From: Penny Parker <PParker@mauriceblackburn.com.au>
Sent: Thursday, 26 May 2022 9:09 AM
To: Chambers - Ross J <Chambers.Ross.j@fwc.gov.au>; Chambers - O'Neill C <Chambers.ONeill.C@fwc.gov.au>; Chambers - Asbury DP <Chambers.Asbury.dp@fwc.gov.au>
Cc: Alex Grayson <AGrayson@mauriceblackburn.com.au>; Nigel Ward <Nigel.Ward@ablawyers.com.au>; Jordan Lombardelli <jordan.lombardelli@ablawyers.com.au>; Alana Rafter <Alana.Rafter@ablawyers.com.au>; Nick White <nwhite@gordonlegal.com.au>; Ben Redford <Ben.Redford@unitedworkers.org.au>; Philip Gardner <pgardner@gordonlegal.com.au>
Subject: AM2020/99, AM2021/63, AM2021/65 - Aged Care Work Value Case [MBC-VIC.FID4764043]

Dear Associate

I refer to the above proceedings.

Please find the following documents **attached:**

1. The Report referred to by Professor Charlesworth during the course of giving oral evidence; and
2. The amended report from Professor Meagher referred to by Professor Meagher during cross-examination. In addition to making the amendments identified during the hearing, Professor Meagher has also identified one additional amendment. She has amended Table 4, so that the final figure on the bottom right hand side, is 1.9 rather than 29. We have alerted ABI to same

Please also find the Report referred to by Professor Eagar during cross examination at this link: https://www.gen-agedcaredata.gov.au/Topics/Quality-in-aged-care/Residential-Aged-Care-Quality-Indicators-October-to-December-2021

The legal representatives for the active parties are included in this correspondence.

Kind regards

Penny Parker
Associate
T 02 8267 0940 **F** 02 9261 3318
E pparker@mauriceblackburn.com.au
Gadigal
Level 32, 201 Elizabeth Street
Sydney NSW 2000

mauriceblackburn.com.au

maurice blackburn lawyers
Experience you can count on

RMIT UNIVERSITY | Centre for People, Organisation & Work

21 March 2022

Aged Care Data Improvement Unit,
Australian Institute of Health and Welfare

Submission in response to the Exploring future data & information needs for aged care issues paper

I have competed the online survey in response to the AIHW *Exploring future data & information needs for aged care* issues paper. I wish to make a longer submission in relation to data on the aged care workforce.

Much of my recent research has focused on the links between job quality and care quality in aged care at both the system and provider level. I focus on the frontline workforce - the personal service workers and home care workers in aged care services. I also have a specific interest in the growing migrant workforce both in residential aged care and in home care.

Over the years, I have made use of the publicly available datasets on the aged care workforce, all of which have some considerable limitations. I have arranged my comments on the adequacy of the current ABS and workforce census and survey data by data source with some brief recommendations for improvement at the end of each section. In doing so, I draw on my submission to, and evidence before, the Royal Commission into Aged Care Quality & Safety and my two expert reports for the Health Services Union's work value claim under both the Aged Care and Social Community Home Care & Disability Services awards.

ABS Industry & Occupational Classifications

The Australian Bureau of Statistics (ABS) industry (ANZSIC) and occupational (ANZSCO) classifications, are increasingly inadequate in accounting for the rapidly growing employment of frontline aged care workers and the increasing number of migrant workers employed in the sector. ABS industry and occupational data underpins Census data collection and workforce analysis and integrated datasets such as the Australian Census & Migrants Integrated Dataset. It also provides a basis for labour force surveys including the Characteristics of Recent Australian Migrants survey by the ABS.

Some of the key issues with ABS data in terms of the aged care workforce include:

- Aged care industry level data is only available for aged care residential services (8601), a 4-digit ANZSIC industry code. In single digit ANZSIC industry sectors, such as construction and manufacturing, ABS industry level data is readily available including in labour force surveys, which provides regular data on key features of employment in those sectors. However, the fact 'aged care residential services' is a 4-digit ANZSIC industry limits analysis of the residential aged care workforce, including by occupational classifications, to an analysis of Census data only.

- While industry level data is at least available for residential aged care, specific industry data on the community-based aged care sector is not available in ABS ANZSIC classifications. Home care services are grouped with other very diverse community service sub-sectors. For example, at the aggregated level of 'other social assistance' (ANZSIC 879) alongside 'aged care assistance services' are youth welfare, disability support, adoption services, adult day care centre operations and marriage guidance services. The lack of any industry disaggregation of the home care sector has flow-ons including limiting the capacity of the Fair Work Ombudsman to monitor and respond to potential breaches of the employment rights of aged care workers (Charlesworth & Howe 2018).

The ABS ANZSCO occupational classifications used to identify the majority frontline aged care workforce are also unfit for purpose.

- Personal care assistants (ANZSCO 423313) are inadequately described as people who provide 'routine personal care services' to people in a range of health care facilities or in a person's home and holding a level of skill commensurate with the qualifications and experience of the AQF Certificate II or III (ANZSCO Skill Level 4). Further, even though the ANZSCO 423313 description states that it does not include the occupational category of 'aged and disabled carers' who do provide care in people's homes, as above ANZSCO 423313 appears to blur the lines between people working in health care facilities and those working in a person's home.
- Home care workers are mainly captured in the ANZSCO classification 'aged and disabled carer' (ANZSCO 4231), although disability support workers may also be included in this classification. The title of this occupation with its reference to 'carers' belittles its status as an occupation in which people are formally employed. This occupation is inadequately described as people who provide 'general household assistance, emotional support, care and companionship for aged and disabled persons in their own homes' and holding a level of skill commensurate with the AQF Certificate II or III (ANZSCO Skill Level 4).

The ANZSCO classifications are used in government policy, including migration policy, to designate the skill levels of particular occupations. The designation of non-professional aged care work as 'low-skilled' both reflects and contributes to the historical and contemporary gendered undervaluation of the skills currently used in these occupations.

Even if they once historically described tasks undertaken by frontline aged care occupations neither ANZSCO classification captures the range of skills and competencies currently used and required in both residential aged care and home care. The increases in the complexity of the nature of the work and skills and responsibility involved in doing frontline aged care work and changes to the conditions under which this work is undertaken are acknowledged in the December 2021 Aged Care Sector Stakeholder Consensus Statement by the aged care provider peak bodies, the relevant unions and consumer groups to the Fair Work Commission in the current HSU work value case.

As set out in Howe, Charlesworth & Brennan 2019, what constitutes 'skill' in migration Australian regulation intersects directly with the gendered undervaluation of frontline care work. Labour migration pathways are devised according to designated occupational skill levels with different conditions for visas depending on the skill classification of the visa holder's job. The basis for these skill designations is the ABS ANZSCO classification. As above, frontline care workers are classified as requiring only ANZSCO Level 4 skills. This is the second lowest skill level in a five-level skill hierarchy and is considered to be 'low skilled'. The consequence of this classification makes it difficult for workers who have arrived through temporary migration programs, such as international students, to successfully apply to transition to a permanent visa. Such transition is dependent on the skill level of the current job held and is restricted in the main to those in jobs deemed 'skilled' at ANZSCO level 3 and above.

Recommendation: Given the importance and growing significance of the aged care workforce to good quality, sustainable aged care services into the future, it is vital that the ABS, in conjunction with Statistics New Zealand, review its ANZSIC and ANZSCO classification structures to ensure that the work undertaken in aged care is sufficiently and accurately disaggregated and described and that industry and occupational classifications, particularly for frontline aged care workers, reflect the increasing complexity and skill level of the work that is undertaken in both residential and home care services.

Survey and 'Census' datasets

2016 NACWCS

The 2016 National Aged Care Workforce Census and Survey (NACWCS), was the fourth and last NACWCS conducted by the National Institute of Labour Studies (NILS), on behalf of the Australian Department of Health. All aged care-funded residential facility and home care support providers were invited to participate. Each organisation was sent a package, which included the employer census, a set of surveys for direct care workers (stratified according to care places/client numbers), and information about how to distribute the surveys to obtain a random sample of workers (Mavromaras et al. 2017: 4-8). Responses were received from a total of 8,885 frontline workers in residential facilities (a response rate of 50 per cent) and 7,024 workers in community outlets (a response rate of 26 per cent) (Mavromaras et al. 2017: 8). This included 2,759 personal care assistants (PCAs) in residential facilities and 4,355 home care workers (HCWs) in community-based outlets. Sampling weights were constructed and applied to the worker survey data based on data on direct care worker numbers and occupational categories provided by residential and community-based outlets (see Mavromaras et al. 2017: 168-172). The weighted data is used in the published 2016 report and, despite its limitations, was used as the best available workforce data by the Royal Commission into Aged Care Quality & Safety.

Nevertheless, there are some relevant limits to the 2016 NACWCS dataset, which need to be considered in any future 'census' and survey instrument

- Firstly, the NACWCS surveyed only workers directly employed by providers despite the increasing aged care provider reliance on agency and brokered employment. However, the NACWCS did not survey these workers and only included workers in a direct employment relationship with the facilities surveyed. In 2016 it was estimated that there was 'quite widespread use' of non-PAYG workers by residential facilities, with half of all facilities reporting some use. In the designated fortnight of the survey, some 9,085 non-PAYG PCWs were employed in residential facilities, mainly agency PCWs (8,588). Home care employer reliance on agency and brokered employment had also increased since 2007. It was estimated that in 2016 27% of all home care providers used non-PAYG workers. In the designated fortnight of the survey, some 10,099 non-PAYG HCWs were employed in community-based aged care, mainly brokered HCWs (6,586).
- Secondly, compared to 2016 Census data, outlined above, the NACWCS sample has both a lower proportion of PCAs and HCWs born overseas, and a lower proportion born in NESB countries., despite the growing share of migrants in the Australian aged care workforce. The NACWCS data also overrepresents both PCAs and HCWs working longer weekly hours and underrepresents those working shorter hours. Thus, the extent of unused capacity in the aged care workforce is difficult to calculate.
- Thirdly, since the 2012 NACWCS, the Department of Health has not made the de-identified NACWCS dataset available to researchers for further analysis. Thus, most analyses of the main relevant characteristics of the directly employed PCWs in the 2016 NACWCS are from the published report or in partnership with researchers involved in the 2016 in the NACWCS (eg Charlesworth & Isherwood 2020).

