



## Social Assistance and Allied Health Workforce Strategy



## ABOUT THE STATE TRAINING BOARD

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The State Training Board is the peak industry training advisory body to the Minister for Education and Training in Western Australia. The State Training Board's functions are set out in Part 3 of the *Vocational Education and Training Act 1996*.

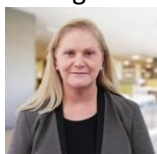
The role of the State Training Board is to provide advice to the Minister for Education and Training on the existing and anticipated supply and demand for skills in various industries, including industries that are expected to grow or may experience a shortage of skilled labour. The Board's role is to provide advice on strategies to support such industries through the vocational education and training (VET) sector.

Our members come from a range of industries and are dedicated to training and skills development. The Board provides a direct link between industry and government. We are committed to fostering strong partnerships with industry, unions, peak bodies, and employers to identify training and skills needed by Western Australian industries for Western Australian jobs.

Members of the State Training Board are:



Jim Walker (Chair)



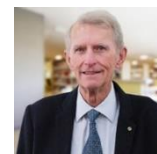
Vanessa Davies



Chris Hall, AM



Professor Cobie Rudd



Wayne Muller



Meredith Hammat



Ray Sputore



Captain Angela Bond



Fran Kirby

### SOCIAL ASSISTANCE AND ALLIED HEALTH WORKFORCE STRATEGY

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Office of the State Training Board  
Department of Training and Workforce Development  
Level 2, 16 Parkland Road, Osborne Park WA 6017  
Telephone: 08 6551 5593  
Email: [ostb@dtwd.wa.gov.au](mailto:ostb@dtwd.wa.gov.au); Website: [stb.wa.gov.au](http://stb.wa.gov.au)

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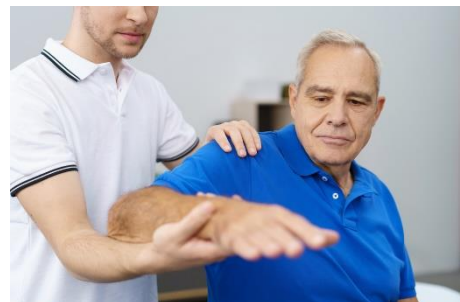
## EXECUTIVE SUMMARY

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Western Australia's community deserves a well-functioning, well-resourced and highly skilled workforce to support its aged care, disability services, allied health and community services sectors. The demand for these services is expected to increase significantly in the coming years and it is essential that the State implements a plan that secures the workforce needed to meet this demand.

The social assistance and allied health sectors have undergone significant reforms in recent years that have changed the funding, policy and operating environment. The ability for consumers to choose who provides their care and support will create a more competitive and innovative market but will present challenges and opportunities for the workforce and service providers, such as remuneration, working conditions, staffing ratios and career pathways.

Medical advances and changes in technology and patient care will require continuous training and skills development. These advancements mean that in order to provide best-practice patient management and residential care services, workers will be required to continually update their skills; particularly in areas where boundaries are often challenged, and new areas explored, such as managing patients with cognitive issues. These factors highlight the importance of providing opportunities for skill development both for existing workers and for new workers joining the industry.



The State Training Board established this project to develop an understanding of the workforce and skill needs of the social assistance and allied health sector. The Board established the Social Assistance and Allied Health Workforce Steering Committee comprising industry peak associations, employers, unions and government agencies to guide the research and the development of an integrated workforce development plan for the sectors.

The Steering Committee's research has found that the Western Australian social assistance and allied health sectors are undergoing fundamental change driven by new government policy, changing consumer expectations and an increasingly contestable market. These changes coincide with an escalating demand for services, with the demand for workers predicted to rise across all sectors, led by the disability and aged care sectors. Significantly, the largest occupational group - support workers – needs to double over the next five years. The short timeline for the rollout of the National Disability Insurance Scheme (NDIS) presents an immediate challenge for Western Australia in ensuring an adequately skilled workforce.

The vocational education and training (VET) sector must provide training that meets the needs of the social assistance and allied health workforce. Understanding the current and future workforce requirements, including the anticipated growth of the sectors resulting from factors such as the ageing population and the roll out of the NDIS in Western Australia will enable the training system to respond to the demand for training places.

Whilst industry is making efforts to meet its workforce skilling commitments with great examples of innovation and commitment this appears to be taking place in isolation of the formal VET system. Traineeships are at an all-time low and classroom learning appears to be in decline. Increased casualization of the workforce and less than favourable salaries and employment conditions are further barriers to the attraction and retention of a skilled workforce.

Considering the current environment, it is likely that the Social Assistance and Allied Health sectors will face a challenging future in sustaining a sufficiently skilled workforce.

The Steering Committee has identified the opportunity to make changes that will help avert a skill shortage and the risk that inadequately trained workers could present to vulnerable people in the community. In particular, there is strong industry support for the introduction of a “white-card” to ensure new workers complete base-level training prior to working with vulnerable people.

The cost of VET is a major barrier for students, existing workers and employers in the social assistance and allied health sector. Financial support to students and employers from the Australian and State Governments that fully covers or heavily subsidises the cost of learning could help drive the growth in skilled workers.

The State Government should consider lowering course fees, particularly for the Certificate III in Individual Support and the Certificate III/IV in Allied Health Assistance, to encourage the uptake of these critical qualifications and encourage more people to pursue careers in the social assistance and allied health workforce.

The State Government and the VET sector will need to consider whether the current funding of training places is adequate to meet the growing demand for skilled workers. The State Government’s VET funding policy must safeguard training opportunities for existing unskilled and semi-skilled workers to gain new skills or qualifications needed to care for people with complex needs.

While cost is influencing the take-up of training, the Steering Committee has identified other opportunities to make the VET sector more accessible to both industry and the public. Firstly, streamlining training pathways to provide flexible employment options for students. Secondly, enhancing the quality of training and supporting the regions through a stronger focus on partnerships between TAFE and local employers (similar to the resources sector). The Steering Committee has also identified the opportunity for industry to take a greater leadership role in providing work experience and placements, particularly for school-aged students.

With the State Government and industry working together there is considerable scope to increase community awareness of the career opportunities associated with a VET trained job in and across the Social Assistance and Allied Health sectors. Significantly, the opportunity already exists within the current training program to equip people with the skills to move across sectors as career aspirations change. The Inquiry has also identified the opportunity to incorporate a greater focus in schools on awareness of the breadth of career opportunities available across the sectors.

There is considerable opportunity to adopt a whole of government approach to the planning currently being undertaken to maximise the response to the workforce requirements of the sectors. Further collaboration between the Australian and State Government on the implementation of the NDIS is a key part of this work. Government, as a major funder and employer, has considerable scope to drive upskilling of the sectors.

The Steering Committee is particularly grateful to Jamie Mackaway and the staff at the Community Services, Health and Education Training Council for their research and consultancy work with industry in the development of an integrated workforce development plan.

The recommendations presented in this report can be readily implemented given the commitment of industry to deliver high quality services and the State Government’s focus on jobs and the opportunity that the expansion of the Social Assistance and Allied Support sector presents to the Western Australian economy. However, further consultations will be required with and between industry and Government to develop an implementation plan that establishes a timeframe, targets and budget necessary to ensure a timely response.

**CHRIS HALL, AM**  
**CHAIR, SOCIAL ASSISTANCE AND ALLIED HEALTH STEERING COMMITTEE**

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# SOCIAL ASSISTANCE AND ALLIED HEALTH WORKFORCE PROJECT

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## PROJECT OVERVIEW

The State Training Board initiated this project to understand the workforce needs of Western Australia's Health Care and Social Assistance industry. The Board invited National Disability Services (WA Branch), Aged and Community Services (WA Branch) and WA Council of Social Services to provide presentations in May 2017 on current workforce issues. It became evident that there were common issues affecting each sub-sector and an agreement that a coordinated approach would be beneficial.

In June 2017, the State Training Board resolved to establish a steering committee to inquire into and provide advice to the Minister for Education and Training. Accordingly, the Board passed a resolution to establish the steering committee incorporating representatives from Western Australia's aged care, disability, mental health, allied health and community service sectors (the "sectors") with a vocational education and training (VET) focus.

In September 2017, the State Training Board established the Social Assistance and Allied Health Workforce Steering Committee comprising industry, government and non-government representatives. The Community Services, Health and Education Training Council were appointed to guide research and consult with industry in the development of an integrated workforce development plan for the sectors.

## DEFINING "SOCIAL ASSISTANCE AND ALLIED HEALTH"

For the purposes of this project, it is important to understand what the Steering Committee defines as the "social assistance and allied health workforce". The Committee has agreed that the project will include the following areas:

- Aged Care;
- Disability Services;
- Mental Health;
- Allied Health: excluding services delivered in acute health care and care in hospitals but including primary health, community health and services that are supported under the National Disability Insurance Scheme; and
- Community Services sectors including Aboriginal and Torres Strait Islander services, childcare services, child protection, youth services, drug and alcohol support programs and other community support programs.

## TERMS OF REFERENCE

The Steering Committee is to provide advice on:

1. identification and development of points of integration and intersection to encourage workforce development, mobility and shared resources between sectors;
2. the current composition and future requirements of the workforce in Western Australia in the public, private and not-for-profit sectors, including full-time, part-time and casual workers, including:
  - a. the common and sector-specific entry level skills and qualifications needed by frontline and service support roles across the sectors;
  - b. the common and sector-specific skills and qualifications needed by management and governance roles across the sectors; and
  - c. factors impacting workforce attraction and retention, such as remuneration, working conditions, recognition, staff ratios, and career progression and pathways.
3. the role of the vocational education and training system in addressing the workforce development needs of the sectors, including:
  - a. quality and consistency of competencies, qualifications and skills sets being delivered



- that respond to the needs of learners and industry;
  - b. the coordination, management and supervision of work placements for students and trainees;
  - c. barriers and their potential solutions to training participation and completion by marginalised groups, such as fees, ineffectual delivery models and the complexity of the VET system; and
  - d. the appropriateness of administration, compliance and reporting requirements on providers.
4. the future workforce requirements, including:
    - a. anticipated growth of the sectors resulting from factors such as the ageing population and the rollout of the National Disability Insurance Scheme in Western Australia;
    - b. challenges and opportunities associated with changes in Commonwealth and State Government policy, funding and regulation in relation to service delivery and the VET system;
    - c. challenges and opportunities associated with access of delivery of services to and by Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse groups, people with disability, young people, and the LGBT community;
    - d. challenges and opportunities associated with the delivery of services in rural and remote towns and communities in Western Australia; and
    - e. the use of technology, medical advances and other innovative practices to support the delivery of services.
  5. such other matters that the Committee may recommend and the Board may determine for inquiry.

## SOCIAL ASSISTANCE AND ALLIED HEALTH STEERING COMMITTEE

The membership of the Social Assistance and Allied Health Steering Committee is as follows:

- Chris Hall, AM, State Training Board (Chair);
- Professor Cobie Rudd, State Training Board;
- Wayne Muller, State Training Board;
- Dr Felicity Jefferies, Healthfix Consulting<sup>1</sup>;
- Julie Waylen, State Manager, National Disability Services (WA);
- Trevor Lovelle, Chief Executive Officer, Aged and Community Services;
- Louise Giolitto, Chief Executive Officer, WA Council of Social Service;
- Christine Allen, Chief Executive Officer, Leading Age Services Australia (WA Branch);
- Sharon Bushby, Manager Sector Development, Aboriginal Health Council of WA;
- John Bouffler, Executive Director, Community Employers WA;
- Dan Hill, Secretary, Health Services Union of WA;
- Rachelle Tucker, Executive Officer, Australian Childcare Alliance Western Australia;
- Jamie Mackaway, Chief Executive Officer, Community Services, Health and Education Training Council;
- Margaret Denton, Executive Director, WA Country Health Service;
- Karen Bradley, Chief Nurse and Midwifery Officer, Department of Health;
- Renae Hodgson, Assistant Director, Mental Health Commission; and
- Dr Ross Kelly, Director, Policy, Planning and Research, Department of Training and Workforce Development.

Mr Arron Minchin, Executive Director Strategy and Development, Department of Primary Industries and Regional Development was a temporary member of the steering committee between September and December 2017.

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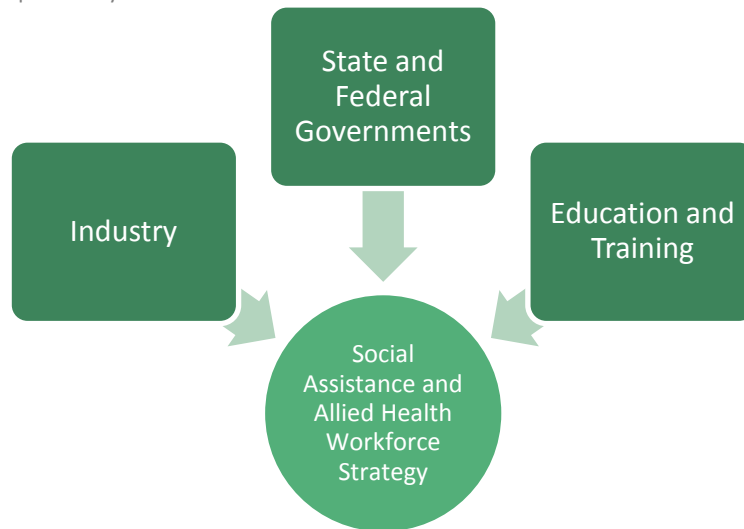
<sup>1</sup> Dr Felicity Jefferies was a member of the State Training Board until 31 December 2017.

## RECOMMENDATIONS

### A COORDINATED RESPONSE

The Social Assistance and Allied Health Steering Committee strongly believes that the implementation of the Social Assistance and Allied Health Workforce Strategy is a shared responsibility between industry, State and Federal Governments and the State's education and training sectors.

Figure 1: A shared responsibility



#### A COORDINATED AND SHARED RESPONSIBILITY

**RECOMMENDATION 1:** That a coordinated and integrated approach is taken to maximise the development and growth of the social assistance and allied health workforce to meet the growing and diverse demands of people in the Western Australian community.

### WORKFORCE DEVELOPMENT STRATEGIES

#### A CONTEMPORARY, SKILLED AND FLEXIBLE WORKFORCE

**RECOMMENDATION 2:** Simplify and streamline employment and training pathways urgently and build a contemporary, skilled and flexible workforce to meet the growing and diverse needs of people in Western Australia.

#### QUALITY SERVICES FOR REGIONAL AND REMOTE COMMUNITIES

**RECOMMENDATION 3:** The State Government ensures that the social assistance and allied health sector has appropriately skilled workers in regional and remote communities.

#### ATTRACTING AND RETAINING A DIVERSE WORKFORCE

**RECOMMENDATION 4:** Grow and develop the social assistance and allied health workforce through innovative attraction and retention strategies, career and training pathways aimed at diversifying the workforce and raising awareness in the community of the many rewarding job opportunities.

## VOCATIONAL EDUCATION AND TRAINING STRATEGIES

### QUALITY TRAINING OUTCOMES

**RECOMMENDATION 5:** The Department for Training and Workforce Development work with industry peak bodies, the Training Accreditation Council and the Australian Skills Quality Authority (ASQA) to increase confidence in VET delivery in the social assistance and allied health sector.

### TRAINING AFFORDABILITY

**RECOMMENDATION 6:** The State Government explore ways to decrease the cost of training for social assistance and allied health sector employers and students/trainees so that it is more affordable.

## FUTURE RESEARCH

### FUTURE WORK REQUIREMENTS

**RECOMMENDATION 7:** The Social Assistance and Allied Health Steering Committee to undertake further research and industry consultations to determine the future workforce requirements of the social assistance and allied health sectors to improve portability of skills and ensure a skilled workforce into the future.



## WORKFORCE DEVELOPMENT PLAN SCOPE

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The social assistance and allied health workforce strategy and development plan aims to support Western Australia's aged care, disability services, mental health, allied health and community services sectors attract and retain skilled workers to meet the increasing demand for services from people in Western Australian communities.



The focus of the project is on occupations with a vocational education and training pathway and does not cover the entire health care and social assistance sector in Western Australia. The plan does not attempt to address the workforce requirements of mainstream health services including hospitals, specialist medical services, maternity services, emergency medicine, medical services offered through general practice, pathology or diagnostic imaging services.

The workforce strategy and action plan is responsive to issues raised by key stakeholders in extensive industry consultation undertaken by the Community Services, Health and Education Training Council and issues identified by members of the Steering Committee. It explores specific workforce issues raised by service providers, peak bodies and government agencies working in the industry. The primary focus of this project has been the frontline and support workers that are at the forefront of demand. Without these critical workers, service providers will be unable to meet individual needs of people within the Western Australian community.

The social assistance and allied health sectors are likely to face significant challenges in attracting and retaining suitably skilled workers in sufficient numbers to respond to this growth. The sectors already face skill shortages in the regions, and this situation is likely to extend to the metropolitan area as the demand for services grow, the economy recovers and competition for workers increases. Lower than average wages, increased casualization and high staff turnover are additional challenges. The decline in publicly funded training poses a unique challenge in training and upskilling an increasingly casual workforce to provide the services required in an expanding, consumer driven care economy.

From the outset, the project identified that the challenges are common across each of the industry sub-sectors. The project aims to address these emerging challenges collectively. The project aims to take advantage of the opportunity that exists to achieve greater coordination in workforce planning for the sectors, understanding the potential to coordinate efforts and to share workers with common skill sets. The consultations have identified a range of options for change to assist in ensuring an adequate supply of skilled workers is available to meet future demand. The consultations have also identified a range of good practices occurring across industry.

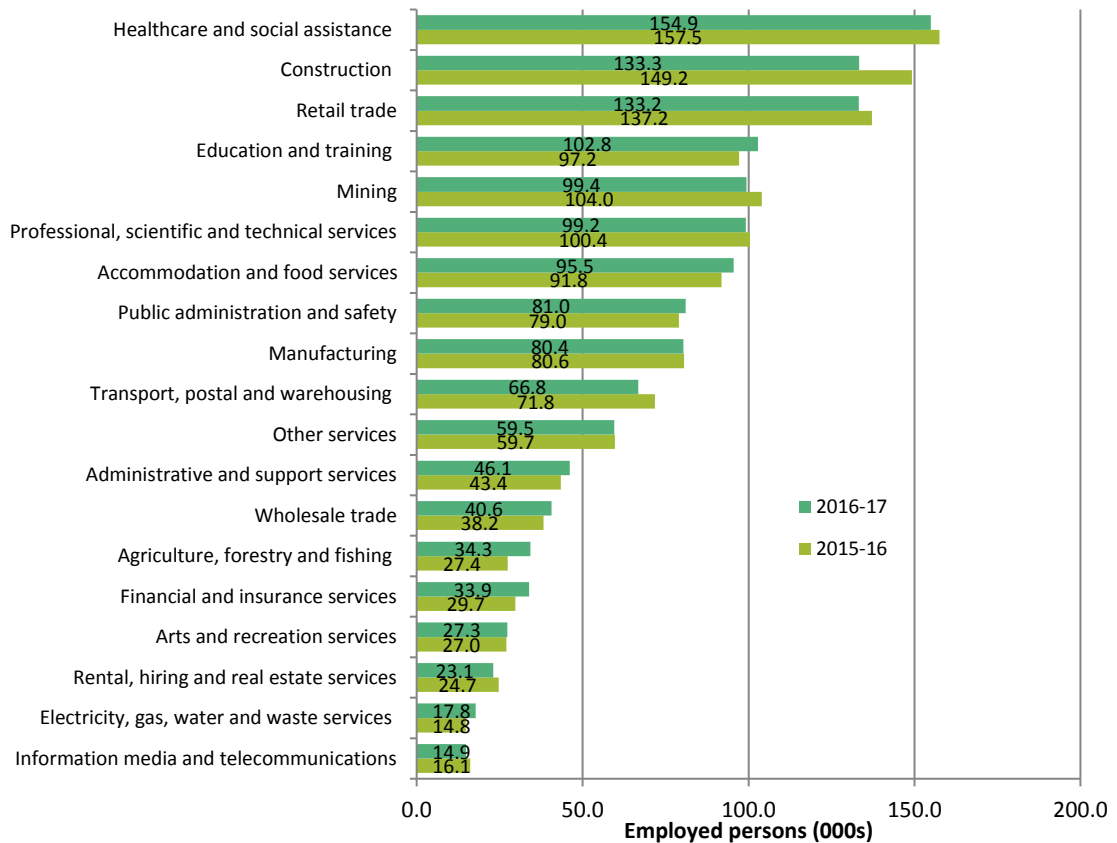
Overall, the project has found significant opportunity for Government and industry to work together to position the State to meet future demands for a skilled workforce for the social assistance and allied health sectors. In some cases, the changes proposed relate to Government funding and service delivery arrangements and in others the opportunity for industry to take a leadership role in driving sector wide improvement.

The plan is a living document that will be updated on a regular basis, as more information becomes known and further examinations of workforce issues are addressed. It is important to note the data used in this report is for the total health services workforce, including mainstream health services that is out of scope for this project. This has been used for best efforts at a point in time.

## A CRITICAL AND GROWING INDUSTRY

The Health Care and Social Assistance industry is critical to the social and economic development of Western Australia. The sector is the largest employing industry in Western Australia employing 154,900 people in 2016-17.

