Aged Care Association
NEW ZEALAND

Aged Care Association submission to Ministry of Education's consultation document on the 'Options on the future of work-based learning'

February 2025

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About the Aged Care Association

This submission is from the Aged Care Association (ACA), the peak body for the aged residential care (ARC) sector in New Zealand.

New Zealand has over 670 aged residential care facilities, with more than 40,000 beds and 35,000 residents. In comparison, Te Whatu Ora oversees 10,748 public hospital beds.

Our members provide rest home, hospital, dementia, psychogeriatric, respite, and palliative care and care for around 700 younger people with disabilities.

Sixty six percent of beds are run by religious institutions, charitable trusts, family-owned, not-for-profits, and privately owned facilities. Most of the remaining beds are operated by listed companies (34 percent), with less than 1 percent provided by Te Whatu Ora.

Residents may be

- very frail and clinically unstable,
- well but disabled and have very high care needs,
- cognitively impaired or with mental health issues, with some requiring a secure environment,
- receiving end of life care.

Funding for aged residential care is a mix of means-tested user-pays and government subsidy.

Aged residential care providers are contracted by Te Whatu Ora to provide care services at a rate that is set annually.

The aged care workforce is under-resourced and overworked.

The ACA welcomes the opportunity to make a submission to the Ministry of Education on its consultation document on the *'Options on the future of work-based learning'*. The Association is available for discussion at any time that suits the Ministry.

Context

1. The ARC sector provides services across four care categories:
    - Rest home care: the resident is assessed as generally able to be independent (are mobile and can feed themselves) but needing assistance with personal care or supervision of activities of daily living. The residents are assessed as unable to safely live in their own homes (or other community settings) either due to their disability needs and/or lack of informal supports.
    - Hospital level care or continuing care: the resident is assessed as having significant disability, usually in combination with medical problems, which requires 24-hour supervision with registered nurse input for their care.
    - Dementia care: the resident is assessed as needing 24-hour supervision and care, in a secure environment due to risk of wandering or becoming lost due to memory loss or confusion.
    - Psychogeriatric care (also known as specialised hospital care): the resident is assessed as needing 24-hour supervision and care. This level of care is for people with major behavioural issues (including severe dementia or addictions). They need a high level of specialist nursing care.
2. The staffing requirements, including skill level of the workers, vary across these four levels, as the acuity and medical needs of residents also vary.
3. The Age-Related Residential Care Services Agreement, which is the sector agreement between Te Whatu Ora and ARC facilities, set annually and negotiated by the Aged Care Association, lays down the requirements for staffing across these four levels. It also specifies the training and certification requirements for care workers across these levels. The agreement is negotiated on an annual basis and in close consultation with the aged residential care sector.
4. There are several unique workforce challenges impacting the sector. Primary among them is the lack of sufficient New Zealand-specific contextual training to the internationally qualified workforce.
5. Approximately 70 percent of the ARC workforce is made up of internationally qualified care workers and nurses. Our members have told us that a recurring challenge for our sector, is that the migrant workforce has insufficient opportunities to gain contextual learning around the provision of clinical services in New Zealand, especially at the entry-level.
6. While some large facilities can support these workers as they adapt, smaller facilities, those most likely to require a migrant workforce, find it difficult to identify a suitably experienced care worker or registered nurse.
7. Among the care workforce, ARC sees a huge turnover. A key reason for this is the poor promotion of career pathways for the care workforce.

ACA response to the consultation questions

1. Which of the two models – Independent or Collaborative work-based learning – does your organisation prefer?

a. The independent model is best suited to meet the needs of our sector's employers and the workforce. The multi-lateral work-based learning model management-heavy, over-engineered and complex. It would be cost and resource intensive. Furthermore, with option 3 requiring substantial redesign of the current systems, we have concerns that it could lead to change fatigue. This could in turn contribute to a decline in the service delivery given the more complex transition for the learners and employers. Such a cost-intensive exercise, which is currently uncosted, could further create significant fiscal risk to an already economically constrained government. As stated in the consultation document, a multilateral relationship could also lead to a blurring of accountability between the different actors, making the system inaccessible for its consumers.
b. We need a system that is flexible, responsive to sector skills needs, and avoids undue complexity. The Independent model, with its straightforward transition and simpler structure, aligns with these preferences.
c. The Independent model will offer more scope for the industry and employers to have direct input into the standard setting and training delivery functions of ISBs.