- The lower response rate from community-based aged care workers compared to residential care workers means that workforce data from the largest aged care sector may be less reliable than that for residential care.
- Finally, this survey was only run every 4 years.

Aged Care Workforce Census 2020

The NACWCS study was not repeated in 2020 and instead the Department of Health used a new methodology to undertake its Aged Care Workforce Census. In residential aged care, the Census survey was sent to 2,716 facilities across Australia. Responses were received from 1,329 RAC facilities (49%) Their responses were weighted to estimate results for all RAC facilities.

In community-based care, the census survey was sent to 834 Home Care Packages Program (HCPP) providers who were asked to complete a separate response for each of the aged care planning regions in which they operated (a total of 1,308 responses); and 630 Commonwealth Home Support Programme (CHSP) providers who were asked to complete a separate response for each of the aged care planning regions in which they operated (a total of 1,340 responses) (Department of Health 2021: 7). In community-based care, survey responses were received from 47% of the 616 HCPP and 38% of the 505 CHSP providers (38%) who were asked to complete a separate survey response for each service type. Given the fact that there are far more providers in the CHSP (1454 in 2019/20) than in the HCPP (920 in 2019/20), with over 70% providing just one form of home care service (ACFA 2021: 11), this weighting of the sample and the lower response rate of the CHSP providers may bias any aggregate responses. The CHSP still remains the largest home care program in terms of service users. In 2019/20 there were 839,373 service users of the CHSP (ACFA 2021: 35, 41) compared to 173,743 service users of the HCPP (ACFA 2021: 35, 41).

There are several other distinct limitations to this data in respect of worker demographics and experiences of employment that were collected in the ACWC, which include but are not limited to the following:

- The 2020 report relies on workforce data only reported by providers, which it assumes is unbiased and factual. While significantly, the report documented providers reports of non-directly employed workers, no workers were surveyed in the ACWC to cross check this data.
- Providers are left to report also on worker demographics and worker qualifications, rather than the workers themselves. Further no data is available in the ACWC on workers experiences of the work of aged care or their levels of satisfaction with different aspects of their job, as in previous NACWCS surveys. Nor was data collected on workers current working time arrangements and their preferences to work more or fewer weekly hours. This makes it very difficult to identify aspects of the job that may be associated with an intention to quit or remain in aged care.
- Even without input from workers, another key defect in ACWC was that the responses were collected at the provider level for each service care type, and hence 'workers may be counted more than once across providers as well as across service care types'. This makes any estimates of the numbers of workers employed in 2020 quite unreliable and provides no basis for future workforce planning.
- Finally, there is no clarity as to why the analysis of the ACWC workforce data is mainly by FTE rather than by headcount. Appendix 2 of the report states that FTE numbers 'were derived by multiplying the number of roles identified by each provider by the number of hours and then dividing by 35 hours, the ABS standard hours in a full-time working week'. However, errors by providers in completing the ACWC and the methodology used to calculate FTE, without data from workers on the actual hours they work, severely limits the usefulness of FTE estimates in the report.

Recommendation: Given the importance and growing significance of the aged care workforce to good quality, sustainable aged care services into the future, annual reliable data on the key socio-demographic and employment characteristics of the aged care workforce *as reported by aged care workers* is crucial no matter what form of contract workers are on. The completion of an annual census by all aged care providers and a firm commitment to the distribution of an annual workers survey to all workers who are engaged in the provision of aged care services should be a condition of the receipt of aged care funding from the federal government. Further:

- The annual workforce census and survey should be conducted by an independent agency
- Socio-demographic data collected from migrant workers should include their country of birth and visa status as well as languages spoken
- De-identified census and survey data should be made publicly available to researchers and other stakeholders

Both poor job quality and quality of life have been associated with intention to quit and difficulties with attraction and retention of workers in aged care. In an annual aged care workforce census and survey, questions relating to worker job quality and the type of work undertaken by aged care workers should build on relevant questions in the 2016 NACWCS and include specific questions on job quality covering the dimensions of job quality identified by Eurofound (2021) which include:

- Physical environment
- Work intensity
- Working time quality
- Social environment
- Skills and discretion
- Prospects
- Earnings

Job quality questions could also draw on the very recently developed Scale of Care Work-Related Quality of Life for Long-Term Care Workers (Hussein et al., 2022) to measure the work-related quality of life among aged care workers in Australia and how it shapes their engagement with care work.

Sara Charlesworth

Professor of Gender, Work & Regulation, School of Management
Director, Centre for People, Organisation & Work (CPOW)
RMIT University

Email: sara.charlesworth@rmit.edu.au

References:

Aged Care Finance Authority (2021) *Annual Report 2020*

Charlesworth, S & Howe, J (2018) 'The enforcement of employment standards in Australia: Successes and challenges in aged care' *International Journal of Comparative Labour Law & Industrial Relations* 34(2), 1-30.

Charlesworth, S & Isherwood, L (2021) 'Migrant aged care workers in Australia: Do they have poorer quality jobs than their locally born counterparts?' *Ageing & Society* 41(12), 2702-2722.

Eurofound (2021) *Working conditions and sustainable work: An analysis using the job quality framework, Challenges and prospects*, Publications Office of the European Union, Luxembourg

Howe J, Charlesworth S & Brennan D (2019) 'Migration Pathways for Frontline Care Workers in Australia and New Zealand: Front Doors, Side Doors, Back Doors and Trapdoors' *University of NSW Law Journal* 42(1), 211-241.

Hussein, S., Towers, A. M., Palmer, S., Brookes, N., Silarova, B., & Mäkelä, P. (2022). 'Developing a Scale of Care Work-Related Quality of Life (CWRQoL) for Long-Term Care Workers in England'. *International Journal of Environmental Research and Public Health*, 19(2), 945.

Faculty of
Arts

MACQUARIE
University

Research Report

Supplementary report on workforce and work value issues in Australian home care for older people

Prepared by
Dr Gabrielle Meagher
Professor Emerita
School of Social Sciences

Contents

Introduction

This supplementary report presents the findings of research on the nature and valuation of care work in home care and home support in Australia, in the context of change in the structure of the sector and in community expectations about aged care. The focus is the care work carried out by employees under the Social, Community, Home Care and Disability Services [SCHADS] Industry Award (2010), who provide personal care, maintenance, domestic assistance and support services to older people living in the community.

These employees work in organisations that are funded under two main Australian Government programs: the Commonwealth Home Support Programme (CHSP) and the Home Care Packages program (HCPs). The CHSP is described by the government as providing 'entry level support',[1] while HCPs 'are designed for those with more complex care needs that go beyond what the Commonwealth Home Support Programme can provide'.[2] Unless any findings relate specifically to one of these programs, they are referred to together as 'home care and support' throughout this report. The non-professional workforce who deliver these services are referred to as 'community care workers'.

To understand the changing nature of care work in home care requires knowledge about change in 1) the group of people who receive home care services, 2) the role and operation of the home care and support system, and 3) the structure and characteristics of the workforce employed to provide care and support, and 4) models of care and support. The report analyses these aspects of the Australian home care and support system and discusses the implications of the trends identified for home care and support work. The research is based on analysis of a wide range of official data, public policy documents related to aged care, and other national and international peer-reviewed studies about home care and support.

The findings should be considered in the context of international peer-reviewed research on the nature and valuation of care work, specifically on factors that lead to the historical and contemporary undervaluation of work in occupations such as community care worker in home care. This research on undervaluation of care work is presented in an earlier report, *Changing aged care, changing aged care work: workforce and work value issues in Australian residential aged care* (Meagher, 2021).

[1] https://www.myagedcare.gov.au/help-at-home/commonwealth-home-support-programme.
[2] https://www.myagedcare.gov.au/help-at-home/home-care-packages

1. Who receives home care and support and how is this group changing?

Around a million older people receive care and support in their own homes through an Australian Government funded program. On 31 March, 2021, more than 167,000 older people were receiving a home care package, while during the year to 30 June 2020, around 830,000 older people received some form of care, assistance and support through the Commonwealth Home Support Program.[3]

In recent years, the proportion of people aged 65 years and older who use home care services has increased and the proportion using residential care has decreased,[4] in line with government policies of ageing-in-place and older people's preferences to remain in their own homes for as long as possible (for more detail, see Section 2 below). **Overall, the home care and support system is growing and the profile of older people using services is becoming more diverse and complex.**

While people aged 65 and over (and Aboriginal and Torres Strait Islander people aged 50 and over)[5] are eligible for aged care services, the majority of people receiving home care and support are 80 years or over. Among recipients of home care packages, 64% were aged 80 and over in 2020, while around two-fifths were aged 85 and over (41%). Among recipients of support under the CHSP, 53% were aged 80 and over in 2020, while 30% were aged 85 and older.[6]

Older people who use home care and support are often frail and many suffer from multiple health conditions. Starting to receive home care and support is often precipitated by a health event, such as hospitalisation for a heart attack, stroke or heart failure.[7] Around two fifths (41%) of people entering home care and support have a major cardiovascular disease, compared to less than one fifth (16%) of older people who do not receive aged care services.[8] Older people who receive home care are twice as likely to fall, compared to those who do not receive home care,[9] with falls being the main injury-related reason older people present to emergency or are admitted to hospital.[10] Injuries sustained during falls increase

[3] See 'Client summary' table in the *2020 Aged Care Data Snapshot*, published by the Department of Health. Retrieved from https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Data-Snapshot/Aged-Care-Data-Snapshot-2020-Release-3-1.xlsx.
[4] Khadka, Lang, Ratcliffe, Corlis, Wesserlingh, et al. (2019).
[5] Eligibility for aged care services is defined this way in Australian policy. Planning for aged care services uses the ratio of service provision to the share of the population aged 70 and over. Various data are reported using these two different definitions of the relevant population, which is why usage varies in this report.
[6] Aged care data snapshot 2020–third release. Retrieved from https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Data-Snapshot/Aged-Care-Data-Snapshot-2020-Release-3-1.xlsx.
[7] For example, a study by Hsu, Korda, Lindley et al. (2021) found that older people in New South Wales who had been hospitalised for a heart attack, stroke or heart failure were significantly more likely to start to use 'community care' (encompassing HCP, CHSP and smaller programs such as Transitional Care) during the year following discharge, with the probability increasing over that year (Table 2).
[8] Hsu, Korda, Naganathan, Lewis, Ooi et al. (2021).
[9] Burton, Lewin, O'Connell, & Hill (2018).
[10] Lee, McNamara, English, & Meusemann (2020).

older peoples' immediate need for care and support if they are able to return home, and may also lead to long term increases in care and support needs.