Figure 2: Employment by industry in Western Australia, 2015-16 and 2016-17

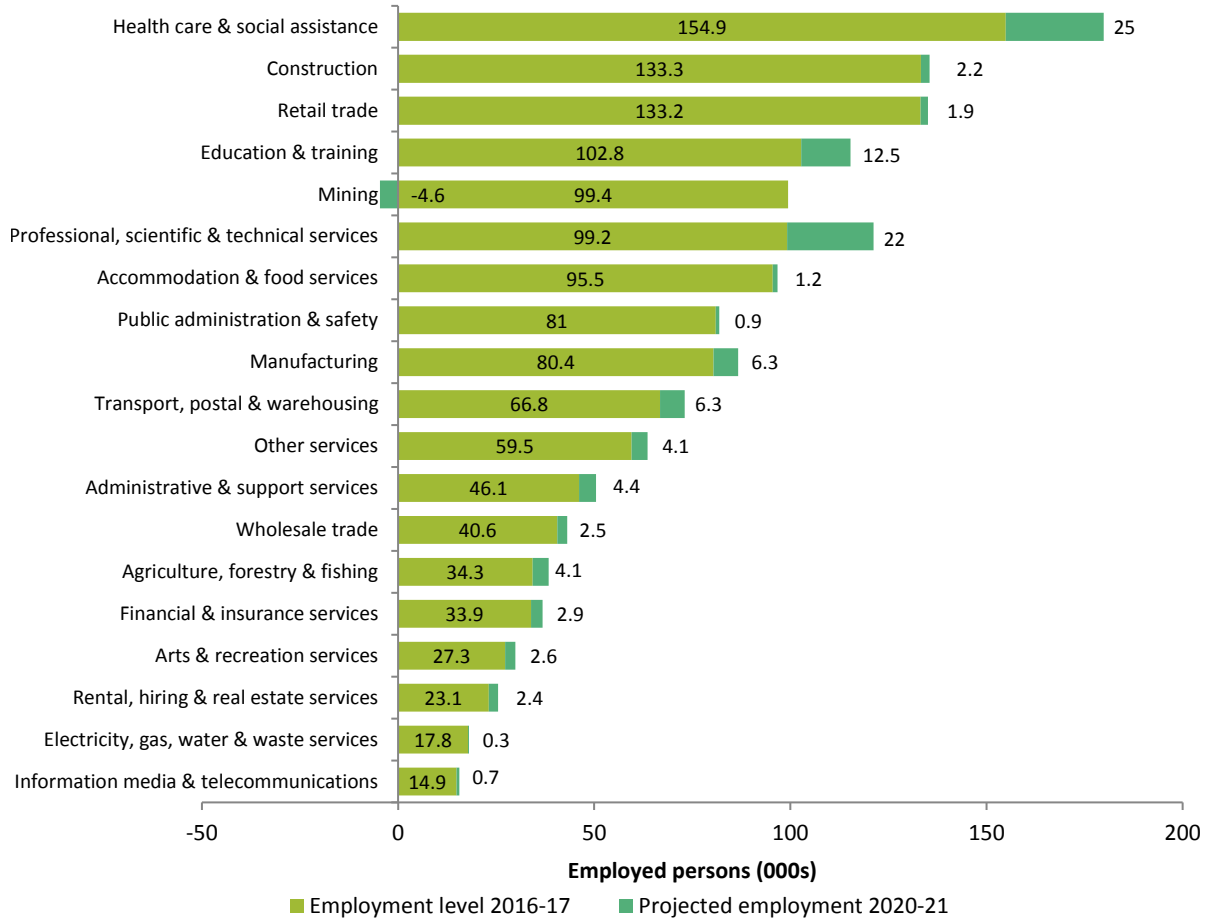


Source: Australian Bureau of Statistics, Cat. 6291.0.55.003 (annual four quarter average)

The Health Care and Social Assistance industry is expected to grow faster than any other part of the economy over the next 5 years (forecast 15% by Centre of Policy Studies) and faces unique challenges to meet the growing demand of consumers. This growth will be driven by:

- additional demand for services for the ageing population;
- full-scheme implementation of the National Disability Insurance Scheme (NDIS) by 2020 in Western Australia;
- shift from institutional to person-centred care, including homecare;
- enhancement of services to combat mental health, drug and alcohol problems;
- further growth in demand for child care, youth services and child protection services; and
- focus on improving Aboriginal and Torres Strait Islander health outcomes.

Figure 3: Western Australia's projected employment growth by industry 2016-17 to 2020-21



Source: Victoria University Centre of Policy Studies

The Steering Committee is acutely aware that much of the sector's workforce is trained through the vocational education and training (VET) sector. Occupations that will be at the forefront of the demand (based on Department of Employment projections to 2022) include:

- Aged and Disabled Care Workers/Therapy Aides (48% employment growth);
- Personal Care Workers and Assistants (32% growth);
- Education Aides (24% growth);
- Child Care Worker (18% growth);
- Health and Welfare Support Workers (16.5% growth); and
- Nursing Support/Personal Care Workers (14.3% growth).

## THE DEMAND FOR SERVICES IS GROWING

The Healthcare and Social Assistance industry will need to grow its workforce to meet the demands of a growing base of need in Western Australia, driven mainly by the aged care and disability services sectors.

### AGED CARE

*Western Australia Tomorrow*<sup>2</sup> forecasts that by 2026 the number of people in Western Australia aged 65 years and above will increase from 359,900 to between 500,800 and 505,800 individuals. This represents a significant increase of up to 146,000 people in this age cohort in the next ten years, at an

<sup>2</sup> Western Australia Tomorrow is a set of forecasts representing the best estimate of Western Australia's future population size based on current fertility, mortality and migration trends.



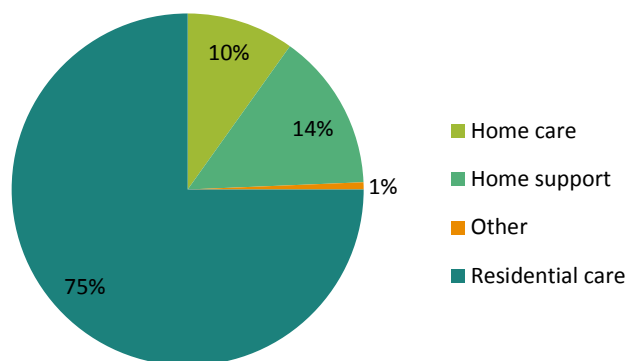
annual average growth rate of 3.8%, which is significantly above the State’s overall population annual average growth rate of between 1.8% and 2.2%.

Our population of people aged 70 years and above has a much faster projected annual growth rate of between 4.3% and 4.4% out to 2026.

The aged care sector in Australia provides services to 1.3 million Australians and generates annual revenues totalling around \$21.5 billion. The sector makes a significant contribution to the Australian economy, representing almost 1% of Gross Domestic Product (GDP)<sup>3</sup>.

The Australian Government expenditure on aged care increases year on year. In 2014—15 the total expenditure was \$15.2 billion, increasing to \$16.2 billion in 2015—16 and is expected to increase to \$20.8 billion by 2019—20<sup>4</sup>. In addition to the Australian Government’s expenditure, consumers contribute an additional 30% (around \$5 billion annually) to the aged care sector through the payment of fees and accommodation. The majority of Australian Government funding goes into residential care as shown in the figure below.

Figure 4: Aged care funding by service, Australian Government 2015-16



There are four main programs/services offered in the aged care sector:

- **Home support programs** provide entry-level support services for frail, older people aged 65 years and older (or 50 years and older for Aboriginal and Torres Strait Islander people) who need assistance to keep living independently at home and in their community. In Western Australia, this service was delivered through either the Commonwealth Home Support Program (CHSP) or the Western Australia Home and Community Care (HACC) program. Around 1 in 5 people using home support reported having a disability and the most common type of service provided in 2016–17 was domestic assistance (37% of people received at least some help around the house), followed by allied health services (29%).
- **Home care** provides similar services to help people remain at home, and provides support for people with complex needs, including nursing and other clinical services. The Australian Government offers four levels of package care depending on the assessed level of care needs of the person. At 30 June 2017, around 1 in 10 people using home care were eligible for the dementia and cognition supplement, indicating they had moderate to severe levels of cognitive impairment associated with dementia or other conditions.
- **Transition care** enables older people to return home after a hospital stay, rather than prematurely entering a residential aged care home. A person can only enter transition care directly after being discharged from hospital. The program provides time-limited, goal-oriented and therapy-focused packages of services to older people after a hospital stay.

<sup>3</sup> Aged Care Financing Authority, Fifth report on the Funding and Financing of the Aged Care Sector, July 2017, Australian Government

<sup>4</sup> ibid

- People in **permanent residential care** require assistance with most activities and often have complex care needs. Their needs are assessed through the Aged Care Funding Instrument (ACFI), an assessment tool which looks at three different areas of care—activities of daily living, cognition and behaviour, and complex health care.

Understanding the nature and level of demand for aged care is difficult but important; both to determine whether the government is offering the right amount and mix of services now and to plan for future increased demand. .

Currently the supply of home care packages and residential care places is determined using a national target of aged care places for every 1,000 people aged 70 years and over. Also known as the *Aged Care Provision Ratio* (the Ratio) it is currently set at 125 places per 1,000 people aged 70 and over, and is split into three targets: 78 residential care places, 45 home care package places and 2 restorative care places<sup>5</sup>.

Between 2009 and 2017, Western Australia experienced a significant increase in the number of people accessing aged care services. The Perth Metropolitan area experienced a 555% increase in home care aged care services and 447% increase in residential care services. This reflects the notion of an ageing population.

Table 1: Users of aged care in Perth metropolitan area 2009-2017

Age cohort	2009			2017		
	Home care	Residential care	Transitional	Home care	Residential care	Transitional
0-49 years	3	10	0	10	12	0
50-59 years	11	47	1	47	136	6
60-69 years	74	171	4	376	648	22
70-79 years	204	373	7	1,358	2,161	59
80-89 years	395	1,031	19	2,551	5,050	129
90-99 years	140	580	12	1,056	4,019	63
100+ years	2	22	0	38	201	1
<b>TOTAL</b>	<b>829</b>	<b>2,234</b>	<b>43</b>	<b>5,436</b>	<b>12,227</b>	<b>280</b>

Source: Australian Institute of Health and Welfare, GEN Aged Care Data, May 2018

## DISABILITY SERVICES

The National Disability Insurance Scheme (NDIS) represents a major reform of disability services in Australia. The NDIS aims to provide support to people who have a significant and permanent disability and need assistance with everyday activities. This includes people with intellectual, cognitive, neurological or sensory disability, a physical impairment or a psychiatric condition.

The primary focus of the NDIS is to improve the outcomes and life chances of people with disabilities. Under the NDIS, people with disability have an individualised plan that reflect their personal aspirations and goals and the supports they need to achieve them. Unlike funding arrangements under previous federal/state agreements, which were largely block-funded, the NDIS provides more choice and control and delivers a lifelong, individualised funding approach to support. Through individualised funding plans, people with disability can determine the services that are most appropriate for them.

For many this individualised approach to disability services is a welcomed reform. For too long, Australia's disability services sector has been underfunded, inflexible and built around the needs of the system rather than the needs of the individual. However, these reforms do indicate a shift towards

<sup>5</sup> Department of Health, Legislated Review of Aged Care 2017

greater self-management of chronic conditions and disability and as such, signal an urgent need for both training and capacity building for affected individuals, care workers and families.

The principal goal of the NDIS is for greater social inclusion for people with disabilities. This includes increasing labour participation of people with disabilities. The NDIS alone will not achieve an increase in labour market participation – it will require a concerted and coordinated approach by policymakers in the labour market as well as in disability support. The VET sector will play an important role in achieving this outcome. The Steering Committee would like to see more effort by government agencies in the employment of people with disabilities.

Western Australia has been relatively late in joining the NDIS. In 2013, the Australian Government and Western Australian Government agreed to a two-year trial of two service delivery models:

- a National Partnership Agreement on Trial of *My Way* Sites, to test the WA NDIS *My Way* model delivered by the WA Disability Services Commission (DSC) under State legislation, with additional Commonwealth Government funding from 1 July 2014. The WA NDIS sites cover the Lower South West DSC region and the Cockburn/Kwinana DSC region; and
- Schedule G to the Intergovernmental Agreement for the National Disability Insurance Scheme Launch (the IGA NDIS), to test the NDIS model delivered by the National Disability Insurance Agency (NDIA) in the Perth Hills area under national governance arrangements set out in the National Disability Insurance Act 2013 (the NDIS Act 2013).

In April 2016, the agreement was amended to include a 12-month extension of the Perth Hills trial to 30 June 2017 and expansion of the trial from 1 January 2017 into local government areas of Bayswater, Bassendean, Chittering, Toodyay, York and Northam covering 1,223 people by 30 June 2017<sup>6</sup>. By 31 March 2018, Western Australia had 4,008 people with an approved NDIS plan<sup>7</sup>.

The State Government has signed a bilateral agreement with the Commonwealth for the National Disability Insurance Agency (NDIA) to deliver the NDIS in Western Australia. The Department of Communities has committed to work with the NDIA to facilitate a successful transition of disability services from State to Commonwealth responsibility over the next two years. The transition will affect over 26,000 individuals previously supported through the Department. The Government has also established a Sector Transition Fund, to be administered by the Department, committing \$20.3 million to safeguard the sustainability of the disability sector in Western Australia. The fund will assist people with disability and service providers to adapt to new requirements under the NDIS, maintain the delivery of quality community services and standards, and promote and grow disability service delivery to meet the increased demand for services.

The rollout of the NDIS in Western Australia will occur in a staged approach. The NDIS (delivered through the NDIA) is currently available in the original trial areas and include people living the following local government areas: Mundaring, Kalamunda, Swan, Bassendean, Bayswater, Toodyay, Chittering, Northam and York.

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<sup>6</sup> Bilateral Agreement for the extension and expansion of the National Disability Insurance Scheme National Disability Insurance Agency trial between the Commonwealth and Western Australia dated 26 April 2016.

<sup>7</sup> NDIS WA Public Dashboard, 31 March 2018 retrieved 19 June 2018 from <https://www.ndis.gov.au/medias/documents/dashboard-wa-mar-18-pdf/dashboard-wa-march-18-pdf.pdf>

Table 2: Rollout schedule for nationally delivered NDIS in Western Australia

Rollout date	Local government areas
April 2018	Services currently delivered through the WA State Government including Ashburton, Broome, Derby-West Kimberley, East Pilbara, Halls Creek, Port Hedland, Wyndham-East Kimberley, Karratha, Mandurah, Rockingham, Augusta-Margaret River, Boyup Brook, Bridgetown-Greenbushes, Busselton, Donnybrook-Balingup, Manjimup, Nannup, Cockburn, Kwinana, Armadale, Murray and Serpentine-Jarrahdale.
1 July 2018	Wheatbelt and Central South Metro regions
1 October 2018	Goldfields-Esperance, North Metro regions and to new participants in the South West region
1 July 2019	Midwest Gascoyne, Great Southern, Central North Metro and South East Metro regions.
1 July 2020	Christmas Island and the Cocos (Keeling) Islands.

All people currently receiving disability support from the Western Australian Government will transition to the NDIS by July 2020. By 2023, all eligible people across Western Australia will be able to join the nationally delivered Scheme.

Existing aged care and disability services provided in Western Australia under the Home and Community Care (HACC) Program will transfer to the Australian Government as a result of the bilateral agreements for the NDIS transition and for revised responsibilities for aged care services. WA Health is working with the Department of Communities to manage the complexities of the current HACC service needs prior to transitioning to the NDIS.

## MENTAL HEALTH SERVICES

Mental health services cover services for mental illness, suicide prevention, alcohol and other drug services. Services are delivered through community services (including support services, treatment services, bed-based services), acute and specialised services (hospital-based services, specialised state-wide services and forensic services).

One in five Australians will be affected by mental health disorder each year. Severe mental health disorders are experienced by approximately 3% of the Australian population<sup>8</sup>.

In 2016–17, 9.8% of the Australian population received Medicare-subsidised mental health-specific services (an increase from 5.7% in 2008–09)<sup>9</sup>.

Suicide is a prominent public health concern. The suicide rates in Western Australia are among the highest in the nation, with 14.4 deaths per 100,000 people in 2016<sup>10</sup>. International research estimates, that for every suicide, there are approximately 20 suicide attempts<sup>11</sup>.

While intentional self-harm accounts for a relatively small proportion (1.8%) of all deaths in Australia, it accounts for a higher proportion of deaths among younger people. In 2016, suicide accounted for over one-third of deaths (35.4%) among people 15–24 years of age, and over a quarter of deaths (28.6%) among those 25–34 years of age<sup>12</sup>. Specialised services for young people are needed.

<sup>8</sup> Mental Health Commission, *Better Choices, Better Lives, Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*

<sup>9</sup> AIHW, *Mental health services in Australia*, Web report, 3 May 2018

<sup>10</sup> Australian Bureau of Statistics, *Causes of Death, Australia 2016*, Cat No. 3303.0, issued 16 May 2018

<sup>11</sup> World Health Organisation. *SUPRE: WHO Suicide Prevention*. Geneva: 2002.

<sup>12</sup> Mental Health Commission, *Better Choices, Better Lives, Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*

Harmful drug use, including alcohol, is another serious public health issue in Australia. In 2016, there were 1,808 drug-induced deaths in Australia; the highest drug deaths in twenty years<sup>13</sup>. According to the Mental Health Commission, around one in five Western Australians over 14 years of age are drinking at a rate which will increase their tendency towards alcohol-related diseases and about one in five recently used illicit drugs<sup>14</sup>.

In Western Australia in the 2016–17 financial year \$20.6 million was spent on prevention, \$46.5 million on community support, \$383.7 million on community treatment, \$44.6 million on community bed based services and \$367.8 million on hospital based services.

In 2016–17 more than 173,500 hours of community support was provided to people with mental health problems at an average cost per hour of \$144.

The mental health system in Western Australia is responsible for the diagnosis and treatment of people who suffer from the effects of alcohol, drugs and mental health. In Western Australia, the Mental Health Commission provides a variety of services to the community including;

- Counselling, in person, online and via telephone;
- Sobering Up Centres;
- Residential services for mental health;
- Alcohol and Drug Support lines; and
- Western Australian Community Program for Opioid Pharmacotherapy.

## **ALLIED HEALTH SERVICES**

Allied health services are growing rapidly due to increased demand from the aged care, mental health, disability and health sectors. Allied health workers provide a broad range of services including diagnostic, technical, therapeutic and direct health services aimed at improving the health and wellbeing of individuals<sup>15</sup>.

Private health insurance covers some allied health services, however the level of rebate and allied health services covered will depend on the individual policy and level of cover. This has contributed to the growth of the allied health sector. Services include Australian Health Practitioner Regulation Authority (AHRPA) registered professions: chiropractic, occupational therapy, optometry, osteopathy, pharmacy, physiotherapy, podiatry and psychology. Allied health also covers self-regulating professions including audiology, sonography, perfusion, social work, orthotics, dieticians, exercise and sport science and speech pathology.

Allied health professionals have essential roles in the prevention, management and treatment of chronic diseases. Chronic diseases are becoming increasingly common and are a priority for action in the health sector. It is estimated that approximately half of the Australian population has at least one chronic disease<sup>16,17</sup>. Chronic diseases are further impacted by being overweight or obese. It is estimated that nearly 2 in 3 adults and 1 in 4 children in Australia are considered overweight or obese<sup>18</sup>.

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<sup>13</sup> Australian Bureau of Statistics, Causes of Death, Australia 2016, Cat No. 3303.0, issued 16 May 2018

<sup>14</sup> Mental Health Commission, *Better Choices, Better Lives, Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*

<sup>15</sup> Allied Health Professions Australia

<sup>16</sup> AIHW, *Health conditions, disability and deaths, Chronic disease*, 18 January 2018

<sup>17</sup> The AIHW commonly reports on eight major groups of chronic disease: arthritis, asthma, musculoskeletal conditions, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes and mental health conditions.

<sup>18</sup> AIHW, *Australia's health 2016*. Australia's health series no. 15. Cat. No. AUS 199. Canberra: AIHW.

The Australian Burden of Disease Study<sup>19</sup> conducted by the AIHW found that chronic diseases such as cancer, cardiovascular diseases, mental and substance use disorders, and musculoskeletal conditions, along with injury contribute significantly to Australia's healthcare budget. It is estimated that almost a third of the overall disease burden could be prevented or reduced by removing exposure to risk factors such as tobacco use, high body mass, alcohol use, physical inactivity and high blood pressure.

Child development services, including early childhood intervention, refers to a range of community based services designed to support the development of children, with a focus on early intervention for those children and families at risk of or presenting with a delay in developmental milestones. Services are provided by a range of allied health professionals including speech pathologists, physiotherapists and occupational therapists. Both the Western Australian Government and the Australian Government (via the NDIS Early Childhood Early Intervention pathway) have strong investment in strategies to supporting the development of children – which includes enhanced allied health services.

### **SOCIAL ASSISTANCE SERVICES**

To help address fragmented service delivery to individuals, families and communities, the State Government through the Department of Communities has coordinated the functions of six former entities and over 6,000 staff across 151 current office locations. It presents a challenging but unique opportunity to fundamentally reform government services to deliver more person-centred and place-based outcomes. An integrated outcomes framework has been developed with input from staff, along with a new structure to support the delivery of quality community services, including the integration of strategy, policy and service delivery, while maintaining specialisation where needed.

All social assistance and allied health sector workers need to be responsive to the diversity and complexity of Western Australia's community, including:

- people from Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse (CaLD) backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- people who are veterans of the Australian Defence Force or an allied defence force including the spouse, widow or widower of a veteran;
- people who are homeless, or at risk of becoming homeless;
- people who are care leavers (which includes Forgotten Australians, Former Child Migrants and Stolen Generations); and
- people from lesbian, gay, bisexual, trans/transgender and intersex (LGBTI) communities.

