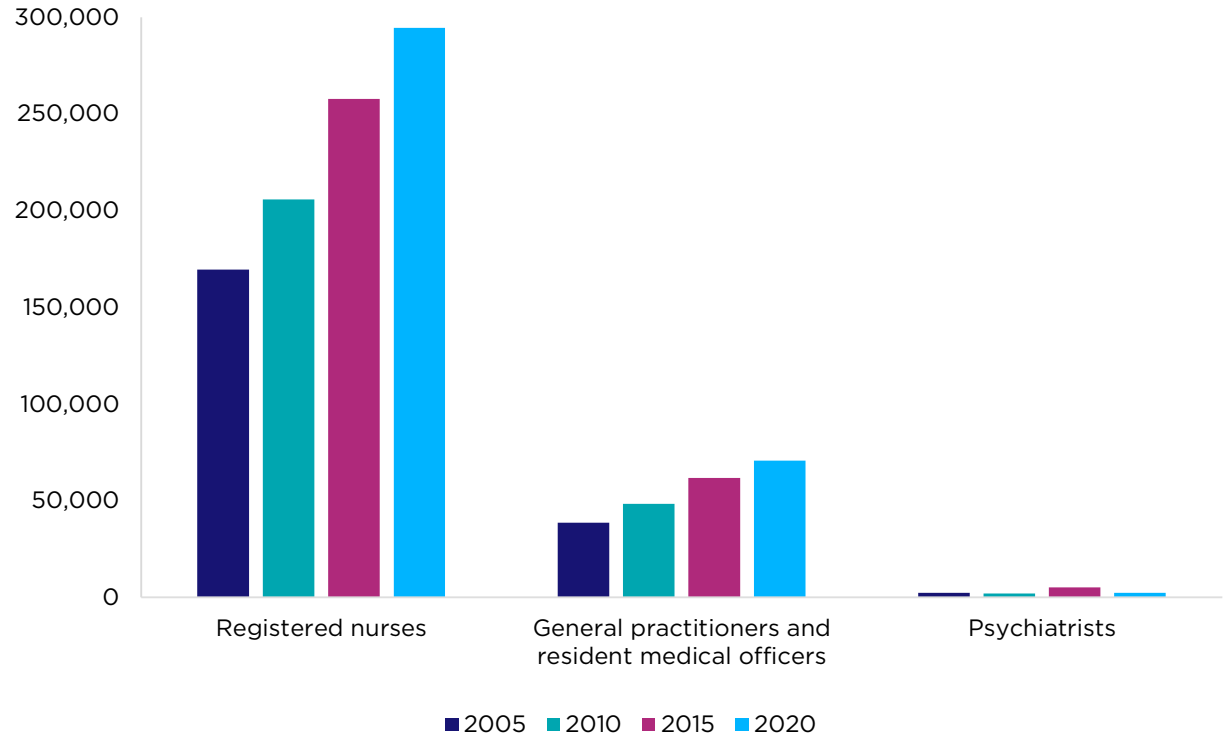
Figure 387: Employment growth, Non-medical mental health occupations, November 2005 to November 2020



Source: ABS Labour Force Survey Detailed, May 2021. Employed across all industries.

Among Medical mental health occupations, *Registered nurses* and *General practitioners and resident medical officers* have consistently grown since 2005 (Figure 388). *Psychiatrists* was the only occupation to decline in size between November 2005 and 2020, from 2,300 to 2,100 workers, which may be due, in part, to a combination of higher average age and retirements.

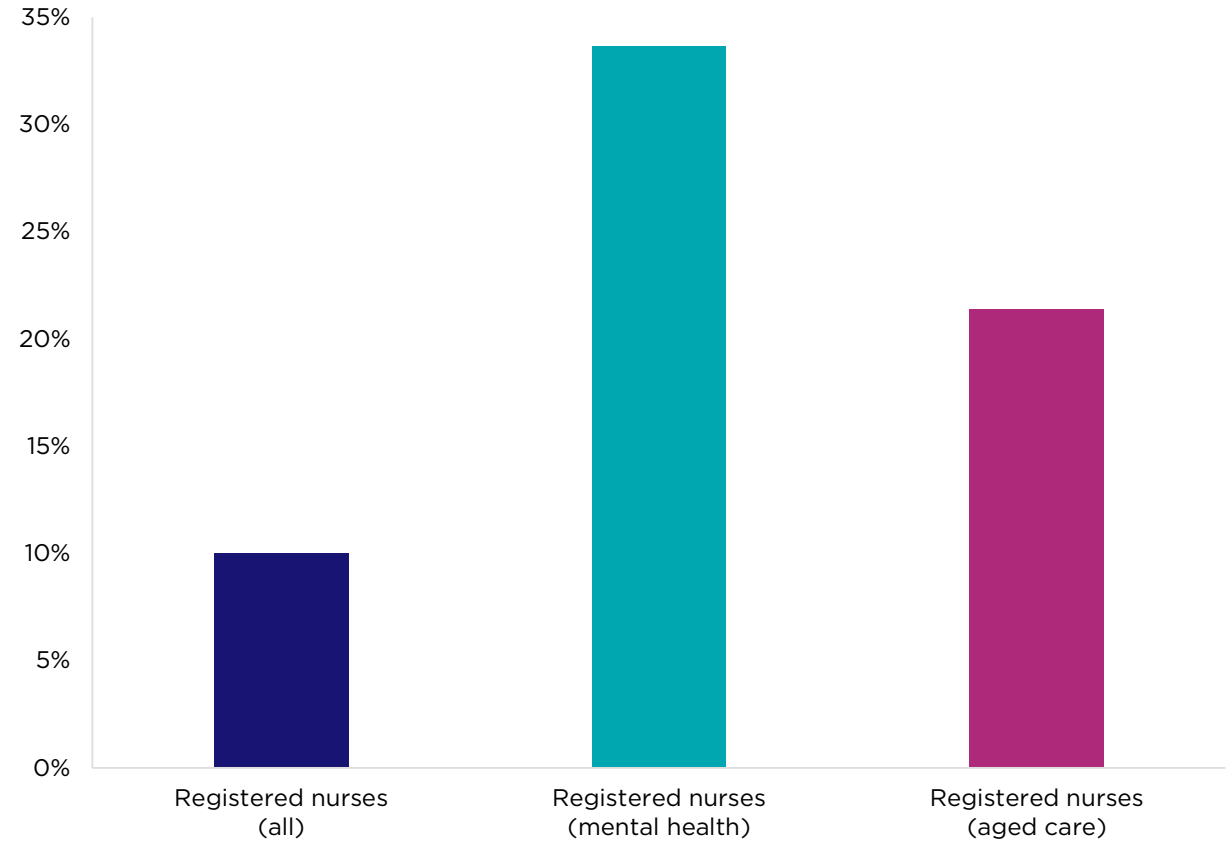
Figure 388: Employment growth, Medical mental health occupations, November 2005 to November 2020



Source: ABS Labour Force Survey Detailed, May 2021. Employed across all industries.

As explored in Part5.9, *Registered nurses* is comprised of many sub-occupations, such as mental health nurse. In 2018-19, 4.5% of *Registered nurses* in taxation data were reported as mental health nurses. While this highlights the proportion of *Registered nurses* whose role is predominantly in mental health care and support, it is important to note that nurses across all sub-occupations may also provide mental health care and support. There may also be *Registered nurses* that work predominantly in mental health but report in tax data as another sub-occupation (such as general, medical, or disability *Registered nurses*). Between 2013-14 and 2018-19, the mental health sub-occupation grew over 3 times the rate of the *Registered nurses* average (Figure 389).

Figure 389: Registered nurse employment growth by sub-occupation, 2013-14 to 2018-19



Source: ATO Taxation Statistics, 2013-14 and 2018-19.

12.2.3 New roles emerging in mental health care and support

Throughout the Study a range of job titles have been used by stakeholders to identify the occupations within mental health workforce, which do not align precisely with occupation titles in ANZSCO, including lived experience (peer) workers, psychosocial support workers and allied health assistants.

12.2.3.1 Lived experience (peer) workers

An increasingly person-centred, holistic approach to mental health and wellbeing may be influencing the expansion of what could be considered mental health care and support. Peer-delivered services, for example are considered an important part of embedding a person-centred approach to mental health, and the OECD has recognised Australia as a leader in growing the lived experience (peer) workforce across mental health care and support.[277]

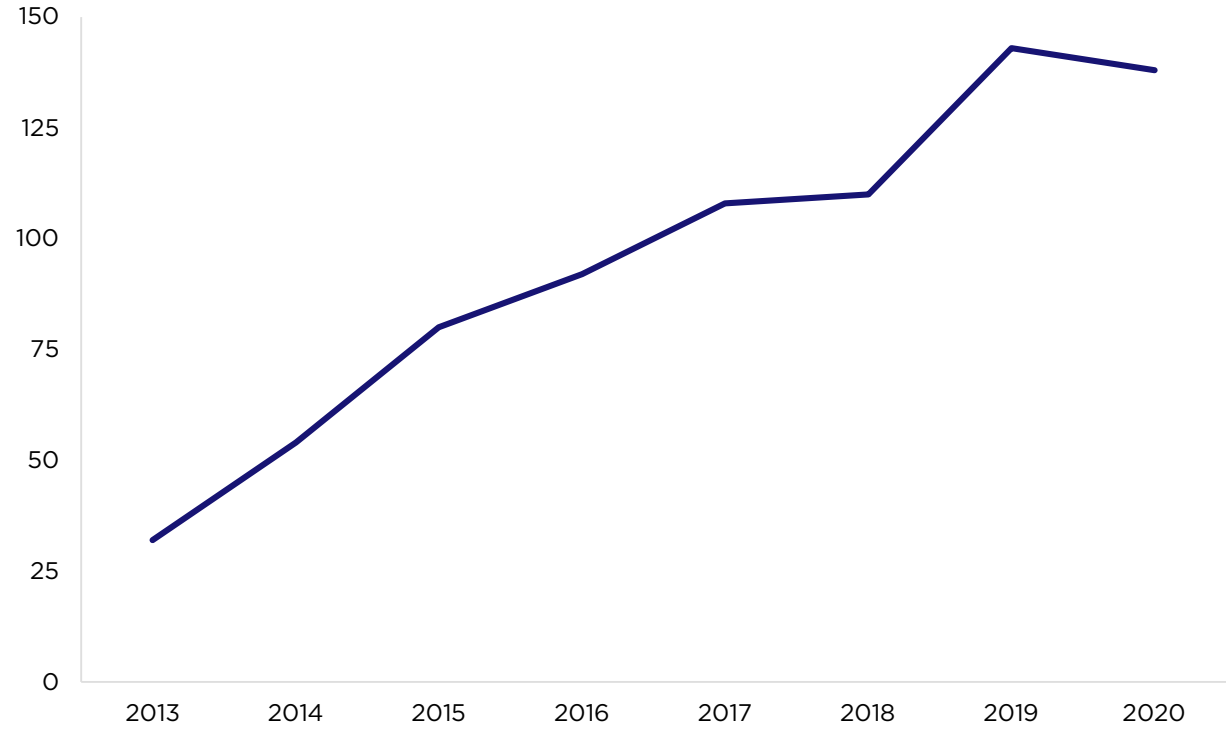
Both the Royal Commission into Victoria's Mental Health System (2021) and the Productivity Commission Mental Health Inquiry (2020) emphasised the importance of lived experience (peer) workers in the mental health workforce. People with lived experience of mental illness have a valuable role to play in supporting the recovery of others by providing empathy, insight, and advocacy.

Job advertisements for peer support workers (sometimes referred to as lived experience workers) have been growing in recent years with around 4 times as many online job advertisements for this role in 2020 compared with 2013 (Figure 390) (although the number of job advertisements is still quite small). Further, since 2016, enrolments in the Certificate IV in Mental Health Peer Work have grown by 58% (Part 12.5.2.2). This qualification, released in 2015, was designed to support workers who have lived experience of mental illness as either a consumer or carer, and who work in mental

[277] OECD, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, 2021

health services, to assist consumer peers or carer peers. Together these provide early indication of an emerging lived experience (peer) workforce.

Figure 390: Online job advertisements for peer support workers, 2013 to 2020



Source: NSC analysis, Burning Glass Technologies.

The draft *National Mental Health Workforce Strategy* recognises the role lived experience (peer) workers may play in the future mental health workforce and considers that an important part of realising this will be clarifying the scope of the role.[278] The National Mental Health Commission is leading the development of the Peer Workforce Development Guidelines to support this work.[279]

As an emerging job role, however, lived experience (peer) workers are not yet classified within ANZSCO, which makes it difficult to identify how many of these workers are employed in the mental health system, or to understand relevant workforce characteristics to inform workforce planning and development.

12.2.3.2 Psychosocial support workers and the NDIS

NDIS participants can access a variety of psychosocial supports to help them achieve their aims and goals under their NDIS plan, including retaining the services of a psychosocial support worker. These workers can include, but are not limited to, lived experience (peer) workers and recovery coaches.[280] The overlap here between the broad category of psychosocial support workers and lived experience (peer) workers as a kind of psychosocial support worker may be indicative of the lack of clarity around these definitions, roles, and scope. Observable instances of these job titles is not yet analytically significant in job advertisement data, however NDIS providers have reported difficulties in recruiting and training a workforce with the necessary skills and experience to assist participants with psychosocial disability.[281]

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[278] Parliament of the Commonwealth of Australia, *Mental Health and Suicide Prevention - Interim Report*, 2021

[279] National Mental Health Commission, Mental Health Lived Experience Work Development and Promotion, 2021

[280] NDIS Quality and Safeguards Commission, *NDIS Workforce Capability Framework*, 2021

[281] DSS, *NDIS National Workforce Plan: 2021 - 2025*, 2021

12.2.3.3 Allied health and mental health care and support

Industry stakeholders noted that the NDIS was also driving increased demand for allied health services. Although allied health professions such as speech pathologists and occupational therapists may not typically focus on the delivery of mental health care and support, there is increasing overlap between these roles, especially in relation to autism diagnosis and support. However, stakeholders expressed concern around the capacity of the system to capture the number of Allied health professionals working in, for example, disability and mental health settings, and the effects of this limitation on workforce planning.

With the exception of Allied health professionals providing care and support within a mental health setting, it is notable that the qualification level of workers in the emerging lived experience (peer) worker roles and potentially emerging (psychosocial support workers) roles is comparable to Personal care and support workers (Part 3.2). This suggests that, in the event of increased demand for care and support, these systems may be drawing from similar pools of workers which could further increase workforce pressure in both the care and support and mental health workforces.

12.2.4 Informal carers and volunteers

Informal carers make a substantial contribution to the provision of mental health care and support, with the Productivity Commission estimating the value of care and support provided by family and friends to be worth around $15 billion per year in 2018-19.[282] Further, volunteers make a valuable contribution to mental health service delivery. While there is no reliable source of volunteer information across organisations providing mental health services, analysis of several organisation's annual reporting of volunteer numbers amounted to approximately 16,000 volunteers. However, this is likely to be an underestimate as it is not representative of all organisations.[283] When compared to the size of the mental health workforce, which is estimated by the Mental Health Workforce Strategy Taskforce at around 50,500 (FTE) in 2021,[284] volunteers provide a significant augmentation to mental health service delivery.