Further, there is evidence that the population of older people entering the home care and support system is becoming more frail and less healthy over time. A study published in 2021 examined the health status and health care usage trends of older people using aged care in Australia between 2006 and 2015.[11] The study included **home care package recipients** and found that:[12]

- In 2015, 61% of HCP clients had at least five health conditions, up from 53% in 2006, while one in 14 had ten or more health conditions, up from one in 17 in 2006.
- In 2015, more than one fifth of HCP clients had dementia (22%). Overall, older people with dementia are significantly more likely to use a home care package than older people without dementia.[13]
- Half (51%) had a high frailty score in 2015, up from 15% in 2006.
- More than a third were assessed as having depression in 2015 (36%), up from 32% in 2006, and a third had pain (34%) in 2015, up from a quarter (24%) in 2006.
- The median number of medications prescribed for HCP clients within one year of entering home care was nine; identical to that of older people entering residential care. This 'polypharmacy' (usually defined as use of five or more medications) opens the risk of adverse medication interactions and use of unnecessary and inappropriate medicines.[14]
- A fifth (20%) had an urgent attendance after hours at a health care service during the first year of services in 2015, up from 15% in 2006.
- Around one in twenty recipients died within three months of entering home care services and more than a third (35%) died within three years. Further, the rate of death among home care package recipients was four times higher than the rate of death in the Australian population as a whole, adjusted for age and sex.[15]

More than two fifths of older people receiving a home care package lives alone (43%).[16] The remainder mostly live with their partner or other family members.

In 2019-2020, the median length of time a person held a HCP was 16 months, while the average length of stay was 27 months.[17] This suggests that there are large minorities of both

[11] Inacio, Lang, Bray, Visvanathan, Whitehead, et al. (2021). Studies that provide robust measures of the health status of older people using aged care services require the linking of records across multiple data systems. Establishing databases takes a considerable length of time, hence the delay in reporting on older people currently using the system.
[12] Inacio, Lang, Bray, Visvanathan, Whitehead, et al. (2021), Table 1. All findings reported in this list are taken from this study, unless otherwise noted. This study included older people who received residential care or a home care package only, because it relied on ACAT assessments for health data. CHSP clients are assessed under a different process.
[13] Welberry, Jorm, Barbieri, Hsu & Brodaty (2021), p. 1159.
[14] Bony, Lloyd, Hotham, Corre, Corlis et al. (2020).
[15] Inacio, Lang, Khadka, Watt, Crotty et al (2020), page e540.
[16] Department of Health (2020b), page 26.
[17] Aged Care Financing Authority (2021), page 21.

short-term HCP clients (since half stay less than 16 months) and long-term HCP clients (since the average is much higher than the median). There also appears to be considerable turnover among HCP clients.[18] While the majority of people who exited a HCP in 2019-20 moved into residential care (55%) in 2019-20, a third (34%) exited because they died.[19]

Table 1 shows the entry and turnover of older people into the HCP system in the context of system expansion. Column A shows the number of people holding a home care package at 31 March for each of the last three years. As discussed in more detail in Section 2 below, the data in Column A show that the HCP program has been expanding rapidly in recent years. Column B shows the number of people who entered a HCP for the first time in the year to 31 March, for each of the last three years. In a growing system, we need to separate people entering because there are now more places from people entering a vacancy created by another person's exit. Accordingly, Column C captures *system growth*, showing the increase in the number of people in a HCP package over each of the last three years. (For example, on 31 March 2021, there were 30,125 more people in a home care package than there were on the same date in 2020.). Column D captures *turnover* in the HCP system, showing the number of new entrants over the preceding year that cannot be accounted for by system growth. These data suggest that there has been 20% turnover in home care package clients over the last two years.

Table 1: New entrants, system growth and turnover in the HCP program, 2018-2021[20]

	A In a HCP at 31 March	B Entered a HCP for first time in year to 31 March	C Growth in no. of HCP holders since previous year (system growth)	D Net new entrants (Total entrants less system growth)	E Net new entrants as a share of all HCP holders at year's end
2021	167,124	63,192	30,215	32,977	20%
2020	136,909	65,638	37,799	27,839	20%
2019	99,110	41,451	14,139	27,312	28%
2018	84,971	-	-	-	-

There is less recent research about older people receiving services from the Commonwealth Home Support Scheme. **CHSP recipients** are slightly younger, on average, than home care package recipients.[21] A small minority of CHSP clients lives with a carer; only 16% did so in 2018.[22]

[18] Welberry, Jorm et al. (2021) looked at use of aged care by all members of a longitudinal ageing study (the 45 Up Study) who died between 1 July 2011 and 30 June 2014. Among users of lower level home care packages, median length of stay was 9 months for people with dementia and 12 for people without dementia. Among users of higher level packages, median length of stay was 9 years, regardless of dementia status (Table 1).
[19] See https://www.gen-agedcaredata.gov.au/Topics/People-leaving-aged-care.
[20] Author's analysis of data provided in quarterly Home Care Packages Program Data Reports. Retrieved from https://gen-agedcaredata.gov.au/Resources/Reports-and-publications/2020/September/Home-care-packages-report.
[21] Author's analysis of data provided at https://www.gen-agedcaredata.gov.au/Topics/People-using-aged-care#Aged%20care%20use%20by%20age%20and%20sex%20over%20time.
[22] Department of Health (2020a), page 16.

Like HCP clients, CHSP clients are relatively frail compared to the rest of the community-dwelling population, and their use of services is higher the more health and social concerns they face. A longitudinal study of older women found that those who had chronic health conditions, and those who reported lower health, social and physical functioning were significantly more likely to use home support services than those without chronic conditions and with higher levels of functioning.[23] And once a person accesses home support, there is evidence that people with more functional limitations and specific health conditions, such as dementia or stroke, use more services.[24]

There is considerable turnover in the group of older people receiving services under the CHSP. A recent study for the Department of Health found that the average length of service from entry to exit was around two years (102 weeks). In 2017-18, around half clients received services for the whole year, one fifth began services and continued, and around a third either exited (17%) or started and exited within a year (15%).[25] Some clients exit to other aged care services (a home care package or residential care) because they require additional assistance, while others pass away. A small minority exit services because they no longer need assistance.[26]

Older people receiving home care and support come from a diverse range of backgrounds and 'special needs groups', as identified under the Aged Care Act. Identified special needs groups include people who are: Aboriginal and Torres Strait Islander; from culturally and linguistically diverse (CALD) backgrounds; living in rural or remote areas; financially or socially disadvantaged; veterans; experiencing homelessness or at risk of becoming homeless; care leavers; parents separated from their children by forced adoption or removal; [and] lesbian, gay, bisexual, transgender and intersex.[27]

While the CHSP and HCP program are funded separately and have ostensibly different target populations, they serve at least partly overlapping target groups, and to some extent, the same clients. A 2020 study of the CHSP for the Department of Health found that nearly a quarter (24%) of older people receiving a home care package *also* received services from the CHSP. Clients using both programs tended to be older and were more likely to come from special needs groups, including Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse (CALD) backgrounds and people with a disability.[28] And while half all CHSP clients (50%) accessed only one service type during 2019-20, more than two fifths (43%) accessed between two and four service types. The remaining 7% accessed five or more service types.[29] This is approximately 58,000 people – the same as the number of Level 2 HCPs in 2020.

---

[23] Rahman, Efird, Kendig & Byles (2019).
[24] Department of Health (2020a), page 7.
[25] Department of Health (2020a), author's calculations based on data presented in Chart 1.8, page 18.
[26] Department of Health (2020a), page 18.
[27] https://www.health.gov.au/health-topics/aged-care/providing-aged-care-services/working-in-aged-care/working-with-diverse-groups-in-aged-care
[28] Department of Health (2021), page 32.
[29] Aged Care Financing Authority (2021), page 35. Number of people receiving five or more service types calculated as 7% of the total number of CHSP recipients.

2. How does the home care and support sector operate and how is this changing?

Change in the nature of work in home care and support has been partly driven by change in the design, funding and operation of the home care and support system.

Home care and support have an increasing role relative to residential care in Australia's aged care system, as successive Australian governments have used funding and planning levers to shift the distribution of aged care funding and operations towards home care and support and away from residential care. These changes help explain the increasing level of need among home care and support clients.

Governments have also changed models of home care and support through concepts such as 'consumer directed care' and 'wellness and reablement', and in recognition of the diversity of the ageing population and the special needs of particular groups, such as older people with dementia. Social expectations around the quality and availability of care have also changed, bringing new demands on care systems and care workers. These issues are discussed in more detail in Section 2.4 below.

Meanwhile some problems persist, notably unmet and under-met need for care and support, which also make strong demands on care systems and care workers.