### **Aboriginal and Torres Strait Islanders**

Service delivery to Aboriginal and Torres Strait Islander people is more complicated and faces many different challenges to non-indigenous aged care, disability, health, mental health and community sector service delivery.

Due to a number of factors, such as living conditions, access to medical treatment, diet and lifestyle Aboriginal and Torres Strait Islanders have a shorter life expectancy than non-indigenous Australians. Aboriginal and Torres Strait Islanders are more likely to access aged care at a younger age than non-indigenous Australians. In all age groups under 85 years of age, Aboriginal and Torres Strait Islander peoples used aged care at higher rates than non-indigenous Australians<sup>20</sup>.

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<sup>19</sup> Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011, Cat. No. BOD 4, Canberra: AIHW

<sup>20</sup> Senate Community Affairs Reference Committee, Future of Australia's aged care sector workforce, Senate, Parliament of Australia, June 2017



## Culturally and linguistically diverse community

Around one-third of Australians accessing social assistance and allied health services are from a CaLD background.

There is no ‘one size fits all’ planning for services for people from CaLD backgrounds. CaLD communities are extremely diverse in terms of countries of origin, English language proficiency, length of time in Australia, reasons for migration, post-migration experiences, age, sex, religion, socio-economic status and geographical location<sup>21</sup>.

Planning for services will also need to understand how different cultures access services. The common barriers reported for people from CaLD backgrounds accessing aged care services are shown in the table below. However, many of the barriers will also be experienced in accessing disability services, mental health and social assistance services.

Table 3: Barriers to service access and use by people from CaLD backgrounds

<b>CULTURAL</b>	Attitudes to family and caring responsibilities	<ul style="list-style-type: none"> <li>• Culturally defined roles for women</li> <li>• Cultural norms that prevent men from engaging with services</li> <li>• Negative views about ‘relinquishing care’</li> </ul>
	Communication difficulties, relating to English proficiency	<ul style="list-style-type: none"> <li>• Capacity to express needs</li> <li>• Participation in assessment and other processes</li> </ul>
	Beliefs, behaviours and preferences	<ul style="list-style-type: none"> <li>• Views on health and disability</li> <li>• Propensity to use formal care services</li> <li>• Fear of ‘authorities’</li> <li>• Concerns about privacy, especially in use of interpreters</li> </ul>
<b>STRUCTURAL</b>	Awareness of the Australian community care and service system	<ul style="list-style-type: none"> <li>• Lack of awareness of the availability of services</li> <li>• Lack of accessible information (i.e. information in appropriate languages, and information marketed appropriately)</li> </ul>
<b>ASSESSMENT/ SERVICE-RELATED</b>	Cultural appropriateness	<ul style="list-style-type: none"> <li>• Assessment instruments not culturally aligned</li> <li>• Services not meeting cultural needs</li> </ul>
	Service providers	<ul style="list-style-type: none"> <li>• Lack of cultural competence and a culturally diverse workforce</li> <li>• Lack of experience using, or failure to use, interpreters</li> <li>• Perception of CaLD clients as posing additional costs</li> </ul>
	Lack of services	<ul style="list-style-type: none"> <li>• Especially for emerging cultures</li> </ul>
	Negative attitudes	<ul style="list-style-type: none"> <li>• Intolerance</li> <li>• Prejudice</li> <li>• Discrimination</li> </ul>
<b>ADDITIONAL ISSUES</b>	Individual experiences	<ul style="list-style-type: none"> <li>• Dementia, resulting in the loss of some acquired language and other skills</li> <li>• Post-traumatic stress, including among refugees and asylum seekers</li> <li>• Loss of culture and intergenerational culture change</li> <li>• Increased isolation with reduced networks, as peers die</li> <li>• Rural or remote location</li> </ul>

Source: Australian Institute of Health and Welfare 2014 Cultural and linguistic diversity measures in aged care: working paper. Cat. No. AGE 74. Canberra: AIHW.

<sup>21</sup> Department of Health, 2017, Review of the Culturally and Linguistically Diverse (CaLD) Ageing and Aged Care Strategy. Publications Number: 12060

## **Lesbian, gay, bisexual, transgender and intersex (LGBTI)**

It is estimated that the LGBTI community account for approximately 11% of Australia's population<sup>22</sup>.

The growing numbers of LGBTI people accessing aged care services represents an emerging and potentially challenging area for aged care service providers. People of diverse sexual orientation, sex or gender identity are a group requiring particular attention due to their experience of discrimination and the limited recognition of their needs by service providers and in policy frameworks and accreditation processes.

As with any group, LGBTI people also have other diverse characteristics that overlap and influence their specific needs and how they access services. This 'diversity within diversity' includes LGBTI veterans; care leavers; people from culturally and linguistically diverse backgrounds; Aboriginal and Torres Strait Islander people; people living with HIV; people living with dementia; those in palliative care; those suffering financial disadvantage; and those living in rural and regional areas.

## **CHILD CARE SERVICES**

Approximately 1.3 million children aged 12 years of age and under are expected to attend some form of government approved or government funded child care service in the Child Care Services industry in 2017–18<sup>23</sup>. Government assistance has helped drive industry growth, with revenues reaching \$12 billion in 2017–18.

According to the Australian Bureau of Statistics<sup>24</sup> children spend an average of 16 hours per week in childcare at a mean weekly cost (after subsidies) of \$110.50. Children aged 2 or 3 years are the most likely to attend formal and/or informal care (71.8% and 71.1% respectively); while children aged under 1 year are the least likely to attend care (30%). Children aged 2 or 3 years are the most likely to attend formal care only (37.2% and 37.6% respectively).

The most common types of care usually attended for children aged up to 12 years who attend school are grandparents (18.6%) followed by before and/or after school care (14.8%). The most common types of care for children who do not attend school are long day care (36.9%) and grandparents (25.8%).

The use of flexible work arrangements by female parents (i.e. part time work or flexible work hours) decreased by 4.8% from 74.3% in 2011 to 69.5% in 2017. Male parents using flexible work arrangements to care for their children increased by 1.9% from 40.4% in 2011 to 42.3% in 2017

## **SERVICES FOR YOUNG PEOPLE**

In response to offending by at-risk young people, *Target 120* is a new approach toward the delivery of intervention services. It aims to make communities safer by targeting the young people most at risk of escalating criminal activity, and working with families to make positive changes in their lives.

The Department of Communities will work with other government agencies to address the drivers of young people offending, such as substance abuse, mental health issues and family and domestic violence. A linked database will be developed to evaluate and focus the initiative and calculate the social return on investment.

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<sup>22</sup> National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy

<sup>23</sup> IBISWorld, Child Care Services – Australia Market Research Report, May 2018

<sup>24</sup> Australian Bureau of Statistics, Childhood Education and Care, Australia, June 2017, Cat. No. 4402.0

## FAMILY SUPPORT

The increased incidences of family and domestic violence in Western Australia have seen an increased need for specialised services. These include additional crisis accommodation for women and children, behavioural change programs for male perpetrators of family and domestic violence, culturally appropriate support services for Aboriginal and Torres Strait Islander and multicultural communities, inter-agency information sharing for better case management, the introduction of *Respectful Relationships* programs into schools and a pet referral project.

## ABORIGINAL AND TORRES STRAIT ISLANDER SERVICES

In 2008 all Australian governments signed the National Indigenous Reform Agreement (NIRA) which included outcomes-based reform targets for '*Closing the Gap*':

- close the life expectancy gap by 2031;
- halve the child mortality rate by 2018;
- all four-year-old children in remote areas have access to early childhood education by 2013;
- halve the gap in reading, writing and numeracy achievements by 2018;
- halve the gap in Year 12 or equivalent attainment by 2020;
- halve the gap in employment by 2018; and
- in 2014 an additional target was added to the agreement, to achieve 90% student attendance rates by 2018.

Progress against the targets is provided in the table below.

Table 4: Australia's and Western Australia's progress against the Closing the Gap targets

Target	Australia's progress	Western Australia's progress
LIFE EXPECTANCY	Not on track: Between the periods 2005-2007 and 2010-2012 there was a small reduction in the gap of 0.8 years for males and 0.1 years for females. Over the longer term, Indigenous mortality rates have declined by 14% since 1998.	Not on track: Western Australia has the second highest Indigenous mortality rates in Australia (1,225 per 100,000). Although, Western Australia has a significant decline in mortality rates since 2006, narrowing the gap with non-indigenous Australians by 27.2%.
CHILD MORTALITY	On track: Over the long term (1998 to 2016) the Indigenous child mortality rate has declined by 35%, and there has been a narrowing of the gap (by 32%). Improvements in key drivers of child and maternal health over the past few years suggest there are further gains to be made.	Not on track: The gap has closed by 25 deaths per 100,000 people but is unlikely that the gap will be halved. To meet the target, Aboriginal and Torres Strait Islander child mortality rates would need to fall by 20% from 2008-12 levels.
EARLY CHILDHOOD EDUCATION	On track: In 2016, around 14,700 Indigenous children (91%) were enrolled in early childhood programs.	On track: In 2013, 99.3% of WA Aboriginal and Torres Strait Islander four-year-old children were enrolled in early child education. Western Australia met the original COAG target.
LITERACY AND NUMERACY	Not on track: In 2017, the proportion of Indigenous students achieving national minimum standards in NAPLAN is on track in only one (Year 9 numeracy) of the eight areas (reading and numeracy for Years 3, 5, 7 and 9). However, the gap between Indigenous and non-indigenous students has narrowed since 2008 across all the NAPLAN areas, particularly reading in Years 3 and 5, and numeracy in Years 5 and 9.	Not on track: In 2017 Western Australia is on target to meet the Year 3 reading, Year 5 reading and Year 9 numeracy areas. But is not on track in any other targets. Western Australia has shown improvement between 2008 and 2017 in four areas. It should be noted that outcomes for Aboriginal and Torres Strait Islander students vary substantially by remoteness areas.

YEAR 12 OR EQUIVALENT ATTAINMENT	Not on track: Nationally, the proportion of Indigenous 20-24 year-olds who had achieved Year 12 or equivalent increased from 47.4% in 2006 to 65.3% in 2016. While the attainment rates for non-Indigenous Australians also improved, the gap has narrowed by 12.6 percent points over the past decade (from 36.4 percent points in 2006 to 23.8 percent points in 2016).	On track: Western Australia has made progress against this target and currently above the trajectory to meet the COAG target. The Indigenous Year 12 or equivalent rate improved from 39.6% in 2006 to 59.9% in 2016.
EMPLOYMENT	Not on track: Indigenous employment rates are falling slightly over the past decade. However, progress is being masked by a change in remote employment programs during this period. If this effect is removed, the employment rate has improved by 4.2 percent points over the past 10 years. In 2016, the Indigenous employment rate was 46.6%, compared with 71.8% for non-Indigenous Australians.	Not on track: Western Australia has experienced a fall in indigenous employment between 2006 and 2016. To meet the COAG target Aboriginal and Torres Strait Islander employment in Western Australia would need to increase by 25%.
STUDENT ATTENDANCE	Not on track: In 2017, the overall attendance rate for Indigenous students nationally was 83.2%, compared with 93.0% for non-Indigenous students.	Western Australia, like all other Australian States and Territories has had no meaningful improvement to indigenous attendance rates between 2014 and 2017.

Source: Closing the Gap Prime Minister's Report 2018; Closing the Gap WA Progress

## COMMUNITY SERVICES SUPPORT

Social and economic factors are large factors in the provision of community services in the community. In general terms, the community services sector focus is the most disadvantaged and vulnerable sectors of Western Australia's community. The support services cover a range of services aimed at supporting individuals and families to live in the community. This includes services for child protection and family support, housing and homelessness support, counselling services, community support programs, regional services, services for young people and justice-related services.

The model of person-centred care is already prevalent in aged care and disability services but is equally transferrable to other types of social services. Western Australia is following global trends of empowering individuals to make their own choices and to determine the services that best suit their needs. Unlike aged care and disability services, most services under community services are funded by the community services organisations themselves<sup>25</sup> or are funded or delivered by the State Government.

<sup>25</sup> The Charities and Not-for-Profit sector raises 59% of its income from its own sources. See <http://wacoss.org.au/wp-content/uploads/2017/06/CURTIN-Landscape-Report.pdf>

## THE WORKFORCE

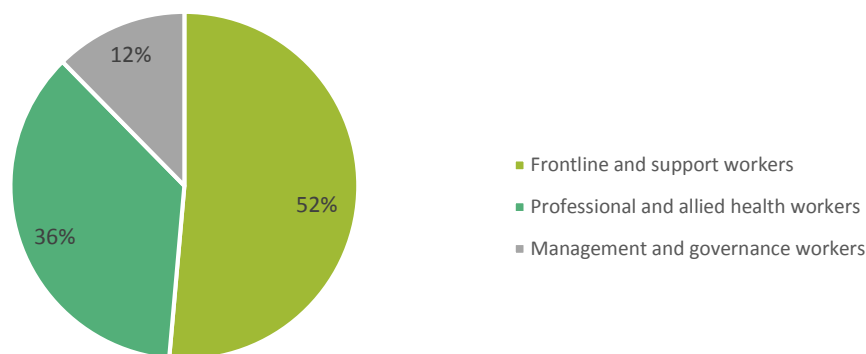
It is important to understand that this project's scope does not cover the entire health care and social assistance sector in Western Australia. The project is focussed on those occupations with a vocational education and training pathway, primarily mapped to the Health Training Package (HLT) and the Community Services Training Package (CHC). These occupations cover the aged care, disability services, mental health, allied health and community service sectors of Western Australia.

It is also possible to identify the Social Assistance and Allied Health industry sector by combining the Australian Bureau of Statistics (ABS) industry groups of Allied Health Services (group 853), Other Health Care Services (group 859), Residential Care Services (group 860), Child Care Services (group 871), and Other Social Assistance Services (group 879).

To assist with interpretability these occupations have been allocated to the following groups:

- Frontline and support service workers;
- Professional and allied health workers<sup>26</sup>; and
- Management and governance roles.

Figure 5: Social assistance and allied health workforce composition



The largest employing occupations in the industry sector are:

- Aged and disability care workers (12,065 workers, or a 16.4% share of total employment in the sector);
- Child care worker (7,513 workers, or 10.2%);
- Nursing Support and Personal Care Workers (5,357 workers, or 7.3%);
- Registered Nurses (3,993 workers, or 5.4%); and
- Welfare Support Workers (3,323 workers, or 4.5%) which collectively represented 43.9% of total employment for the sector.

In 2017, more than half of employees (51%) in the social assistance and allied health industry sector worked part time, while 49% worked full time. This is significantly different to the State's overall workforce profile with only 32% of employees working part time and 68% working full time<sup>27</sup>.

Over the past ten years, part time employment grew by 16,900 workers at an annual average employment growth of 5%. This was slightly higher than the full time employment growth of 13,600 workers at an annual average growth rate of 4% over the same period.

<sup>26</sup> Allied health is defined as primary health care (excluding acute care), community health care and services that can be accessed through the National Disability Insurance Scheme.

<sup>27</sup> ABS 6202.0 – Labour Force, Australia, January 2018.

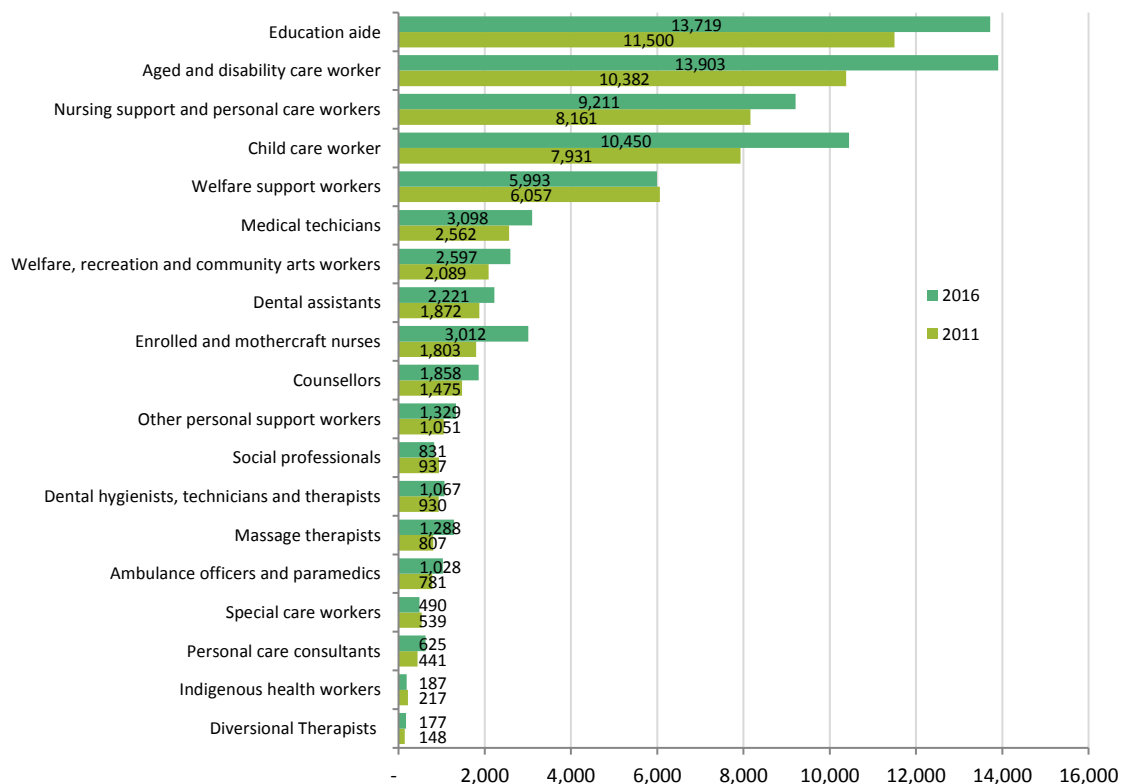
It should be noted that the Social Assistance and Allied Health industry sector also employs many more general occupations such as Receptionists (2,756 workers), General Clerks (1,221 workers), Kitchenhands (1,017 workers), and Commercial Cleaners (637 workers). While these general occupations are not in the scope of this workforce profile it provides an overall sense of scale to better understand the contribution of all occupations within the industry sector.

## FRONTLINE AND SERVICE SUPPORT WORKERS

### WORKFORCE STATUS

Frontline and services support workers are the main employment group in social assistance and allied health workforce. In 2016 the total employment for this occupation group was 73,805 workers.

Figure 6: Frontline and service support workers by employment, WA, 2011 and 2016 Census data



Source: Australian Bureau of Statistics, 2011 and 2016 Censuses

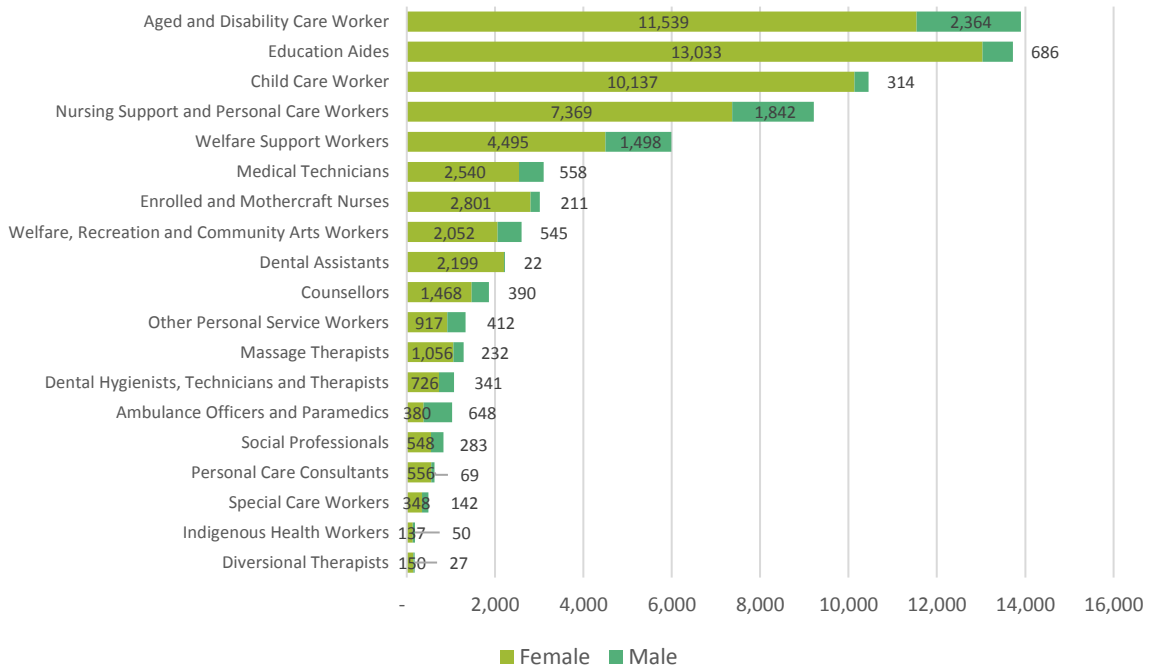
Across all occupations most workers are part-time (53%). Massage therapists (75%), Other Personal Support Workers (71%), Education Aides (70%), Personal Care Consultants (68%), Diversional Therapists (67%) and Aged and Disability Care Workers (66%) have more than two-thirds of their occupational group working part-time. The average for all occupations in Western Australia from the 2016 census was 34%.

### GENDER PROFILE

Frontline and service support workers are traditionally, and currently, predominately female. The only occupation with more male than female workers was Ambulance Officers and Paramedics (males make up 63% of all employees). Dental assistants are almost fully comprising of female workers, representing 99% of all employees. This is a situation that adds to the gender pay gap in Australia, and Western Australia, as the occupations in this realm are in the lower pay brackets and as well, do not provide the incumbents with competitive superannuation arrangements.