[282] Productivity Commission, *Mental Health, Inquiry Report*, 2020

[283] NSC analysis of 2019-20 annual reports for Lifeline, Beyond Blue, WayAhead, Grow, and the Black Dog institute website

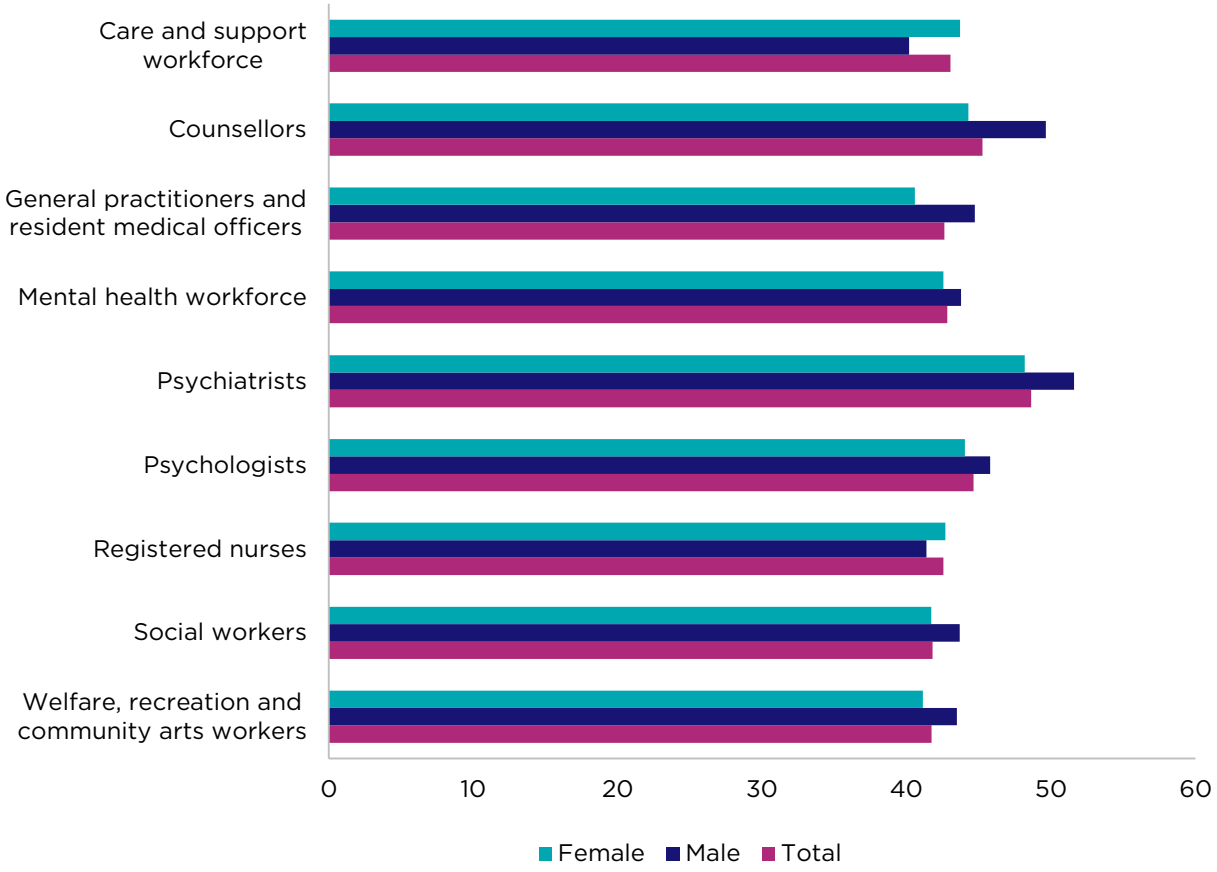
[284] ACILAllen, *National Mental Health Workforce Strategy: Background Paper*, 2021

12.3 The demographic characteristics of the mental health workforce

Mental health workers, similar to care and support workers, are typically older than other Australian workers. Between February 2015 and February 2021, the average age of the mental health workforce was 43 years – the same as the care and support workforce, but older than the average for the overall workforce (40 years). The average age of the mental health workforce has been increasing over time, in contrast to the care and support workforce, which has a declining average age. The age profile varies considerably across occupations with *Psychiatrists* more likely to be older (with an average age of 49 years) and *Welfare, recreation and community arts workers* more likely to be younger (average age of 42 years) (Figure 391).[285]

However, in contrast to the care and support workforce, the ageing of the mental health workforce is attributed to the prevalence of relatively older males employed in the sector. Over this period, male mental health workers had an average age of 44 years, compared with 43 years for females. Males are also more likely to be older than their female counterparts across all mental health occupations except for *Registered nurses*, with the gender age gap widest among *Counsellors* (5 years difference) and smallest among *Psychologists* (2 years difference) (Figure 391).[286]

Figure 391: Average age of mental health workforce, by gender, February 2015 to 2021

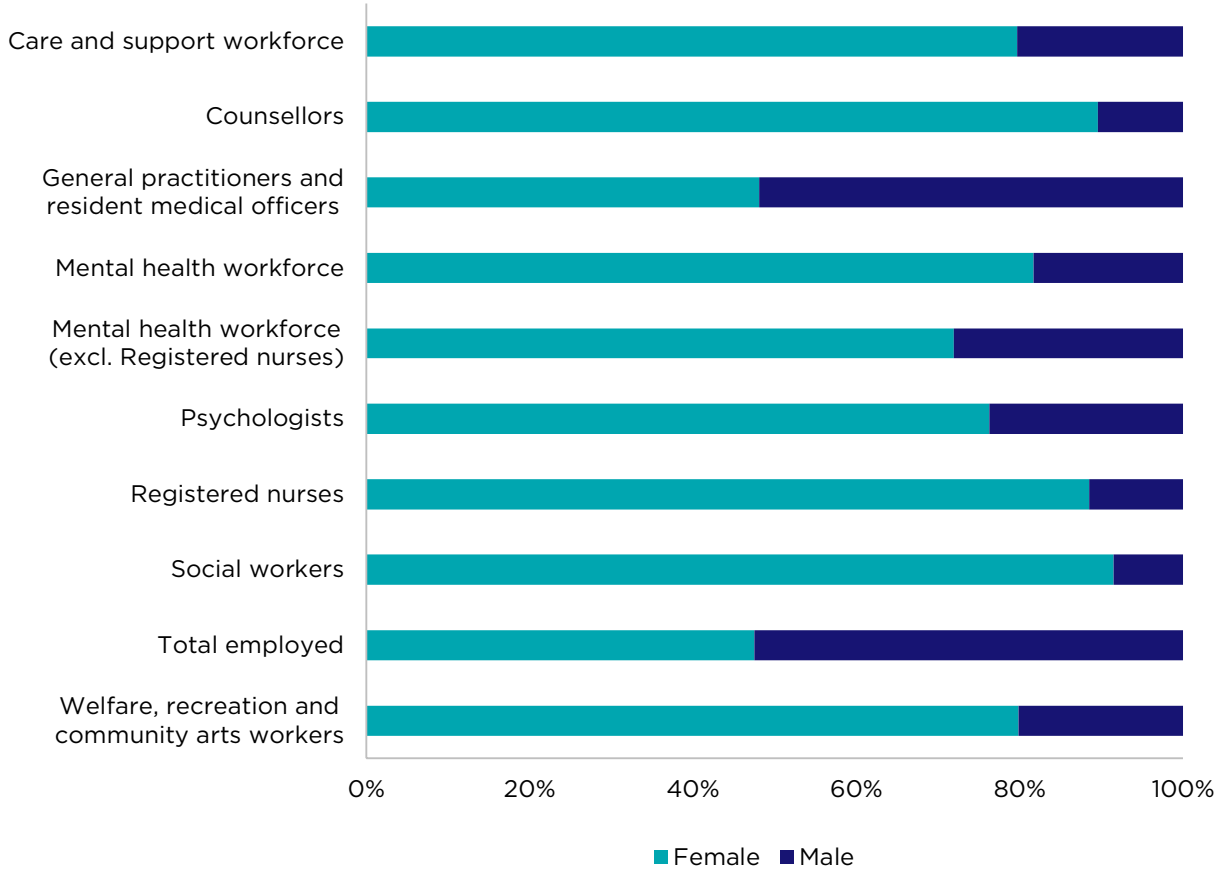


Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Average age is calculated as the average weighted mean age of occupations between February 2015 and February 2021. Note the average age for female *Psychiatrists* is the average for 2016, 2018, 2020 and 2021 only, while the average age for male *Psychiatrists* is the average for 2015 and 2017 only (only years reliable data available).

[285] ABS, Participation, Job Search and Mobility, Australia [TableBuilder], 2015-2020, 2021
[286] ABS, Participation, Job Search and Mobility, Australia [TableBuilder], 2015-2020, 2021

The mental health workforce also has a much higher concentration of employed females (82%) than the overall workforce (48%) – primarily driven by a high prevalence of females in Non-medical mental health occupations. This share is slightly higher than the care and support workforce (79%), but also includes *Registered nurses* across all industries, the majority of whom are female. If *Registered nurses* are excluded from the analysis (as many nurses do not specialise in mental health services), the share of female employment in the mental health workforce falls to around 71% (Figure 392).[287]

Figure 392: Mental health workforce, by occupation and gender, February 2021

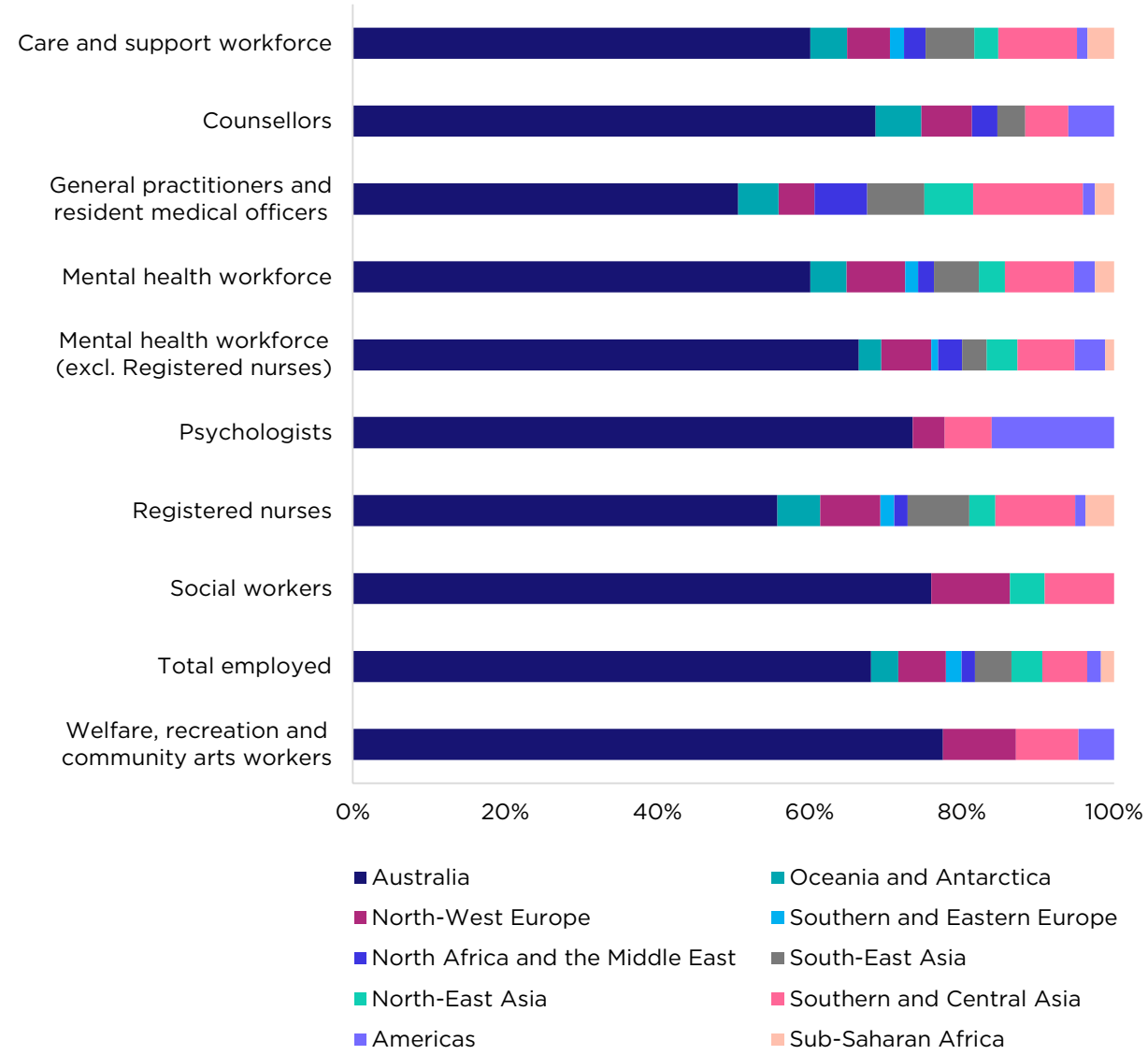


Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Data for *Psychiatrists* is not included due to small counts.

The mental health workforce is culturally and linguistically diverse with around 40% of the workforce born overseas (similar to the care and support workforce). There is a greater reliance on overseas-born workers among Medical mental health roles, compared with non-medical roles where a higher proportion of the workforce are born in Australia (Figure 393).

[287] ABS, Participation, Job Search and Mobility, Australia [Tablebuilder], 2015-2020, 2021

Figure 393: Share of mental health workforce born overseas, by occupation and region of birth, February 2021

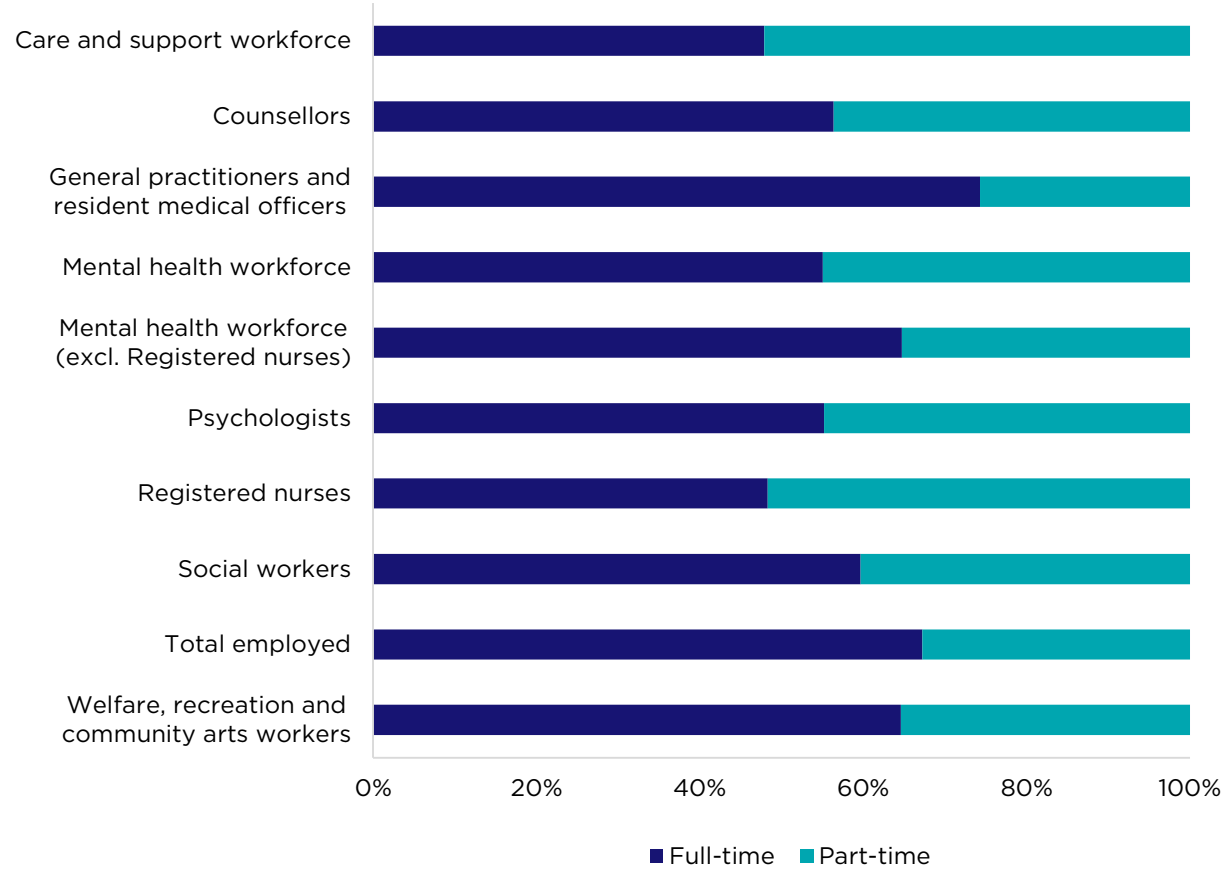


Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Data for *Psychiatrists* is not included due to small counts.

12.4 Labour market characteristics of the mental health workforce

Mental health workers are less likely to work part-time than those employed in the care and support workforce. In February 2021, around 45% of the mental health workforce (or 35% not accounting for *Registered nurses*) were employed on a part-time basis, compared with 52% of the care and support workforce (Figure 394). The part-time share for the overall mental health workforce remained relatively stable between 2015 and 2021, although shares across occupations have fluctuated. For instance, the share of part-time *Psychologists* and *Counsellors* rose between 2015 and 2019, before declining in the years after that – reflecting, in part, the increased demand for mental health services following the onset of the COVID-19 pandemic. Meanwhile, the proportion of *General practitioners and resident medical officers* working part-time has increased since 2017.[288]

Figure 394: Employment share of mental health workforce, by occupation, February 2021



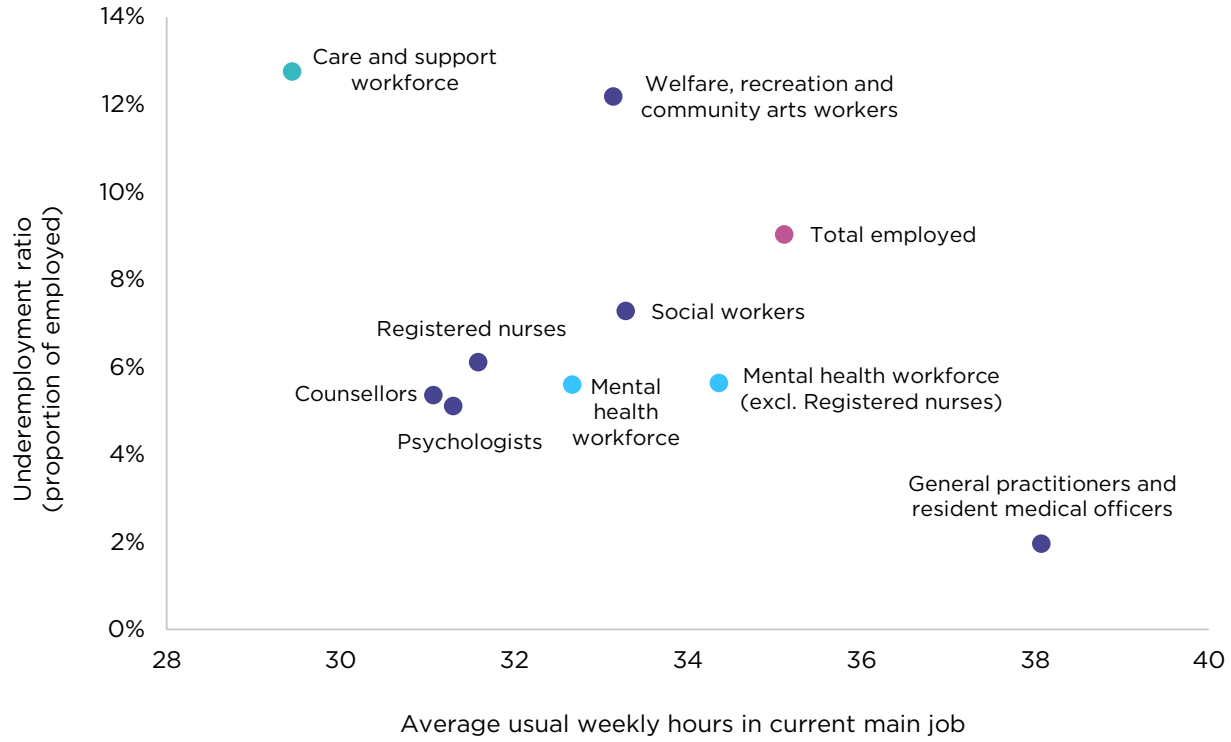
Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Data for *Psychiatrists* is not included due to small counts.