2.1 The growing and changing role of home care and support in the aged care system

As noted above, there are two main programs for home care and support. **The Commonwealth Home Support Programme (CHSP) is framed as an 'entry level' service.** According to the Department of Health, the CHSP's program goals are to 'help people live as independently as possible', to 'focus on working with them, rather than doing things for them', and to 'give a small amount of help to a large number of people'.[30] The CHSP is a block-funded program, whereby providers receive grants to deliver services including allied health care, domestic assistance, specialised equipment and assistive technology, home maintenance, home modifications, meals, nursing, personal care, social support, transport and respite for carers. Unlike Home Care Packages, as discussed below, funding and provision under the CHSP 'have never been formally linked to the size of the population base through a device such as the planning ratio'.[31]

The Home Care Packages program 'supports older people with complex care needs' through a 'a coordinated mix of services' offered in a tiered system 'from level 1 for basic care needs to level 4 for high care needs'.[32] The list of services that can be provided within an HCP is much the same as the services offered under the CHSP (see Section 2.2

[30] https://www.health.gov.au/initiatives-and-programs/commonwealth-home-support-programme-chsp/about-the-commonwealth-home-support-programme-chsp.
[31] Gibson (2020), page e520.
[32] https://www.health.gov.au/initiatives-and-programs/home-care-packages-program/about-the-home-care-packages-program.

below), although the amount and mix of services differs especially at higher levels of HCP, and care management is also included.

Unlike the CHSP, the HCP program is integrated into the population-based 'aged care provision target ratios'. Successive governments since the mid 1980s used these ratios in an effort to distribute residential care, and later community care packages, between 'aged care planning regions' according to local need, including the share of older people in the population. Together, home care packages and residential care places are 'aged care places', offered in a ratio per 1,000 people aged 70 and over.[33] **Over time, the share of residential and home care packages has shifted in favour of home care packages.** In 1992, the planned ratio was 10 home care[34] and 100 residential care places[35] per 1,000 people aged 70 and over. In 2013, the planning ratio was set at 27 home care and 86 residential care places under a total of 113 places.[36] The *Living Longer, Living Better* policy of 2012 adjusted the target ratios to progressively increase total places per 1,000 people 70 and over from 113 to 125 by 2021-22. Within this overall total, the target for home care packages was increased from 27 to 45, with a corresponding fall in the number of residential care places from 86 to 78.[37] In fact, more packages have been released than planned for in the LLLB package. At 30 June 2020, there were 53.6 mainstream packages available per 1,000 people aged 70 and over.[38]

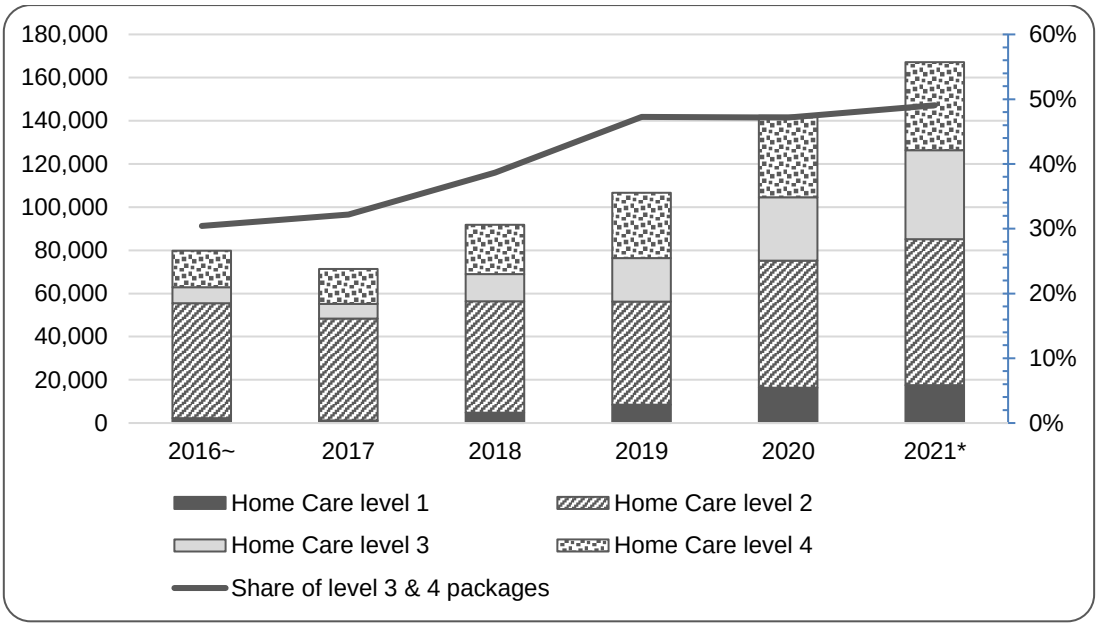
The trend towards home support is clear: **the share of people aged 65 and over who lived permanently in residential care during the year fell from 65 per 1,000 in 2011-12 to 56 per 1,000 in 2019-20, while the share receiving a home care package increased from 23 per 1,000 to 41 per 1,000 across the same period.**[39] Over time, then, the **Home Care Packages Program has 'increasingly developed as a viable alternative to residential care**, allowing older people to age in their own homes'.[40] This is especially the case with rapid growth in the number and share of higher level packages over recent years, as the share of older people receiving services from the CHSP and its precursors has declined slightly over the last decade. As *Figure 1* shows, between 2016 and 2021, the number of packages has more than doubled from around 80,000 to nearly 170,000, while the share of level 3 and 4 packages increased from less than a third (30%) to almost half (49%).

There is also some evidence that CHSP services are a partial substitute for residential aged care, especially in remote and regional areas. A recent study reported that greater use of home support in remote/regional areas reflected limited access to residential aged care and

[33] The annual Aged Care Approval Rounds through which 'operational places' in residential and home care were 'released' for provider tender are
[34] Australian Institute of Health and Welfare (2000), Section 2.1. At this time, packages were called 'Community Aged Care Packages'.
[35] Australian Institute of Health and Welfare (1993), page 208.
[36] Aged Care Financing Authority (2013).
[37] The two remaining places were allocated to the Short Term Restorative Care Programme. Aged Care Financing Authority (2021), page vi.
[38] ACFA *Annual Report on the Funding and Financing of the Aged Care Sector – 2021*, page vi
[39] *Report on Government Services 2013* for 2011-12 and *Report on Government Services 2021* for 2019-20.
[40] Gibson (2020), page e520.

the relative costs to older people of the two services (higher in residential care; lower in home support).[41]

Figure 1: Number of home care packages at 30 June 2016-2020, and at 31 March 2021 (left axis), and share of level 3 and 4 packages 2016-2020 (right axis)



Notes: ~ In 2016, the reported numbers are operational HCP places. Following the introduction of 'consumer-directed care' in 2017, reported numbers are people in packages as at 30 June.
* Data are available only to 31 March for 2021.

2.2 What services are offered in home care and support?

To understand work in home care and support, it is useful to know more in detail about the amount and kinds of services offered under these programs. Analysis shows that the majority of services are provided by community care workers, as would be expected on the basis of the workforce data (see Section 3 below).

As noted above, both the CHSP and HCP programs offer similar services. *Table 2* shows the services offered under the CHSP in 2019-20, the latest year for which data are available. Services can be divided into those offered to older people, mostly in their own homes and those offered in group settings or centres. Community care workers and home maintenance staff under the SCHADS Award deliver the vast majority (80%) of hours of service to individuals, and more than half (54%) of the total hours of all CHSP services.

As noted above, 50% of CHSP clients use two or more services. Some common combinations of services suggest that it is possible for the same worker to deliver more than one service type to the same client. For example, Among the 329,700 people who received domestic assistance in 2018-19, 13% also used personal care, 18% also used individual social support, and 4% also used flexible respite. Among the 79,900 who used personal care, 60% also used

[41] Rahman, Efird, Kendig & Byles (2019), page 300. See also Royal Commission into Aged Care Quality and Safety (2021), page 72.

domestic assistance, 24% also used individual social support and 13% also used flexible respite.[42]

Table 2. CHSP services received per 1,000 people aged 65 years or over and Aboriginal and Torres Strait Islander people aged 50–64 years, 2019-20[43]

	Hours	Share of hours services received by individuals at home	Share of total CHSP hours received
Care and support services to individuals at home			
Domestic assistance*	2,156	40%	30%
Personal care	606	11%	8%
Individual social support and flexible respite	1,131	21%	16%
Home maintenance	358	7%	5%
Nursing and allied health	973	18%	13%
Specialised support for people who are homeless	111	2%	2%
Total, hours of care services to individuals at home	***5,335***	***100%***	
Care services in group settings or at centres			
Centre-based and cottage respite	429		6%
Group social support	1,473		20%
Grand total	***7,237***		***100%***

* Includes 'Other food services', a very small service separate from meals provided at home or in a centre.

Table 3 shows the shows the services offered HCP program in 2018-19, the only year for which such data are available.[44] As can be seen in the table, although some service titles differ, the services offered are much the same as under the CHSP.[45] Further, just as for services delivered to individual CHSP clients, the majority of hours of service in home care packages (74% across all package levels) are delivered by community care workers under the SCHADS Award.

[42] Department of Health (2020a), page 29, Table 2.3.
[43] Author's calculations based on data in the *Report on Government Services*, 2021, Table 14A.23.
[44] As noted in Department of Health (2020b), page 1, 'the Department of Health … has limited data on the volume or cost to the consumer of specific services delivered under a Home Care Package, as this information is documented and agreed between the provider and the consumer. To rectify this limited data resource, a survey of home care providers has been conducted'. The survey collected data for the year 2018-19.
[45] There are some differences in reporting because of the different program structures. All services under a HCP are delivered to individual older people, so there are no group services in the service categories as in the CHSP. Further, care management is not reported as a client service under the CHSP, while it is reported for HCPs. Transport is reported as the number of one-way trips in CHSP data (see Report on Government Services 2021, Table 14A.23), not as hours of services, as for HCPs. The slightly lower proportion of 'SCHADS hours' in level 1 packages is because care management is a higher proportion of hours at level 1 than at higher package levels.