Figure 7: Frontline and service support workers by gender, WA

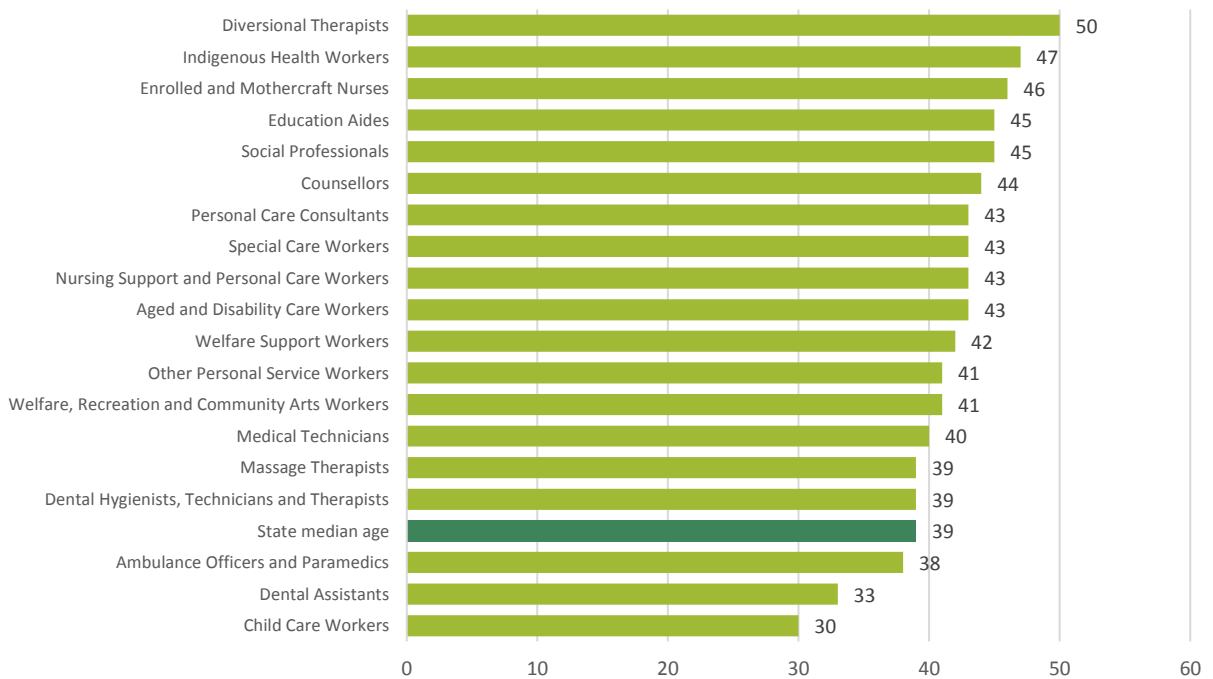


Source: Australian Bureau of Statistics, Census 2016

### AGE PROFILE

The average age in 2016 for a frontline and personal support worker was 41.6 years of age. Most occupations have an older median age than the State’s overall median age of 39 years. The oldest median age was Diversional Therapists having a median age of 50 years, Indigenous Health Workers (47 years), Enrolled and Mothercraft Nurses (46 years). This suggests a number of these occupations may be impacted by the need to replace these older workers into the future as they retire from the workforce.

Figure 8: Frontline and service support workers median age Western Australia, 2016 Census



Source: Australian Bureau of Statistics, Census 2016

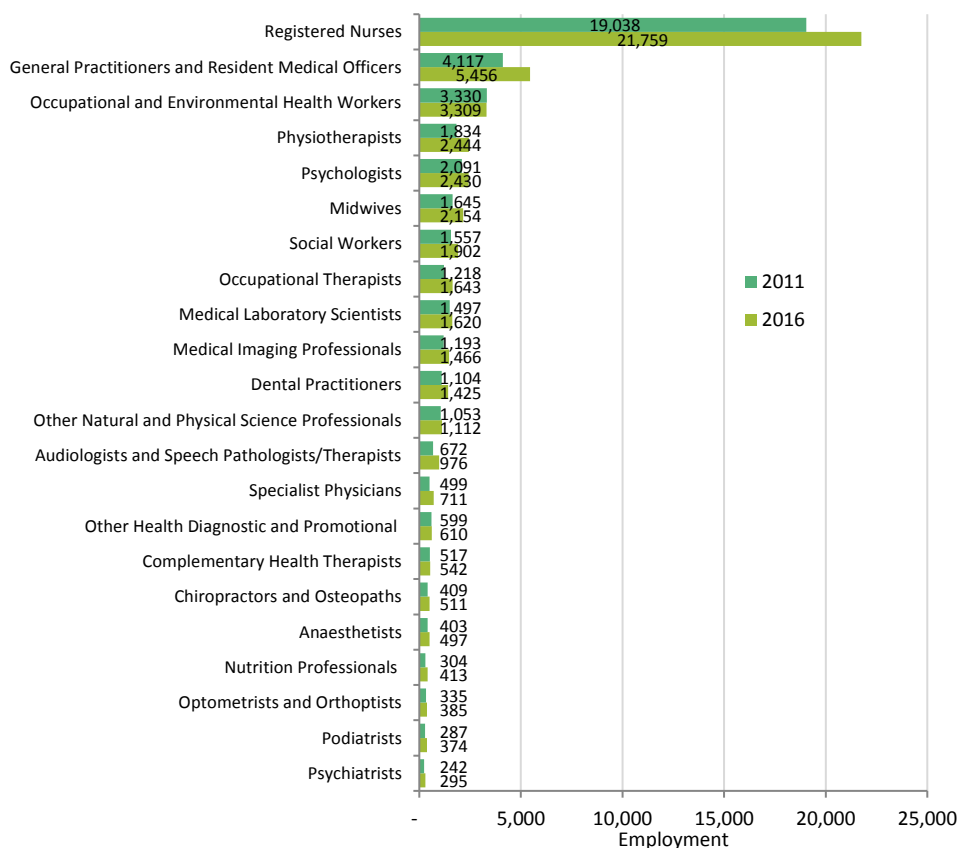
Only three occupations had a younger average age than the State average: Child Care Workers (30 years), Dental Assistants (33 years) and Ambulance Officers and Paramedics (38 years).

## PROFESSIONAL AND ALLIED HEALTH WORKERS

### WORKFORCE STATUS

Professional and Allied Health workers are the second biggest employing group in the social assistance and allied health industry. In 2016 there were 52,034 workers employed in Western Australia.

Figure 9: Professional Allied Health Workers by employment, WA, 2016 and 2011 Census



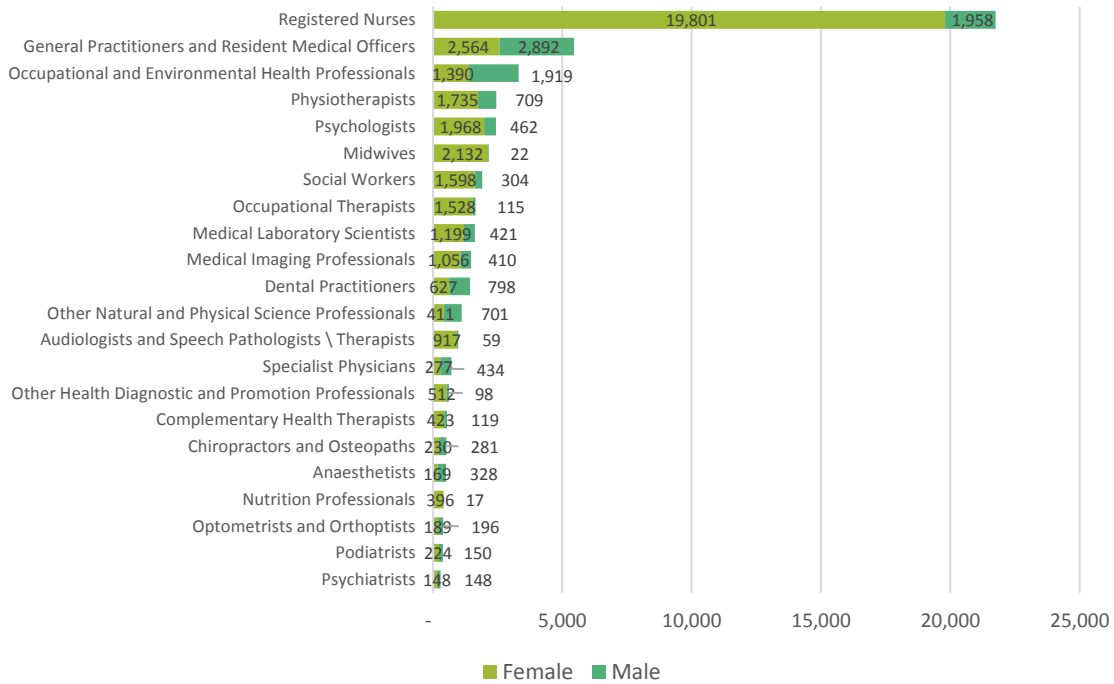
Source: Australian Bureau of Statistics, Census 2011 and 2016

Most of the Professional and Allied Health Worker occupations had a majority of full time workers, apart from Complimentary Health Therapists (64% part time), and Midwives (64% part time). Note that for all occupations in Western Australia from the 2016 Census, the part time proportion was 34%.

### GENDER PROFILE

Professional and Allied Health workers are predominately female. There were a high proportion of occupations with females comprised majority of employees. For example, 99% of Midwives were female, with high proportions also recorded for Audiologists and Speech Pathologists (94%), Nutrition Professionals (96%), Occupational Therapists (93%), and Registered Nurses (91%). Males comprised the majority of specialist medical occupations such as Anaesthetists (66%) and Specialist Physicians (61%).

Figure 10: Professional and Allied Health workers, by gender, WA

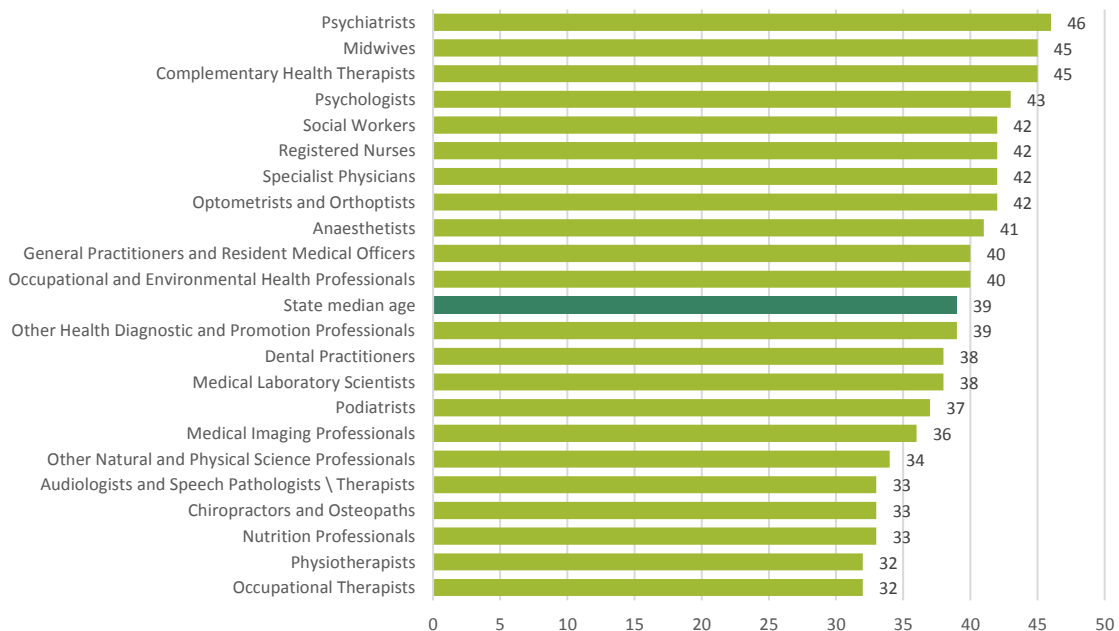


Source: Australian Bureau of Statistics, Census 2016

## AGE PROFILE

In 2016 the median age for professional and allied health workers was 38.7 years of age, slightly below the State median age at 39 years.

Figure 11: Professional and Allied health workers median age, Western Australia 2016 Census



Source: Australian Bureau of Statistics, Census 2016

The occupations of Occupation Therapists (32 years), Physiotherapists (32 years), Nutrition Professionals (33 years), Audiologists and Speech Pathologists (33 years) and Chiropractors and Osteopaths (33 years) all recorded significantly younger median ages than the State's overall workforce median of 39 years of age.

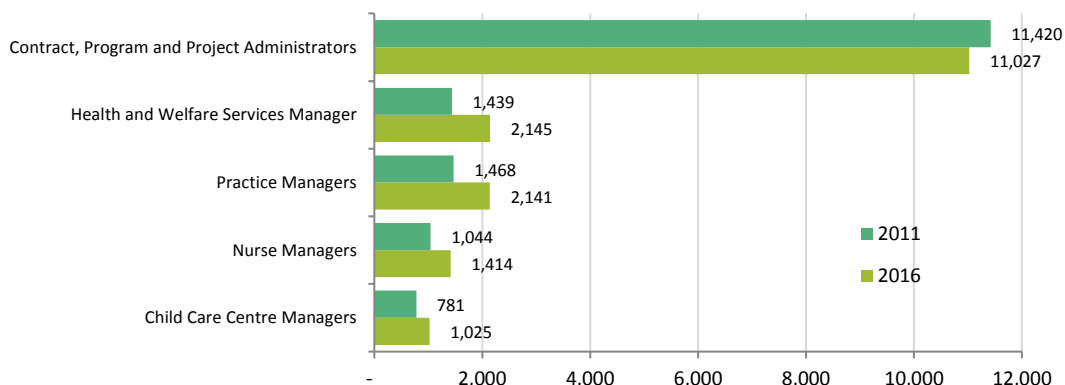
Psychiatrists (46 years), Midwives (45 years) and Complementary Health Therapists (45 years) all recorded significantly higher median ages. This suggests a number of these occupations may be impacted by the need to replace these older workers into the future as they retire from the workforce.

## MANAGEMENT AND GOVERNANCE ROLES

### WORKFORCE STATUS

Management and Governance roles are the smallest employment sector in the social assistance and allied health workforce. In 2016 there were 17,752 workers.

Figure 12: Management and Governance roles employment, WA 2011 and 2016 Census



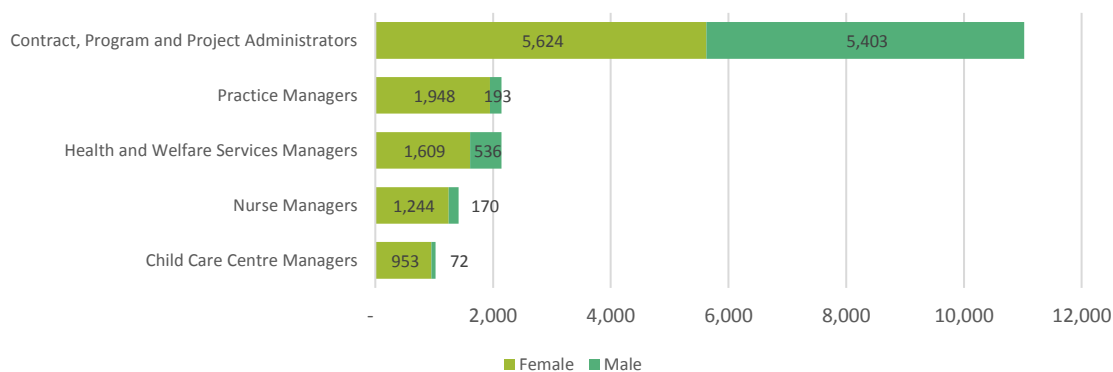
Source: Australian Bureau of Statistics, Census 2011 and 2016

A high proportion of management and governance workers were employed on a full-time basis.

### GENDER PROFILE

As with the other occupational groups in this sector, there is a high proportion of female workers in management and governance occupations. The only occupation with slightly more males was Contract, Program and Project Administrators, which is likely to be spread across a variety of industry sectors outside of the Social Assistance and Allied Health sector. Again, this situation adds to the gender pay gap in Australia, and Western Australia.

Figure 13: Management and Governance roles by gender, Western Australia, 2016 Census

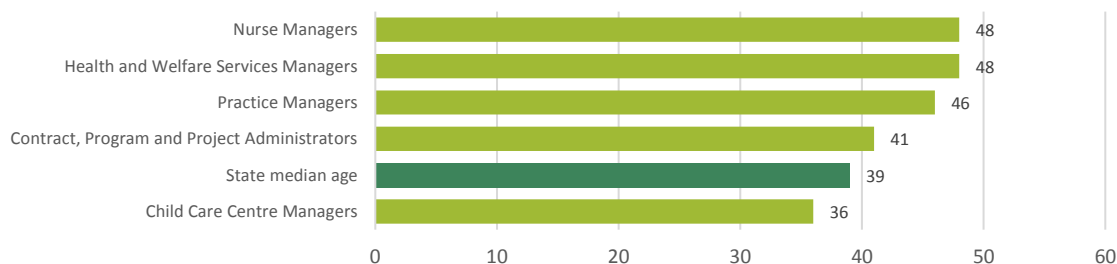


Source: Australian Bureau of Statistics, Census 2016

### AGE PROFILE

In 2016 the median age for management and governance workers was 43.8 years of age, which is expected for management roles. The occupations of Health and Welfare Services Manager (48 years), Nurse Managers (48 years) and Practice Managers (46 years) all had higher median ages than the State's overall median employment age of 39 years. As before, this is further substance to the issue of women's superannuation savings not being equitable and thus their retirement prospects compromised.

Figure 14: Management and Governance roles, median age, Western Australia, 2016 Census



Source: Australian Bureau of Statistics, Census 2016

## WORKFORCE BY INDUSTRY SECTOR

### AGED CARE

The 2016 National Aged Care Workforce Census and Survey (NACWCS)<sup>28</sup> estimates there were 366,027 aged care workers in Australia, 235,764 in residential care and 130,263 in home care and home support roles<sup>29</sup>. Assuming the same level of representation as health care practitioners in which Western Australia accounts for 10.2% of the Australian workforce, the estimated workforce for Western Australia would be around 36,600 in total – approximately 23,500 in residential care and 13,000 in home care and home support roles.

Approximately two thirds of employees in the aged care sector are engaged in frontline and service support work. This workforce consists of six primary occupational groups: Nurse Practitioners, Registered Nurses, Enrolled Nurses, Personal Care Attendants/Community Care Workers<sup>30</sup>, Allied Health Professionals and Allied Health Assistants.

Around 14% of personal care attendants in residential aged care had no previous paid employment compared with around 7% of community care workers in home care and home support aged care.

The majority of registered nurses (65% in residential aged care and 70% in home care and home support) had prior nursing experience in acute care, community or other health care prior to employment in the aged care sector.

Less than 5% of aged care workers had prior disability care employment. This suggests that there hasn't been a significant shift in workers choosing to transfer from disability care to aged care as a result of the rollout of the NDIS across Australia.

The majority of direct care aged care workers had prior employment experience in non-related fields such as sales, hospitality, cleaning or clerical work. All of these jobs roles are female-dominated occupations that require minimal qualifications, are relatively low paying and are more likely to be casual or contract work.

Aged care does not appear to be an industry of choice for young people. In 2016 35% of the direct care

<sup>28</sup> Every four years the National Institute of Labour Studies conducts a census and survey of Australia's aged care workforce. The primary focus of the National Aged Care Workforce Census and Survey (NACWCS) is workers primarily involved in direct care, including PAYG employees in both residential facilities and home care and home support outlets.

<sup>29</sup> 2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016, Commonwealth of Australia, Department of Health

<sup>30</sup> For the purposes of this report the term "Personal Care Attendant/Community Care Worker" includes the following ANZSCOs: 423111 Aged or Disabled Care Worker; 423311 Hospital Orderly; 423312 Nursing Support Worker; 423313 Personal Care Assistant; 423314 Therapy Aide who are involved in accompanying aged persons during the daily activities, including assisting patients with personal care needs such as showering, dressing eating, assisting with mobility and communication, and following therapy plans to assist with health conditions.

workforce had entered aged care at 40 years of age or older. There is a need for promoting working in aged care as a contemporary industry with appeal to the aspirations of young people, as well as with alignment to the current and future needs of women in the workforce, including salary and superannuation prospects.

The use of volunteer staff is widespread within aged care, with 83% of residential facilities and 51% of home care and home support outlets reporting using the services of volunteers. Volunteers are more likely to be engaged in social and planned group activities, companionship roles and transport than engaged in direct care roles.

## **DISABILITY SERVICES**

The Western Australian disability sector has grown significantly over the past decade in line with increased funding directed to the sector<sup>31</sup>. Workforce data drawn from the National Disability Services Workforce Wizard estimates there were 8,348 disability support workers directly employed in Western Australia in 2016<sup>32</sup>.

The disability care and support workforce is diverse; involving a range of skill levels and includes disability support workers and allied health professionals. With specific relevance to the NDIS and workers providing disability services, this profile primarily focuses on VET associated occupations.

NDS WA has established a *WA Disability Services Sector Industry Plan*<sup>33</sup> to implement the NDIS in this State that highlights the importance of skilling the Western Australian disability workforce. Western Australia needs a contemporary, adaptable and high performing disability workforce to implement the NDIS. To meet increased demand for support services as the NDIS is rolled out across Western Australia, there must be investment in building a strong quality workforce and capability and this remains a key priority as identified in the *WA Disability Services Sector Industry Plan*.