Mental health workers typically work more hours per week than the care and support workforce but less than the total workforce, with Medical mental health workers (other than *Registered nurses*) working more hours than non-medical staff (Figure 395). In February 2021, usual weekly hours worked by the mental health workforce in their current main jobs was around 33 hours a week – ranging from a low of around 31 hours a week for *Counsellors* and *Psychologists,* up to a high of 38 hours a week, on average, for *General practitioners and resident medical officers*. This coincides with very low reported rates of underemployment among the latter (2%) compared with slightly higher underemployment among those employed in the former 2 occupations (5%). However, the overall underemployment ratio (share of employed) for the mental health

[288] ABS, Participation, Job Search and Mobility, Australia [TableBuilder], 2015-2020, 2021

workforce, which stood at around 6% in February 2021, is much lower than for the total workforce (9%) or the care and support workforce (13%).[289]

Figure 395: Average usual weekly hours in current main job (weighted mean – 2015 to 2021) and underemployment ratio, February 2021



Source: ABS Participation, Job Search and Mobility, 2015 to 2021 in TableBuilder. Data for *Psychiatrists* is not included due to small counts.

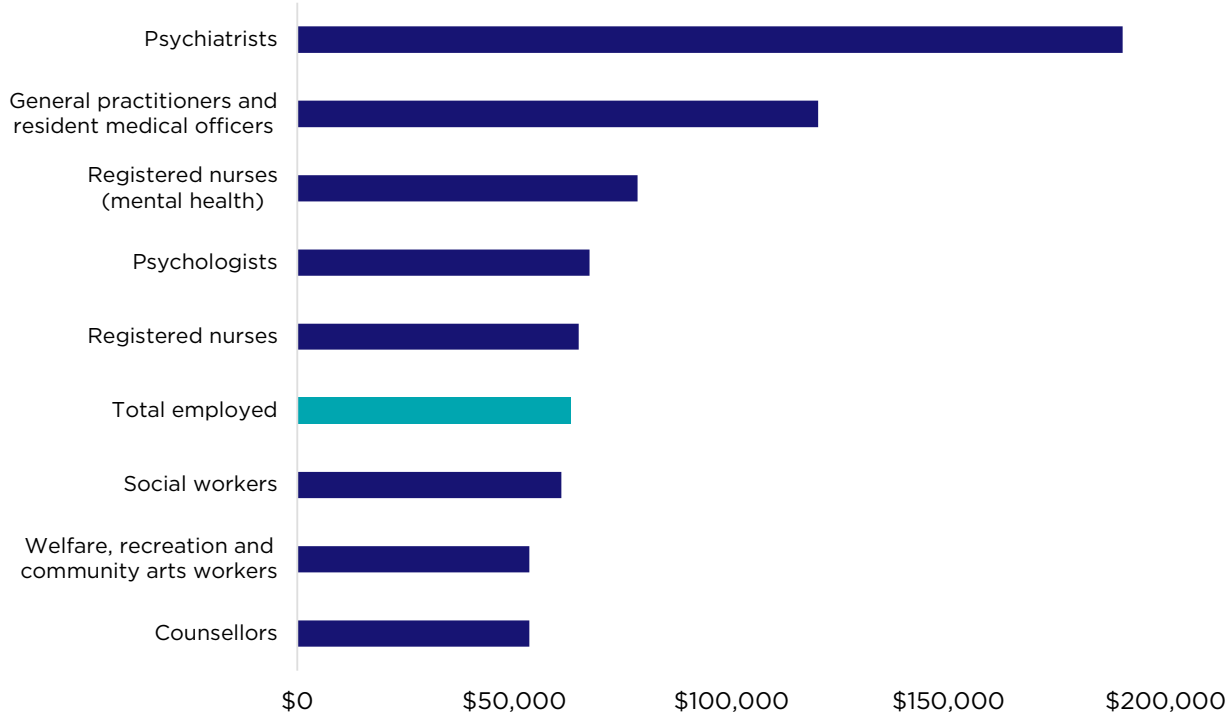
12.4.1 Wages

The wage income of mental health workers varies significantly by occupation, with medical occupations mostly earning more than non-medical occupations (Figure 396). In 2018-19, the mental health occupation with the highest wage income was *Psychiatrists,* followed by *General medical practitioners* and *Registered nurses (mental health).* Of the non-medical occupations, *Psychologists* had the highest wage income, followed by *Social workers, Welfare, recreation and community arts workers,* and *Counsellors.* Only 2 occupations earned less than the Australian average: *Counsellors and Welfare, recreation and community arts workers.*

As explored in Part 5.9, mental health nurses earned more than any other type of Registered nurse in 2018-19, 19% above the occupation average. There is currently no direct undergraduate pathway for mental health nursing in Australia, with the Australian College of Mental Health Nurses requiring specialist mental health nursing qualifications for credentialisation.[290] These additional qualification requirements may be one factor contributing to higher annual earnings of mental health nurses relative to the broader Registered nurse occupation.

[289] ABS, Participation, Job Search and Mobility, Australia [TableBuilder], 2015-2020, 2021
[290] ACILAllen, *National Mental Health Workforce Strategy: Background Paper*, 2021

Figure 396: Annual wage income by mental health occupation, 2018-19



Source: ATO individual taxation statistics, 2018-19. *Registered nurses (mental health)* is a 6-digit ANZSCO occupation.

12.5 Qualifications and skills of the mental health workforce

The mental health workforce is highly qualified, with education pathways predominantly associated with higher education.

Mental health skills are also growing in importance across a range of different occupations.

12.5.1 Qualifications and professional registration of the mental health workforce

All mental health occupations considered in this Study are skill level 1 – commensurate with a bachelor degree or higher. This distinguishes the mental health workforce from the care and support workforce where the skill level profile is mixed, with the majority of the workers employed in skill level 4 roles (Part 3.2).

All Medical mental health workers (*General practitioners and resident medical officers*, *Psychiatrists* and *Registered nurses*), as well as *Psychologists* require a higher education qualification and AHPRA registration to practice (Table 17).

The remaining Non-medical mental health workers (*Counsellors*, *Social workers* and *Welfare, recreation and community arts workers*) are not AHPRA regulated, but workers in these occupations are able to gain accreditation from their relevant professional associations. Professional accreditation for these occupations requires applicants to hold minimum qualifications and can include undertaking continuous professional development. For example, to be accredited by the Australian Association of Social Workers as a Mental Health Social Worker, in addition to qualification requirements, members are required to annually undertake 20 hours of study relevant to mental health practice, and 10 hours relevant to Focussed Psychological Strategies.[291]

[291] Australian Association of Social Workers, CPD requirements for AMHSWs, 2021. Focussed Psychological Strategies is a requirement set by Medicare for social workers to be eligible to provide services under the 'Better Access to Mental Health' program.

Table 17: Qualification mix for mental health workforce occupations

ANZSCO code	Occupation	Skill level	AHPRA regulated	Industry membership	Indicative entry qualifications
Non-medical mental health workers					
2721	Counsellors	1		✓	Diploma of Counselling
2723	Psychologists*	1	✓		Masters in Psychology plus supervised practice
2725	Social workers	1		✓	Bachelor of Social Work
2726	Welfare, recreation and community arts workers	1		✓	Bachelor in related field
Medical mental health workers					
2531	General practitioners and resident medical officers	1	✓		Bachelor degree or higher in Medicine and at least a one-year internship
2534	Psychiatrists	1	✓		Bachelor degree or higher in Medicine, 2 years hospital-based training, and at least 5 years specialist study and training
2544	Registered nurses	1	✓	Specialist credentialing available	Bachelor of Nursing
254422	Registered nurse (mental health)	1	✓	✓	Bachelor of Nursing plus graduate diploma or masters' degree in mental health to obtain industry mental health nursing credentials

Source: ANZSCO, 2013, Version 1.3; AHPRA website, National Alliance of Self-Regulating Health Professions website, Psychotherapy and Counselling Federation of Australia website, Australian Community Workers Association website. *Currently, psychology students can obtain AHPRA registration with an honours degree plus 2 years supervised practice, but this pathway is closing in June 2022.

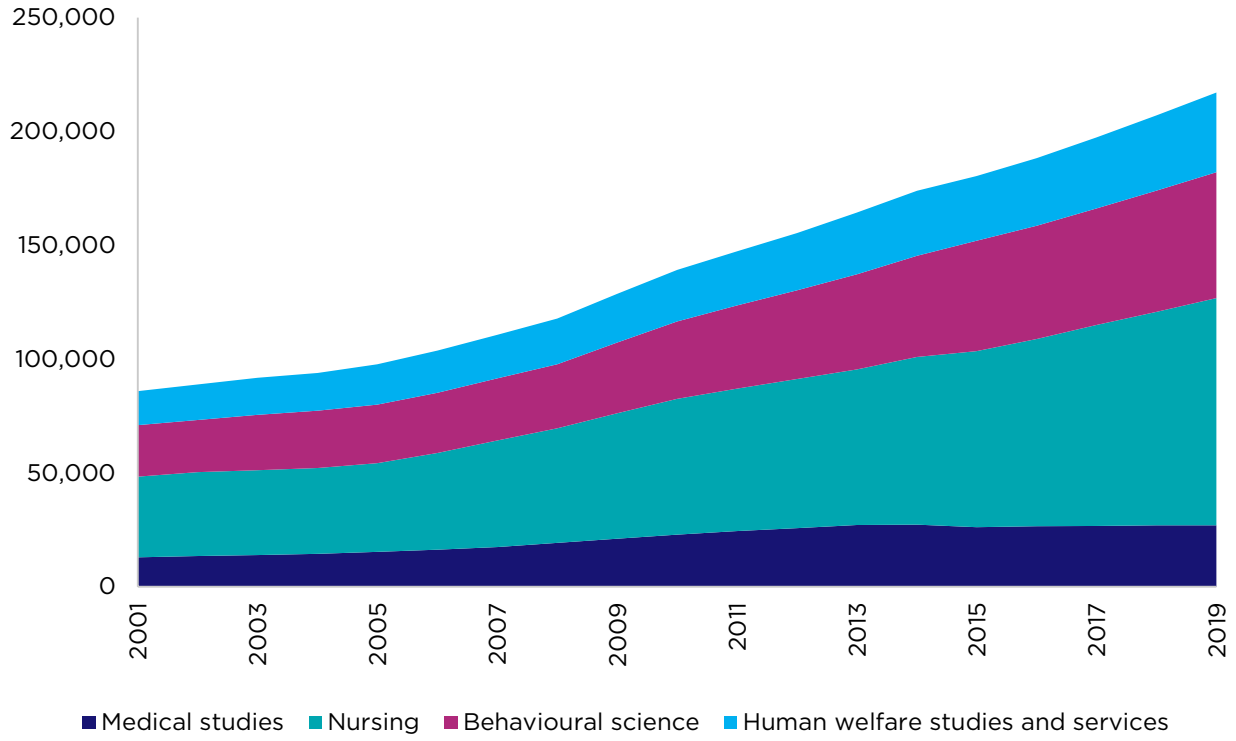
12.5.2 Enrolments and completions for mental health qualifications

The mental health workforce is highly skilled and the following analysis summarises the current pipeline of skills through the higher education and VET training systems. The majority of occupations in the mental health workforce require a higher education qualification at the bachelor degree level or higher in order to gain the appropriate licencing and accreditation for practice (Table 17). However, the VET system does have a role in upskilling the existing mental health workforce as well as developing mental health skills across the broader workforce.

12.5.2.1 Higher education

Enrolments for higher education qualifications related to mental health occupations have increased by almost 160% between 2001 and 2019 which is higher than the growth in all higher education enrolments which increased by 90% over the same period. The largest growth was seen in the field of nursing, which increased by over 180% between 2001 and 2019, followed by Behavioural science which increased by 144% (Figure 397). The drivers behind this overall trend may be similar to the care and support higher education pipeline (Part 6.3).

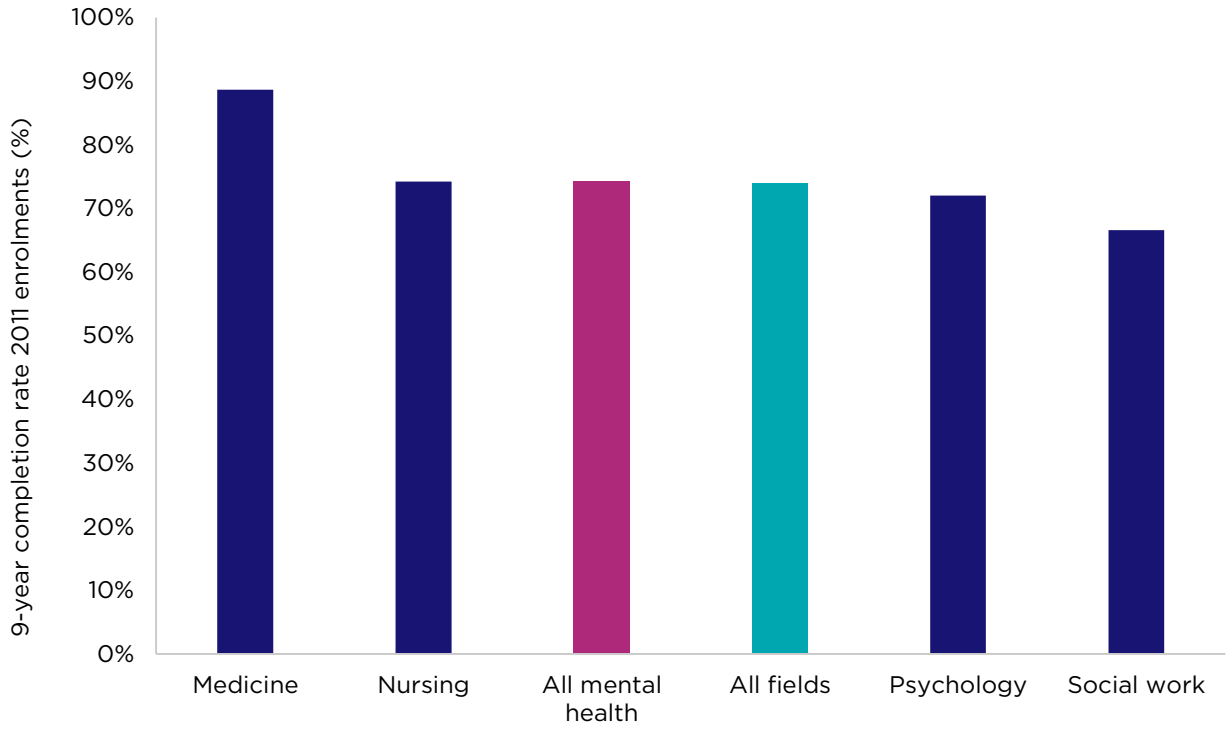
Figure 397: Higher education enrolments by relevant mental health related fields of education, 2001 to 2019



Source: Department of Education, Skills and Employment; unpublished data.

The 9-year completion rate for enrolments (2011-2019) for all mental health higher education qualifications is similar to all higher education fields (74%). Medicine has the highest completion rate (89%) while Social work has the lowest (67%) Figure 398. The completion rates for all mental health related fields of study has remained constant over the last 10 years (2001-2009 to 2011-2019).

Figure 398: Completion rate for mental health related fields of education, 2011 enrolments (9-year completion rates)



Source: Department of Education, Skills and Employment (unpublished data).

12.5.2.2 VET

Counsellors is the only in-scope mental health occupation that requires a VET qualification (Diploma of Counselling) as an indicative entry qualification, however the VET system can also provide further training and skillsets to those with existing qualifications.

Over the last 4 years, enrolments and completions for mental health VET qualifications have declined by 30% and 26% respectively (Table 18). This was largely driven by Counselling-related VET qualifications with enrolments down by almost 57%. The decline in these courses may be driven by prospective students choosing to pursue a higher education pathway for these occupations or employers and professional bodies having a stronger preference for higher level qualifications.

Table 18: Total enrolments and completions in mental health related VET qualifications, 2016 to 2019

	2016	2017	2018	2019
Total enrolments	29,085	22,265	18,805	20,305
Total completions	5,730	5,765	4,385	4,235
Completion ratio	0.20	0.26	0.23	0.21

Source: NSC analysis of National Centre of Vocational Education Research (NCVER) 2021, Total VET Activity 2020 in DataBuilder. Data for 2020 is preliminary and subject to change, therefore not included in analysis.

Other mental health-related courses, particularly in welfare and community services, have increased over the same period. This includes courses such as Certificate IV in Mental Health and Certificate IV in Mental Health Peer Work (Table 19). Both courses have grown in the number of enrolments (27% and 58% respectively) whereas the number of completions has declined for Certificate IV in Mental Health.

Table 19: Number of enrolments and completions, and completion ratios for Certificate IV in Mental Health and Mental Health Peer Work, 2016 to 2019

	2016	2017	2018	2019
Enrolments	**6,375**	**6,095**	**6,915**	**8,245**
Certificate IV in Mental Health	5,920	5,485	6,210	7,525
Certificate IV in Mental Health Peer Work	455	610	705	720
Completions	**1,820**	**1,330**	**1,390**	**1,515**
Certificate IV in Mental Health	1,705	1,155	1,225	1,345
Certificate IV in Mental Health Peer Work	115	175	165	170
Completion ratios	**0.29**	**0.22**	**0.20**	**0.18**
Certificate IV in Mental Health	0.29	0.21	0.20	0.18
Certificate IV in Mental Health Peer Work	0.25	0.29	0.23	0.24

Source: NSC analysis of National Centre of Vocational Education Research (NCVER) 2021, Total VET Activity 2020 in DataBuilder. Data for 2020 is preliminary and subject to change, therefore not included in analysis.