2. Why will your preferred model work best for employers and learners in work-based learning?

The benefits of an independent work-based learning model are:

a. *Less disruptive transition:* We have expressed concern about the risks associated with reconfiguring the sector and the potential for change fatigue. The Independent model offers a relatively straightforward transition, maintaining existing relationships and minimising disruption; vital for the health care sector, where stability is crucial in maintaining a steady stream of suitably qualified workers.
b. *Flexibility and responsiveness:* The Independent model allows employers to work directly with training providers, allowing control over programme design and ensuring that training is tailored to their specific needs.
c. *Clearer lines of responsibility:* With a single provider managing all aspects of a learner's programme, there are clear lines of responsibility. This avoids the potential for duplication and blurred accountability that are inherent in the multi-lateral model.
d. *Reduced bureaucracy:* With fewer parties involved in the delivery of training, the Independent model has the potential to reduce bureaucracy and improve efficiency.
e. *Industry-led approach:* The Independent model allows direct links between industry and training providers, which aligns with our preference for industry-led standards-setting.
f. *Cost and resource effective:* Given the straightforward design of the Independent model, it could be more cost and resource effective. In the multi-lateral model, allowing ISBs to charge fees to providers for quality assurance functions would increase costs and create a barrier to access.

3. What does your organisation think are the main benefits, costs and risks of each option for employers and learners in your industry?

Independent work-based learning:

Benefits:

- A straightforward transition that maintains existing relationships and avoids the potential for disruption.
- A direct and simple relationship between employers and providers.
- Sector knowledge can come to the fore in training content and assessment.
- A single point of contact for employers to engage with standard settings and training delivery.
- Employees/students can access pastoral care at their place of work and learning, a place where they are already known and have meaningful relationships.

Costs and risks:

Increased competition for funding between providers which may disadvantage smaller providers.

Without adequate processes in place, ISBs may have fewer resources and incentives to get direct feedback from the industry.

Multi-lateral (Collaborative) work-based learning:

Benefits: A direct feedback loop from employers and apprentices' trainees to the standards-setting ISBs, and dedicated responsibility for pastoral care from the ISB, could improve learner success.

Costs and risks: A complex transition, and an over-complicated management model, will add cost and reduce efficiency, while increasing the risk of single point of failure. A multi-lateral contractual model would unnecessarily complicate the process for learners and educators.

4. Both models will involve a transition process but this will be different for each. What will be the critical factors in making transitions work for your industry?

The critical factors for a successful transition with a focus on the Independent-model include:

A smooth transfer of the work-based learning divisions of Te Pūkenga: The key priority would be to ensure that the transfer of the work-based learning divisions of Te Pūkenga to independent providers is seamless, with minimal disruption to learners and employers. Clear timelines and communication would be essential.

Clear industry ownership and control: The transition should ensure that industry has sufficient opportunities to share their feedback for standards and training.

Maintaining existing relationships: Current training agreements and relationships should be maintained wherever possible during the transition process.

Adequate Funding: The funding model should ensure that the newly independent training providers are adequately funded to operate successfully. The model should not be determined by profitability but rather by actual need for specific skills and qualifications in the sector, as well as global trends.

Clear communication: Clear communication with all stakeholders is essential throughout the transition process.

Focus on quality: A focus on the quality and relevance of training must be a priority to ensure that the needs of the sector are met.

Practical learning: We would like to emphasise on the importance of workplace learning rather than online or classroom-based learning, especially for the health sector. As a significant share of the health workforce is made of people who have migrated from other countries, a practical learning model would ensure that they are better work-ready.