Table 3. Average hours of service per package per fortnight, by service type and package level, 2018-19*

	All Average	Level 1	Level 2	Level 3	Level 4
Care management	1.23	0.65	0.82	1.43	2.01
Nursing (registered and other licensed)	0.14	0.03	0.04	0.17	0.34
Allied health care	0.13	0.03	0.07	0.14	0.25
Cleaning and household tasks	2.04	0.98	1.67	2.13	2.92
Personal care	2.58	0.50	1.10	2.64	5.82
Social support, shopping services, community access	1.65	0.45	1.05	1.87	2.89
In-home respite	0.52	0.07	0.14	0.49	1.35
Light gardening	0.18	0.12	0.15	0.22	0.24
Transport services	0.45	0.16	0.3	0.54	0.73
Other services provided to home care recipient	0.53	0.12	0.33	0.58	0.97
Total Hours of Service Provision	**9.45**	**3.11**	**5.67**	**10.21**	**17.52**
Total hours of core activities of SCHADS workers	**6.97**	**2.12**	**4.11**	**7.35**	**13.22**
Share of work carried out by SCHADs workers in HCPs	***74%***	***68%***	***72%***	***72%***	***75%***

* Source: Department of Health (2020b), Table 27; categories given in original; author's calculations in final two rows. Core activities of SCHADS workers shown in shaded rows. Hours are expressed in decimal terms, not with minutes; for example, 9.45 hrs is equivalent to 9 hours and 27 minutes.

Community care workers also meet the vast majority, if not all, HCP clients. A survey of clients undertaken for the Royal Commission into Aged Care Quality and Safety found that 90% used domestic assistance, 46% used personal care, 49% used home maintenance, 35% used social support and 10% used respite care.[46] Many, of course, use multiple services in various combinations.

2.3 Unmet need for home care and support

Around one third of older Australians living at home have needs for assistance that remain unmet.[47] Some of these older Australians may be receiving some, but not enough, care and support from either the CHSP or HCP; some may be waiting for assistance, and some may not be accessing care and support at all.

There is documented unmet need across both the CHSP and HCP program. Need can be unmet when older people cannot access a service or when they cannot access enough services. Both these forms of unmet need have implications for the skills and judgement demanded of care workers, as discussed below, in Section 4.

In the CHSP, providers reported that they could not meet demand for assistance from across the full range of services included in the program. The following proportions of providers could not meet need for domestic assistance (21%), home maintenance (17%), personal care (13%), individual social support (13%), allied health and therapy services (14%), and nursing (8%), among other services.[48]

For home care packages, rationing through the target ratio planning system, proposed for continuation until 2024,[49] has been a cause of unmet need. The process of intermittent release of packages and the number of packages released has resulted in long waiting times. In May 2021, the wait time between approval and receiving a HCP for a person with a medium priority approval entering the National Priority System was 3-6 months for a level 1 package and 9-12 months for levels 2, 3 and 4.[50] Further, as shown above, the share of higher level packages has grown only very recently. Indeed, one reason for the strong growth in HCPs in recent years has been the government's response to ongoing community concern about lengthy waiting times for people assessed as eligible for a package but who are unable to access one because there is not a package available.

[46] Batchelor, Savvas, Peck, Dang, Wade et al. (2020), page 31, Table 10.
[47] Australian Bureau of Statistics Survey of Disability, Ageing and Carers, as collated in the Report on Government Services 2021, Table 14.A31.
[48] Department of Health (2020a), page 59. Providers are counted at the level of aged care planning regions for this measure; the aim is to understand (relatively) local availability of services.
[49] Australian Government response to the Final Report of the Royal Commission into Aged Care Quality and Safety, page 21.
[50] Department of Health (2021b), page 14. This is an improvement; less than two years before, in August 2019, equivalent times were 3-6 months for a level 1 package and more than 12 months for levels 2, 3 and 4; see Department of Health (2019a), page 13.

Despite the increase in the number of HCPs released in recent years (see *Figure 1*), there is still considerable unmet and under-met need for home care and support. As of 31 March 2021, there were:[51]

- 87,162 people waiting for a HCP at their approved level. This is equivalent to slightly over half the number of people who were actually in a HCP on that date (167,124). Of the people waiting for a package at their approved level:
    - 55,483 (64%) had not yet been offered a package. Of these:
        - 6,380 (11%) were waiting for a level 4 package.
    - 31,679 (36%) had already been offered a lower level HCP. Of these:
        - 21,011 (66%) had chosen to take the lower level package.
    - 86,094 (99%) had also been assessed as eligible for CHSP services; there is no data about how many actually receive them.
    - 53,036 (60.8%) had also been assessed as eligible for permanent residential care, providing further evidence that home care and residential care are positioned as alternatives in the aged care system.

2.4 Current principles of aged care quality and associated regulation

As noted in the main report,[52] regulatory requirements and community standards, which are underpinned by principles of care quality, should guide the practice of the aged care workers, so understanding these principles, how they are embodied in regulation, and how they are changing, sheds light on the expectations and roles of aged care workers.

Community expectations now encompass high quality support to enable older people with significant health concerns and frailty to live at home. Just as in residential care, prevailing ideals relate to autonomy for the older person and person-centredness in care, with individually-adapted and flexible supports grounded in caring relationships. Further, regulatory oversight and increasing quality expectations combine to increase documentation requirements in home care and support services.

The same principles of aged care quality apply in both residential and home care and support; the only exception is that principle 5, which relates to 'the organisation's service environment' does not apply in home care.[53] Accordingly, please refer to the main report for further discussion of the expectations that the quality standards establish for care workers. While the discussion in that report relates specifically to residential aged care, the principles are the same. As in residential aged care, there is a large body of research internationally that

[51] All data in this list are taken from Department of Health (2021c), page 3.
[52] Meagher (2021).
[53] There are also some specific reporting and regulatory requirements in residential aged care only, including the Serious Incident Response Scheme (see https://www.agedcarequality.gov.au/sirs), and regulations to minimise restrictive practices (see https://www.agedcarequality.gov.au/minimising-restrictive-practices).

establishes the organisational requirements, including employment and working conditions, that allow the underlying ideals of high quality home care and support to be realised.[54]

2.5 Changing models of home care and support

The nature of home care and support is changing under the influence of multiple drivers. This section discusses those most important for affecting the skills, responsibility and judgement required to work in a transforming sector. How the skills, responsibility and judgement are affected is discussed below in Section 4 below.

The expectation that older people can be maintained longer at home, delaying or avoiding admission to residential care despite significant ill-health and frailty is one major driver of change in home care and support. The impact of these changes on the service profile of aged care and on the needs profile of older people who use home care and support has been discussed above. However, one issue not yet touched on is end-of-life care. Older people are increasingly remaining at home, and a significant minority currently die while receiving home care and support. This means that possibility that they will die at home may also have increased. This, in turn, raises the need for quality end-of-life care, including palliative care, for older people receiving care at home.

Other drivers include new service goals and new modes of service organisation and funding. In recent years, **concepts of consumer choice and control have become very important in organising and funding aged care services,** building in various ways on longer-standing ideas in disability support. Since 2015, when the CHSP was established, one of this program's key principles has been 'consumer choice'. Older people have options to choose a provider, following a new, more centralised assessment process that should focus on their needs and goals. Since 2017, all home care packages have been required to be delivered on a 'consumer directed care' (CDC) basis. The aim of CDC is to give older people more choice about the kinds of services they receive and how and when the services are delivered. Previously, funding for packages was allocated to providers, who controlled service provision and delivery.[55] Choice of provider and increased control over the use of funds are central features of CDC, and funds are now 'individualised', that is, allocated to eligible individuals.[56] Under these models, home care and support providers negotiate the types of services older people prefer and community care workers negotiate the day-to-day implementation of clients' service preferences at work.

New service goals of 'wellness and reablement' have been introduced in home care and support programs as these have been reformed over the last half decade or so. The Department of Health defines these concepts as follows:

[54] For example, see Barken, Denton, Sayin, et al. (2018); Charlesworth & Malone (2017); Franzosa, Tsui & Baron, S. (2019); Hart, Bowman & Mallett (2021); King, Parsons, Robinson & Jörgensen (2012); Leverton, Burton, Beresford-Dent, et al. (2021); Macdonald & Charlesworth (2021); Wise (2020); Yeh, Samsi, Vandrevala & Manthorpe (2019).
[55] Gill, McCaffrey, Cameron, Ratcliffe, Kaambwa et al. (2017).
[56] Department of Health (2019b).

> **Wellness** is an approach that involves the assessment, planning and delivery of supports that build on an individual's strengths, capacity and goals. This includes encouraging actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home.
>
> Wellness as a philosophy is based on the premise that, even with frailty, chronic illness or disability, people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing to live autonomously and as independently as possible.
>
> **Reablement** involves short-term or time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Like wellness, reablement aims to assist people to reach their goals and maximise their independence and autonomy.[57]

These very wide-ranging principles embody the idea that home care and support services should enable older people live a good life, including having high levels of social and emotional well-being, regardless of their level of health and their need for assistance. Home care and support practice is changing as a result, as new approaches are being explored to embed these ideas in daily work, including that of community care workers. These approaches include having community care workers:

a) use diverse strategies to engage with home care and support clients so they are optimally engaged in activities[58]
b) offer exercise interventions to prevent falls at home[59]
c) participate in health literacy training of their clients[60]
d) incorporate social support and recreational activities as part of home care[61]
e) participate in and improve oral health care for older people living at home[62]
f) collaborate in designing assistive technologies for preventing malnutrition in older people with dementia[63]
g) be integrated into interdisciplinary palliative care teams to support clients at the end of life[64]

Particular attention has been given to working with the reablement approach and non-pharmacological interventions with people living with dementia at home. Both the Royal Commission into Aged Care Quality and Safety, and the Aged Care Quality Standards point to the inappropriateness of the use of anti-psychotic medications to manage the behavioural and psychological symptoms of these older people. Instead, non-pharmacological interventions are a focus, such that interactions and practices in care provision are adapted to the needs of people with dementia.

[57] Department of Health (2021c), page 14.
[58] Baker, Harrison & Low (2016).
[59] Burton, Boyle, O'Connell, Lewin, Petrich et al. (2021).
[60] Palesy & Jakimowicz (2020).
[61] Low, Baker, Harrison, Jeon, Haertsch et al. (2015).
[62] Lewis, Harvey, Hogan & Kitson (2019).
[63] Jayatilaka, Ranasinghe, Falkner, Visvanathan & Wilson (2020).
[64] Poulos, Harkin, Poulos, Cole, & MacLeod (2018).