Compared to VET qualification pathways for the care and support workforce, most mental health VET qualifications have been designed outside of training packages with almost two-thirds of courses developed as accredited courses.[292] This may suggest that large industry and nationwide endorsement for mental health VET qualifications are only starting to emerge. Given the highly skilled nature of the mental health workforce, VET qualifications may not be viewed as a necessary qualification but rather a resource for upskilling existing mental health workers. When looking at the enrolments for mental health full qualifications in the community services training package, 60% were employed at the time of enrolment.[293] The emergence of specific mental health VET qualifications such as Mental Health Peer Work, may suggest the growing significance of care and support roles in the mental health workforce outside of clinical settings.

12.5.3 Skills of the mental health workforce

As discussed in Part 6.6 for the care and support workforce, the skills profile of the mental health workforce, as defined by the Australian Skills Classification, is underpinned by core competencies, specialist tasks and technology tools. The following section summarises the key features of these skills profiles and the diversity of skills required for mental health workers.

12.5.3.1 Specialist Tasks

The specialist tasks in the mental health workforce are concentrated in the Health and Care skills cluster family (61% of all specialist tasks), which is similar to the overall profile of the care and support workforce discussed in Part 6.6. Communication and collaboration is the next most common skills cluster family (17% of specialist tasks) followed by Human resources (8% of specialist tasks).

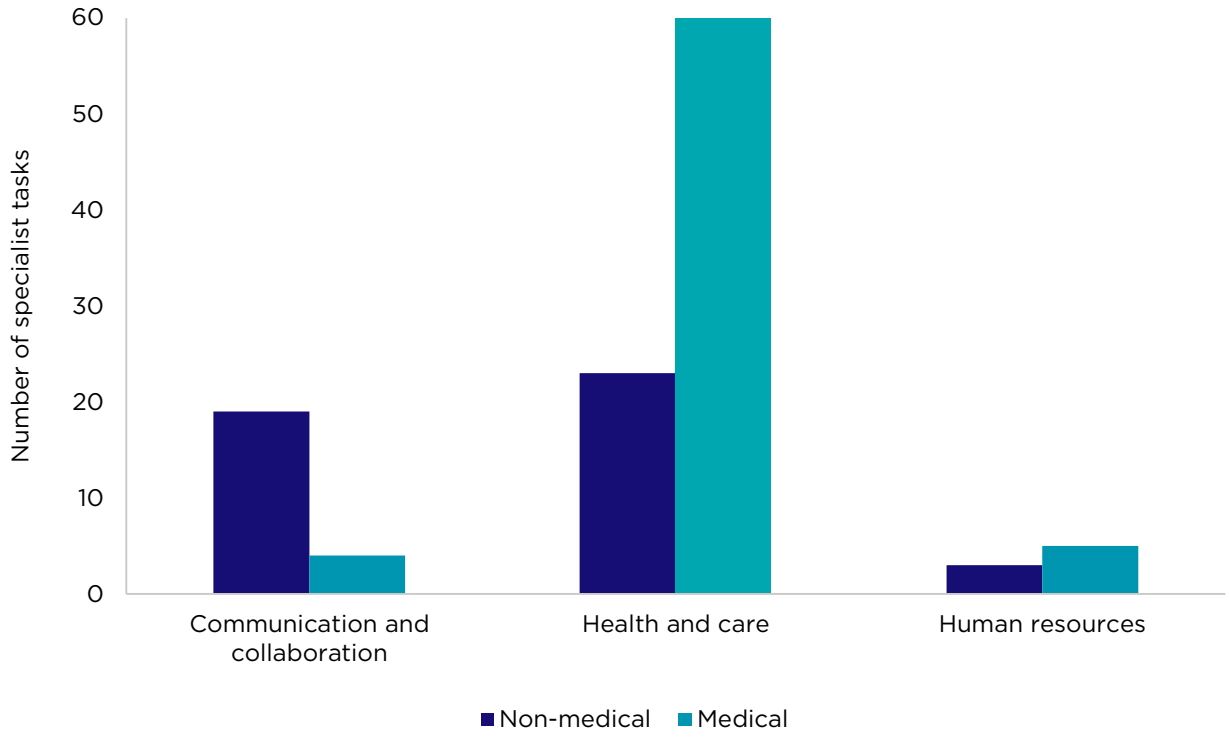
However, there is a significant difference in how these skills cluster families are distributed across the medical and non-medical occupation groups of the mental health workforce (Figure 399). The medical group has a higher share of health and care skills clusters and a much lower share of communication and collaboration skills clusters compared to the non-medical group. These differences demonstrate a distinction in the roles across both groups in the delivery of mental health care, support and treatment. This distinction also demonstrates that there may be

[292] NCVER, Total VET students and courses 2020, 2021

[293] NCVER, Total VET students and courses 2020 [DataBuilder], 2021

significant skills gaps when transitioning between these occupation groups. This also highlights the complexity in the delivery of mental health care as it is delivered across a continuum with different approaches to improve the overall mental wellbeing of individuals and communities.

Figure 399: Number of specialist tasks by most common skill cluster families for Medical and Non-medical mental health occupation groups



Source: NSC, Australian Skills Classification (Version 1.1), 2021.

The Medical mental health occupations generally operate within a clinical setting as opposed to the broader range of settings for the non-medical occupations. Medical mental health workers are well-defined in their scope of practice given their settings which are predominantly focused on treatment and rehabilitation. This is also influenced by the highly regulated and well-defined competencies required to provide mental health care through licensing and qualifications.

The scope of practice of the non-medical occupations may not be as well defined given the diverse range of settings across psychosocial support, early intervention, and mental health care and support. This occupation group involves a mix of training pathways which may prepare these workers in different contexts. This group may also have a higher degree of transferable skills to other care and support occupations and the broader labour market.

12.5.3.2 Core competencies and technology tools

The mental health workforce requires a high proficiency in teamwork, planning and organisation and oral communication. The levels of proficiency for these core competencies indicate that mental health workers are often required to explain highly complex information to clients, develop and plan multiple complex programs or tasks, and engage with others who have diverse backgrounds and individual needs. This is reflective of the interpersonal nature of these roles and the collaboration that is required in mental health care. Both mental health occupation groups are similar in their core competencies with a few points of difference.

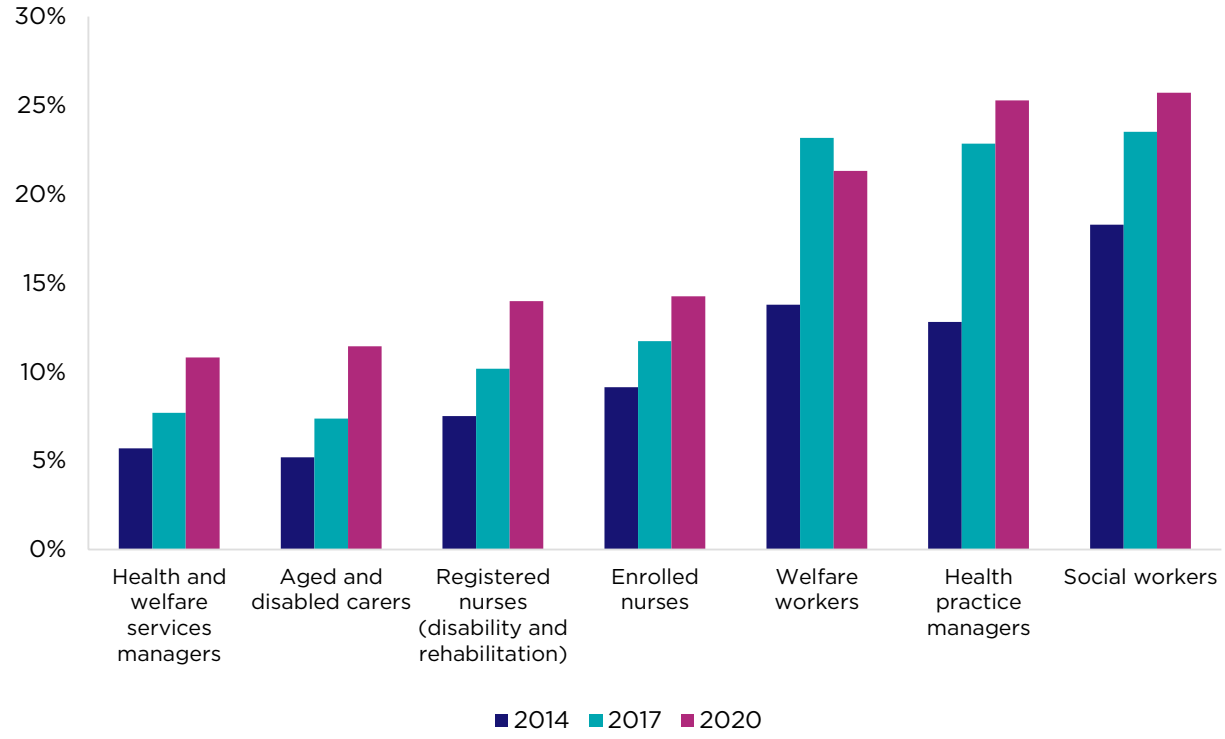
The mental health workforce also requires the ability to use specific technology tools to carry out daily activities in their roles. Like the care and support workforce, the most common technology tool used by mental health workers are Patient management, diagnostic and medical imaging software (6 occupations) followed by Data base user interface and query software (3 occupations).

12.5.3.3 Employer demand for mental health skills is increasing across many health and social assistance roles

Online job vacancies suggest employers are increasingly looking for workers with mental health skills across a range of occupations. Between 2014 and 2020, the percentage of online job vacancies mentioning mental health skills grew across a number of health and welfare occupations, including *Social workers, Enrolled nurses* and *Welfare workers* (Figure 400). Mental health skills are also becoming more prevalent in vacancies for *Aged and disabled carers,* the largest care and support occupation. This reflects the growing need for, and importance of, mental health skills in the delivery of health and welfare services.

The draft *National Mental Health Workforce Strategy* also recognises the broader workforce has a role in supporting people experiencing suicidality, mental distress and/or ill health, and includes training initiatives to support the development of basic mental health skills across a range of care and support occupations (including aged care, disability services and allied health workers).[294]

Figure 400: Proportion of online job vacancies seeking mental health skills by occupation, 2014 to 2020



Source: NSC analysis, Burning Glass Technologies.

12.5.3.4 Mental health skills are not exclusive to health and welfare occupations and settings

Mental health skills are also becoming more common in job advertisements for roles outside of health and welfare occupations and settings.

Job vacancies for *Student counsellors*, who work predominantly in education settings,[295] have seen an increase in mentions of mental health skills (Figure 401). In 2012, only 8% of online job vacancies for *Student counsellors* mentioned mental health skills, compared with 39% in 2020. This aligns with the increased prevalence or awareness of mental health conditions in younger people as well as the increasing focus on early intervention and prevention, particularly in education settings.

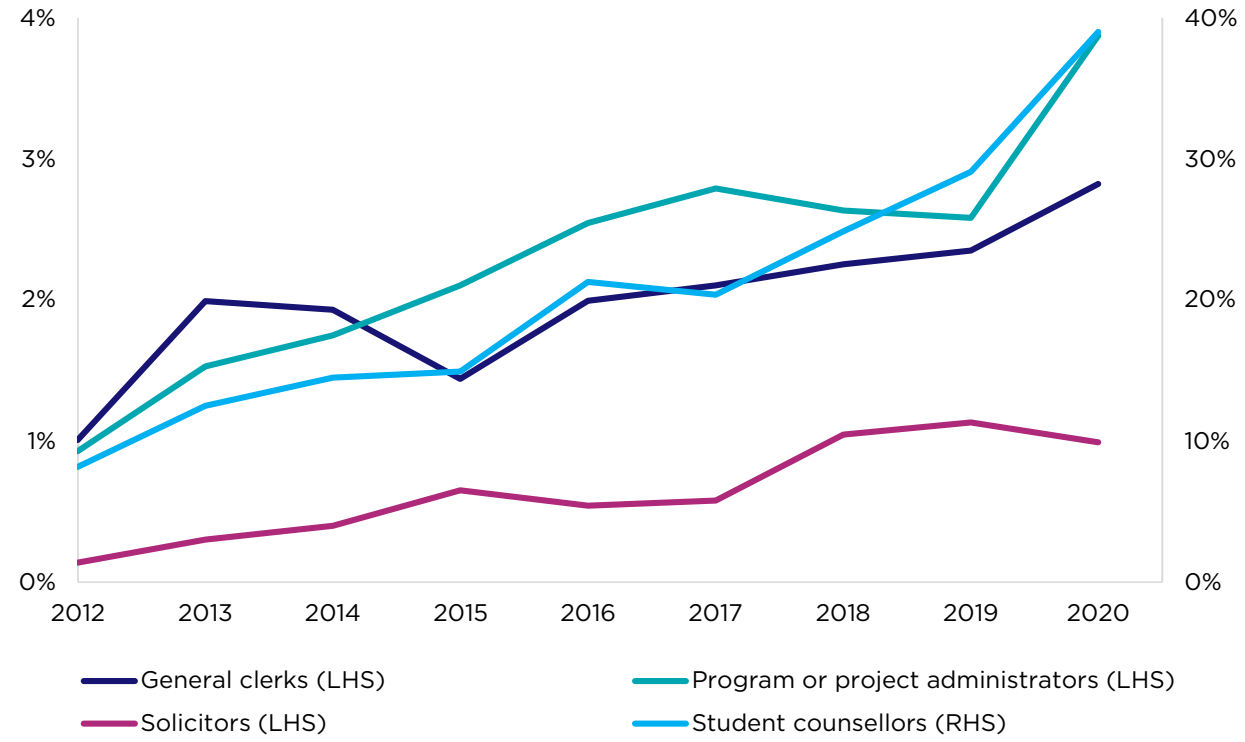
[294] ACILAllen, *National Mental Health Workforce Strategy: Background Paper*, 2021

[295] ABS, Census of Population and Housing, 2016, 2017

Further, growth in the mention of mental health skills has increased for *General clerks*, *Program or project administrators* and *Solicitors* (Figure 401). These occupations are most common in legal services and local, central and state government administration industries, indicating that mental health skills are increasingly relevant in areas which are not directly related to mental health.

As awareness of mental health issues rises, it may be expected that skills in these areas will increasingly be required for a wide range of jobs, particularly in service-based industries, including care and support and to support early intervention and prevention.

Figure 401: Proportion of online job advertisements mentioning mental health skills, 2012 to 2019



Source: NSC analysis, Burning Glass Technologies.

12.6 Workforce flows and factors affecting supply

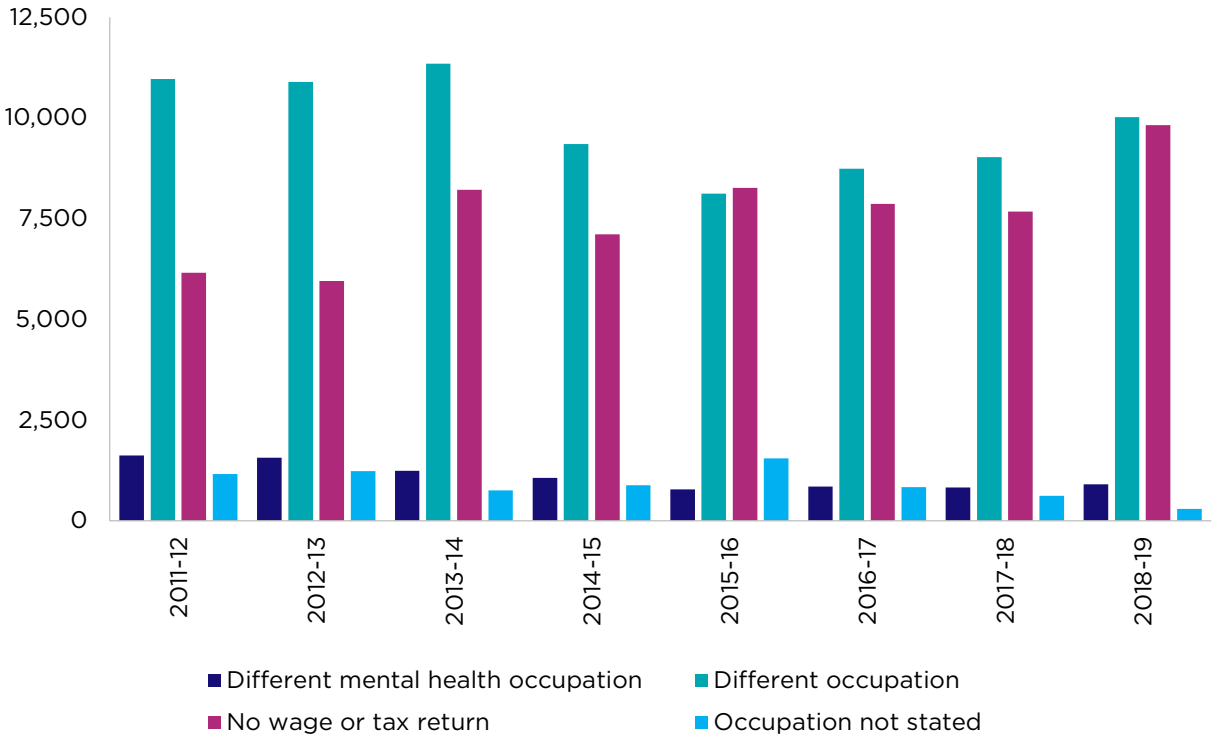
There is considerable overlap in the range of factors affecting supply of both the care and support and mental health workforces.

