Submission to the Australian Department of Education and Training on the 2017-18 Skilled Occupations List update

21 November 2016

Introduction

1. This submission is from the New Zealand Aged Care Association (NZACA), the peak body for the aged residential care sector in New Zealand. With over 590 members, we represent over 90% or approximately 37,000 beds of the country's aged residential care (ARC) sector. Our members range from the very small stand-alone care homes to the large co-located sites that include care services and retirement villages. Our members' services include rest home, hospital, dementia and psychogeriatric care, as well as short-term respite care and a small number of YPD (young persons with disabilities) beds.

2. Advocating and lobbying to government to shape policies and create an environment that helps our members provide outstanding quality care is at the heart of what we do. We also provide leadership on issues that impact on the success of our members. We also produce valuable research, professional development opportunities, information and publications to help our members make informed business decisions, improve capability and keep them up to date with sector developments.

3. We have a small team of five staff based in Wellington and led by Chief Executive, Simon Wallace, a representative Board of eleven directors chaired by Simon O'Dowd and a network of sixteen branches around New Zealand.

4. Any enquiries relating to this paper should in the first instance be referred to Kathryn Maloney, Senior Policy and Research Analyst at kathryn@nzaca.org.nz or by phone on 04 473 3159.

Comment

5. During the development of ANZSCO it was recognised that the needs of non-statistical users of ANZSCO would best be served if the classification could reflect the contemporary labour markets of Australia and New Zealand. To achieve this, the primary focus of the review was making changes at the occupation (6-digit) level of the classification, and included the addition of new occupations and specialisations within occupations, changes to the titles of existing occupations, and amendments to definitions to update and help clarify the scope and content of certain occupations. ANZSCO was developed jointly by the Australian Bureau of Statistics (ABS), Statistics New Zealand (Statistics NZ) and the Australian Government Department of Employment and Workplace Relations (DEWR) to improve the comparability of occupation statistics between the two countries and the rest of the world.

6. The past decade has seen ongoing structural change in the Australian and New Zealand labour markets with strong employment growth in areas such as health, community services, business services, tourism and hospitality, and retail. Occupations have become more specialised and new occupations have emerged and evolved, particularly in information technology, communications and health services.

7. An up-to-date occupational classification is an essential response to the changing labour market. ANZSCO will assist the many enterprises, education and training bodies, government agencies, and industry and professional organisations to understand and adapt to emerging occupational requirements (retrieved directly from Australian and New Zealand Standard Classification of Occupations First Edition ANZSCO 2006).

8. This submission recognises the comments made above and asks for a change in classification to a health care vocation, detailed in the following material.

Position statement

9. The Health Care Assistant role is currently represented within the code: ANZSCO 4233 - Level 4 Nursing Support and Personal Support worker.

10. We submit that this code no longer reflects the occupation of the Health Care Assistant (and all related names) and request that a new title be used, especially pertaining to aged care, that of Health Care Assistant (as being the most common term) and reflect the nature of this occupation by classifying it at ANZSCO Level 3.

11. We also submit that the person requiring the ANZSCO is usually someone of a health background, holding a degree from a country which for various reasons may not be recognised within Australia or New Zealand. This person, however has their knowledge and skills exploited by the employer who does recognise this person's contribution to the workplace and thus employs them in senior positions. The employer, however is not required, or cannot remunerate them for their contributions to that workplace. We submit that the change in level will assist to reflect their status.

12. We acknowledge that a Level 4 (New Zealand Qualifications Framework) trades person in New Zealand has progressed through an apprenticeship or similar and is deemed to be very competent, highly recognised and valued. We submit that the Level 4 Health Care Assistant (HCA) position also be similarly recognised as Level 3 (minimum) ANZSCO.

Executive summary

13. Both New Zealand and Australia are encouraging their older people to stay in their own home for as long as possible which results in two vocational needs: home care support to assist with this and then a knowledgeable and skilled workforce to provide care for the person once they enter into aged care, now having very complex and serious health issues.

14. The HCA provides 90% of this care, whether it be as the independent worker in the home, or as the virtually independent worker in the aged care facility. The nature of the role once thought of to be a Registered Nurses Assistant has rapidly changed and the numbers of nationals wishing to undertake this role has significantly decreased, for a variety of reasons but predominantly for the low pay and poor recognition of this very skilled and complex role. This means that due to increased workforce demand both New Zealand and Australia are becoming reliant on the migrant care worker. If we do not change the status of the migrant worker and improve conditions such as access to residency and improved visa status, this person will find another country in which to work and live. We will shortly have a workforce supply crisis and it is our very vulnerable population who will be at most risk.

15. These assertions will now be explained and evidence supplied.

The ageing population

16. The rise in the numbers of aged people is causing increasing concern throughout the world and it is recognised that extensive planning for workforce demand is required. In 2001 it was reported that almost one fifth of the global population was aged 60 or older and by 2050

this proportion is expected to reach one third (Australian Department of Economic and Social Affairs, [DESA], 2001). The advances in technology and medical knowledge complemented with an improvement of general living conditions has resulted in the fastest growing age group in the world being aged 80 years or older. By 2050, one fifth of older persons will be in this age group and the global aged population will amount to some two billion people (DESA, 2001). New Zealand is predicted to experience similar growth with numbers of those aged 65 years and over increasing by 84% from 512,000 in 2006 to 944,000 predicted in 2026 (Thornton, 2010). Australia is in a similar position with the Australian Treasury reporting that "the proportion of Australia's population aged over 65 years has grown from eight per cent in 1970-71 to thirteen per cent in 2001-02. The IGR [Intergenerational Report] projects that over the next 40 years, the proportion of the population over 65 years will almost double to around 25 per cent".