In addition to calling on home care and support providers to promote independence, reduce risks, assist clients to meet their goals, and maintain and make gains in their physical, social, and emotional well-being, **aged care policies now formally recognise the special needs of specific groups,** as noted above. **Meeting the needs of these groups requires service providers to recognise and respond to what causes people of particular groups to be more likely to have special needs.** For example, meeting the needs of Aboriginal and Torres Strait Islander older people requires recognising historical legacies of discrimination and exclusion, as well as sensitive engagement to focus on people's strengths.[65] Another special needs group is care leavers, which includes the 'Forgotten Australians', who are child migrants and non-Indigenous Australian-born children raised in institutions.[66] Research with Forgotten Australians has found that they 'suffer lifelong health and well-being impacts, have lower educational attainment, lower paid employment, are less likely to own their home, and have difficulty forming relationships' and that members of this group 'are unlikely to access care when needed due to high levels of mistrust and fear of reliance on others and authorities'.[67] Other groups are not formally recognised in policy also have special needs related to trauma, such as Holocaust survivors.[68]

Another driver of change in home care and support is the take-up of digital technologies, which are being promoted as a means of enabling 'new models of care and support where consumers can connect more easily to programs and to care professionals'.[69] Some new technologies are based with the older person at home and allow forms of monitoring and communication; others are based with providers, including community care workers, and used to work with client records, care plans, staffing and so on. Because of home care and support clients are both dispersed in the community and living in private homes, and because community care workers are 'out and about' rather than stationed in a workplace (such as a residential aged care home), some aspects and challenges of the digital transformation of care are distinctive to home care. For example, it may be more demanding to maintain client privacy.

3. Who cares for older Australians using home care and support and how is this workforce changing?

Home care and support services employ more than 156,000 people in Australia.[70] The majority of these, around 123,000, are the direct care workers (including community care

[65] Gibson, Crockett, Dudgeon, Bernoth, & Lincoln (2020).
[66] Dow & Phillips (2009).
[67] Browne-Yung, O'Neil, Walker, Smyth & Putsey et al. (2021), page 174.
[68] Teshuva, Borowski & Wells (2021).
[69] Barnett, Livingstone, Margelis, Tomlins, Gould et al. (2020), page 13. This document has been produced by the Aged Care Industry Information Technology Council, which is a project of the two main aged care industry peak bodies, Leading Aged Care Services and Aged and Community Services Australia, and which has received support from the Australian Government. See: https://www.aciitc.com.au/about-us/.
[70] Department of Health (2021a); author's calculations based on data presented on pages 27 and 39 for the HCP and CHSP workforces respectively. The 2020 Aged Care Workforce study was affected by the COVID-19 pandemic; e.g., there was no workforce survey or worker interviews, so the report relies on manager reports of

workers, nurses and allied health workers) who assist older people to maintain their lives at home and with some of their health needs. A further 6,100 employees offer other forms of support, including cooking, cleaning and gardening. The work of these two groups: community care workers and (to the extent that data is available) other support workers is the main focus of this report. Another 27,000 employees in home care and support are care managers/coordinators, managers or administrators, while a further 100 or so provide spiritual or pastoral support.[71]

As noted above, the home care packages program and the CHSP are funded separately, and have ostensibly different target groups. Yet there is clear evidence of complex overlaps both in client groups (nearly a quarter of HCP clients also receive services under the CHSP), and in target groups (around 58,000 CHSP clients receive five or more CHSP services in a year).

There is also an overlap in providers sharing staff across both HCP and CHSP services. Not all providers offer both kinds of service. Nevertheless, HCP providers responding to the Aged Care Workforce survey in 2020 reported that 27% of their community care workers also worked in their CHSP operations, while CHSP provider respondents reported that 36% of their community care workers also worked in their HCP operations.[72] Further, **more than half all HCP providers (52%) and CHSP providers (54%) also offer services under the National Disability Insurance Scheme**.[73]

3.1 Gender in the home care and support workforce

The direct care workforce in home care and support is overwhelmingly female.

Among community care workers, 89% identified as female in 2020, the same proportion as in 2016 and 2012.[74] Other direct care workers, including nurses and allied health workers are also predominantly female.

The National Aged Care Workforce Census does not collect demographic information about workers other than those directly delivering care. Home and community care services for older people are not classified separately as an 'industry' in the Australian and New Zealand Standard Industrial Classification which is used to classify labour force and other data by the Australian Bureau of Statistics, whereas residential care for older people is. Therefore, it is unfortunately not possible to use other sources of data, such as the Census of Population and Housing, to understand the demographic profile of people who work in non-direct care roles in the home care and support sector.

---

staff demographics. Data on employees in non-direct care roles were reported in less detail than in previous reports.

[71] Author's calculations, based on data presented in Tables 5.1 and 5.4 and on page 27 of Mavromaras, et al. (2017), and Tables 3.1 and 4.1 and pages 27 (HCPs) and 39 (CHSP) in Department of Health (2021a). Numbers are weighted, estimated headcounts of people employed in different occupations and rounded to the nearest 100 for ease of reading.

[72] Data provided by the Australian Government Solicitor to the Fair Work Commission. 'Response to Question 1(3) Part 2: Proportion of providers sharing staff across their other service care types'; letter dated 31 Aug 2021.

[73] Department of Health (2021a), pages 36 and 54 for the HCP and CHSP respectively.

[74] Department of Health (2021a), pages 29, 41. In both the HCP and CHSP workforces are 89% of community care workers female.

3.2 The changing occupational structure of the home care and assistance workforce

The occupational structure of the residential care workforce has changed in recent years, in two ways.[75]

***First,* the share of community care workers in the direct care workforce increased from 78% to 83% between 2007 and 2020**, measured as full-time equivalent employees, while the share of nurses fell and the (small) share of allied health workers fluctuated (see *Table 4* and *Figure 2*). There was also a large absolute decline in the number of registered nurses on this measure. Almost all the growth in the FTE direct care workforce was among community care workers (99%).

***Second,* the share of direct care workers in the total workforce increased from 62% of all employees to 78% between 2012 and 2020**, on a headcount measure.[76] Full-time equivalent data are not available for the following comparison, but the headcount measures available do provide some useful information. *Figure 3* shows that the number of direct care workers increased 32% while the number of non-direct care workers fell 41%. All this increase is in the occupation community care worker. *Figure 4* provides more detail on the non-direct care workforce, showing that the decline appears to be among managers and administrators. Unfortunately, unlike in the earlier aged care workforce studies,[77] there is no further breakdown of this group, so it is not possible to determine whether there were fewer of one, two or all categories of care managers/coordinators, managers and/or administrators.

Table 4: Full-time equivalent direct care employees in the home care and support workforce, by occupation: 2007, 2012, 2016 and 2020[78]

	2007	2012	2016	2020	*% change, 2007-2020*
Registered Nurses	6,079	6,599	4,692	3,698	-39.2
Enrolled Nurses	1,197	2,345	1,143	1,170	-2.3
Allied Health Workers	2,948	4,199	3,540	2,995	1.6
Community Care Workers	**35,832**	**41,394**	**34,712**	**39,069**	**9.0**
Community Care Workers (%)	*78%*	*76%*	*79%*	*83%*	
All direct care workers (FTE)	*46,056*	*54,537*	*44,087*	*46,932*	*1.9*

[75] As noted in my earlier report (Meagher, 2021) 'There are two ways of measuring change in distribution of workers between occupations: a 'headcount' and 'full-time equivalents'. A headcount captures the total number of people employed in each occupation, without considering the hours they work. A 'full-time equivalent' (FTE) measure captures the size of the workforce in terms of the available labour time. The two measures have different strengths and weaknesses. It is preferable to compare occupations and to measure change over time with FTEs, but this data is not always available.'

[76] Calculations based on data in Table 3.1 in Mavromaras et al. (2017), and data presented in Department of Health (2021a), pages 25 and 37.

[77] Mavromaras et al. (2017), page 54.

[78] Sources: Mavromaras et al. (2017), Table 3.3 and in Department of Health (2021a), Tables 3.1 and 4.1.

Figure 2: Occupational structure of the direct care workforce in home care and support 2012, 2016, per cent of total full-time equivalent workforce[79]