12.6.1 Mental health transitions

Like the care and support workforce, across the mental health workforce the number of people exiting the workforce has been trending upwards since 2014-15 (Figure 403). While this analysis was not performed by age group, it is expected that a significant proportion of these transitions are retirements, as the first Baby Boomer cohorts begin to leave the workforce. This trend is expected to continue, with exits out of the workforce continuing to be the most common reason for people leaving the mental health workforce rather than moving to other occupations within the workforce. In February 2021, around 6,000 mental health workers reported that they expected to retire in the next year (or less than 2,000 if *Registered nurses* are omitted).[296]

The number of people joining the mental health workforce from outside the workforce (i.e. no wage or tax return previous year) has increased over recent years, growing from around 6,200 in 2010-11 to 9,800 in 2018-19 (Figure 402).[297] The number of people moving into a mental health occupation from different occupations outside the mental health workforce has been increasing in recent years, following a decline between 2013-14 and 2015-16.

Figure 402: Mental health workforce (excluding *Registered nurses*), previous occupation, 2011-12 to 2018-19

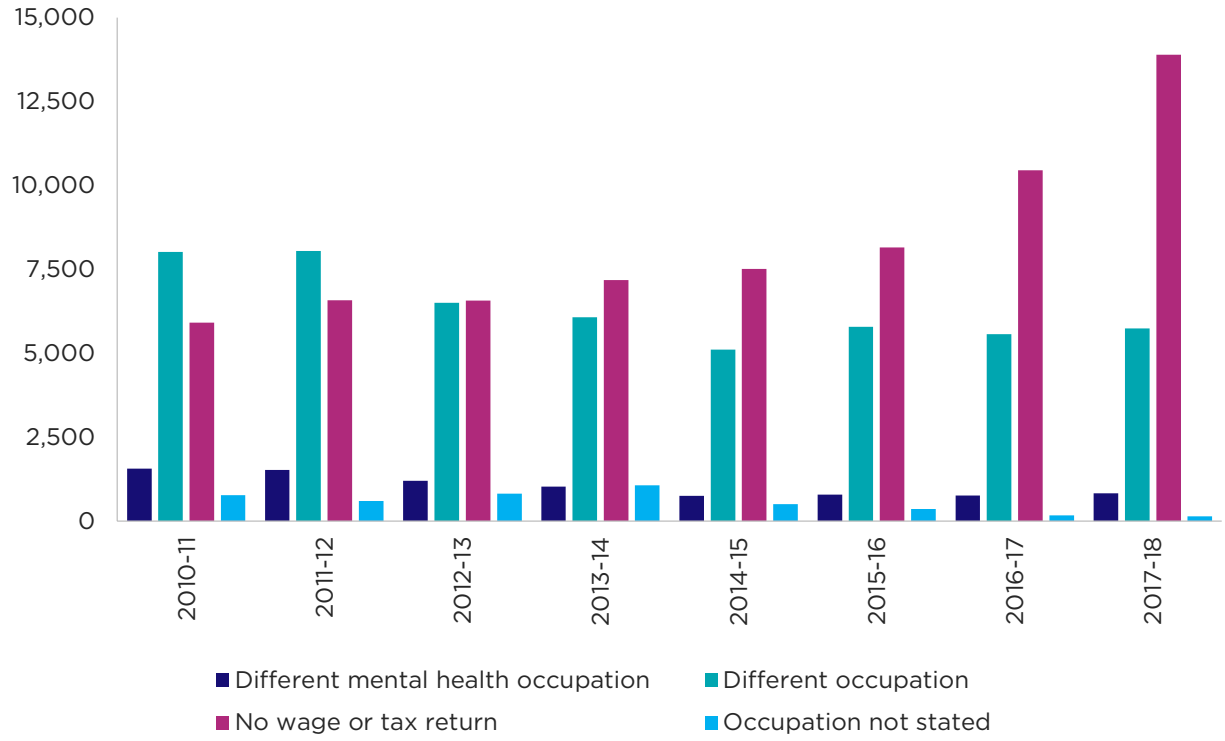


Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Excludes people working in the same occupation.

[296] ABS, Participation, Job Search and Mobility, Australia [TableBuilder], 2015-2020, 2021

[297] Note the number of people joining the mental health workforce may be overstated as people with no wage or tax return in the previous year may also include those who are employed but have not submitted a tax return.

Figure 403: Mental health workforce (excluding *Registered nurses*), next occupation, 2010-11 to 2017-18



Source: NSC analysis of longitudinal linked tax data sourced via MADIP. Includes all industries. Excludes people working in the same occupation.

12.6.2 Factors influencing workforce supply

Similar to the care and support workforce, there are a range of factors influencing the supply of the mental health workforce. Indeed, there is a considerable degree of overlap between the issues identified for the care and support workforce, and those facing the mental health workforce, including:

- negative perceptions and stigma of working in mental health (Part 8.2.1)
- attraction and recruitment difficulties (Part 9.1.1)
- retention and workloads (Part 8.1)
- an older workforce and the impact of future retirements (Part 7.2)
- placement availability and access to supervisors (Part 8.1.3)
- access to professional development (Part 8.2.2.2)
- workforce distribution (Part 4.7)
- increasing skill specialisation (Part 6.6).

Strategies to address these workforce challenges are reflected in the draft *Mental Health Workforce Strategy*. The following outlines some additional issues identified during the Study specific to mental health, including defining scopes of practice, use of technology and system fragmentation.

12.6.2.1 Defining scope of practice

Stakeholders expressed the benefit of the workforce operating at the top of their occupational scope of practice as important for efficiency, and care and support outcomes, as well as

enhancing job satisfaction. The need to support workers to work to top of scope is also reflected in the National Mental Health Commission's *Vision 2030* project.[298]

However, some stakeholders were concerned that scopes of practices were not well-understood across different occupations. For example, some stakeholders indicated that counsellors and lived experience (peer) workers are currently underutilised and more could be done to integrate them into multidisciplinary teams. It was also noted that inclusion in these teams must be within clearly defined roles, and should not be used as a substitute for treatment by fully qualified mental health professionals. Further, stakeholders noted that well-defined scopes of practice were critical for articulating and embedding the training and professional development requirements for the workforce.

The draft *National Mental Health Workforce Strategy* has identified a number of occupations that would benefit from confirmation or development of a nationally consistent and/or accepted scope of practice. The draft Strategy also identifies the need for scope of practice to reflect the components of care and competencies required to provide mental health support, recognising discipline-specific contributions and multidisciplinary care.

12.6.2.2 Technology opportunities in mental health are being leveraged

The uptake of technology-enabled service delivery in mental health has been increasing in recent years, including as an effective way of improving access to person-centred mental health services. Australia's delivery of mental health online includes a wide range of technology to provide mental health resources and information, online and telehealth services and therapy, including:

- Head to Health's digital gateway, which provides access to hundreds of digital mental health resources
- telehealth psychological and psychiatric services
- automated digital therapies, such as those offered by virtual clinics like MindSpot, This Way Up, and Mental Health Online
- online peer support forums, such as those provided by Beyond Blue and SANE
- online and telephone counselling, crisis support, and information services, such as eheadspace, Beyond Blue, Lifeline, Kids Helpline, and Reach Out
- self-guided apps.[299]

Stakeholders noted that more could be done to support the integration of telehealth, online and digital services, however caveated that these should not be seen as the single solution to address service delivery gaps. It was noted that technology may be limited in its effectiveness if the telecommunications infrastructure does not exist to support delivery, or the consumers and providers who may not have an adequate level of digital literacy to benefit from this mode of service delivery. Further, this mode of service delivery may not be suitable for all circumstances, and should not be viewed as a substitute for face-to-face engagement.

Throughout the COVID-19 pandemic technology-enabled services have been important, with a number of these services reporting increased demand (Part 12.1.3). Further, the pandemic had accelerated the use of digital tools in mental health across OECD countries. In Australia, as at the end-April 2020, 49.9% of MBS mental health services were being provided via telehealth, while the United Kingdom saw increased rates of non-face-to-face service delivery across its mental health services and virtual care increased in the United States and Canada.[300]

As part of the *National Mental Health and Suicide Prevention Plan*, the Australian Government is investing $111.2 million in digital services under the Head to Health platform to enable access to free or low-cost digital mental health services and supports. The Australian Government has also extended funding for telehealth services.[301]

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[298] Parliament of the Commonwealth of Australia, *Mental Health and Suicide Prevention - Interim Report*, 2021

[299] Productivity Commission, *Mental Health, Inquiry Report*, 2020

[300] OECD, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, 2021

[301] Department of Health, *National Mental Health and Suicide Prevention Plan*, 2021

As noted in Part 12.2.3, Australia has been recognised by the OECD as a country leading the way in the implementation of mental health policies and programs across several benchmarks, including in the areas of person-centred, integrated and cross-sectoral models of mental health care and use of technology.[302] A relevant example is headspace - a 'one stop shop' for young people, aged 12-25, seeking mental health services, however, its remit also includes physical health, sexual health, and alcohol and drug services.

12.6.2.3 A fragmented landscape of mental health services and roles

Delivery of mental health care and support services is complicated by shared roles and responsibilities across governments and the non-government sector. Stakeholders cited fragmentation of the mental health system and a range of factors that may be contributing to this complex environment, including:

- variable policy settings and governance across jurisdictions and programs
- multiple service delivery models which are not well-integrated
- various funding approaches.

The workforce and service delivery implications of fragmentation can impact the remuneration and conditions of mental health workers differently across occupations and settings. With many different funding sources, such as the NDIS, state and territory health systems, and the community sector, the pay settings and entitlements of workers can differ widely based on the context and setting in which they work.[303] Differential remuneration can have consequences for the supply of workers, contributing to high staff turnover and workforce shortages.[304]

Grants-based and short funding cycles were cited as creating financial uncertainty in community mental health settings, inhibiting service providers' capacity to train and upskill their existing workforce and difficulty retaining skilled workers.[305] Additionally, non-recurrent funding approaches from multiple sources, across governments and programs, was raised as an administrative overhead with complicated and inconsistent reporting requirements.

Further, other funding mechanisms are more likely to direct consumers towards services that are subsidised under the MBS, or acute care settings, rather than referring to other mental health services which may be more aligned to the person's situation.[306]

System fragmentation has been recognised by governments as a challenge and work is progressing to address this under the National Mental Health and Suicide Prevention Agreement.

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[302] OECD, *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, 2021

[303] ACILAllen, *National Mental Health Workforce Strategy: Background Paper*, 2021

[304] Institute for Social Science Research, *National Mental Health Workforce Strategy – A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries*, 2020

[305] Productivity Commission, *Mental Health, Inquiry Report*, 2020

[306] Productivity Commission, *Mental Health, Inquiry Report*, 2020

12.7 Outlook for mental health care and support

To effectively answer the question 'is there a mental health workforce gap?' requires sufficient information to translate the demand for mental health services to workforce demand and to estimate the current size of the mental health workforce. However, as has been outlined in this Study, there are significant challenges in establishing reliable starting point estimates for demand and supply for the mental health workforce. This significantly constrains the utility of applying forecasting approaches given the data inputs are unreliable, incomplete, or unavailable.

Notwithstanding these limitations, it is possible to form a view about the workforce pressures that may exist in the mental health workforce – both on the demand and supply side.

12.7.1 Demand and supply indicators of pressure

There are indications of latent and unmet demand for mental health services. Most people self-manage their mental health through social interaction, positive lifestyle adjustments and support networks, including family and friends.[307] Despite the high levels of self-management and wide range of mental health programs available, there are indications that people are not accessing the mental health supports that they need.

The Productivity Commission estimates that around one million people with mental illness are receiving no clinical care[308] and noted many people do not receive the treatment and supports they need, or at the level that they need them. Two key gaps in mental health services were identified by the Productivity Commission:

- Low intensity gap – low intensity services are those characterised as low cost, low risk, and easy to access. Examples of these include clinician-supported online treatment and group therapy. The Productivity Commission noted many people would benefit from increased delivery of low intensity services, including an estimated 500,000 people not accessing any care, but who require some level of support.
- 'Missing middle' gap – refers to a service gap whereby people have symptoms that are too complex for treatment by a general practitioner and the limited number of government subsidised individual sessions with a psychologist, but whose severity does not reach the threshold for specialised mental health services provided by states and territories. The Productivity Commission estimates that this gap is encountered by several hundred thousand people each year and indicative of the lack of community-based mental health services.[309]

Similarly, the Royal Commission into Victoria's Mental Health System concluded the system was overwhelmed. Reviews and stakeholder commentary in other states also point to demand pressure for mental health services.[310]

Combined, these insights suggest a level of unmet demand for mental health services. The implication then for the mental health workforce is a cumulative one. To deliver both existing mental health services and address any potential latent demand would require an increase to the size of the mental health workforce.

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[307] Productivity Commission, *Mental Health, Inquiry Report*, 2020

[308] Productivity Commission, *Mental Health, Inquiry Report*, 2020

[309] Productivity Commission, *Mental Health, Inquiry Report*, 2020

[310] Mental Health Commission of New South Wales, *Living Well in Focus 2020–2024: A strategic plan for community recovery, wellbeing and mental health in NSW: Fact sheet # 7*, 2020; RANZCP, *SA State Parliament Budget submission 2021-22, Prioritising South Australia's mental health*, 2021; Tasmanian Government Department of Health, *Better Integration of Mental Health Services in Southern Tasmania, Mental Health Integration Taskforce Report and Recommendations*, 2019; Western Australian Department of Health, *Review of the Clinical Governance of Public Mental Health Services in Western Australia, October 2019*, 2020; Royal Commission into Victoria's Mental Health System, *Royal Commission into Victoria's Mental Health System, Final Report, Volume 4: The fundamentals for enduring reform*, 2021

Further, on the supply side there are indications of workforce shortages in some mental health occupations:

- The Productivity Commission found that there was a shortage of psychiatrists in Australia, particularly those specialising in the treatment of children, adolescents, and older people.[311]
- *Psychiatrists, General practitioners and resident medical officers* and *Psychologists* are identified on the NSC's Skills Priority List (also discussed in Part 6.1.1.1) as in shortage at the national or regional levels, which may be linked to thin markets. Further, all occupations in the Study's mental health occupation groups are included on the SPL and with future workforce demand ratings of either strong or moderate (Table 20).
- Analysis undertaken to inform the draft *National Mental Health Workforce Strategy* also estimated that the current mental health workforce is significantly below the national target levels in the 2019 National Mental Health Service Planning Framework.[312]

Combined these insights support a view that there is a degree of pressure in the mental health workforce that may be increasing.

Table 20: Mental health workforce occupations by Skills Priority List category, 2021

In shortage; strong future demand	
● Clinical psychologist	● Organisational psychologist
● Educational psychologist	
In shortage; moderate future demand	
● General practitioner (regional areas only)	● Resident medical officer (regional areas only)
● Psychiatrist	
No shortage; strong future demand	
● Careers counsellor	● Psychotherapist
● Drug and alcohol counsellor	● Rehabilitation counsellor
● Family and marriage counsellor	● Student counsellor
● Welfare worker	● Community arts worker
● Recreation officer	
No shortage; moderate future demand	
● Registered nurse (aged care)	● Nurse practitioner
● Registered nurse (child and family health)	● Registered nurse (medical practice)
● Registered nurse (community health)	● Registered nurse (mental health)
● Registered nurse (critical care and emergency)	● Registered nurse (perioperative)
● Registered nurse (developmental disability)	● Registered nurse (surgical)
● Registered nurse (disability and rehabilitation)	● Registered nurse (paediatrics)
● Registered nurse (medical)	● Social worker

Key to occupation groups: ● Non-medical mental health workers, ● Medical mental health workers.

Source: NSC, Skills Priority List, 2021

[311] Productivity Commission, *Mental Health, Inquiry Report*, 2020

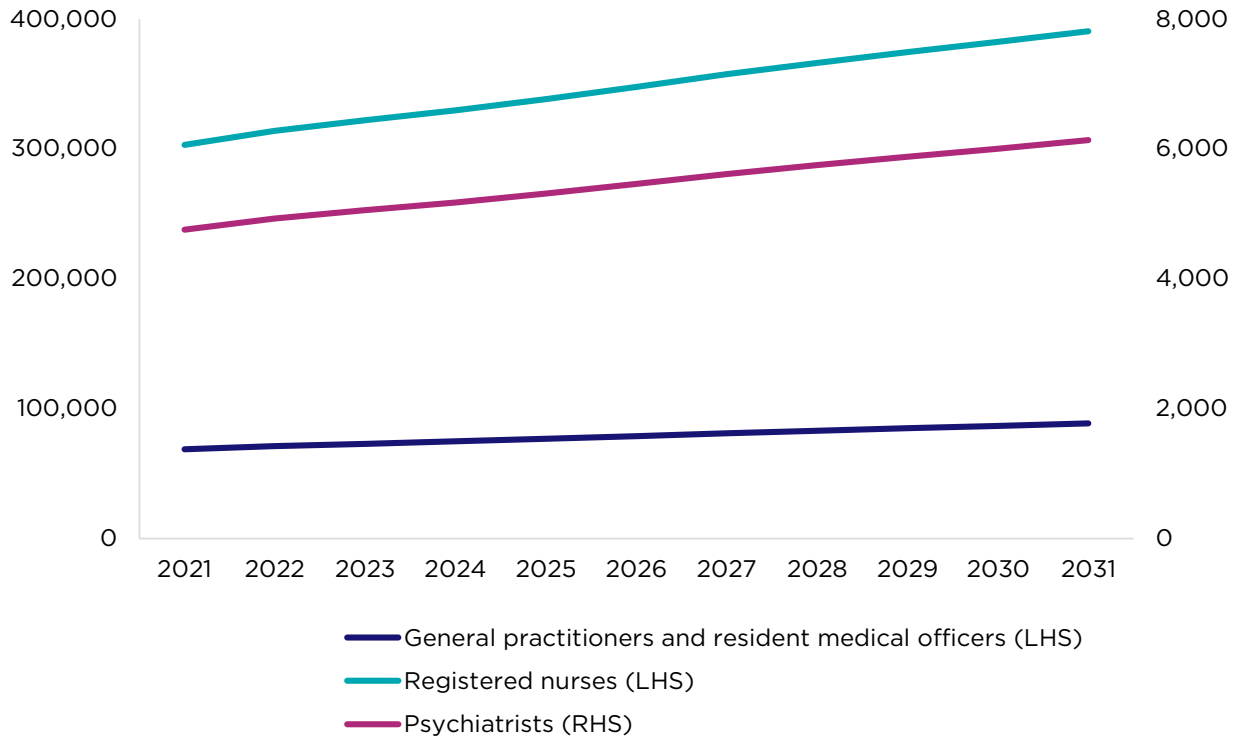
[312] ACILAllen, *National Mental Health Workforce Strategy: Background Paper*, 2021

12.7.2 The mental health workforce is projected to continue to grow

As outlined in Part 12.2.2, mental health occupations have experienced employment growth in recent years, and this is expected to continue over time. While, the Study has not modelled supply of the mental health workforce, 10-year occupation projections have been developed out to 2031. However, it is important to note that these projections are for the total occupation and therefore the mental health-related component would be a subset of these projected totals. These employment forecasts are at the 1-digit ANZSIC and 1-digit ANZSCO level and are derived from Deloitte Access Economics' broader macroeconomic forecasts from the March quarter 2021. These forecasts do not consider specific drivers of demand for mental health care or changes to government funding allocated to mental health care.