The WA Industry Plan puts forward the sector's view that a high-quality disability workforce will strengthen safeguards and provide greater choice for people with disability. It outlines the need for targeted attraction and retention initiatives to build a contemporary, adaptable and high-performing workforce. This means recruiting and retaining committed individuals who are able to implement the changes required while maintaining the highest standards of care and support. Education and training requirements need to be considered and supported and effective transition to the NDIS depends on the capacity of Government and the sector to work together to get the right people into the right jobs.

As per the Industry Plan, the knowledge of the Western Australian disability services sector needs to be drawn upon to design a system that facilitates the delivery of high quality supports and protects people with disability from abuse and neglect. NDS WA supports regular, active meeting groups of disability service providers, and can provide a conduit to promote good practice and innovative workforce strategies across the sectors. NDS WA also has experience and expertise in supporting various communities of practice, which can augment a connecting role, and further assist in the interaction with other sectors to embed innovative practice across the sectors.

The WA Industry Plan can also be used as pivotal vehicle to reshape the VET system to deliver the skills needed for vital growth in the disability sector. This important piece of research can assist in the State Training Board's deliberations on what can be done to increase the take up of apprenticeships and traineeships in Western Australia and in particular, the types of services offered at local TAFE. The VET system can help deliver the skills needed for full implementation of the NDIS across Western Australia.

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<sup>31</sup> NDS, WA Disability Services Sector Industry Plan

<sup>32</sup> National Disability Services, Australian Disability Workforce Report, July 2017.

<sup>33</sup> The plan can be viewed: <https://www.nds.org.au/resources/wa-disability-services-sector-industry-plan>



## MENTAL HEALTH SERVICES

Workers in the mental health services are employed by service providers as well as by State and Australian Government services. The workforce is divided into different services: Prevention – including alcohol and other drug services; Community Support; Community Treatment; Community Bed-Based Services; and Hospital Based Services.

The exact number of workers in the mental health workforce is unclear. Figures from 2015 estimate that specialist alcohol and other drug sector employs approximately 1,200 people<sup>34</sup>. However in 2016–17, the Mental Health Commission partnered with 112 non-government organisations for the provision of services across the spectrum of care and established contracts with five public health service providers under the *Health Services Act 2016*.

## ALLIED HEALTH SERVICES

In 2016–17, there was 69,012 registered health practitioners in Western Australia, an increase of 2.4%<sup>35</sup>. Western Australia accounts for 10.2% of all registered health practitioners in Australia.

Table 5: Registered health practitioners with WA as principal place of practice, by profession 2016–17

Profession	Western Australia	National Total	% of National Total
Aboriginal and Torres Strait Islander Health Practitioner	105	608	17.3%
Chinese medicine practitioner	264	4,860	5.4%
Chiropractor	623	5,284	11.8%
Dental practitioner	2,608	22,383	11.7%
Dental hygienist	268	1,439	18.6%
Dental hygienist and dental therapist	56	472	11.9%
Dental hygienist and oral health therapist	5	8	62.5%
Dental prosthetist	90	1,271	7.1%
Dental therapist	277	965	28.7%
Dental therapist and oral health therapist	6	6	100.0%
Dentist	1,777	16,732	10.6%
Oral health therapist	129	1,470	8.8%
Medical practitioner	11,135	111,166	10.0%
Medical radiation practitioner	1,335	15,683	8.5%
Midwife	408	4,624	8.8%
Nurse	35,396	357,701	9.9%
Enrolled Nurse (Division 2)	5,444	64,021	8.5%
Enrolled Nurse (Division 2) and Registered Nurse (Division 1)	639	7,264	8.8%
Registered Nurse (Division 1)	29,313	286,416	10.2%
Nurse and midwife (dual registration)	2,937	28,928	10.2%
Enrolled Nurse (Division 2)	0	70	0.0%
Enrolled nurse and registered nurse and midwife	12	66	18.2%
Registered nurse and midwife	2,925	28,792	10.2%
Occupational therapist	2,766	19,516	14.2%
Optometrist	422	5,343	7.9%
Osteopath	63	2,230	2.8%
Pharmacist	3,219	30,360	10.6%
Physiotherapist	3,598	30,351	11.9%
Podiatrist	457	4,925	9.3%
Psychologist	3,676	34,976	10.5%
<b>Total Western Australia 2016–17</b>	<b>69,012</b>	<b>678,938</b>	<b>10.2%</b>

Source: AHPRA, Annual report summary 2016–17, Health practitioners in Western Australia

<sup>34</sup> Western Australian Network of Alcohol and other Drug Agencies, Comprehensive Alcohol and other Drug Workforce Development in Western Australia, Full Report, May 2017

<sup>35</sup> AHPRA, Annual report summary 2016/17, Your National Scheme: Regulating health practitioners in Western Australia

## SOCIAL ASSISTANCE SERVICES

### Childcare services

The August 2017 Labour Force Study and 2016 Census showed that in Western Australia there were around 13,700 employees in the child care industry. The Census estimates around 75.2% of the industry were Child Care Workers, 7.7% Child Care Centre Managers and 3.4% Early Childhood (Pre-primary School) Teachers.

The *National Quality Framework for Early Childhood Education and Care* (NQF) was introduced in 2012 which requires minimum national standards across a range of services including minimum child care qualification requirements, as set out in Table 6.

Table 6: Minimum qualification requirements for child care workers

For centre-based services	
Birth to pre-school age	All educators required to meet the relevant ratios at the service must have, or be actively working towards, at least an approved certificate III level education and care qualification.  50% of educators are required to meet the relevant ratios in the service must have, or be actively working towards, at least an approved diploma level education and care qualification.
Over pre-school age	There are no national qualification requirements for educators at centre-based services educating and caring for children who are over preschool age.
For family day care services	
Birth to 13 years	All family day care coordinators must hold an approved diploma level education and care qualification.

Source: <http://www.acecqa.gov.au/Diploma-level-education-and-care-qualifications>

Table 7: Early childhood teacher requirements

Number of children in centre	Early childhood teacher requirement
Fewer than 25 approved places at the service or fewer than 25 children in attendance.	At least 20% of the time that the service provides education and care, the service must have access to an early childhood teacher working with the service.
25 to 59 children in attendance on any given day.	If a service operates for 50 or more hours a week, an early childhood teacher must be in attendance at the service for six hours on the given day.  If a service operates for less than 50 hours a week, an early childhood teacher must be in attendance for 60% of the operating hours of the service on the given day.  These requirements do not apply if the service has 25-59 approved places, and employs or engages a full time or full time equivalent early childhood teacher at the service.
60-80 children in attendance on any given day.	If a service operates for 50 or more hours a week, an early childhood teacher must be in attendance at the service for six hours on the given day.  If a service operates for less than 50 hours a week, an early childhood teacher must be in attendance for 60% of the operating hours of the service on the given day.  These requirements do not apply if the service has 60 to 80 approved places, and employs or engages a full time or full time equivalent early childhood teacher at the service.
More than 80 children in attendance on any given day.	If a service operates for 50 or more hours a week, an early childhood teacher must be in attendance at the service for six hours on the given day, and a second early childhood teacher or suitably qualified person must be in attendance at the service for at least six hours on the given day.  If a service operates for less than 50 hours a week, an early childhood teacher must be in attendance for 60% of the operating hours of the service on the

	<p>given day, and a second early childhood teacher or suitably qualified person must be in attendance for at least 60% of the operating hours on that day. These requirements do not apply if the service has more than 80 approved places, and employs or engages a full time or full time equivalent early childhood teacher at the service, and employs or engages a second full time or full time equivalent early childhood teacher or suitably qualified person at the service.</p>
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Source: <http://www.acecqa.gov.au/Early-childhood-teaching-qualifications>

### **Aboriginal and Torres Strait Islander services**

Aboriginal and Torres Strait Islander people make up 3.8% of the Western Australian population. To support Aboriginal and Torres Strait Islander people to live long and healthy lives, current Aboriginal Health services delivered in Western Australia will be maintained and integrated into the WA Health system’s base budget settings<sup>36</sup>.

The Aboriginal and Torres Strait Islander health services employ a variety of roles from Doctors, Nurses, Aboriginal Health Workers/Practitioners, administration staff, transport drivers, environmental Health Officers, social and emotional wellbeing workers, child and maternal health workers. There are also speciality positions within each service.

The majority of workers are considered permanent with a remainder consisting of casual, locum or agency staff. A proportion of the workforce is classed as visiting specialists.

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<sup>36</sup> 2018–19 Budget Statements, Budget Paper No. 2 Volume 1, Government of Western Australia, 2018

## WORKFORCE CHALLENGES

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Western Australia needs a contemporary, adaptable and high-performing social assistance and allied health workforce to meet the growing demand for services, particularly in aged care and disability services.

### COORDINATED RESPONSE TO WORKFORCE CHALLENGES

The research for this project has shown that each sector faces similar issues and a coordinated approach to workforce development is needed. The growth in the aged care and disability sectors is expected to lead to greater competition for workers with similar skill sets from other sectors facing similar pressures, including health, community services, youth and mental health.

It is recognised by all Steering Committee members that there is a need to build capability across the broader human and health services sector. Government and industry must work together and in harmony with the VET sector to develop the skills and pathways to meet the growing demands of people in Western Australia's community.

Individual State Government agencies, including the Department of Health, Department of Communities, Department of Primary Industry and Regional Development and the Department of Training and Workforce Development are separately planning responses to workforce issues across the different sectors. The Committee recommends that this work is overseen by a single taskforce that comprises the relevant decision makers from each agency along with the principal peak bodies engaged in this sector.

A key focus for the Western Australian government agencies is the client-interface with service providers, particularly government-run services. The Department of Health has noted in the State Budget 2018–19:

“The need to improve interfaces in the health system is a key focus, noting that Western Australia needs to be more proactive in partnering to meet consumers and carer calls for greater levels of care in the community, more person-centred care and seamless access to support across our health, disability, aged care and mental health systems”<sup>37</sup>.

Government agencies, such as the WA Country Health Service, that supplies workers in regional and remote communities must be appropriately funded to not only maintain the current supply of skilled workers but grow in areas of need.

For the training sector, the Department of Training and Workforce Development must work with TAFE and other training providers, to ensure students take up the training places that lead to occupations in the social assistance and allied health sector. Government incentives to encourage service providers to employ trainees may also be beneficial to the sector.

The Australian Government is the principal funder of aged care and disability services in Australia and this influence cannot be ignored in terms of the development of a workforce development plan for the social assistance and allied health workforce sector. The relevant government agencies will need to work with the Australian Government to leverage the additional funding to build the workforce in Western Australia.

The Australian Government established a taskforce to develop an aged care workforce strategy. The

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<sup>37</sup> 2018–19 Budget Statements, Budget Paper No. 2 Volume 1, Government of Western Australia, 2018

taskforce was employed to examine a range of issues to boost workforce supply, address demand issues and improve productivity of the aged care workforce, and was due to report to the Minister for Aged Care by 30 June 2018. The taskforce is a significant opportunity for the sector to develop a considered view of what needs to be done to achieve a skilled and sustainable workforce that supports safe, quality aged care for senior people.

The Australian Government has also committed funding of \$33 million over three years, from 2017-18, to help existing service providers in the disability and aged care sectors grow their workforce, particularly in regional, rural and outer suburban communities. This package will help employers increase the supply of care workers in the right geographical areas to meet the needs of both NDIS participants and the aged care sector.

The expected employment growth in the Social Assistance and Allied Health sectors will create challenges in finding appropriately skilled workers. In particular, the shift to community-based care will significantly increase the demand for personal care workers and aged and disabled care workers (Department of Employment estimates 17,000 in Western Australia over the next 5 years).

The implementation of the full scheme of the NDIS in Western Australia, by 2019–20, will require a significant increase in the disability sector workforce to respond to the growth in rates of individualised funding (NDS estimate 70% growth in the Perth metropolitan area and 78% in the South-West) and associated demand for services. The NDIS is expected to provide total direct employment growth of approximately 7,900 full time equivalent positions; with flow-on effects of up to 15,400 new jobs in Western Australia.

Many peak bodies and government agencies are working in isolation, yet are dealing with many similar workforce challenges. The Steering Committee believes that implementation of the workforce development plan must be done jointly across Government and non-Government agencies, adopting a coordinated and integrated approach.

Evidence-based strategies to combat workforce challenges are needed to establish and maintain the optimum number and mix of suitably qualified and skilled staff to effectively deliver the services and programs that are needed by people living with disability.

## A SKILLED AND QUALITY WORKFORCE

There is wide agreement that a skilled workforce for the social assistance and allied health sectors is essential for optimal outcomes, health and safety of individuals and workers.

Industry has raised concerns around their capacity to recruit sufficient numbers of appropriately qualified and skilled workers. Unmanaged growth of these critical sectors through the employment of unskilled care workers/support workers poses considerable risks to both individuals and workers, particularly when providing unsupervised services in a person's home.

Long term ageing of the population will also require support workers in aged care facilities to have higher-level skills to support residents suffering from chronic disease, dementia and mental health issues and residents needing palliative care. This requires further training, which may not be met by employers due to cost pressures, and workers will need to find additional funds to attend training.

## IS REGULATION THE ANSWER?

The childcare sector has undergone significant reform in recent years, including the introduction of the *National Quality Framework for Early Childhood Education and Care*, which has set the minimum qualification levels for childcare workers. Currently there is no minimum requirement for qualifications in the aged care, disability services, allied health or community services sectors. Similar reforms may

be implemented in the aged care and disability services sectors to address community concerns regarding the health and safety of consumers in these sectors. However, this will add additional cost pressures to the industry already struggling to meet the growing demand of clients.

Regulation and compliance does not necessarily mean quality. There is community expectation about the quality and standard of care offered in residential facilities and at-home care provided by a funded organisation. There tends to be a reactionary approach rather than a systemic change. If Government wants regulation, then it will have to fund appropriately to have the skilled and qualified workforce to deliver the care.

There is an urgent need to simplify and streamline employment and training pathways. There may be benefit in the industry and government working together to identify a strategy that can help the social assistance and allied health workforce meet its skilling requirements.

### **STANDARDISED MINIMUM REQUIREMENTS**

Concerns have been raised about the need to manage the quality, safety and compliance of untrained support workers. It has been proposed that new starters be required to have achieved a minimum standard prior to commencing as a personal support worker in sectors such as aged care, disability and community services. The principles of a 'white card' may warrant further exploring.

This concept is already successful in the construction industry and requires all new entrants to undertake mandatory training before entering a worksite. This would require industry to establish a mandatory skill set (e.g. manual handling, providing care and medication management). This skill set may vary from one sector to the other, depending on need.

### **SKILLS PASSPORT**

There is also growing recognition of the need to recognise the skills that workers are gaining in the form of unaccredited training provided by employers. Industry could work with the Government to evaluate the need for the development of a skills passport. This initiative could be considered as an alternative to a white card, however to achieve the same effect industry agreement would be required as to the suitability of the training. More in-depth research for a skills passport can be undertaken in phase two of this project.

### **ADDITIONAL FUNDING TO SUPPORT THE WORKFORCE**

The Steering Committee acknowledges that the Australian Government has committed \$33 million over three years from 2017-18 to help existing service providers in the disability and aged care sectors grow their workforces, particularly in regional, rural and outer suburban communities<sup>38</sup>. The application of this funding is unclear, but may be worth pursuing for aged care providers in Western Australia.

In addition, the Australian Government's *Skilling Australia Fund*, prioritised towards apprenticeships and traineeships, includes occupations in high demand and growth industries, as well as rural and regional Australia. Whilst the Committee is aware that the State Government is yet to sign the new National Partnership, it does note that there may be potential funding to increase the number of traineeships for this workforce.

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<sup>38</sup> Australian Government response to the Senate Community Affairs Reference Committee report: Future of Australia's aged care sector workforce, June 2018

## REGIONAL AND REMOTE COMMUNITIES

Regional and remote areas of Western Australia face unique challenges that often result in significant skill shortages, including in most social assistance and allied health occupations. The State Government is committed to building community sustainability and economic diversity by creating jobs in regional Western Australia.

Many regional communities face significant attraction and retention challenges. In particular, the reliance on fly-in and fly-out workers for mining projects is having devastating effects on regional communities as well as employees and their families. Transient and fluctuating populations can have an impact on the provision, demand and availability of health services in rural and remote regions. Services are either available in the local town or community or are located in a regional centre that may require hours of travel.

The setting of prices for services offered through the NDIA by the Australian Government and its agencies is often calculated on either New South Wales or Victoria. This is problematic for regional and remote communities in Western Australia where distances are far greater. There is a concern that for-profit organisations will only choose to deliver services in regional towns or cities of sizeable populations than delivery in small communities. In New South Wales, it was found that for-profit organisations set up offices in regional cities such as Orange and Dubbo but did not set up in small towns and communities in the west of the State.

To attract workers to regional and remote communities there needs to be consideration of living expenses, including affordable accommodation, transport costs and communication (telephone and internet) connections. Due to cost pressures of service providers, there is a need to have workers based close to people requiring support and care, rather than having them travel long distances.

Given the tyranny of distance and low population numbers that exist in rural and remote communities, delivery of training and ongoing support, as well as employment prospects need careful consideration and potentially different training and employment models to metropolitan locations. Workers need to be equipped with diverse skill sets to enable employment across sectors, i.e. disability, aged care, community services. Training needs to be delivered flexibly to minimise the need for people to leave their home communities for education/training and skill development. It is important to minimise the risk of social and professional isolation by building networks and supporting workers with mentors. The concept of establishing cultural mentors for Aboriginal people entering into educational and workforce opportunities should be supported.

Regional and remote communities need access to Western Australia's training system to meet the skill needs of their communities. The State Training Board supports measures to ensure that the skill needs of regional and remote communities are identified and planned for through the VET system. The VET Regional Partnerships Program provides an opportunity for regional TAFEs to invest in new and innovative long term partnerships to create training and job opportunities in the community.

The Department of Training and Workforce Development will be undertaking a labour market review for each of the nine regions in the State. The Department of Training and Workforce Development will engage with local businesses across all industry sectors, TAFE colleges, Development Commissions, Chambers of Commerce, industry training councils and relevant government agencies as part of the process. The outcomes of the review will provide a basis for the development of a regional priority occupation list.

It is expected that the annual labour market reviews will identify the particular workforce challenges for the social assistance and allied health workforce. The Department will then use this information to target training in these regions to meet the demand.



It is critical for the social assistance and allied health sector, as with any other industry, training be made available locally in regional and remote communities. Students and employers based in Western Australian regions need greater flexibility in the way training is offered and delivered.

For many students in regional and remote communities VET provides an important pathway to further education and work opportunities in the community. The Australian Governments offers a range of incentives to encourage regional and remote students to take up options in the VET sector, including apprenticeships and traineeships, however this is dependent on the options being available locally.

Students should not be forced to travel to Perth to attend training. All registered training providers, including TAFE, scoped to deliver qualifications in the social assistance and allied health sector, should be encouraged to deliver training in regional communities. This must include the option of face-to-face delivery in the classroom or workplace settings.

The Committee noted that the Australian Government's recent response to the Senate Community Affairs Reference Committee report into the aged care sector that the Australian Government supports reviewing opportunities for eligible service providers operating in remote locations to access block funding. In the 2018–19 Budget, the Australian Government made \$105.7 million available to expand the *National Aboriginal and Torres Strait Islander Flexible Aged Care Program* progressively over four years. This will allow eligible service providers operating in remote and very remote locations to access block funding.

## CONSUMER-DIRECTED FUNDING IMPLICATIONS FOR THE WORKFORCE

Service providers are facing increased financial uncertainty related to the shift to individualised funding arrangements. This market disruption is making it difficult for providers to predict future work and cash flows.

Whilst issues relating to remuneration, job security and working conditions of employees are matters for service providers, it must be considered as part of any overall workforce development strategy.

It is not expected that the competition for workers in the social assistance and allied health sectors will result in a wages-boom that was experienced in the resources sector. However, the sectors need a stable environment that provides financial certainty and confidence in their ongoing viability to invest in service expansion, staff recruitment and development.

At the forefront of any service delivery needs to be improved outcomes for people in the community. Without the qualified and skilled staff to deliver the services, consumers in aged care, disability services, mental health, allied health and community services sectors will have scaled-back services and will not be able to fulfil their own goals and objectives.

The National Disability Insurance Agency (NDIA) currently sets the maximum price of disability supports permissibly charged by registered providers and monitors them through annual price reviews. Price updates are published each year in the NDIS's Price Guide for NDIS service providers.

The temporary regulation of prices in the sector was a recommendation of the Productivity Commission in its 2011 *Disability Care and Support* inquiry<sup>39</sup>. The Commission deemed transitory price controls necessary to ensure access to affordable disability supports during the transition period as the market grows to meet increased demand. Price controls are intended to remain in place only during the transition phase and then be deregulated and determined by market forces in the long term.

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<sup>39</sup> Productivity Commission Disability Care and Support Inquiry 2011, p 348.

There has been much concern among providers groups and stakeholders, participants, and the Productivity Commission regarding the inadequacy of current NDIS pricing arrangements and their impact on:

- wage growth for a sector needing to grow its workforce;
- the financial sustainability of disability support providers;
- providers ability to deliver high quality supports; and
- participants and providers in regional and remote areas where ‘thin markets’ are a persistent feature of disability supports.

In their most recent report, the Productivity Commission was highly critical of the NDIA’s approach to price setting suggesting that it has hindered market development and caused providers to withdraw some services from the market and that price caps have led to poorer outcomes for participants, particularly those with complex needs<sup>40</sup>.