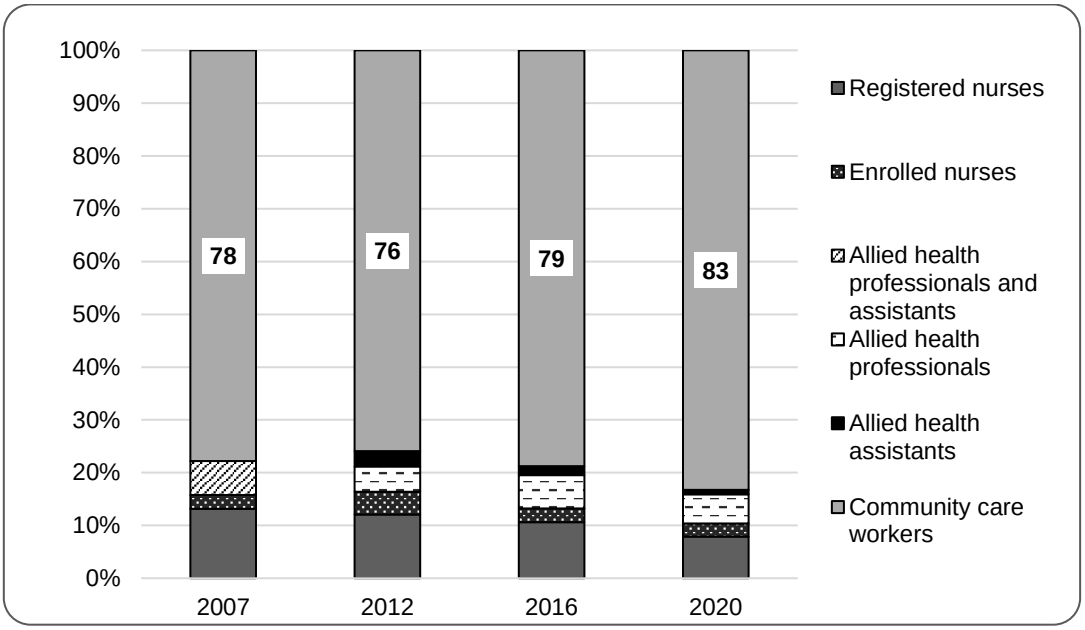
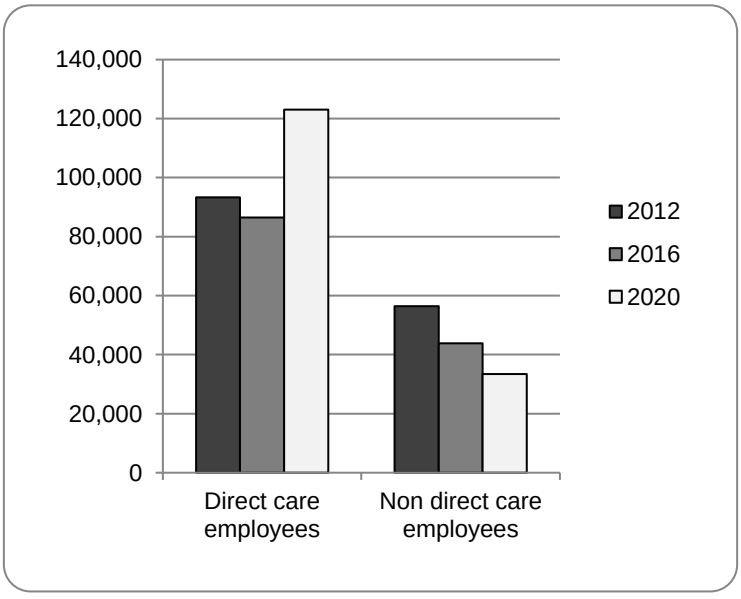
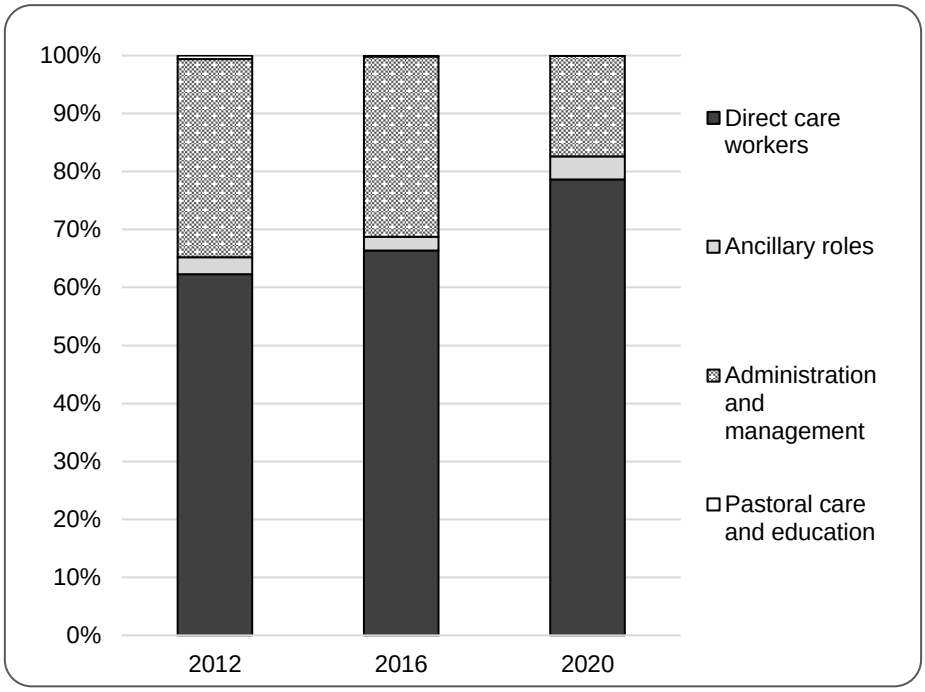


Figure 3: Number of direct care and non-direct care employees in home care and home support, 2012, 2016 and 2020, headcount measures



[79] Sources: Years 2007, 2012, 2016 from Mavromaras et al. (2017), Table 3.3, and for 2020 from Department of Health (2021a), Tables 3.1 (HCP workforce) and 4.1 (CHSP workforce).

Figure 4: Direct care employees and main groups of non-direct care employees in home care and home support, 2012, 2016 and 2020, percent of the total workforce, headcount measure)



4. Sector trends impacting the skills, responsibilities and judgement required in home care and support work

Trends in home care and support, with some exceptions, mirror many of the trends in residential aged care documented in the earlier report to which this is a supplement. The skill, responsibility and judgement demands of work in home care and support have increased because of the trends identified above: high and increasing needs and diversity among older people, enhanced principles of care quality and care regulation, new models of care, and the changing staffing profile in the sector. As in residential care, these trends can pull in contradictory directions, and front-line community care workers are called upon to negotiate and manage these contradictions in their daily work.

First, there is evidence that **the needs profile of older people receiving community care has increased, as care at home has become a 'viable alternative' to residential care.**

Second, **there is significant turnover in the population of older people receiving care at home**, so that community care workers likely work with a steady stream of new clients, along with those receiving care over the longer term. Community care workers are required to get to know the needs and preferences of a range of people and respond to them in an individualised way throughout their work days and weeks.

Third, **in addition to higher turnover among older people receiving care at home is increased recognition of diversity in this group**, not least in the concept of special needs

groups in aged care policy. As discussed in detail in the main report,[80] Aged Care Quality Standards require that staff have and exercise skills and knowledge about a wide range of social groups so they can meet their individual needs.

Fourth, **prevailing regulatory and community standards have increased expectations of the capacity and quality of home care and support.** As in residential care, responsibility for realising increased expectations falls to home care and support staff, who are required to care for and support older people in ways that respond to their individual needs, goals and preferences, and promote their emotional, spiritual and psychological well-being in all aspects of their work. Again, as in residential care, **to provide person-centred and relationship-based care, a task-oriented approach to aged care work is not appropriate.** Instead, home care and support staff need to get to know each older person as an individual, and be enabled with the skills, knowledge and work environment necessary to provide care that meets each person's specific needs.

Fifth, **new technologies** are being incorporated into home care and support practice, both with older people directly, and with care staff.

Finally, **the COVID-19 pandemic has made heightened awareness of infection control and emphasised the need for all care workers to have up-to-date knowledge and skills about infection control procedures and practices.**

4.1 Some 'basic' features of home care work and an apparently 'basic' task

The findings of a recent study summarise some essential features of home care and support work, and the skills involved in doing it. The study 'examined the challenges faced by home-care workers and the strategies they used to manage these challenges'. The authors found that:[81]

> Challenges included time allocation for visits, completing care plan tasks, lone working, communication and understanding, refusals of care, and client behaviours. To mitigate these challenges, home-care workers utilised system support, time management, training and experience and enacted a caring relationship, thought about their approach, and used distraction and communication skills. Workers relied on skills such as, relationship building, team working, observation, communication, decision making and interpersonal sensitivity. They drew on knowledge about the person, the person's needs, their own abilities, company policies and procedures and their role and responsibilities as a home-care worker.

Before discussing the impact of the trends outlined above in more detail, **it is important to note a basic difference between residential care work and work in home care and support: community care workers largely work alone in their day-to-day practice with older people.** In addition to the trends summarised above, working alone makes particular

[80] Meagher (2021), Section 4.
[81] Backhouse & Rushton (2021), page 1. The study was carried out in England, but its findings are wholly applicable in Australia.

demands on the skills, responsibility and judgement they are called upon to exercise in their daily work.

Further, **even a 'basic' service such as domestic assistance makes some strong demands on community care workers' skills, responsibility and judgement.** As shown above, domestic assistance is one of the services most used by older people receiving HCPs and services from the CHSP. As a publicly-subsidised service directed at meeting a need that is recognised in policy as an entitlement, domestic assistance is different in important ways from what might seem equivalent work in cleaning the home of an able-bodied adult in a private context. Community care workers need to exercise situational judgement about how to organise and prioritise their tasks in consultation with their clients, within the framework of services they can reasonably be expected to provide. Care workers meet older people in their own homes, and negotiating the boundaries of their work can call for sensitivity, tact and ethical decision-making – for example in relation to requests to complete tasks from friends or relatives present who are not clients, or in dealing with unexpected extra work related to clients' pets.

Moreover, **community care workers providing domestic assistance may be the most frequent, or sometimes the only, regular contact an older person has with an aged care organisation,** particularly for the large proportion of clients who live alone. On average, the 330,000 older people who received domestic assistance in 2018-19 had around 22 sessions per year, or a bit less than fortnightly. The 70,000 who received personal care had on average 55 sessions a year, or a bit more than weekly. These community care workers are in a position to observe closely an older person's condition and make an assessment about whether they should report any changes, perhaps even when an older person does not want them to. They may also be a highly trusted person to whom an older person gives information about their needs and concerns. Given the general level of physical ill-health and frailty of the client group, the large number of medications they take on average, their additional susceptibility to falls, and their high rates of dementia and depression, community care workers' opportunities for 'gentle oversight' of older peoples' well-being is potentially important in enabling timely intervention when an older person's condition deteriorates.

The point is that **even community care workers providing 'only' domestic assistance are in a position of responsibility in relation to the wellbeing of many frail older people.** Home care managers often describe community care workers as 'the eyes and ears' of the organisation.[82] This position requires skills of observation and assessment and of relationship-building and interpersonal sensitivity to gain trust, and it demands judgement about what, when and to whom to communicate about an older person's (changing) condition. Research with home care providers and workers has found the exercise of these skills and judgement can be decisive for a person's well-being, even survival, especially for older people with limited decision-making capacity. One study gives the example of 'not noticing or not acting on a chest infection [which] could mean the client would become very ill'.[83]

[82] See, for example, Payne & Fisher (2019), page 198.
[83] Backhouse & Rushton (2021).