Based on these projections (Figure 404), it is anticipated that *Registered nurses* will experience the largest growth over the 10 years to 2031 (302,890 to 390,370, 29.9%), followed by *General practitioners and resident medical officers* (68,610 to 88,610, 29.1%) and *Psychiatrists* (4,750 to 6,130, 29.0%)

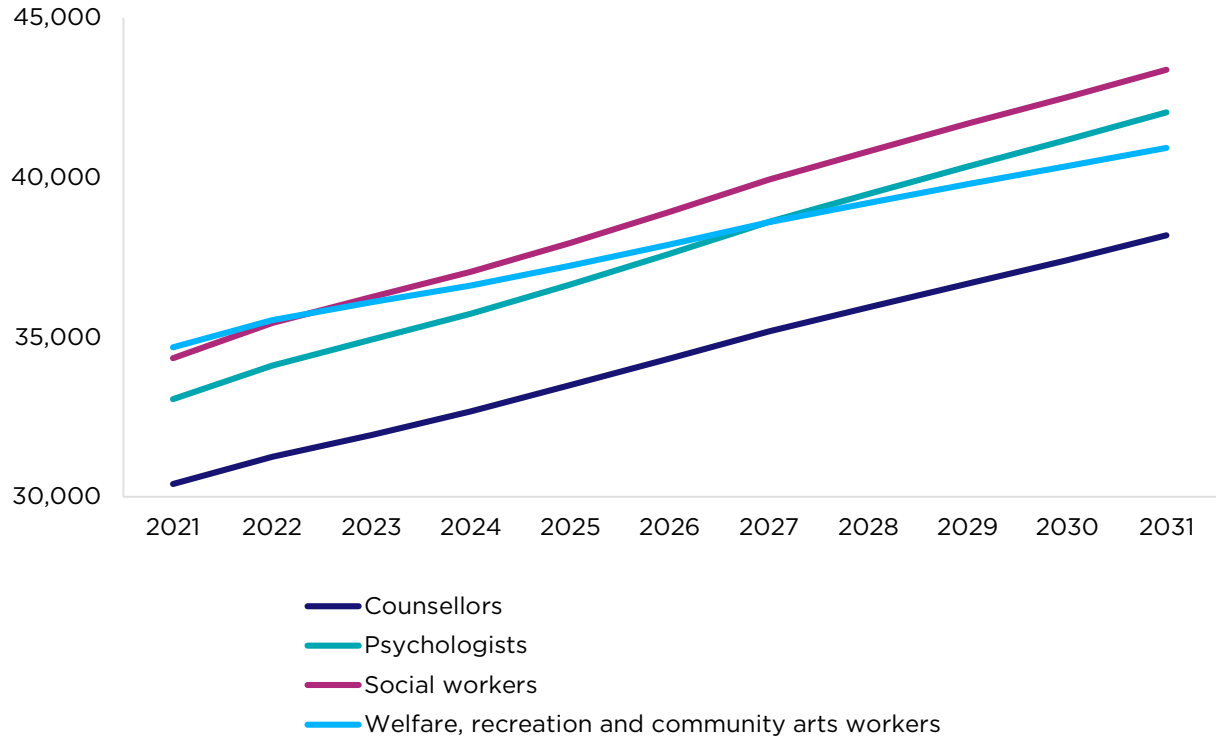
Figure 404: Projected employment size, Medical mental health occupations June 2021 to 2031



Source: Deloitte Access Economics, 2021.

Further, continuing growth is expected across all Non-medical mental health roles, with *Social workers* expected to be the largest Non-medical mental health occupation by 2031, growing from 34,340 to 43,370 (26.3%), followed by *Psychologists* (33,060 to 42,040, 27.2%) and *Counsellors* (30,400 to 38,190, 25.6%) (Figure 405). The lowest percentage growth is anticipated for *Welfare, recreation and community arts workers* (18.0%).

Figure 405: Projected employment size, non-medical mental health occupations June 2021 to 2031



Source: Deloitte Access Economics, 2021. Employment size is for occupation across all industries, it does not reflect the proportion of these occupations which are specifically working in mental health services. These occupations may also provide other health and social assistance services unrelated to mental health.

12.7.3 The size of any gap is harder to estimate across the mental health workforce

Given the unclear starting point for demand and supply across mental health, it is difficult to conclude if there is currently a gap between workforce demand and supply, or the magnitude of any such gap. That said, a number of indicators discussed earlier in this Part suggest a gap may exist.

While the many data constraints present in mental health make workforce planning and development much more challenging, the conclusions from the care and support workforce modelling are likely to also prove salient in the mental health context.

- These conclusions are that workforce gaps (in the absence of change) will emerge in coming years and are likely to be more pronounced in lower skill level occupations. That said, gaps emerge across all skill levels, with the age profile of *Psychiatrists* presenting some risk to this skill level 1 occupation in the mental health workforce.

To the extent that a workforce gap and pressure currently exists for mental health occupations, any increase in demand will likely exacerbate any existing workforce shortage and will be cumulative over time, just as it is in the care and support workforce. This is particularly relevant in the short-term as the ongoing impact of the COVID-19 pandemic is driving increased pressure on mental health services and the long-term implications for mental health are not yet understood. Shifts in societal attitudes, particularly increased awareness of the importance of mental health, are also likely to lead to increased demand for mental health services.

For mental health occupations at skill level 1, the supply of workers will be both a function of enrolments and completions in higher education and skilled migration levels. Negative trends in either of these supply changes will exacerbate any gap, noting that the education pipeline for some occupations takes many years to complete (including *Psychiatrists*, *General practitioners and resident medical officers*). `

At lower skill levels it is possible that the emerging mental health occupations and those providing early intervention, prevention, and mental health care and support may have similar skill level characteristics to more of the care and support workforce. As the gap is most acute at these skill levels for the care and support workforce (Part 9.5.1), this may also be where the largest mental health workforce gap may emerge, particularly if all programs and services across aged, disability, veteran and mental health care and support are competing for the same pool of potential workers.

Accordingly, consideration will need to be given to the workforce implications and intersections across the mental health and care and support workforces. If not well-understood, workforce gaps across essential services may be exacerbated – just as the cross-cutting approach taken in this Study has highlighted how workforce outcomes have emerged in the care and support workforce from complex system and program settings.

There is unlikely to be one solution that will fully address any workforce supply issues being experienced in the mental health workforce.

Instead, a range of strategies will be required to attract, retain, and grow the mental health workforce. The Study notes that the draft *National Mental Health Workforce Strategy* and the *National Mental Health and Suicide Prevention Plan* and various other initiatives underway will contribute to the workforce planning and development for mental health, with many areas of focus aligned to those highlighted in this Study.

The framework outlined in Part 11 may provide useful considerations for the Mental Health Workforce Strategy Taskforce in establishing a system to monitor and report progress, as outlined in its terms of reference.

Appendix A
Stakeholder consultation process

The Study's stakeholder consultation process ran from May to August 2021. Consultation activities are outlined below.

Consultation with Australian Government agencies

Throughout the Study, the NSC worked closely with the Department of Education, Skills and Employment, Department of Health, the Department of Social Services and the Department of Veterans' Affairs.

It also consulted the following Australian Government agencies and positions:

- Aged Care Quality and Safety Commissioner
- Attorney-General's Department
- Australian Institute of Health and Welfare
- Australian Skills Quality Authority
- Australian Bureau of Statistics
- Chief Allied Health Officer
- Department of Finance
- Department of Foreign Affairs and Trade
- Department of Home Affairs
- Department of the Prime Minister and Cabinet
- National Disability Insurance Agency
- National Indigenous Australians Agency
- National Rural Health Commissioner
- NDIS Quality and Safeguards Commissioner
- Productivity Commission
- The Treasury.

Consultation with providers, industry, unions, peak bodies and advocacy groups

The NSC met with representatives from the following organisations, committees and groups:

- Ability First Australia
- Aged Care Industry Information Technology Council
- Aged Care Workforce Industry Council
- Australian Allied Health Leadership Forum
- Australian Nursing and Midwifery Federation
- Australian Services Union
- Committee for Economic Development of Australia
- Department of Education, Skills and Employment VET Stakeholder Committee
- Department of Health *A Matter of Care* – Australia's Aged Care Workforce Strategy Program Board
- Department of Health National Mental Health Workforce Strategy Taskforce
- Department of Social Services NDIS Advisory Group on Market Oversight
- Department of Veterans' Affairs National Aged and Community Care Forum
- HammondCare (provider)
- Health Services Union
- Hireup (provider)
- Human Services Skills Organisation
- Japara (provider)
- Juniper (provider)
- National Aboriginal and Community Controlled Health Organisation
- National Advisory Group for Aboriginal and Torres Strait Islander Aged Care
- National Aged Care Alliance
- National Disability Services
- Opal HealthCare (provider)
- Prom Country Aged Care (provider)
- Regis (provider)
- Rural Workforce Agency Network
- SkillsIQ
- TAFE NSW
- United Workers Union.

Discussion paper and submission process

A discussion paper was published to support the consultation process outlining the Study's scope and focus, existing work that would be used in the analysis and questions to guide responses on areas of the care workforce where a deeper understanding was needed to inform the Study.

Submissions to the Study were open from 19 May to 16 June 2021. The Study received a total of 49 submissions from the organisations and individuals listed below.

Organisations / individuals
Aged and Community Services Australia
Aged Care Workforce Industry Council
Anglicare Australia
Australian Association of Social Workers
Australian Community Industry Alliance
Australian Counselling Association
Australian Nursing and Midwifery Federation
Australian Physiotherapy Association
Australian Psychological Society
Australian Services Union
Australian Work and Family Policy Roundtable
Brotherhood of St Laurence
Co-Group
Community Care Tasmania
Community Colleges Australia
Community Services and Health Industry Training Board (Vic)
Community Services Industry Alliance
Community Skills WA
Dementia Australia
Department of Foreign Affairs and Trade – Office of the Pacific
Federation of Ethnic Communities' Council of Australia
Health Services Union
Hireup
Home Instead
Indigenous Allied Health Australia
Leading Age Services Australia
Life Without Barriers
Lifestyle Solutions
Macdonald, Dr Fiona
Mental Health Australia

Organisations / individuals
National Aboriginal and Community Controlled Health Organisation
National Disability Services
National Rural Health Alliance
Occupational Therapy Australia
Pukallus, Dominic Guy
Psychotherapy and Counselling Federation of Australia
Qualski
Royal Australian and New Zealand College of Psychiatrists
Rural Health West
Services for Australian Rural and Remote Allied Health
SkillsIQ
Speech Pathology Australia (1 of 2)
Speech Pathology Australia (2 of 2)
TAFE Directors Australia
Thrive Allied Health
United Workers Union
UnitingCare Australia
Universities Australia
Vision 2020 Australia

Appendix B
Definition of ANZSCO occupations

This table provides a list of ANZSCO occupations and their definitions that were aligned with the care support workforce as part of the Study.

Table 21: Care and support occupation definitions

ANZSCO code	ANZSCO occupation title	Skill level	ANZSCO occupation description
Personal care and support workers			
4231	Aged and disabled carers	4*	Aged and disabled carers provide general household assistance, emotional support, care and companionship for aged and disabled persons in their own homes.
4233	Nursing support and personal care workers	4	Nursing support and personal care workers provide assistance, support and direct care to patients in a variety of health, welfare and community settings.
Health and welfare support workers			
4113	Diversional therapists	3	Diversional therapists plan, design, coordinate and implement recreation and leisure-based activity programs to support, challenge and enhance the psychological, spiritual, social, emotional and physical wellbeing of individuals.
4114	Enrolled and mothercraft nurses	2	Enrolled and mothercraft nurses provide nursing care to patients in hospitals, aged care and other health care facilities and in the community, and assist parents in providing care to newborn infants under the supervision of a Registered nurse or Midwife.
4115	Indigenous health workers	2	Indigenous health workers assist with the coordination and provision of health care delivery to Indigenous communities.
4117	Welfare support workers	2	Welfare support workers provide support, information and advice to clients on emotional, financial, recreational, health, housing and other social welfare matters, and evaluate and coordinate the services of welfare and community service agencies.
2724	Social professionals	1	Social professionals research and study human behaviour, society and institutions from current and historical perspectives, and verbally render spoken statements, and transcribe text and recorded spoken material from one language into another.

ANZSCO code	ANZSCO occupation title	Skill level	ANZSCO occupation description
Registered nurses			
2544	Registered nurses	1	Registered nurses provide nursing care to patients in hospitals, aged care and other health care facilities, and in the community.
Allied health professionals			
2511	Nutrition professionals	1	Nutrition professionals apply the science of human nutrition to assist people to attain better health and to help prevent and treat various illnesses and diseases.
2524	Occupational therapists	1	Occupational therapists assess functional limitations of people resulting from illnesses and disabilities, and provide therapy to enable people to perform their daily activities and occupations.
2525	Physiotherapists	1	Physiotherapists assess, treat and prevent disorders in human movement caused by injury or disease.
2526	Podiatrists	1	Podiatrists prevent, diagnose and treat disorders of the feet.
2527	Audiologists and speech pathologists/therapists	1	Audiologist and speech pathologists provide diagnostic assessment, treatment, rehabilitative services and management of human hearing defects, and communication and swallowing impairments.
Health and welfare managers			
1342	Health and welfare services managers	1	Health and welfare services managers plan, organise, direct, control and coordinate the professional and administrative aspects of health and welfare programs and services.
2543	Nurse managers	1	Nurse managers manage health service units and sub-units of hospitals, aged care and community health care facilities, supervise nursing staff and financial resources to enable the provision of safe, cost effective nursing care within specified fields or for particular units, and monitor quality, clinical standards and professional development of nurses.

Source: ABS, ANZSCO (Version 1.3), 2013. *ANZSCO (Version 1.3) classifies *Aged and disabled carers* as skill level 4 but notes that some roles within the occupation are skill level 3.

Figure 406: Mental health occupation definitions

ANZSCO code	ANZSCO occupation title	Skill level	ANZSCO occupation description
Non-medical mental health occupations			
2721	Counsellors	1	Counsellors provide information on vocational, relationship, social and educational difficulties and issues, and work with people to help them to identify and define their emotional issues through therapies such as cognitive behaviour therapy, interpersonal therapy and other talking therapies.
2723	Psychologists	1	Psychologists investigate, assess and provide treatment and counselling to foster optimal personal, social, educational and occupational adjustment and development.
2725	Social workers	1	Social workers assess the social needs of individuals, families and groups, assist and empower people to develop and use the skills and resources needed to resolve social and other problems, and further human wellbeing and human rights, social justice and social development.
2726	Welfare, recreation and community arts workers	1	Welfare, recreation and community arts workers design and implement strategies and programs to meet community and individual needs and assist individuals, families and groups with social, emotional and financial difficulties to improve quality of life by educating and supporting them and working towards change in their social environment.
Medical mental health occupations			
2531	General practitioners and resident medical officers	1	General practitioners and resident medical officers diagnose and treat physical and mental illnesses, disorders and injuries, recommend preventative action and refer patients to specialist Medical Practitioners, other health care workers, and social, welfare and support workers.
2534	Psychiatrists	1	Psychiatrists diagnose, assess, treat and prevent human mental, emotional and behavioural disorders. Psychiatric Registrars training as Psychiatrists are included in this unit group.
2544	Registered nurses	1	Registered nurses provide nursing care to patients in hospitals, aged care and other health care facilities, and in the community.

Source: ABS, ANZSCO (Version 1.3), 2013.

Appendix C
Modelling methodology

This Appendix details the approach for forecasting the demand and supply of the care and support workforce. This approach was developed and implemented by Deloitte Access Economics for the purposes of this Study.