Employers anticipate that the NDIS hourly price for support work does not provide enough funding for overheads such as: client case managers; worker training; managers and coordinators; staff meetings and support structures; and risk assessments in client homes. This additional support will either need to be subsidised through other funding sources (where they are available), or provide care in a context of reduced safety standards and quality<sup>41</sup>.

Local disability providers are concerned that the level of funding available under the NDIS will not cover the induction and training costs required to upskill staff to address the complex needs of people with a disability, which may compromise delivery. The short timeframe for implementation of the NDIS raises additional concerns about the sector’s capacity to source allied health staff and direct support workers with appropriate training and commitment to work in the disability field.

This uncertain funding environment is leading to greater casualization of the workforce and a reduced incentive for employers to train workers. This shift has the potential to reduce the skill level of the personal care worker workforce at a time when higher level support skills will be increasingly required.

The question also remains – who would pay workers’ wages while they are undertaking training. In addition, the new *NDIS Quality and Safeguarding Framework* will require a mandatory 45-minute online orientation program for the disability sector.

In fact, the National Disability Services (WA Branch) warns that without adequate staffing levels, Western Australians eligible for NDIS funding will not be able to access the level of services outlined in their plan. This cannot be an acceptable outcome.

The introduction of the new funding model is forcing industry to adopt lower cost service delivery models e.g. shifting treatment work from higher cost allied health professionals to allied health support workers. This shift is increasing the requirement to upskill the existing personal care worker workforce in areas such as customer service, information technology and reablement<sup>42</sup> care strategies.

Most sectors continue to experience high turnover of staff (estimated to be up to 30% per annum in some organisations) due to the nature of the work (part-time, shift work and low remuneration levels). Following the mining downturn the sectors have been able to recruit replacement staff; however this

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<sup>40</sup> Productivity Commission Study Report, NDIS Costs, October 2017, p 304.

<sup>41</sup> Evesson J, Oxenbridge S, The Psychosocial Health and Safety of Australian Home Care Workers: Risks and Solutions, August 2017

<sup>42</sup> Reablement is a short and intensive service, usually delivered in the home, which is offered to people with disabilities and those who are frail or recovering from an illness or injury.

is expected to change as the economy recovers. Most recently pay and conditions in the aged care sector were considered at the national level.

## **EQUAL REMUNERATION ORDER/INDEXATION POLICY**

On 22 June 2012, the Fair Work Commission issued an Equal Remuneration Order (ERO) for the Social, Community, Home Care and Disability Services Award (SCHCDS) 2010. The ERO applies to social and community service workers, crisis accommodation workers and home care workers (disability); but not family day care workers or home care workers (aged care). The definition of social and community service employees includes employees in administration and other corporate service roles.

The ERO provides for 'above Award' pay increases for social and community service workers of between 23% and 45% over an eight-year period commencing December 2012 to December 2020. These increases are in addition to the Fair Work Annual Wage Review, which applies to Modern Awards from 1 July each year.

Employers who previously paid above Award wages have been able to absorb the ERO increases for the first 3 or 4 years of the Order. Employers are now facing average pay rises of 5% to 6% a year<sup>43</sup>, when the Perth Consumer Price Index (CPI) is running at 0.5% to 1.5% and government funding is indexed at 0.83% for 2018–19<sup>44</sup>.

The aims of the ERO are well supported by human services organisations, but for service provision to be maintained, it is imperative that the impact of the ERO be understood in the context of individual service users, government policy and expenditure, and human services providers.

The issues of maintaining appropriate service provision and investing in training and capacity building, are further challenged by the limitations of the State Government's Non-Government Human Services Sector Indexation Policy. In 2008, the State Government developed in partnership with the community service sector, a formula that reflected the real cost to deliver sustainable services, 80% of the annual increase of Perth Wages Index (WPI) and 20% of the annual CPI. This approach was unilaterally varied by the government in 2016, with indexation now based solely on CPI. The change did not take into account the wage costs incurred by NFPs, and in times of an imbalance between wage growth and CPI growth, is creating sustainability issues. The impact of this for many service providers, is a need to reduce all costs and services to remain viable, with some of the major reductions being in workforce development, planning and attracting suitably skilled staff. The Steering Committee notes the importance of ensuring that sustainable funding is provided to NFPs through appropriate indexation methodologies, including applying the weighting for WPI and other measures, so as to provide capacity to invest in workforce development.

The NDIA's pricing structure has implemented price controls to grow the market for disability supports and services with a view to establishing a balance between demand and supply. The NDIA pricing structure includes wage price indexes, the minimum award wage increases and the limited number of disability support workers impacted by the ERO. It is anticipated that price controls will remain in place during the ramp-up of the NDIS, but as the market matures in size, quality and innovation, it is expected that prices will be deregulated and determined by market forces<sup>45</sup>.

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<sup>43</sup> Australian Bureau of Statistics, December Key Figures, December Quarter 2015 to December Quarter 2016, available at: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/6401.0>

<sup>44</sup> [http://www.finance.wa.gov.au/cms/uploadedFiles/Government\\_Procurement/Publications/Not-for-Profit/bulletin\\_68.pdf](http://www.finance.wa.gov.au/cms/uploadedFiles/Government_Procurement/Publications/Not-for-Profit/bulletin_68.pdf)

<sup>45</sup> David Bowen, 2017, Letter to registered NDIS providers, 12 June 2017 <https://www.ndis.gov.au/news/letter-to-ndia-registered-providers.html>

Research undertaken by Curtin University<sup>46</sup> regarding the impact of the ERO on service organisations in Western Australia suggests that the implementation of the ERO will cause financial stress to the majority of service providers. The Steering Committee notes the recommendations of the research and believes that these should be incorporated into any workforce development plan developed through this project.

The ERO also highlights the concerns regarding superannuation and retirement savings for the social assistance and allied health workforce, particularly the frontline support workers on low incomes. Closing the gender pay gap in lifetime earnings would do the most to improve the retirement savings of women<sup>47</sup>. Whilst this would require a range of policy measures that are beyond the scope of this workforce strategy, the Steering Committee calls for investigations into superannuation arrangements within the sector as a way of addressing this imbalance.

## ATTRACTION AND RETENTION CHALLENGES

Attracting and retaining staff will be a challenge for many service providers, with further challenges in rural and remote communities. Existing constraints limit solutions to workforce shortages specifically relating to flexibility, role advancement and migration/recruitment options.

Many people in the community overlook the job opportunities available in the social assistance and allied health workforce. The ability to make social assistance and allied health work a job of choice for potential jobseekers, career changers and young people will be a challenge for the sector.

Specific and targeted programs to attract workers across the social assistance and allied health workforce have been successful. For example, projectABLE was a program developed by NDS in response to the expected 70,000 new jobs expected to be created in the disability and care sector by 2019 because of the rollout of the NDIS. Through interactive workshops for students in years 10, 11 and 12, projectABLE inspires students to apply their passions, skills and abilities to enrich their lives and the lives of others by pursuing a rewarding career in the disability and community service sectors. Through the workshops students learn:

- ways to promote positive perceptions of people with disability;
- the importance of inclusion and participation for people with disability in the community;
- career opportunities in the disability and community care sector; and
- educational opportunities in the disability and community care sector.

The social assistance and allied health sector will be the largest area of job growth in the Western Australian economy. Strategies that inform potential workers of the many possibilities in these sectors need to be explored and funded appropriately.

## RECRUITMENT DIFFICULTIES

Across Australia, service providers have had trouble recruiting and retaining appropriately-qualified staff. Workforce shortages are exacerbated by the low public awareness of careers in disability services and comparatively low wages. Workforce shortages also are likely to increase as the demand for services grow within the community.

Already, 75% of residential aged care and 50% of home care and home support aged care outlets report staff shortages<sup>48</sup>. At the same time the disability services sector needs to almost double its current

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<sup>46</sup> Gilchrist, D. J., and P. A. Knight, (2017), *The 2012 Equal Remuneration Order: Sustainability Impacts on Human Services Delivery in Western Australia. A Report to the Western Australian Council of Social Service*, Perth, Australia.

<sup>47</sup> Brendan Coates, *What's the best way to close the gender gap in retirement incomes?*, Grattan Institute 2018

<sup>48</sup> Leading Age Services, *Policy Statement: Workforce*, July 2016

workforce by 2020<sup>49</sup>.

In 2014–15, 66% of Australian Government-funded Indigenous organisations reported the recruitment, training and support of Aboriginal and Torres Strait Islander staff as one of the top five challenges in providing quality care to clients<sup>50</sup>. In remote areas this was as high as 85%. Among all staff, retention and turnover was reported as a challenge by 54% of organisations—highest in remote (58%) and very remote areas (67%) where staff housing was also a challenge (54% and 51% respectively compared with 28% overall).

A majority of NDS Workforce Wizard users (95%) who entered data on their disability support workers in March 2017 quarter also responded to the supplementary questions on recruitment difficulty.

Among the valid responses, more than three-quarters of organisations indicated that they advertised to fill a disability support worker's position in March 2017 quarter. Among valid responses nearly two-thirds of organisations were able to fill disability support positions advertised in March 2017 quarter (65%). However, more Western Australian organisations had trouble in filling their vacancies on disability support workers. Only 56% of Western Australian organisations were able to fill all positions. Organisations in Queensland, on the contrary, had the least difficulty, with four-fifths of organisations filling in all disability support positions advertised<sup>51</sup>.

When being asked about why the vacancies were unfilled, the most common response was the lack of suitable or qualified candidates (29%). The lack of suitable candidates can be a result of a range of factors. It can be the lack of attractiveness of the job position, leading to a low level of interest from qualified candidates. Or, it can be a short supply of qualified talent to meet the increasing demand after the roll out of NDIS.

A common difficulty faced by providers is the increasing specification of job requirements for a vacant disability support position, possibly a result of the NDIS roll-out. More than one fifth of responses (22%) mentioned that the advertised role required specific job skills (which range from experiences with community access support to gardening, horticulture and cleaning), demographic characteristics (e.g. young male, indigenous or other cultural background), personality (to pass psycho-metric test, or suitability to care for clients with challenging behaviour). Some mentioned that the requirements for flexible working hours or working in shifts were common obstacles for candidates to consider the position.

The employment conditions however, are not catching up with the increasing specification of job requirements for disability support positions. Indeed, about one eighth of responses (13%) mentioned poor employment conditions, especially the lack of permanent full-time position, and low rate of pay as possible reasons for the vacancies to be unfilled.

Geographic location can also pose a challenge for recruitment. About one eighth of responses (13%) mentioned that rural or remote areas or the need to travel across long-distance locations as a factor for the vacancies to be unfilled.

Other key factors mentioned in the responses include organisational factors (e.g. lengthy recruitment policy, policy to recruit internal applicants only or a change in policy directions during the recruitment process) and a limited labour supply to meet the increasing vacancies under NDIS.

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<sup>49</sup> NDS, WA Industry Plan

<sup>50</sup> Australian Institute of Health and Welfare 2016. Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2014–15, Online Services Report, Cat. No. IHW 168, AIHW: Canberra.

<sup>51</sup> NDS Workforce Wizard, March 2017 quarter

The NDS use benchmarking tools such as Workforce Wizard<sup>52</sup> to reveal NDIS-related trends in the disability workforce. 21 out of 25 organisations who entered workforce data on allied health professionals responded to the supplementary questions on recruitment difficulty (84%). Among the valid answers, 13 respondents indicated that they advertised to fill an allied health professional position in March 2017 quarter (62%)<sup>53</sup>.

Among those who advertised to fill a position, eleven organisations provided a valid answer on whether they were able to fill all advertised positions in March 2017 quarter. Among them, seven organisations who advertised were able to fill all allied health professional positions (64%), four organisations were not able to fill all positions (36%). There were an estimated 10 allied health professional positions that went unfilled in March 2017 quarter.

Some reasons mentioned for recruitment difficulty of allied health professionals were similar to the problems faced by disability support workers. This includes the lack of suitable/qualified candidates, poor pay, rural and remote locations and internal organisation factors. One respondent mentioned that the wage offered for the advertised position was above award rate but was still unable to meet the demand of a preferred candidate. The inability to use NDIS funding for the hours of supervision was also mentioned as a constraint for recruitment.

Contrary to disability support workers, allied health professionals do not face a trend of increasing specification of job requirements, possibly due to the different job nature between these two occupations.

NDS Workforce Wizard data shows a similar level of recruitment difficulty between disability support workers and allied health professionals. About a third of organisations were unable to fill in all positions advertised for both occupations. There are common problems faced by employers of both occupations. These include the lack of suitable/qualified candidates, poor pay, rural and remote locations and internal organisation factors.

However, recruiters of disability support workers face a unique problem under NDIS. With the roll-out of NDIS, job requirements of disability support workers are becoming more and more specific in order to better match clients' needs. The increasing specification for a single position, together with the casualization of workforce driven by an increasing need for a flexible workforce, create unfavourable employment conditions and poses a challenge for some organisations to recruit disability support workers.

## **ATTRACTING A DIVERSE WORKFORCE**

The opportunity exists to better promote careers in social assistance and allied health sectors through VET for secondary school programs. It has been proposed that higher targets be set for TAFE in school-based traineeships, preparatory training programs (such as pre-traineeships) and skill sets for individual support, allied health and mental health. Industry should also be an active partner in this space providing more opportunities for school students to gain exposure to jobs in these sectors.

Student work placements in a relevant workplace context are a key requirement of most social assistance and allied health qualifications. Service providers can play a greater role in providing quality work placements for students or increasing the number of traineeships offered in the sector.

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<sup>52</sup> The Workforce Wizard is a questionnaire completed by disability organisations about their workforce, including the number of full-time, part-time, fixed-term and casual workers; total hours of work; entries and exits to the workforce during the quarter; and the age and sex make-up of the workforce.

<sup>53</sup> NDS Workforce Wizard, March 2017 quarter



Western Australia could explore programs such as the Victorian Government's *Industry Sponsored Placement Portal* that provides school students with access to job placements across the State and provides greater oversight of the quality of these arrangements.

The needs and expectations of consumer groups in all sectors need to be considered in terms of the workforce providing the services.

The social assistance and allied health sector is a female dominated sector. Across almost all occupation groups in the social assistance and allied health workforce there are more female workers than male workers.

The Committee recognises that the industry employment is predominately female, and measures must be put in place to increase male participation in the caring workforce. This is a long-term goal and not something that can be fixed immediately. It would be preferable for this to be a long-term goal for the sector, in consultation with the various portfolios.

The industry struggles to attract male workers, which is an issue when it is considered that the social assistance and allied health sectors will be the largest area of job growth in the Western Australian economy.

It is appreciated that cultural barriers and stereotypes play a major part in this imbalance. There is a perception in society that the caring professions, particularly nursing, aged care, child care, disability and social work are feminine roles and men who choose these professions are a bit feminine<sup>54</sup>.

A US-based research project found that occupations with a higher percentage of female workers generally pay less than those with lower percentage<sup>55</sup>. Furthermore, the research project found that improving gender diversity could also be the answer to improving wages in female-dominated roles. An example of this is computer programming, once the 'natural career choice for savvy young women' as it was nothing more than an extension of typing and filing. When male programmers wanted to elevate their job out of the 'women's domain' they created professional associations and discouraged the hiring of women through recruitment strategies that were squarely aimed at male workers, including math puzzles and personality tests<sup>56</sup>.

More males would consider a career in the caring industry if there was a better understanding of the opportunities available. Further, it may be that emphasising the technology/social connectivity domains of these roles is critical to attracting a more gender-balanced pool.

The committee is aware of overseas programs that could be adopted in Australia to attract more male workers into caring roles. In Nordic countries there has been a concerted effort to attract male workers in the health care roles<sup>57</sup>.

Aboriginal and Torres Strait Islander people continue to be under-represented (2%) in the social assistance and allied health workforce despite the demand for workers in remote areas and the ongoing requirement for culturally appropriate service delivery.

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<sup>54</sup> *Why men choose women's jobs*, 5 June 2012, Article from Oslo and Akershus University College of Applied Sciences

<sup>55</sup> Asaf Levanon, Paula England, Paul Allison, Occupational Feminization and Pay: Assessing Causal Dynamics Using 1950-2000 U.S. Census Data

<sup>56</sup> Rose Eveleth, *Computer Programming Used To Be Women's Work*, SmartNews, 7 October 2013

<sup>57</sup> The Finnish campaign "Strengthen care" (Styrka åt omsorgen – voima hoivan) and the Norwegian "Men in health care" (Menn i Helsevesenet) as well as the Danish "Change job, not gender!" (Skift job, ikke køn!) and "MPower" are examples of recruitment campaigns with an explicit gender focus.



The gap in economic participation and life outcomes for Aboriginal people in Western Australia remains significant. This is in part a legacy of the impacts of past policies and practices, part a consequence of health, education and support service systems that are inappropriate or inadequate to meet levels of need. Fear and lack of trust also play a critical role in lower rates of access to universal and secondary support services, training and education.

There is a strong argument for a greater focus on Aboriginal employment in health, disabilities, aged care and community services. Given the projected growth of the service and caring economy, and disproportionately high levels of need for services and support by Aboriginal families and communities, the development of a human services workforce also offers an excellent opportunity for increasing economic participation, helping develop more sustainable and resilient local economies.

There is a need to build on existing programs to increase the Aboriginal and Torres Strait Islander workforce and implement strategies to build the cultural security around the employment of Aboriginal people for services delivered to Aboriginal and Torres Strait Islander people.

Barriers to workforce participation also need to be addressed through public policy. For example, Aboriginal and Torres Strait Islander people have identified potential barriers to their participation in the workforce relating to the eligibility for public rental housing assistance.

The Aboriginal Health Council of Western Australia has established a State-wide young person committee that has regional representation. A part of the committee's role is to encourage young Aboriginal and Torres Strait Islander people to pursue careers in health.

The Aboriginal-targeted services through the Jobs and Skills Centres should be encouraged to work with service providers in the social assistance and allied health sectors to encourage more Aboriginal and Torres Strait Islander jobseekers into growth industries.

A planned and sustained strategy is needed to provide a coordinated approach supporting a skilled Aboriginal human services workforce, and build sustainable Aboriginal organisations and businesses by setting clear employment and training targets.

There is a significant risk that a strategy that does not address the gaps and challenges would be setting up Aboriginal people, communities and community services to fail. There is a need for strategies that enable co-design and co-production of training and support for students at a local level. The strategies should respond to the cultural context for Aboriginal people. Therefore it must be designed by Aboriginal people that is adaptive and inclusive. There is no 'one-size-fits-all' approach to Aboriginal training. Training needs to be adapted to local contexts.

Cultural diversity is one of the State's greatest assets. People from more than 200 different countries live, work and study in Western Australia, speak as many as 270 languages and identify with more than 100 religious faiths<sup>58</sup>.

Meeting the needs of our cultural diversity and expanding population brings many economic, social and cultural benefits, and creates opportunities and challenges for the service providers, government and non-government entities in providing policies, programs and services that successfully meet the needs of all Western Australians.

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<sup>58</sup> Office of Multicultural Interests, Engaging Culturally and Linguistically Diverse Communities, A guide to the Western Australian public service, July 2014

The committee recognises that there is a need to build on existing programs to increase the CaLD workforce and implement strategies to support their employment in various services. For services provided to CaLD communities, there is an understanding that many consumers would prefer the services to be delivered by workers with similar backgrounds, language capacity and cultural awareness.

People with a disability are underrepresented in the workforce and work needs to be undertaken to identify strategies and set targets to increase participation in the workforce. For mental health services there is a need to increase the number of peer workers.

The State Training Board's *State Training Plan* has also identified the need to increase the participation of people with disability in the labour market. The State may need to consider plans from other jurisdictions, for example, the Victorian Government, through *Every Opportunity* strategy, has set a target of 6% employment of people with disability across all Victorian Government departments by 2020, increasing to 12% by 2025<sup>59</sup>.

## **WORKING CONDITIONS AND PERCEPTIONS**

Some perceptions of the work act as barriers to active consideration of frontline support work. This included that the job may cause people to 'burn out', implying a belief that the emotional energy required may be difficult for some people to maintain<sup>60</sup>. Other aspects of the working conditions, low wages, shift work and working conditions also reduce interest of potential workers.

The poor reputation and perceptions of the sector are major barriers to recruiting and retaining newly qualified graduates and people looking for work in the health and community services sector. For the aged care sector in particular, the poor sector reputation has been further exacerbated by recent media reports of abuse, poor catering and living conditions for aged care residents. The number of inquiries into the aged care sector has also not helped with attracting workers into the sector.

For nursing staff, the aged care sector is not viewed favourably. Professor Melanie Birks of James Cook University described to a Senate Committee that "There is a perception that aged care nursing is less glamorous than nursing in the acute care sector. This perception is fed by a belief that nurses working in an aged-care setting require a lower skill set than those working elsewhere"<sup>61</sup>. There is also a belief that nurses in the aged care sector are there because they couldn't get work elsewhere.

With respect to working conditions and shift work, research undertaken through the National Aged Care Workforce Census and Survey in 2016 revealed that much of the workforce works on a permanent part-time basis. Only 10% of residential care workers and 13.5% of home care and home support workers were classed as casual or contract staff. This suggests that work is more stable in the aged care sector than previously thought.