17. The actual numbers of aged persons are not necessarily problematic; it is the decreasing number of people who can support them that is creating challenges and thus the increased demand for aged residential care (Thornton, 2010).

Workforce demand

18. The Thornton Review of aged care services in New Zealand (2010) predicted increased demand between 2010 and 2026 of 12,000 to 26,000 extra residents, and a reciprocal increase in workforce of between 50% and 75% full time equivalent staff. Implications for the workforce numbers of the HCA are significant with the HCA providing 90% of direct care in aged residential care (Bowers, Esmond, & Jacobson, 2003; Carlson, 2007). It is estimated that in the United States the HCA position, in both residential and home care will be the second and third fastest growing employment opportunity respectively (Institute of Medicine, 2008). The World Health Organisation estimates that there is a current global shortage of 4.5 million HCAs; if little changes by 2036 New Zealand will be in deficit close to 28,000 HCAs and Australia will be looking for 200,000 HCAs (Badkar. J, 2009; Human Rights Commission, 2012). Already Australia has recognised the need, to at the very minimum, increase the remuneration of this sector and in 2012 under Fair Work Australia Policy, the Australian Government ordered that wages of approximately 150,000 HCAs be increased between nineteen and 40 per cent, to be phased in over an eight-year period. This was described as an effort to improve equality and to also lift the perception of the work, to increase the status (Human Rights Commission, 2012).

19. Currently in New Zealand an estimated 48,000 HCAs provide care to approximately 42,000 people in over 700 aged care facilities. This predominantly female work force (90 per cent) comprises many ethnicities namely: 56 per cent European, 15 per cent Māori, 13 per cent Asian and eight per cent Pasifika. This is also an ageing workforce with over 60 per cent of the HCAs between the ages of 45 to 65 years, therefore expected to retire from the workforce in the near future. Compounding the problems predicted with the mass exodus from the current employee base are the issues surrounding the increasing use of immigrant workers which comprise 31 per cent of the current work force, who are usually highly qualified health care professionals, unable to obtain registration within their new country (Thornton, 2010). This workforce is frequently exploited with long split shifts, extra demands

placed on them and the threat of a change in visa status hanging over them (Thornton, 2010).

20. Thus, we have an ageing population, an ageing workforce, we are becoming increasingly dependent on a migrant workforce and we know that nationals do not wish to work within this poorly recognised sector. The poor response for nationals to work within this occupation is evidenced in the case study from St Andrew's Village, attached to this submission.

21. Unless New Zealand and Australia address the issues with the provision of aged care we will shortly be in competition for the HCA and will be found wanting.

The role of the Health Care Assistant

22. These titles include the current terms used to describe the position that was once developed to assist the Registered Nurse (RN) provide basic needs such as: Health Care Assistant, Community Care Worker, Long Term Care Worker, Nurse Aide, Home Support Worker, Mental Health Worker, Community Care Assistant, Personal Care Assistant, Clinical Care Assistant, Clinical Support Worker.

23. Regardless of the name, the issue facing the Health Care Assistants is that the role has changed from that envisaged so many years ago and we have not kept up with this change nor do we recognise it. There has been a significant increase in the dependency and complexity of care required in aged care facilities compared with that required 20 years ago (Human Rights Commission, 2012). The increase in longevity, improved technology and the ability for a person to remain in their own home until formal care is required, has resulted in an aged residential care environment where 56% of occupants are classified as requiring the higher levels of care and 60% with some form of dementia (New Zealand Labour, et al., 2010). This increase in acuity and thus in requirements for care has impacted on the work of the HCA, however there is little recognition of the corresponding change in the role of the HCA, other than an intensification and increased expectation on the HCA.

24. The Cavendish Review (2013) reports that the United Kingdom has over 1.3 million health care workers, a rapidly ageing population, significant advances in medicine, and a growing burden of paperwork on the RN. This is resulting in some HCAs performing tasks, including invasive procedures, which were once the domain of nurses, and even doctors.

25. Where once the HCA was closely supervised and assisted the RN, this has now changed, with the HCA at times actually managing the units, staff and leading the care of the clients. As reported within the Thornton Review (2010) supervision and support hours by the RN are declining. Minimum staffing requirements regulations were stipulated in previous legislation such as Old Persons Homes Regulation 1987 and Hospitals Regulations 1993. However, these are not included in current legislation, with facilities able to decide staffing levels, as long as there is a RN on call at all times, not necessarily within easy access. The responsibility placed on the HCA, the demands for, at times, crucial decision making, the increased responsibilities, increase in complexity of tasks, and the increased requirement for accurate documentation all makes for a very changed role from that of even five years ago and we must recognise this.

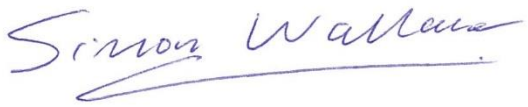
Conclusion

26. We submit that the rapid and dramatic increase in the ageing population will result in the HCA being a position in global demand and that the complexity of this position no longer relates to the position initially developed, that of an assistant to the RN, who was closely watched and assisted.

27. New Zealand and Australia are becoming reliant on the highly qualified, skilled and knowledgeable migrant health professional: the RN, Physiotherapist, Occupational Therapist and other healthcare workers who are employed in our respective countries as Health Care Assistants, assuming significant work load and responsibility. This situation is not reflected in the current ANZSCO codes and should be rectified. We are, after all talking about many thousands of workers currently employed in New Zealand and the many more that we need.

28. Revision of the codes is based on significant change in the occupations, the increased number of those employed within these occupations and on need. We believe that we have sufficiently demonstrated all criteria required to increase the ANZSCO level of this role.

Regards,



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