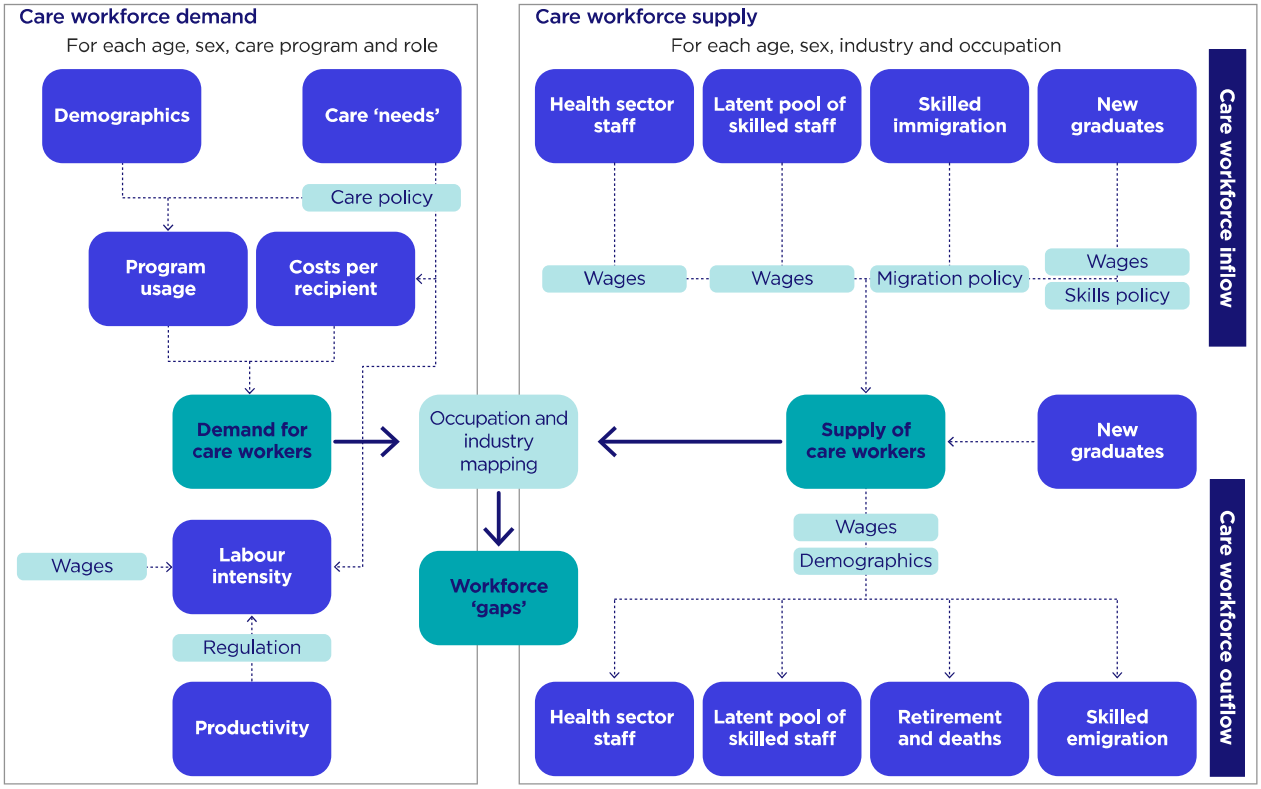
Model overview

Deloitte Access Economics developed a series of detailed and specialised labour market models for the care and support workforce for the purposes of this Study. This modelling approach has the following features:

- The model is a group model. It does not track individual outcomes, but instead identifies outcomes across a large number of groups, defined by a wide range of characteristics. For example, the model identifies the number of Australians aged 25-29 years with a profound core activity limitation.
- The model takes a partial equilibrium approach. It models the care and support workforce and programs in detail but has simpler approaches to other parts of the economy.
- The model involves simultaneous equations. Some parts of the model involve equilibrating values that must work across a system of equations at once, rather than being solved step by step.

The model is divided into 2 halves: (1) workforce supply, and (2) workforce demand (Figure 407). Underlying both halves is a demographic module which forecasts the size of the Australia population by age and sex using a cohort component methodology. The demand side is driven by the age, disability and veterans' profile of the Australian population, in combination with the policy of the Australian Government with regards to the services available to provide care and support services to these individuals. The supply side is driven by the skills in the Australian population, and migrants moving to (and from) Australia, how these skills change over time, and the occupation(s) in which these skills are applied.

Figure 407: Conceptual structure of the care and support workforce demand and supply model



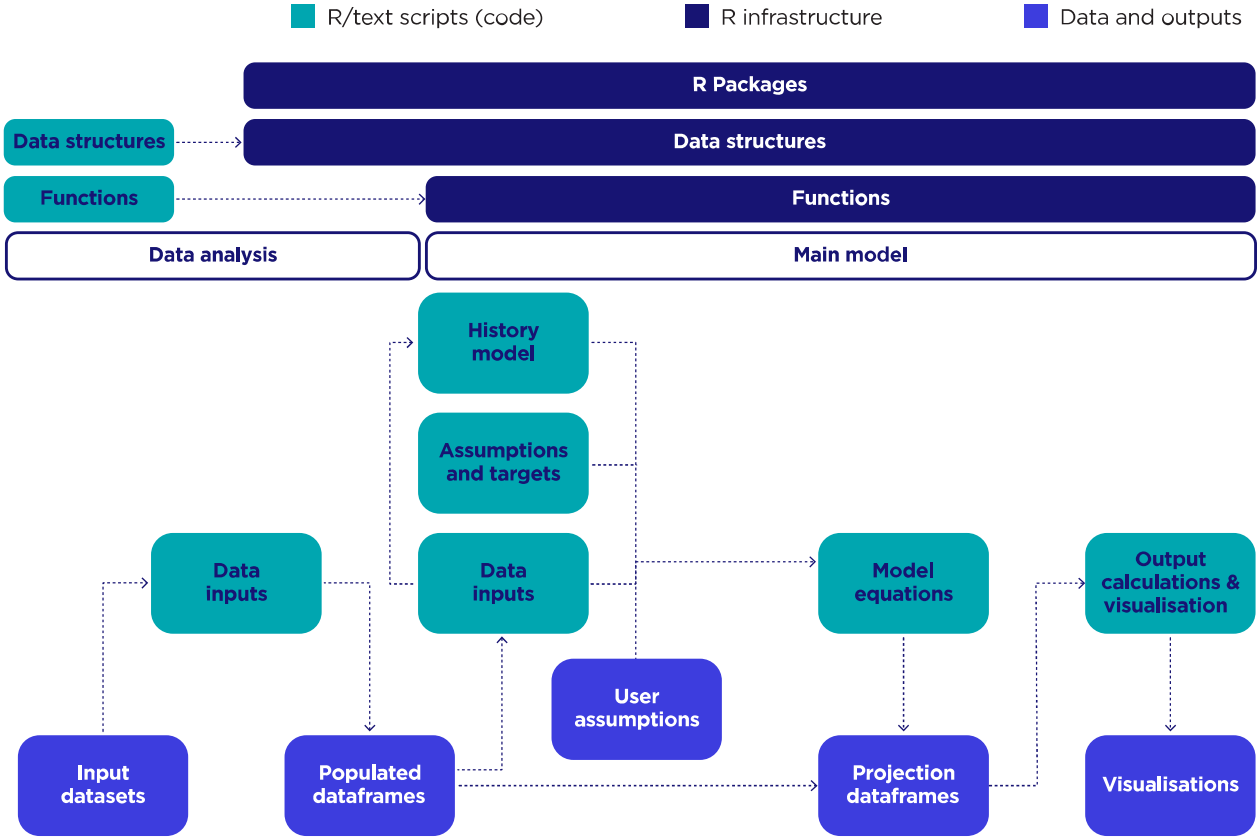
Source: Deloitte Access Economics, 2021.

At the highest level, the model is comprised of:

- A database representing outcomes for the model in history.
- Equations which manipulate that database and calibrate the key model parameters in history.
- Projected outcomes for assumed and known variables over the projection period.
- A large set of equations which combine history and exogenous projections to forecast the values of all the model outputs.

The model has been implemented in the software program R, which has the required flexibility to enable the detailed set of custom functions required for this model. The range of components which make up the model are outlined in Figure 408 below

Figure 408: Structure of model files



Source: Deloitte Access Economics, 2021.

Key concepts

Demand for care and support workers

- The demand for care and support workers is measured as either the headcount, or the number of full-time equivalent (FTE) workers, required to efficiently produce the level of care and support provided to recipients according to Australian Government policy.

Supply of care and support workers

- The supply of care and support workers reflects the number of workers qualified and available to work at the prevailing wages and conditions in the industries and occupations that make up the care and support workforce.

Workforce gap

- The workforce gap emerges when the demand for workers in a particular occupation or industry exceeds the supply of qualified workers available and willing to work in that occupation or industry. Such a gap represents an imbalance between supply and demand based on prevailing conditions in the relevant sector.

Demand methodology

This section outlines the methodology used to project demand for the care and support workforce. In the near-term, the demand projections depend on the amount of funding allocated to the various programs by the Australian Government. Over the long term, the underlying need for care and support services by the Australian population determine the demand for the care and support workforce.

Funding

To project the level of service provided by the various care programs into the future, the demand modelling projects the total level of funding under each program.

This process begins with detailed demographic and disability projections.

Rates of disability within the population over time are informed by the ABS SDAC, which indicates the severity of the most severe core activity limitation. This definition of disability is then consistently applied throughout the demand modelling.

Along with future population projections by disability level, 2 separate components of funding are projected:

- The number of recipients in each program in each year.
- The average level of funding associated with each recipient in each year.

Recipient numbers are projected based on fixed shares of the population in each program by age, sex and disability level (with the exception of veterans, where DVA projections of the treatment population are used to drive forecasts of future recipients).

Average funding amounts are based on known forward funding totals in the short term, and indexation arrangements under current policy thereafter.

Changes in the size, age structure and disability prevalence of the population flow through to the changes in total funding, through both the number of recipients in each program and the effect of changing recipient profiles on the average cost of those recipients.

Labour intensity

The workforce demand projections consider both the total amount of services delivered by the care and support sector and the way in which those services are delivered.

Services that are more labour intensive put greater upward pressure on labour demand. The mix of care-specific and other labour used is also an important factor, as care and non-care labour can be substitutes in some cases.

The modelling underlying these projections assumes that providers in each care program have the opportunity to choose the way they deliver care by selecting a combination of different care labour 'roles', non-care labour, and capital inputs such as buildings and technology.

These inputs are combined using a production function and it is assumed that providers minimise costs subject to that function and the prices of the various inputs.

There are separate production functions for each of the program types identified in the model. These production functions are assumed to be nested:

- At the high level there is a split between combined 'teams' of care labour L and combined capital K.
- Within labour there is a split into high skill level occupations (which includes *Registered nurses* and Allied health professionals), mid skill level occupations (which includes *Enrolled nurses* and allied health assistants), and low skill level occupations (which includes *Aged and disabled carers*).
- Within capital there is a split between cost items other than care labour (including non-care labour costs).

In practice, constant elasticity of substitution (CES) production functions are assumed.

- At the top level, the split is between K and L.
- At the next level down, L is split into high, mid and low skill levels, while K is split between other cost items.

The production function is therefore:

$$y = A\left(\alpha_K^{\frac{1}{\sigma}} f_K^{\frac{\sigma-1}{\sigma}} + \alpha_L^{\frac{1}{\sigma}} f_L^{\frac{\sigma-1}{\sigma}}\right)^{\frac{\sigma\mu}{\sigma-1}} \qquad \text{(C-1)}$$

Where:

- y is the output of the care program.
- A is the coefficient representing total factor productivity.
- The f's represent demand for factor inputs.
- The α's are factor parameters that sum to 1.
- σ is the elasticity of substitution between factors.
- μ = 1 gives constant returns to scale and μ < 1 gives diminishing returns to scale.

For this Study, constant returns to scale are assumed.

This gives factor demand functions with the form:

$$f_K = \alpha_K \left(\frac{y}{A}\right) * A^{\sigma} * \left(\frac{c}{p_K}\right)^{\sigma} \qquad \text{(C-2)}$$

Where:

- *c* is the unit cost of output.
- p_K is the unit price of capital.

And similarly for L.

Unit cost *c* is given by:

$$c = \left(\frac{1}{A}\right) * \left(\sum \alpha_i \, p_i^{(1-\sigma)}\right)^{\left(\frac{1}{1-\sigma}\right)} \qquad \text{(C-3)}$$

The second-level factor demand functions have a similar form to the higher level demand functions above:

$$q_j = \alpha_j \left(\frac{f_L}{A}\right) * A^{\sigma} * \left(\frac{c_L}{w_j}\right)^{\sigma} \qquad \text{(C-4)}$$

Where:

- j refers to labour type
- c_L is the cost of labour, $\sum w_j q_j$

The resulting price of a labour 'team' = $\sum wq \,/ f_L$ then becomes the relevant price for labour in equation (C-2) above, and a similar equation exists for components of K.

The A parameters and the α's are from history. Taking a ratio of 2 of the f equations and then imposing the constraint that the α's sum to 1 gives:

$$\alpha_L = \frac{f_L p_L^{\sigma}}{\sum f_i p_i^{\sigma}} \qquad \text{(C-5)}$$

These are then applied in the mode's projection period. The A parameters are calibrated so that observed input and output values are consistent.

Final workforce demand

Once the total funding committee to each program and the labour intensity of output are known, the model projects the total demand for workers in each of the care labour 'roles' by multiplying total funding by the quantity of each type of care labour used to produce a dollar of output.

These projections are then converted into the industry and occupation framework that makes up the modelled care and support workforce.

Each combination of care program and labour type maps into a number of occupations and industries, with that mapping held constant over time.

As a result, shifts in the mix of labour in each program and shifts between programs, result in changes in the occupation and industry mix of care and support workforce demand.

Demand measures are projected in FTEs, with the conversion to headcount performed based on average hours worked for each occupation within the care workforce. These average hours are held constant throughout the projections. The same conversion is later applied in the supply projections.

Supply methodology

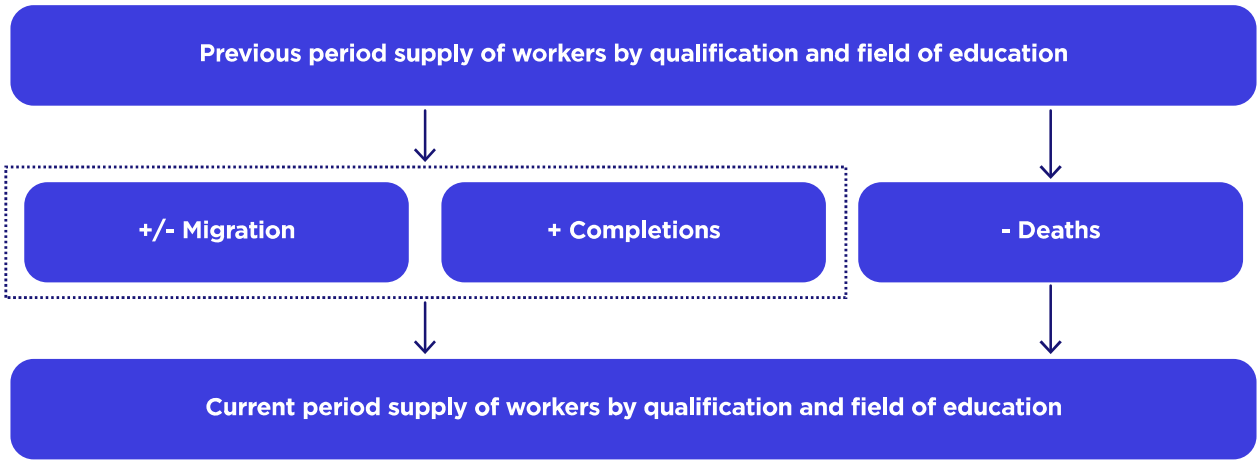
This section outlines how the supply of workers in the care and support workforce and the broader labour market is projected. The supply of workers depends on the composition of the Australian population, the qualifications they hold and the flows of workers between different groups over time.

The modelling approach

The supply modelling takes a group approach and does not track individuals supplying their labour separately. At the highest level, the groups are based on 5-year age groups and sex. At a high level, the total supply of workers is determined by population growth (including migration). The population estimates are informed by the demographic module which incorporates Deloitte Access Economics' population projections.

The supply of workers by qualification and field of education (FOE) grows as individuals complete qualifications, or migrants move to Australia. People leaving Australia, or individuals dying, decrease of workers by qualification and FOE.

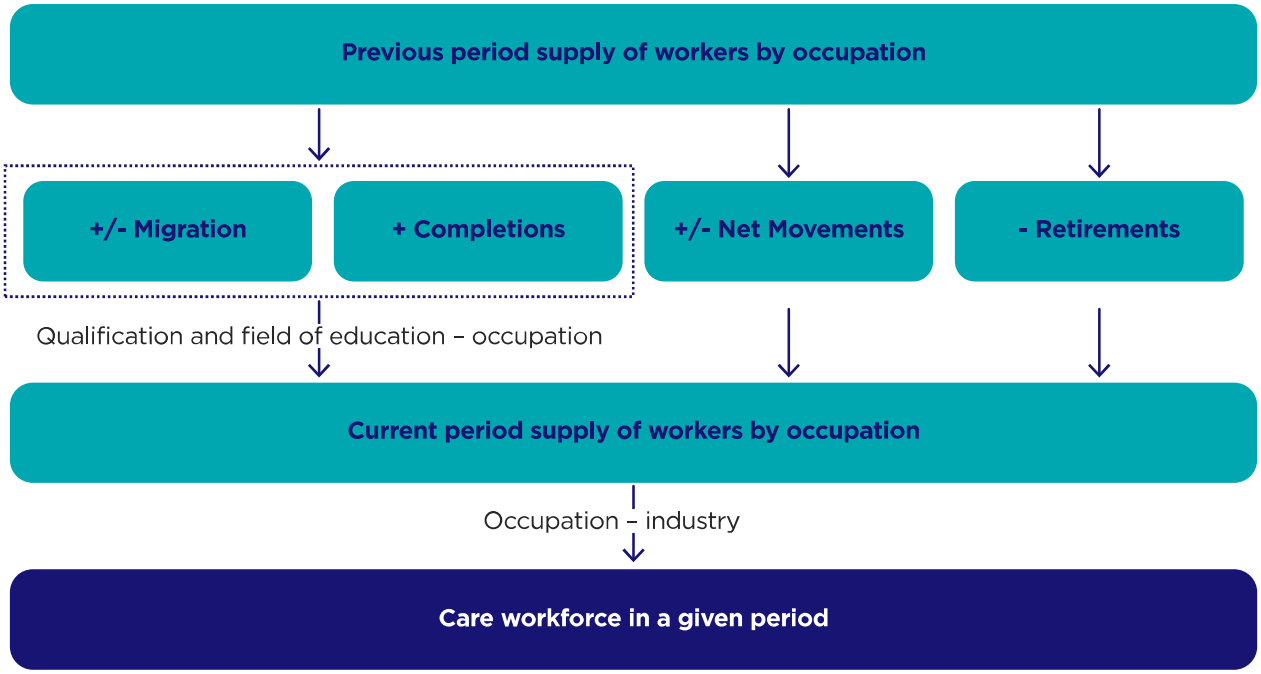
Figure 409: Conceptual supply of workers by qualification and field of education



Source: Deloitte Access Economics, 2021.