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<sup>59</sup> Victorian Government, *Every Opportunity*, Victorian economic participation plan for people with disability 2018-2020, January 2018

<sup>60</sup> Donnelly, D, Given, F, Prof Hogan, A, Mercer, R, Dr Phillips, R and Vittles, P, "Finding the Workforce to Deliver the NDIS Vision" Research report, July 2013

<sup>61</sup> Professor Melanie Birks, James Cook University, Community Affairs References Committee, Future of Australia's aged care sector workforce, Hansard, 23 February 2017

Table 8: Form of employment of the aged care workforce, by occupation 2016

Occupation	Residential direct care			Home care or home support care		
	Permanent Full-time (%)	Permanent Part-time (%)	Casual or contract (%)	Permanent Full-time (%)	Permanent Part-time (%)	Casual or contract (%)
Registered Nurse	22.4	67.7	9.8	34.9	59.4	5.7
Enrolled Nurse	13.4	78.9	7.8	23.8	71.5	4.7
Personal Care Attendant	8.9	80.3	10.8	-	-	-
Community Care Worker	-	-	-	5.7	79.0	15.3
Allied Health	19.9	75.3	4.8	39.0	55.7	5.3
<b>All occupations</b>	<b>11.9</b>	<b>78.1</b>	<b>10.1</b>	<b>11.2</b>	<b>75.3</b>	<b>13.5</b>

Source: 2016 National Aged Care Workforce Census and Survey, The Aged Care workforce

Table 9 shows the average hours worked per week by the different occupations in aged care. Registered nurses appear to work longer hours than any other direct care roles. 41.8% of registered nurses and 38.2% of enrolled nurses worked between 35 and 40 hours per week. 57.2% of personal care attendants and 58.1% of community care workers work between 16 and 34 hours per week.

Table 9: Actual hours per week aged care workforce, by occupation 2016

Occupation	Residential direct care				Home care or home support care			
	1-15 (%)	16-34 (%)	35-40 (%)	>40 (%)	1-15 (%)	16-34 (%)	35-40 (%)	>40 (%)
Registered Nurse	3.0	32.2	41.8	23.0	3.6	41.2	38.9	16.3
Enrolled Nurse	3.4	47.6	38.2	10.8	8.0	51.1	27.4	13.6
Personal Care Attendant	4.6	57.2	31.8	6.4	-	-	-	-
Community Care Worker	-	-	-	-	19.9	58.1	17.6	4.5
Allied Health	4.7	40.3	43.5	11.6	6.9	43.1	38.6	11.4
<b>All occupations</b>	<b>4.3</b>	<b>51.8</b>	<b>34.4</b>	<b>9.5</b>	<b>17.5</b>	<b>55.7</b>	<b>20.8</b>	<b>6.0</b>

Source: 2016 National Aged Care Workforce Census and Survey, The Aged Care workforce

Nursing staff are attracted to aged care due to the shift pattern in work. According to the NACWCS the majority of nursing staff work a regular daytime shift pattern in aged care, particularly home care or home support care, compared to a rotating shift seen in most hospitals. Allied health professionals are predominately employed on a regular daytime shift pattern.

Table 10: Work schedule by occupation 2016

Work schedule	Nurse		Personal Care Attendant/Community Care Worker		Allied Health	
	Residential direct care (%)	Home care or home support (%)	Residential direct care (%)	Home care or home support (%)	Residential direct care (%)	Home care or home support (%)
A regular daytime shift	61.2	82.5	50.6	76.2	93.8	93.2
A regular evening shift	8.8	1.7	15.0	1.0	0.7	0.1
A regular night shift	3.8	0.4	5.0	0.2	0.0	0.1
A rotating shift	19.0	7.4	19.5	3.0	1.4	0.6
Split shift	0.3	2.2	0.8	2.9	0.1	0.0
On call	0.6	0.3	1.5	0.8	0.3	0.7
Irregular schedule	5.3	4.5	6.5	13.8	2.1	1.0
Other	0.9	1.0	1.1	2.1	1.5	4.2

Source: 2016 National Aged Care Workforce Census and Survey, The Aged Care workforce

Given the labour-intensive nature of the services required to be delivered in the Social Assistance and Allied Health sector, it is important to note that wages can significantly impact upon recruitment and retention strategies for employers.

## MENTAL HEALTH OF SUPPORT WORKERS

Research indicates that ‘job stress and other work-related psychosocial hazards are emerging as the leading contributors to the burden of occupational disease and injury’<sup>62</sup>.

Significant administrative, societal and political changes have impacted on the role of frontline support workers and the responsibilities they are expected to assume. In the community services sector, particularly in areas of social work, youth services, mental health and alcohol and other drug services there appears to be an increasing role conflict between client advocacy and meeting agency needs and targets<sup>63</sup>.

The very core of social assistance and allied health work is the relationship with the person seeking the service. For many this relationship is the most fulfilling part of the work. This relationship can be difficult when engaging with clients with unrealistic expectations, inappropriate behaviour, inappropriate demands or personality clashes. Workers in these situations are more likely to experience internal conflict and stress. Almost in all occasions, the frontline support worker will persevere and assume personal responsibility to deliver the service expected of them. This can lead to an emotional toll on the worker and their long-term mental health.

In a research study on NSW home care workers<sup>64</sup> found that a number of job stress risk factors related to the nature of the work being performed by workers.

“These included: isolation; demanding interactions with clients and their families; unpredictability attached to new clients and clients’ homes; and managing unpredictable client behaviours in public settings. Pressure to perform unpaid or unsafe work to satisfy unmet client needs often led care workers to cross professional boundaries. Most workers described emotional demands from frequent exposure to client illness, loneliness and death, which accumulated over time. Having to manage client emotions, while masking their own emotions, was a further source of stress.”

Additionally, many frontline workers in community service roles report that they have little control over the work they do in terms of the clients they see, the nature and length of contacts with clients, the range of functions they are expected to perform, and the value placed on this work by others.

For many of these workers work is performed for not-for-profit or government agencies and there is often no additional funding to reduce the workload or provide additional support to workers.

## REMUNERATION AND JOB SATISFACTION

The aged care sector cannot compete with other industry sectors in terms of remuneration or employee conditions. According to Leading Age Services Australia, the removal of services and funding avenues for providers, such as the Workforce Development Fund and the Dementia and Severe Behaviours supplement in residential services has adversely affected workforce attraction, retention and development<sup>65</sup>.

The ABS Employee Earnings and Hours survey for Western Australia shows that in May 2016, the average annual salary for Medical practitioners of \$216,653 was more than double that of the State’s

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<sup>62</sup> LaMontagne AD, Keegel T & Vallance D (2007) Protecting and Promoting Mental Health in the Workplace: Developing a Systems Approach to Job Stress, Health Promotion Journal of Australia 2007,18, 221–8 (citing Marmot M, Siegrist J & Theorell T (2006) Health and the Psychological Environment at Work, Social Determinants of Health 2006, 97–130)

<sup>63</sup> Lloyd, C, King K and Chenoweth, L, Social work, stress and burnout: A review, Journal of Mental Health, 2002

<sup>64</sup> Evesson J, Oxenbridge S, The Psychosocial Health and Safety of Australian Home Care Workers: Risks and Solutions, August 2017

<sup>65</sup> Leading Age Services, Position Statement, Workforce 2016

overall annual average salary of \$93,523. Midwifery and nursing professionals (\$100,777) and Health diagnostic and promotion professionals (\$100,317) were also paid above the WA average salary. Health and welfare support workers (\$73,884), Personal care workers and assistants (\$57,017), Education aides (\$50,187), and Child care workers (\$46,667) were all paid significantly below the Western Australian average salary.

HESTA's research<sup>66</sup> reported personal fulfilment and job satisfaction gained by caring for residents was a high motivator for job satisfaction in the aged care sector over remuneration. For personal care attendants and community care workers the reasons for entering the aged care sector are significantly different to nursing staff. Staff identified that they entered aged care sector for various reasons, including it suited their disposition, it was a stepping stone to the hospital system and it was a booming industry.

The Productivity Commission's 2011 *Caring for older Australians*<sup>67</sup> made several recommendations about the aged care workforce, including the consideration of the need to pay fair and competitive wages to nursing and other care staff delivering approved aged care services, and the appropriate mix of skills and staffing levels for the delivery of those services.

For workers from non-related fields of employment, the aged care sector represented stability in terms of hours and permanency that was not available in their previous employment. Workers in the aged care sector are more likely to move between employers within aged care rather than leave the aged care sector altogether. 16% of home care and home support workers reported holding more than one current job. Improved working conditions, along with changing personal circumstances, were the primary reasons for moving to a different aged care employer.

Workers in the disability services sector also reported job satisfaction when working with clients and their families. Workers with past or present 'caring' experience are doing this work because they are inherently attracted to disability 'care' or support work. The frontline disability support role appeals on a number of levels, few of which centre on the remuneration or conditions of employment that such a job may involve<sup>68</sup>.

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<sup>66</sup> HESTA, *Transforming Aged Care: Reimagining the aged care workforce of tomorrow*, 2018

<sup>67</sup> Productivity Commission, 2011, *Caring for older Australians*

<sup>68</sup> Donnelly, D, Given, F, Prof Hogan, A, Mercer, R, Dr Phillips, R and Vittles, P, "Finding the Workforce to Deliver the NDIS Vision" Research report, July 2013

## TRAINING DELIVERY

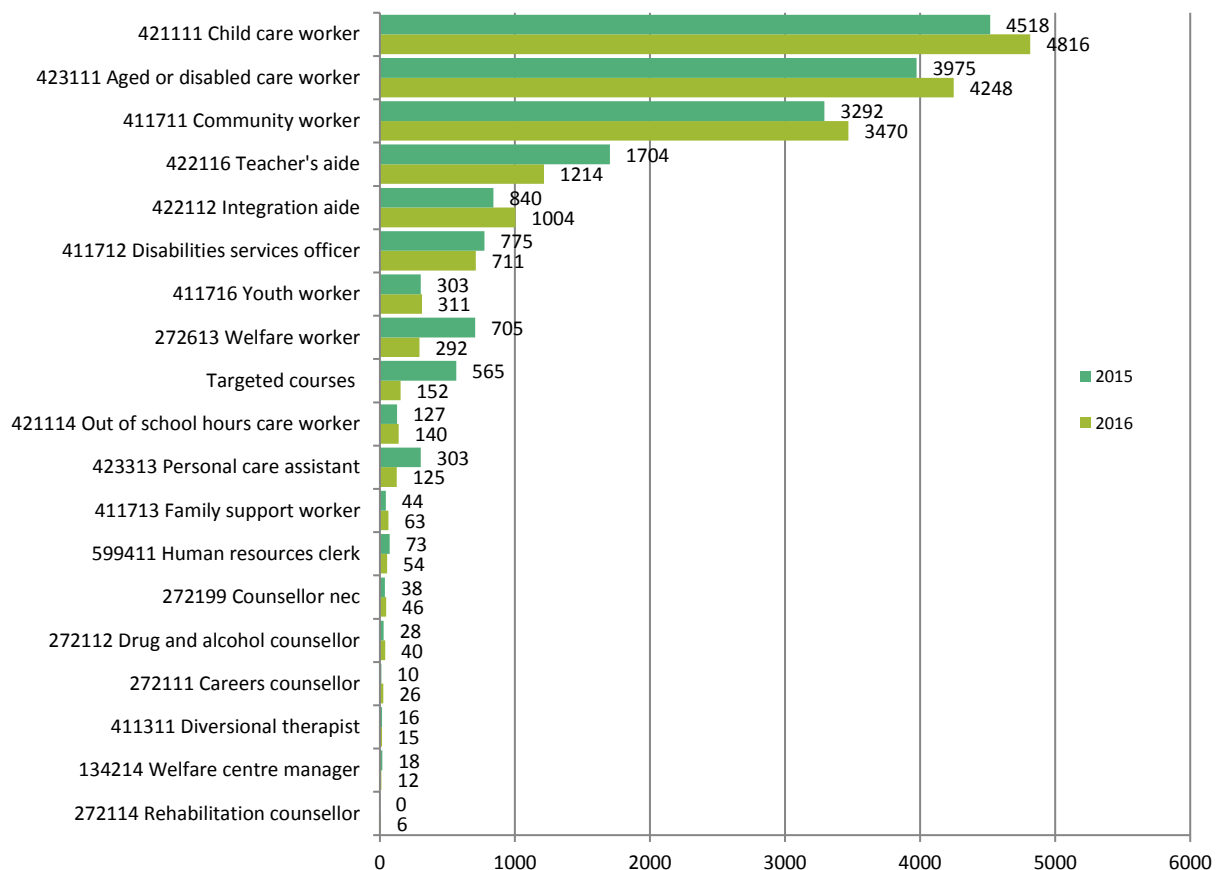
While the social assistance and allied health industry prefers to employ people with a relevant VET qualification, it is neither essential, nor a primary requirement. Childcare is the exception due to regulatory requirements.

### CURRENT TRAINING DELIVERY

The Health training package (HLT) and the Community Services training package (CHC) contain VET courses that are relevant to the Social Assistance and Allied Health sector. These courses have been mapped to 6-digit ANZSCO occupations by the Department of Training and Workforce Development.

In 2016 there were 16,747 course enrolments in the Community Services training package which was slightly lower than the 17,350 recorded in 2015. The bulk of these course enrolments related to Child Care Workers (4,816), Aged or Disabled Care Worker (4,248), and Community Workers (3,470).

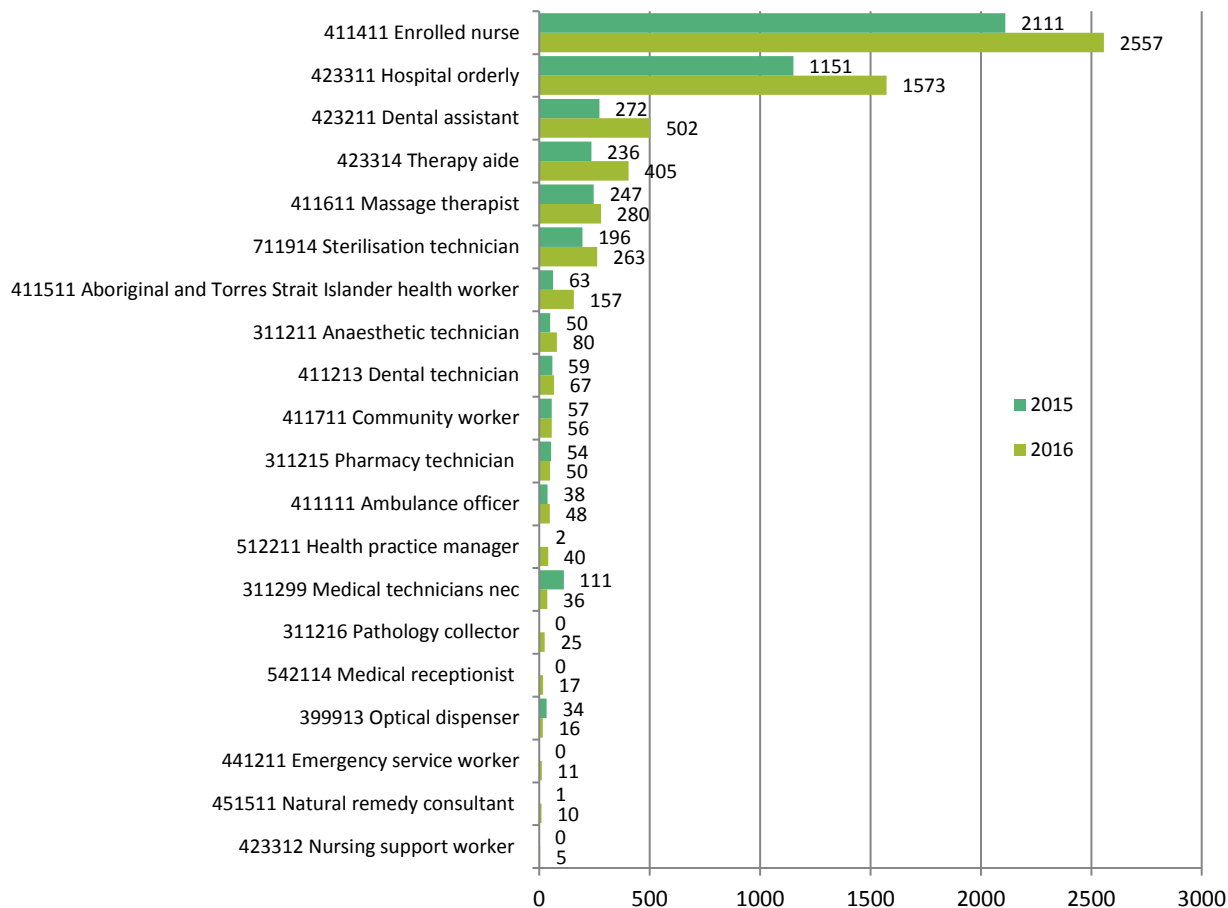
Figure 15: Community Services Training Package by occupation, course enrolments, WA 2015 and 2016



Source: Department of Training and Workforce Development

In 2016 there were 6,198 course enrolments in the Health training package, compared to 4,683 in 2015. The majority of these enrolments were for Enrolled Nurses (2,557), Hospital Orderly (1,573), Dental Assistant (502) and Therapy Aide (405).

Figure 16: Health care training package by occupation, course enrolments, WA 2015 and 2016



Source: Department of Training and Workforce Development

NCVER 2016 data shows that course completion rates are relatively poor for most qualifications in the Social Assistance and Allied Health sectors, with up to 50% of students not completing. However, this doesn't mean that students aren't getting what they need from the VET sector, as many could be doing skill sets or short courses that suit their personal needs or employers' expectations.

Enrolment data for the Certificate III in Individual Support (the primary qualification for a support worker) indicates that approximately 50% of students qualify for a Health Care Card and Pensioner card concession, or a fee exemption.

### TRAINEESHIPS

There is currently an array of traineeships in the social assistance and allied health industry available in Western Australia.

The Community Services training package had a considerable number of trainees in training in 2017 as Child Care Workers (around 833), Personal Care Assistants (357), Aged or Disabled Care Workers (70), Disability Service Workers (61) and Community Workers (58).

The Health training package recorded only a small number of trainees that were in training in 2017, mainly for Dental Assistants (22).

Industry has consistently highlighted the lack of incentives available to take on trainees especially part-time trainees. The *Australian Apprenticeships Incentives Programme* which provides incentives to employers to encourage the take up of apprenticeships and traineeships are not adequately covering



the cost for part-time trainees. This is a significant issue for the social assistance and allied health sectors where part-time workers are common. Incentive payments are geared towards full time employment; a business employing a trainee on a full-time basis receives a \$1,500 commencement payment and \$2,500 on completion. A part time trainee attracts a one off \$1,500 payment on completion.

Table 11: Social assistance and allied health traineeships available in Western Australia as at 30 June 2018

Traineeship	Qualification	Duration
ABORIGINAL AND ISLANDER EDUCATION WORKER (LEVEL 3)	CHC30213 - Certificate III in Education Support	12 months
ABORIGINAL AND ISLANDER EDUCATION WORKER (LEVEL 4)	CHC40213 - Certificate IV in Education Support	12 months
ABORIGINAL AND/OR TORRES STRAIT ISLANDER HEALTH CARE WORKER (LEVEL 2)	HLT20113 - Certificate II in Aboriginal and/or Torres Strait Islander Primary Health Care	12 months
ABORIGINAL AND/OR TORRES STRAIT ISLANDER HEALTH CARE WORKER (LEVEL 3)	HLT30113 - Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care	12 months
ABORIGINAL AND/OR TORRES STRAIT ISLANDER HEALTH CARE WORKER (LEVEL 4)	HLT40213 - Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice	24 months
ABORIGINAL EARLY CHILDHOOD EDUCATOR (LEVEL 3)	CHC30113 - Certificate III in Early Childhood Education and Care	24 months
ABORIGINAL ENVIRONMENTAL HEALTH (LEVEL 2)	HLT26115 - Certificate II in Indigenous Environmental Health	12 months
ABORIGINAL ENVIRONMENTAL HEALTH WORK (LEVEL 3)	HLT36115 - Certificate III in Indigenous Environmental Health	24 months
AGED CARE WORK (LEVEL 3)	CHC33015 - Certificate III in Individual Support	12 months
AGED CARE WORK (LEVEL 4)	CHC43015 - Certificate IV in Ageing Support	24 months
ALLIED HEALTH ASSISTANT (LEVEL 3)	HLT33015 - Certificate III in Allied Health Assistance	12 months
ALLIED HEALTH ASSISTANT (LEVEL 4)	HLT43015 - Certificate IV in Allied Health Assistance	24 months
COMMUNITY CARE WORK (LEVEL 3)	CHC33015 - Certificate III in Individual Support	12 months
COMMUNITY CARE WORK (LEVEL 4)	CHC43015 - Certificate IV in Ageing Support	24 months
COMMUNITY SERVICES WORK (LEVEL 2)	CHC22015 - Certificate II in Community Services	12 months
COMMUNITY SERVICES WORK (LEVEL 3)	CHC32015 - Certificate III in Community Services	12 months
COMMUNITY SERVICES WORK (LEVEL 4)	CHC42015 - Certificate IV in Community Services	24 months
DENTAL ASSISTING (LEVEL 3)	HLT35015 - Certificate III in Dental Assisting	24 months
DENTAL ASSISTING (LEVEL 4)	HLT45015 - Certificate IV in Dental Assisting	12 months
DISABILITY WORK (LEVEL 3)	CHC33015 - Certificate III in Individual Support	12 months
DISABILITY WORK (LEVEL 4)	CHC43115 - Certificate IV in Disability	24 months
EARLY CHILDHOOD EDUCATOR (LEVEL 3)	CHC30113 - Certificate III in Early Childhood Education and Care	24 months
EARLY CHILDHOOD EDUCATOR (LEVEL 5)	CHC50113 - Diploma of Early Childhood Education and Care	36 months
HEALTH PRACTICE MANAGER (LEVEL 5)	HLT57715 - Diploma of Practice Management	24 months
HEALTH SERVICE ASSISTANCE (LEVEL 3)	HLT33115 - Certificate III in Health Services Assistance	12 months
HEALTH SUPPORT SERVICES (LEVEL 2)	HLT23215 - Certificate II in Health Support Services	12 months
HEALTH SUPPORT SERVICES (LEVEL 3)	HLT33215 - Certificate III in Health Support Services	12 months
MENTAL HEALTH PEER WORK	CHC43515 - Certificate IV in Mental Health Peer Work	24 months
MENTAL HEALTH WORK	CHC43315 - Certificate IV in Mental Health	24 months
PROTECTIVE CARE WORK (LEVEL 5)	CHC50313 - Diploma of Child, Youth and Family Intervention	24 months
PROTECTIVE CARE WORKER (LEVEL 4)	CHC40313 - Certificate IV in Child, Youth and Family Intervention	12 months
SCHOOL AGE EDUCATOR (LEVEL 4)	CHC40113 - Certificate IV in School Age Education and Care	24 months
SCHOOL AGE EDUCATOR (LEVEL 5)	CHC50213 - Diploma of School Age Education and Care	36 months
SENIOR CLINICAL CODER	HLT47315 - Certificate IV in Health Administration	24 months
YOUTH WORK (LEVEL 4)	CHC40413 - Certificate IV in Youth Work	24 months

There is a low level of enrolments in relevant school-based traineeships. This is a concern given the career opportunities available in the Social Assistance and Allied Health sectors, including pathways to professional jobs such as occupational therapy and social work. A number of factors appear to be contributing to this situation, including the view that it is not cost effective for training providers and industry to supervise and support school-based trainees on the job. This perception has contributed to limited take-up of the qualifications by Registered Training Organisations. For example, in 2017 TAFE did not offer the school-based traineeship for the Certificate III in Individual Support (Disability). There is however an example where this traineeship is being very successfully offered by an enterprise RTO to school based trainees. They invest in pastoral care of the students and employ approximately 85% on completion of the traineeship.

## **QUALIFICATIONS AWARDED**

In 2016 there were 7,962 qualifications awarded in the Community Services training package compared to 7,824 in 2015. The bulk of the qualifications awarded in 2016 were for the occupations of Aged or Disabled Care Worker (2,232), Child Care Worker (1,782), and Community Worker (1,690).

In 2016 there were 2,464 qualifications awarded in the Health training package compared to 2,232 in 2015. The majority of the qualifications awarded in 2016 were for the occupations of Enrolled Nurse (738), Hospital Orderly (657), Dental Assistant (356) and Therapy Aide (152).

## **TRAINING PATHWAYS**

There does not appear to be a standard pathway to working in the social assistance and allied health sectors. For instance, the majority of workers have worked in other areas prior to employment in the aged care sector. This may explain the higher median age of workers in the aged care sector.

Research undertaken by the Department of Training and Workforce Development suggests that a preparatory training program, similar to pre-apprenticeships, could be developed for the sector. This initiative is supported by the sectors, subject to the cost, as the support worker skill set varies considerably depending on the level of client care required. It is suggested that a pre-traineeship model consists of four units of competency it is a lower cost entry-level program and offers industry considerable flexibility. For example, the disability sector see the pre-traineeship as an opportunity to promote industry-wide take-up of the disability induction skill set CHCCS015 (comprising the following units: provide individualised support, communicate and work in health or community services, follow safe work practices for direct client care, facilitate the empowerment of people with disability). Other sectors see the pre-traineeship as an opportunity to provide potential workers with the opportunity to determine their suitability to work in an industry.

The opportunity exists to better promote careers in social assistance and allied health through the VET for secondary school students program. The Committee sees a correlation between the need to increase the number of people undertaking training in this sector and the State Government's push to re-establish the TAFE brand in Western Australia. The Committee would welcome policy measures or funding incentives to increase training undertaken by TAFE such as increasing the number traineeships, school-based traineeships, pre-traineeships and skill sets for individual support, allied health and mental health. Industry should also be an active partner in this space providing more opportunities for school students to gain exposure to jobs in these sectors.

## **MIX OF SKILLS NEEDED**

Priorities in workforce development across much of the social assistance and allied health workforce are to develop a mix of skills across the workforce and the need to develop career pathways from other sectors.

The Steering Committee found that there is considerable commonality between the competencies

required to undertake work in the aged care, disability, mental health and community services sectors. From the outset the committee was keen to understand whether training programs could be developed that would facilitate the transfer of workers between sectors, particularly in regional and remote communities where the number of workers may not be available. It has been proposed that further work be undertaken to determine the practicalities of this arrangement, given the future workforce requirements of the social assistance and allied health workforce in this State.

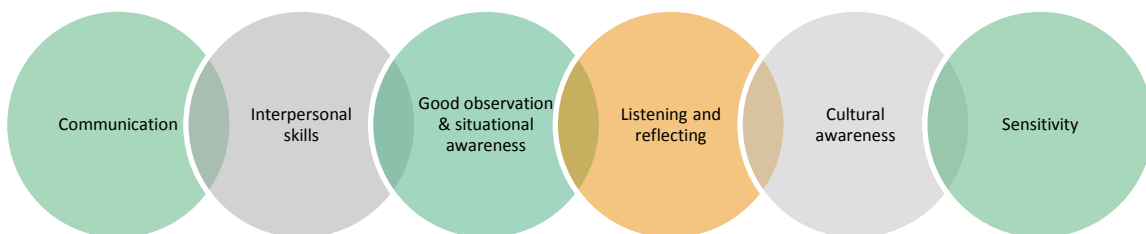
Training and development for workers working in government agencies and community sector organisations in relation to person centred approaches will need to include training around building connections and facilitating prevention, early intervention and recovery for clients.

The Certificate III in Individual Support is the flagship qualification and is designed to provide training to entry-level workers who want to work in residential aged care facilities, community care, nursing homes, disability care, community-based organisations and hospitals. This qualification reflects the role of workers in the community and/or residential setting (residential aged care facilities) who follow an individualised plan for provision of person-centred care to people who may require support due to ageing, disability or some other reason. There is an increasing expectation that workers are required to support people in their homes, support people with increasingly complex needs, to tailor care and support approaches to meet increased individualisation of the services being offered and provided.

## ESSENTIAL SKILLS

It is important to understand that much of the essential skills for the social assistance and allied health sector are interpersonal or social skills. Workers need to have the right 'values' in terms of respect, empathy and understanding, remaining calm in stressful situations and negotiating with family, government and service providers. Teaching these skills is difficult and many registered training organisations do not have a good record of accomplishment in teaching these skills.

Figure 17: Essential skills for working in direct care roles



**Good communication** is critical in supporting people within aged care, disability services, allied health and community services sectors. Some people with complex care needs have no, or very limited speech and may find it difficult to communicate their basic needs or understand straightforward questions or directions. Specific skills may be required for working with people with vision or hearing impairment such as Auslan language.

Good **interpersonal skills** are crucial to building good relationships with people and their support networks, including family and friends, colleagues and people in the wider community. It is essential that registered training organisations work closely with care organisations to ensure that appropriate training is provided in this critical area.

Developing **good observation skills** are critical for working in the social assistance and allied health sector and are essential when working with people with complex needs. Observational skills include recognition and understanding of nonverbal communication, such as facial expressions, body language and eye contact can be used to understand what a person may be feeling or thinking. **Situational awareness** is the perception of environmental elements and events that may have adverse effects on

a person's mental wellbeing. It is the view of the Steering Committee that these skills cannot be learned in a classroom or online and must be delivered through simulated work practice or directly in the workplace. Good observation skills and situational awareness need to be accompanied by development of awareness and understanding of 'risk', with the knowledge of how to respond appropriately to ensure risks are managed and/or mitigated.

**Listening and reflecting skills** are essential in a social assistance and allied health setting. Listening carefully to learn about a person's choices and preferences. Listening to the subtleties in a person's communications can make the difference in understanding and misunderstanding what someone is trying to communicate. Reflection of messages can help alleviate stress or injury resulting from misunderstanding.

Working in direct care roles requires a high-degree of **sensitivity**. Students need to ensure that the person in their care receives the respect and dignity that is every person's basic human right. It means having respect for privacy, physically and emotionally, respecting choices and treating a person with dignity. Workers need to be non-judgemental and respect a person's cultural, spiritual and lifestyle choices when communicating with them. This is particularly important when working in someone's home.

**Cultural awareness training** is essential for working with Aboriginal and Torres Strait Islanders and people from CaLD backgrounds. Workers need to have an awareness of families' cultural practices and norms, particularly to ensure assessments identify appropriate support measures.

## **EMPLOYER EXPECTATIONS**

Employers are increasingly questioning the value of qualifications and are relying more on recruiting people on the basis of organisational fit and values alignment rather than employing someone because they hold a relevant VET qualification.

Where job applicants have completed qualifications such as the Certificate III in Individual Support, many employers are questioning the level of skills acquired through this training and in some cases their overall suitability for the industry. In particular, there is a need to clarify the level of job readiness achieved through completion of VET qualifications in enabling people to work in sectors such as disability.

Employers are choosing to provide targeted training to workers on the job, or where businesses lack this capacity, workers complete informal training, in their own time. There is a risk that the social assistance and allied health care workforce of the future will lack nationally recognised qualifications and have significant skill gaps.

## **TRAINING CURRICULUM**

A feature of the Australian VET system is that the design and content of training curriculum is developed nationally through the Australian Industry and Skills Committee (AISC), Skills Services Organisations and Industry Reference Committees (IRCs).

IRCs are the formal channel for considering industry skills requirements in the development and review of training packages. Each IRC is made up of people with close links to industry. They are leaders in their own sectors from big business to small enterprise and peak bodies to unions, who understand the skills needs of their sector, industry or occupation.

IRCs advise the AISC about the skills needs of their industry sector. IRCs ensure training packages meet the needs and concerns of employers, employees, training providers, and people seeking training qualifications. To make sure industry's voice is heard, IRCs gather information from their industry

sector - including challenges, opportunities, trends and industry requirements for training - to advise on training packages.

For further information on the IRCs and the work they are undertaken, please refer to AISC website: <https://www.aisc.net.au/content/industry-reference-committees>

The relevant industry reference committees relating to the social assistance and allied health workforce are:

- Aboriginal and Torres Strait Islander Health Worker
- Aged Services
- Ambulance and Paramedic
- Children's Education and Care
- Client Services
- Community Sector and Development
- Complementary Health
- Dental
- Direct Client Care and Support
- Education
- Enrolled Nursing
- First Aid
- Technicians Support Services

## TRAINING QUALITY

It is in the best interest of everyone involved that education and training for the social assistance and allied health workforce is of high quality. Students have the right to as good an education as possible, and the public has the right to well-educated and well-trained workers that can deal with a range of issues, provide quality care and meet the needs of individuals.

Training providers are accountable for the quality of the training it provides and the outcomes of its students. The Training Accreditation Council and the Australian Quality Standards Authority play a vital role in safeguarding the quality of training provided in Western Australia. The Department of Training and Workforce Development also plays a significant role in ensuring that Government-funded training is of a high quality and meets the needs of industry.

Increasingly registered training organisations are shifting to online delivery to reduce costs; the industry is concerned this is affecting the volume and quality of training being delivered and the employability of graduates. In general, the sectors are concerned about the variability in the quality of training delivery, particularly in the suitability and support provided in work placements, which is contributing to the decline in support for nationally recognised training and employment of graduates.

The project has identified a range of good skilling practices occurring in individual enterprises. In the interests of promoting good practices across the sectors, it is proposed industry work with the Department of Training and Workforce Development to document and share these good practices. The development of a *Good Practice Placement* guideline would work to improve training and assessment in the workplace. It would be ideal if the Department of Training and Workforce Development imposed a condition of receiving public funding for training delivery that required RTOs to comply with the guidelines.

## SUPPORT FOR STUDENTS

Industry has highlighted the need to improve the literacy and numeracy levels of support workers, particularly those from a CaLD background, considering the growing complexity of the role and greater take-up of technology in the workplace.

Student work placements in a relevant workplace context are a key requirement of most social assistance and allied health qualifications. Industry can play a greater role in sourcing appropriate placements. The Victorian Government has established an *Industry Sponsored Placement Portal* that provides school students with access to job placements across the State and provides greater oversight of the quality of these arrangements.

Western Australia, through the Department of Training and Workforce Development and the TAFE Jobs and Skills Centres, could look to develop a similar portal for student placements. The portal could be a one-stop shop for students, jobseekers and trainers as a referral point for structured workplace learning opportunities offered by employers. Employers could also advertise work placements for secondary, VET and university students to support their learning.

## **VIABILITY OF ENTERPRISE REGISTERED TRAINING ORGANISATIONS**

Enterprise Registered Training Organisations (enterprise RTOs) are companies or other non-educational organisations that have set up specialist training arms within the organisation to offer qualifications, primarily to their own employees. Enterprise RTOs exhibit the same characteristics and have to adhere to the same regulatory framework as other training providers.

Many enterprise RTOs have invested in considerable resources to meet the obligations of meeting training standards and requirements. Enterprise RTOs can deliver nationally recognised qualifications in a customised way that meets the needs of their workers. They can also deliver part of a qualification, known as a skill set to meet a specific skill requirement.

The process of becoming an enterprise RTO is an onerous process for enterprises and those that take the step to become an enterprise RTO are likely do so to meet specialised skill needs for their workforce or a need to train large numbers of workers to a high standard of quality.

Increasingly enterprise RTOs are electing not to renew their registration due to the cost and complexity of the VET sector. The level and cost of regulation and the continuous review of National Training Package requirements are key issues.

Enterprise training organisations are leading industry trainers and represent a major loss to the Western Australian VET sector. While these enterprises continue to train in-house, often, in accordance with the National Training Package, there is a risk that the training will shift eventually from industry to enterprise specific standards. This will impact on the portability of worker skills.

## **SUITABILITY OF TRAINING**

To address industry concerns about the suitability of training it is proposed that an industry representative group review the current qualifications to provide input to the national review of the Training Package. The national review is scheduled to be undertaken in 2018–19. The Western Australian industry review could also consider the support for the delivery of a full qualification considering the view that a targeted skill set specific to each sector would be less costly and more appropriate. The increased priority given to values based recruitment also highlights the opportunity to consider this aspect as part of the review of the training content of the qualification.

## **TRAINING AFFORDABILITY**

The cost of training has been identified as a significant barrier to student and traineeship participation in the social assistance and allied health industry.

Employers have welcomed the McGowan Government's decision to freeze TAFE fees but suggest that a reduction to fees is needed to encourage the take up of VET study. A reduction in fees particularly for aged care, disability services, child care, community services and allied health, where wages are

traditionally low would be helpful. In some cases, due to competing policies, it is cheaper to do a qualification through fully fee-for-service training rather than through publicly funded training.

Employers are finding the cost of training a major barrier to upgrading the skills of their existing workforce. This presents a major challenge for the sectors in responding to the changes taking place and in ensuring contemporary service delivery.

The Department of Training and Workforce Development are encouraged to explore options to reduce the cost of training for this important industry. Options need to include both training targeted at new entrants and training for existing workforce, particularly to manage the quality, safety and compliance of untrained support workers already working in the sector.

The Committee noted the Victorian Government's announcement of 'free' TAFE for nursing, aged care and disability support qualifications. The Committee noted that Victoria's finances were in a better position than Western Australia at the time of the announcement. Given the recent announcement of the changes to the GST distribution and the expected boost in revenue to Western Australia, the Committee urges the State Government to consider additional funding to support the training of workers in the social assistance and allied health workforce.



## WORKFORCE DATA

Table 12: Frontline and service support workers by employment

ANZSCO	Occupation name	Employment	Female share	Part time share	Median age
2721	Counsellors	1,858	79%	51%	44
2724	Social Professionals	831	66%	61%	45
2726	Welfare, Recreation and Community Arts Workers	2,597	79%	39%	41
3112	Medical Technicians	3,098	82%	46%	40
4111	Ambulance Officers and Paramedics	1,028	37%	16%	38
4112	Dental Hygienists, Technicians and Therapists <sup>57</sup>	1,067	68%	44%	39
4113	Diversional Therapists	177	85%	67%	50
4114	Enrolled and Mothercraft Nurses	3,012	93%	56%	46
4115	Indigenous Health Workers	187	73%	30%	47
4116	Massage Therapists	1,288	82%	75%	39
4117	Welfare Support Workers	5,993	75%	35%	42
4211	Child Care Workers	10,450	97%	55%	30
4221	Education Aides	13,719	95%	70%	45
4231	Aged and Disabled Care Worker	13,903	83%	66%	43
4232	Dental Assistants <sup>57</sup>	2,221	99%	56%	33
4233	Nursing Support and Personal Care Workers	9,211	80%	61%	43
4234	Special Care Workers	490	71%	47%	43
4515	Personal Care Consultants	625	89%	68%	43
4518	Other Personal Service Workers	1,329	69%	71%	41

Source: Australian Bureau of Statistics, 2016 Census

Table 13: Professional and allied Health Workers by employment

ANZSCO	Occupation name	Employment	Female share	Part time share	Median age
2346	Medical Laboratory Scientists	1,620	74%	33%	38
2349	Other Natural and Physical Science Professionals	1,112	37%	24%	34
2511	Nutrition Professionals	413	96%	49%	33
2512	Medical Imaging Professionals	1,466	72%	34%	36
2513	Occupational and Environmental Health Professionals	3,309	42%	16%	40
2514	Optometrists and Orthoptists	385	49%	34%	42
2519	Other Health Diagnostic and Promotion Professionals	610	84%	35%	39
2521	Chiropractors and Osteopaths	511	45%	56%	33
2522	Complementary Health Therapists	542	78%	64%	45
2523	Dental Practitioners <sup>69</sup>	1,425	44%	37%	38
2524	Occupational Therapists	1,643	93%	44%	32
2525	Physiotherapists	2,444	71%	39%	32
2526	Podiatrists	374	60%	47%	37
2527	Audiologists and Speech Pathologists \ Therapists	976	94%	43%	33
2531	General Practitioners and Resident Medical Officers	5,456	47%	24%	40
2532	Anaesthetists	497	34%	22%	41
2533	Specialist Physicians	711	39%	19%	42
2534	Psychiatrists	295	50%	27%	46
2541	Midwives	2,154	99%	64%	45
2544	Registered Nurses	21,759	91%	49%	42
2723	Psychologists	2,430	81%	50%	43
2725	Social Workers	1,902	84%	37%	42

Source: Australian Bureau of Statistics, 2016 Census

<sup>69</sup> Dental practitioners is a term to refer to all registered dental professionals including: Dentists – general and specialists; Dental therapists; Dental hygienists; Oral health therapists; Dental prosthetists. Non-registered professionals include dental clinic assistants and dental technicians.

Table 14: Management and Governance roles by employment

ANZSCO	Occupation name	Employment	Female share (%)	Part time share (%)	Median age
1341	Child Care Centre Managers	1,025	93%	34%	36
1342	Health and Welfare Services Managers	2,145	75%	15%	48
2543	Nurse Managers	1,414	88%	22%	48
5111	Contract, Program and Project Administrators	11,027	51%	15%	41
5122	Practice Managers	2,141	91%	42%	46

Source: Australian Bureau of Statistics, 2016 Census

## FUTURE WORKFORCE REQUIREMENTS

The future workforce needs of the social assistance and allied health sectors must be continually monitored in light of the rapidly growing demand for services across many fronts.

### EMPLOYMENT FORECASTS

The Department of Training and Workforce Development, in consultation with the Centre of Policy Studies (CoPS), have reviewed employment level forecasts for the social assistance and allied health sub-sector out to 2024–25 and have forecast an average annual growth rate of 3.4%, or the equivalent of 27,600 extra workers.

The Department of Jobs and Small Business occupational projections to May 2022<sup>70</sup> have suggested strong employment growth in key occupations across Australia. In particular, aged and disabled care worker, the main occupational group is expected to grow by 47.3% in the five years to May 2022 or by 77,400 workers across Australia. Personal care workers and assistants are expected to grow by 32.4% or by 90,600 to May 2022.

### FURTHER RESEARCH REQUIRED

The consultations have identified a range of options for change to assist in ensuring an adequate supply of skilled workers is available to meet future demand. The consultations have also identified a range of good practices occurring across industry. These practices have been taken into consideration in the development of the options for change.

Overall, the project has found significant opportunity for Government and industry to work together to position the State to meet future demands for a skilled workforce for the Social Assistance and Allied Health sectors. In some cases, the changes proposed relate to Government funding and service delivery arrangements and in others the opportunity for industry to take a leadership role in driving sector wide improvement.

The Steering Committee identified areas for potential future work that may address some of the challenges and barriers that the social assistance and allied health sector faces.

- Graduate attributes: What are employers looking for from graduates and alignment with what is being delivered by training providers.
- Pathways: Do employers want greater pathway flexibility, entry/exit points and job outcomes?
- What skills do we need in the community? Links to industry and business plans.
- Generalist workforce – what does this look like, what are skills and personal attributes, ability to work unsupervised or independently
- Exploration of technology-supported learning and development
- Aboriginal and Torres Strait Islander health – specific targeted strategies to grow the workforce.

<sup>70</sup> Department of Jobs and Small Business, Labour Market Information Portal, 2017 Occupation projections – five years to May 2022

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State Training Board  
Level 2, 16 Parkland Road Osborne Park WA 6017  
Telephone: (08) 6551 5593  
Email: [ostb@dtwd.wa.gov.au](mailto:ostb@dtwd.wa.gov.au)  
Website: [www.stb.wa.gov.au](http://www.stb.wa.gov.au)