The supply of qualified workers for an occupation depends on migration flows, completions, the level of retirements from the occupation, and the net movements of workers between occupations. The supply of workers by occupation is then allocated to an industry to obtain a supply of qualified workers by occupation and industry.

Figure 410: Conceptual supply of qualified workers in the care and support workforce



Source: Deloitte Access Economics, 2021.

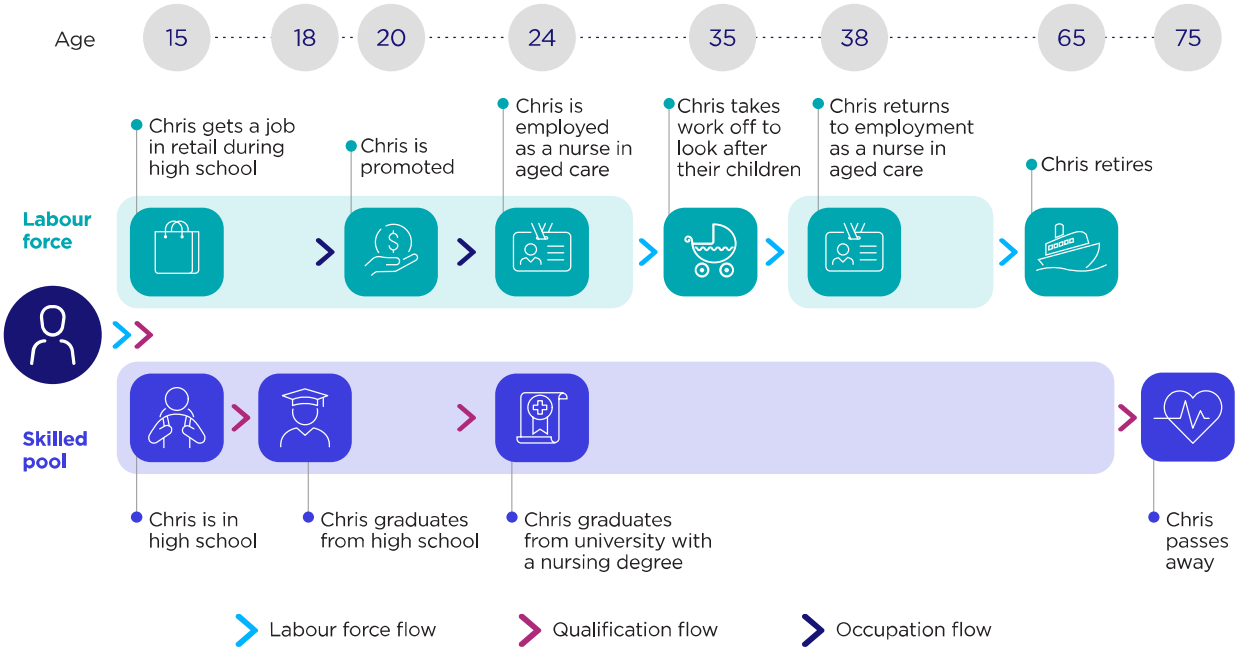
An example of the workforce supply methodology

This section outlines the different stocks and flows captured by the model.

While individuals are not modelled separately, examining the life course of an example individual – *Chris* – assists in highlighting the flows captured by the model.

- *Chris* is born in Australia and worked in a retail store during high school and while at university. After several years' experience, *Chris* is promoted to being a supervisor in their retail job.
- *Chris* studied nursing at university.
- After completing their nursing degree, *Chris* found a job as a *Registered nurse* in an aged care residence.
- In their 30s, *Chris* decides to take some time out of the labour force to take care of their children, before re-entering the labour market in the aged care sector.
- *Chris* retires when they turn 65 years old.
- *Chris* passes away at 75 years old.

Figure 411: Example of supply methodology: Chris's life



Source: Deloitte Access Economics, 2021.

Total potential workforce

The population living in Australia presents a natural upper bound for the total supply of labour. This changes over time due to births, deaths, or migration. However, in Australia children do not generally supply their labour so they can be excluded from the potential workforce. As a result, the total potential workforce is equal to the population aged 15 years and over:

$$Total\ potential\ workforce_{\ t} = \sum_{i=1}^{n}\sum_{j=1}^{2} pop_{i,j,t} \qquad \text{(C-6)}$$

Where $pop_{i,j}$ is the population of age group *i* and sex *j* at time *t*. The change in total potential workforce is determined by the ageing of the population, net migration, and deaths each period:

$$\Delta Total\ potential\ workforce_{\ t} = \sum_{i=1}^{n}\sum_{j=1}^{2}\left(\Delta pop_{i,j,t} + migration_{i,j,t} - deaths_{i,j,t}\right) \qquad \text{(C-7)}$$

In each period, each member of the potential workforce is either employed in an occupation, unemployed or not in the labour force (NILF), so that:

$$Total\ potential\ workforce_{\ t} = \sum_{i=1}^{n}\sum_{j=1}^{2}\left(employed_{i,j,t} + unemployed_{i,j,t} + NILF_{i,j,t}\right) \qquad \text{(C-8)}$$

Chris' workforce flows

When *Chris* turns 15 years old, they enter the age group where people typically begin to supply their labour and *Chris* will be included in the potential workforce. The model will allocate *Chris* as not in the labour force (NILF), employed or unemployed based on the experience of similar people to *Chris* observed in the 2016 Census of Population and Housing. *Chris* turning 15 years of age is an inflow into the potential workforce.

When *Chris* passes away, their death is an outflow from the potential workforce. It should be noted that *Chris's* temporary departure from the labour force to care for their children does not reduce the total potential workforce directly as they become captured in the NILF category.

Supply of workers by qualifications and field of education

Each member of the potential workforce has a qualification level[313] and a FOE (including no qualification and no FOE), so:

[313] Using the Qualification level of education (QALLP) system, which contains information on highest qualification from certificate level through to post graduate degrees.

$$Total\ potential\ workforce_{\ t} = \sum_{i=1}^{n}\sum_{j=1}^{2}\sum_{q=1}^{m}\sum_{f=1}^{k}(pop_{i,j,q,f,t}) \quad \text{(C-9)}$$

Where $pop_{i,j,q,f,t}$ is the population of age group *i* and sex *j* with qualification level *q* and FOE *f* at time *t*. The supply of qualification *q* and field of education *f* is then given by:

$$Supply_{q,f,t} = \sum_{i=1}^{n}\sum_{j=1}^{2}(pop_{i,j,q,f,t}) \quad \text{(C-10)}$$

The change in the supply of qualifications by field of education is given by new completions of study for the relevant qualification and field of education, net migration of individuals with the relevant qualification and field of education,[314] and the deaths of those with the relevant qualification and field of education:

$$\Delta Supply_{q,f,t} = Completions_{\ q,f,t} + Migration_{\ q,f,t} - Deaths_{q,f,t} \quad \text{(C-11)}$$

Chris's qualification flows

When *Chris* turns 15 years old, they add to the supply of workers with some level of high school but no field of education.

Completing high school changes *Chris's* highest qualification level, as does completing their bachelor degree in nursing. In both cases, *Chris's* additional qualification increases the supply of workers with those qualifications.

Chris's completion of high school, while remaining in their retail job, highlights that some occupations can be filled by people with a range of different qualifications. While *Chris's* nursing degree is strongly associated with work in a nursing occupation, many qualifications can be relevant to multiple occupations.

Chris's passing away reduces the supply of people with a bachelor degree in nursing, and a high school completion. Again, note that *Chris's* leaving the labour force temporarily does not reduce the total supply of individuals with a nursing degree.

Supply of workers for an occupation

The supply of workers for an occupation *o* is a function of the supply of qualified individuals for the occupation, the net flow of qualified workers from other occupations, and retirements:

$$Supply_{o,t} = \sum_{(q,f)\in QF} f(Supply_{q,f,t}) + Jobflows_{o,t} - Retirements_{\ o,t} \quad \text{(C-12)}$$

Where *QF* is a list of relevant qualifications by FOE. That is, each member of the list is a qualification and FOE pair (*q,f*). For example, for a *Registered nurse* one element of the QF list will be (bachelor, nursing) the list for *Registered nurses* will also include higher degrees in nursing.

Since each component of the change in the supply of qualified workers can be mapped to an occupation, the change in the supply for an occupation is then:

$$\Delta Supply_{o,t} = Completions_{\ o,t} + Migration_{\ o,t} + Jobflows_{o,t} - Labour\ force\ exits_{o,t} \quad \text{(C-13)}$$

Where $Completions_{\ o,t}$ is the level of relevant completions that will supply occupation *o*, at time *t*. Therefore, for each occupation there are then 5 flows that determine the change in the stock between periods. How each flow is informed is detailed below. It should be noted that labour force exists captures job leavers either to unemployment or NILF, as well as deaths.

By definition:

$$\sum_{q=1}^{m}\sum_{f=1}^{k} Supply_{q,f,t} \geq \sum_{o=1}^{z} Supply_{o,t} \quad \text{(C-14)}$$

since there must be more supply of qualified individuals than supply of individuals by occupation. The difference will be qualified individuals who are not intending to work again (the retired), or those committed to another occupation with the relevant qualifications.

[314] Analysis of Census of Population and Housing data is used to determine the likelihood that an incoming migrant will hold a qualification under the AQF classification system. Qualifications that are not recognised under this classification system are not counted, and the migrant is classified as unskilled for the purposes of this Study.

Chris's occupation flows

When *Chris* begins their retail job, they flow from not in the labour force (NILF) into employment as a sales assistant (a labour force inflow). When they are promoted this is captured as a job flow from sales assistant to retail supervisor.

After finishing their nursing degree, *Chris* begins working in an aged care facility. This is a completion of a bachelor degree which is also associated with a job movement. So, it is both a completion and job flow, but only increases the supply of *Registered nurses* by one (and reduces the supply of retail supervisors by one).

When *Chris* takes time out of the labour force to look after their children, they moved from employed in aged care to NILF, captured in labour force exits and reducing the supply of *Registered nurses*. When *Chris* returns to the labour force, they flow from NILF into employment, again a labour force entry.

Chris's retirement at 65 years reduces the supply of *Registered nurses* as they again move from employed in aged care to NILF.

Supply of workers for an occupation within an industry

The supply of workers within an industry is a function of the supply of workers in the relevant occupations:

$$Supply_{ind,t} = \sum_{o \in IND} g(Supply_{o,t}) = \sum_{o=1}^{k} Supply_{o,ind,t} \qquad \text{(C-15)}$$

Where $Supply_{ind,t}$ is the supply in industry *ind* at time *t* and *IND* is a list of occupations within the industry, and $Supply_{o,ind,t}$ is the supply of occupation *o* in industry *ind* at time *t*.

Industry movements

Where an occupation is in excess supply or demand across the economy, the excess supply or demand is shared across industries. For example, this it means that an individual who would be unemployed as a *Physiotherapist* in the health sector chooses to switch industries to gain employment, or be competing against fewer other physiotherapists, for employment in the care and support workforce. That is, industry movements are modelled as a reaction to the relative demand for the occupation across industries.

Chris's industry flows

When *Chris* moves from being a retail supervisor to being a *Registered nurse*, alongside the occupation flow there is an associated industry flow from retail (other industries) to residential aged care.

Starting stocks

To be able to determine the total available supply of workers for an occupation in each period of the forecast requires a starting stock from which to build. The ABS Census of Population and Housing (2016) is broadly the starting point for most stocks used for the supply forecasting as it allows for a consistent starting point for supply-side variables and contains the required level of disaggregation.

Mapping functions

There are 2 mapping functions on the supply side:

- The mapping from supply of workers by qualification and field of education to supply of workers by occupation.
- The mapping from supply of workers by occupation to supply of workers by occupation and industry.

Field of education to industry mapping

The projection of completions is conducted at the qualification level. That is, individuals graduate with a given highest qualification level, within a given FOE, but are yet to be classified to a specific

occupation. As such, the qualification level by FOE results are mapped back to an occupation basis to fully understand the supply and demand for labour.

Each qualification by FOE is assigned a likelihood in one of up to give occupations, based on relative employment shares from the 2016 Census of Population and Housing. The selection of these 5 possible occupations is based on the occupations that have the highest employment counts for a given qualification and FOE combination. In some instances, qualifications will only be suited to work in a single occupation, based on the specificity of a qualification. These are accounted for in the classification process.

Occupation to industry mapping

Occupations are assigned to an industry based on the forecast shares of occupations within an industry. These shares are based on analysis of occupation distributions by industry using LLFS data.

Retirements

The level of retirements across Australia is a function of known trends in the age structure, labour force status expectations by age, and migration movements.

An estimate of the size of the labour force aged 50 and over at any point in time is compared with the size of the labour force aged 45 years an over 5 years previously, plus the additional migrants aged 50 and over that would have moved to Australia in the past 5 years. The gap is assumed to be a measure of retirement across the five-year period.

This method allows for the level of retirements to be forecast using Deloitte Access Economics' Demographic model based on a combination of:

- population projections by age
- participation rates by age
- international migration levels.

Given Australia's ageing population, there is a large proportion of the workforce now approaching retirement age. This will likely see the rate of retirement increase sharply in the next few years before stabilising.

To determine how retirement rates differ by occupation, occupation-specific offsets from the national average are calculated based on data from the Australian Census Longitudinal Dataset (ACLD) at the 3-digit occupation level (comparing relative rates of retirement by occupation across Australia to the national average). At the 4-digit occupation, relative age structure of each occupation from the 2016 Census are then used to create deviations in retirement rates.

Completions

Completion forecasts are produced to determine the new additions of workers available for each occupation based on the qualification they hold.

The completion of qualifications by domestic students represents the most significant source of additional skills in the Australian economy. Data on the number of historical qualifications by age is obtained from 2 main sources – the Department of Education, Skills and Employment (DESE) and the National Centre for Vocational Education Research (NCVER). Forecasts of completions are estimated by applying projections of population by age and location to recent student completion rates.

Qualification completions by international students studying in Australia do not automatically add to the supply of skills in the Australian economy as many international students return to their home country following the completion of their qualification. Those that go on to work in Australia are captured within the net migration data.

Migration

Overseas migration is a key input into the supply of skills and occupations at the national level over the coming years.

Deloitte Access Economics' demographic modelling provides estimates of immigration and emigration by age and sex, based on historical ABS migration data.

Data from the 2016 Census gives a measure of the qualifications held by different age groups for international migrants into Australia. These proportions are applied to each of the populations of migrants, so that increases in net overseas migration result in increases in the population of workers by highest qualification.

Australia has a substantial skilled migration program, as well as other migration visas, which contribute to the skills available to the labour market.

The modelling includes all migrants entering Australia. This includes permanent migrants, temporary skilled migrants, and others such as migrants entering Australia on student visas.

ABS data, including the 2016 Census, inform the modelling of the skill profile of migrants and this is incorporated in both inflows and outflows. This information is combined with the projected future supply of overseas migrants to generate the expected level of the future supply of skills.

The migration projection depends on key demographic assumptions, notably the expected level of net overseas migration to Australia over the forecast period, as well as its age composition.

Job flows

Over time, individuals may change occupations as they develop new skills and progress along their career or pursue different opportunities.

Overall rates of where individuals move to (job inflows) are based on reported rates of occupation change in the ACLD, which tracks changes in occupation employment at the 3-digit level. The forecast total rate of job inflows in the future assumes that age (and sex) is an indicator of movement propensity, with age-group movements at the 1-digit occupation level from the ACLD used to drive changes in the overall rate of movement between occupations.

Where people move from (job outflows) are derived from the LLFS. The survey is used to calculate propensities of where an individual has moved from, given the occupation they have moved to. For example, for someone who has transitioned to the *Aged and disabled carers* occupation, there is a 47% probability that they were previously employed in the *Nursing support and personal care workers* occupation.

The outflow propensities are applied to the total number of job inflows each year to get job outflows in the same period. This method ensures that net job flows (inflows less outflows) are zero in each year. These considerations give an estimated level of workers switching occupations across Australia in any year.

Although net job flows across the economy will be equal to zero each year, net flows may be either positive or negative for a given occupation. For those occupations that have inflows that exceed outflows, net flows will be positive and the size of employment in the occupation will increase, and vice versa when outflows exceed inflows (i.e. the size of employment in the occupation will decrease).

As with the retirement modelling described above, the age structure of the labour force is a key consideration, and as a result the ageing of the workforce results in a modest downward trend in the rate of 'replacement' demand over time, as older workers tend to move occupations slightly less than younger workers.

Much of the rest of the modelling follows a similar methodology to retirements, with relative rates of movement by occupation modelled for 3-digit occupations based on ACLD data, with 4-digit occupations modelled using information from the ages of current workers.

To be counted in 'replacement' or net new demand for skills, a worker must be employed in both the 2011 and 2016 ACLD samples – those who go from employed in 2011 to unemployed in 2016, or from unemployed in 2011 to employment in 2016 are captured by the change in overall employment levels over time. Those aged over 45 who go from being employed in 2011 to not in the labour force in 2016 are assumed to have retired and are included in the earlier methodologies, while all other movements are effectively lost from the calculations, although they are a small group.

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Appendix E
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