These skills, responsibilities and judgements are also exercised by community care workers offering personal care and social support to older people and respite for their carers, often to an even higher level.

- Providing high quality *personal care* requires community care workers to maintain an older person's safety and dignity in the context of intimate personal care tasks such as toileting and bathing. This care requires both technical (for example, in relation to manual handling and infection control) and ethical and interpersonal skills.

- When providing *social support*, community care workers need to engage older people and to offer activities that meet their social and emotional needs. In addition to any specific technical skills related to an activity, offering social support calls on high level interpersonal skills and the exercise of judgement to negotiate the boundaries of the relationship, in adherence with ethical requirements and workplace policies.[84]

When home care and support clients live alone, community care workers may be the only person their clients regularly meets. However, some home care and support clients have a carer, and community care workers need skills and judgement to negotiate a positive working relationship with their client's carer.

4.2 Changing occupational profile, increasing work demands

Together with the growing share of older people in the population, increased use of home care means that the total workload in home care is considerably larger now than a decade ago. *Table 5* reveals a similar trend to that in residential aged care: **increased levels of need and a larger total workload in home care and support have not been reflected in a larger or more qualified workforce.**

Table 5 shows that:

- **The total workload in home care and support increased substantially between 2012 and 2020.** The number of home care packages more than doubled between 2012 and 2020 (141% increase), as did the share of high level packages (125% increase). Total annual hours of selected CHSP services (domestic assistance, personal care, flexible respite and individual social support), have increased by more than a third (36%).
- **The size of the workforce that provides home and community care appears to have fallen since 2012.** Data presented above show that tasks performed by community care workers consume the vast majority of hours of service in HCPs, and *Table 5* presents evidence that these workers have provided a growing absolute number of hours of service in the CHSP.
- In relation to the occupational profile of the workforce, **increased levels of need among older people receiving home and community care have not resulted in a more highly trained workforce.** Rather, the share of community care workers among the direct care staff has increased from 76% in 2012 to 83% in 2020. Data presented in Table 4 and

[84] Lam & Baxter (2020).

Figure 2 above show a corresponding decline in the share of registered and enrolled nurses and allied health professionals and aides.

Table 5: Services and staffing in home care and support, 2012-2020[85]

	2012	2014	2016	2018	2020	*% change*
Number of home care packages[#]	59,201	66,954	79,819	91,847	142,436	*141*
Level 3 and 4 packages (% of total)[#]	21	20	30.4	38.7	47.2	*125*
Annual hours of selected CHSP services for people >65 years of age (million)*	12.2	11.8	14.0	15.6	16.5	*36*
Community Care Workers (FTE)^	54,537		44,087		46,932	*-14*
Share of CCWs in direct care staff (FTE, %)^	75.9		78.7		83.2	*10*

It is difficult to assess the quality of the workforce data and to verify the apparent decline in the size of the home care and support workforce overall. There may have been significant undercounting of community care workers in 2020, perhaps related to problems with conducting the Aged Care Workforce Survey during the COVID-19 pandemic. However, it does not seem plausible that the scale of undercounting could be so great as to obscure major growth in the workforce.

Even taking the potential for undercounting into account, these data support the inference that **fewer home care and support workers are caring for more older people, a growing proportion of whom are recognised as having a high level of needs. Accordingly, the amount of care work needed is greater, and the content of the work is more skilled, complex and demanding.** For example, in the context of providing personal care, community care workers may also carry out skilled medical tasks such as urinary catheterisation and giving medication.

Moreover, as the group of older people receiving care and support at home becomes frailer and sicker, their condition and care needs become more unpredictable. As members of an already stretched workforce, community care workers are also increasingly likely to confront unplanned-for situations that require them to make situational judgements about what to prioritise and how to handle smaller or larger emergencies. To ensure safe and accountable care, community care workers need communication skills to support timely, accurate written

[85] Sources: # As at 30 June in relevant year; for 2012, Aged Care Financing Authority, *Inaugural Report on the aged care sector – 30 June 2013*, page 26, note that Community Aged Care Packages are counted as Level 1 and 2 packages for the purpose here, and Extended Aged Care at Home (EACH) and EACH(Dementia) packages are counted as levels 3 and 4; for 2014-2018, Report on Government Services (RoGS) 2019, Table 14A.9, for 2020, RoGS 2021, Table 14A.9. * Authors' calculations based on RoGS 2017 Tables 14A.21 and Table 14A.1 for 2011-2017; RoGS 2021 Tables 14A.23 and 14A.1 for 2018-2020; includes personal care, domestic assistance, individual respite, and individual social support as provided to people over 65 and ATSI clients aged 50-64; figures for 2015-16 not available during transition from HACC to CHSP so data for 2016-17 reported instead; ^ Mavromaras et al. 2017, Table 5.3 for 2012 and 2016; author's calculations based on Department of Health 2021, Tables 3.1 and 4.1 for 2020.

reports to their employing organisations and to their colleagues who work with the same client.[86]

Working with older people with dementia in combination with other chronic diseases further increases the skill and responsibility demands of home care and support work. These older people typically have difficulty undertaking aspects of routine self-management of their health, including understanding their condition, taking medication, and following action plans on exacerbation. These limitations make additional demands on community care workers, who observe and make decisions about how to meet the person's needs outside the structured context of a residential aged care facility where disease management would not be delegated to the older person.[87]

In addition, a significant minority of home care and support clients have unmet or under-met need, which further increases work demands. As noted above, most older people assessed as needing a high level home care package are currently not offered one for 9-12 months; this waiting time has been longer in past years. In the meantime, some receive a lower level package or support under the CHSP. These 'fallback solutions' create challenges for home care organisations and community care workers, who work with significantly fewer resources than have been determined as necessary to meet their needs in caring for and supporting these older people. To manage such situations optimally in daily practice requires community care workers to maintain close communication and negotiation with both their managers and their clients, and to make judgements about priorities in care within tightly constrained conditions. Further, the likely high levels of frailty and ill-health among HCP clients assessed as eligible for high level packages make strong demands, even when there are adequate resources to meet needs.

4.3 Changing models of care, increasing work demands

New models of care include wellness and reablement and consumer directed care, which demand new skills and responsibilities to the work of community care workers.

Consumer directed care in the HCP program introduces new ways of working with older clients, who have the right to decide on how the funds in their package are spent (within the permitted range of services) and receive a monthly account setting out expenditures. Consumer directed care can also confer on community care workers more responsibility to their clients. One aspect of the change is a change in the HCP clients' relationships with the service providing organisation. Under CDC, clients may receive fewer visits from the service coordinator, and if they request additional visits or contacts by telephone, these are charged against their accounts. According to one study:

> This has had the effect of discouraging clients to make calls or to request visits, resulting in an increase in home support workers' responsibility for clients' welfare and understanding of the [CDC] model.[88]

[86] Processes as described in Prgomet, Douglas, Tariq, Georgiou, Armour et al. (2017), pages 113-114.
[87] Baird, Woolford, Young, Winbolt & Ibrahim (2019).
[88] Payne & Fisher (2019), page 9.

In some organisations, CDC may also have increased documentation requirements on community care workers.[89] In addition to these enhanced responsibilities and a new educative role, community care workers working within CDC also now have more autonomy to respond to clients' requests for changes. Managers emphasised that community care workers were expected to respond to such requests 'within reason', to avoid risk to both the client and the worker. Studies find that managing client expectations under the new model of care is a major challenge experienced at the frontline by community care workers. Thus, the expectation of increased responsiveness also increases the expectation that care workers interpret what is 'within reason'. They need to make judgements, taking into account organisational policies, individuals' care plans, and clients' requests on the day, about what they do and when.

Another role community care workers have in the context of CDC is as the 'face' of the provider organisation at the front-line, managing any concerns clients may have locally, to avoid escalation. This may require community care workers to make ethical judgements about the validity of client concerns, and to negotiate perhaps conflicting interests of the provider organisation (their employer) and the client.

Realising wellness and reablement principles in home care and support has far-reaching implications for the skills, responsibilities and judgement required by community care workers. As noted above, meeting the full range of older people's needs, allowing older people's goals to drive care planning and seeking to maintain and rebuild older people's capacities gives community care workers a role in exercise interventions, health literacy training, social and recreational support, improving oral health care, and palliative care among other things. These enhancements to home care and support are being offered in a context where a smaller proportion of the workforce has specialised skills. Some of the skills required of community care workers include specific technical and interpersonal skills related to these various domains of practice and working in interdisciplinary teams. One study of implementing a reablement intervention found that community care workers used skills to carefully assess their client's progress in rebuilding their capacity to do tasks, to maintain progress without under-supporting the client or taking over from them.[90]

Further, research has found that reablement practices are not always welcomed by older people, and community care workers need skills to manage this in their daily work. A study on exercise interventions to prevent falls, for example, found that some older people resisted community care workers' attempts to engage them in reablement activities. Instead, older people said things such as 'I don't want to do any of that, I just want you to clean the house', 'I am too old for this', 'I can't be bothered', or 'oh no I was forced to do that in hospital (exercises), and you're not going to force me to do it in my own home'.[91] In such cases, community care workers need to use interpersonal and negotiation skills as they manage the

[89] Mackay & Goodwin-Smith (2019).
[90] Maxwell, Bramble, Prior, Heath, Reeves et al. (2021).
[91] Burton, Boyle, O'Connell, Lewin, Petrich et al. (2021), page 421.

sometimes conflicting principles of reablement on one hand and consumer choice and control on the other.

4.4 Digital technologies in home care work

Digital technologies have an increasing role in most workplaces and require new skills and new safeguards for client privacy. As noted above, under CDC home care clients are to receive itemised accounts, which has prompted some provider organisations to develop their IT infrastructure to digitise various aspects of their operations, such as client records and staff rostering.[92] There is little research on the use of digital technologies in home care work in Australia, although implementation of these technologies is established and expected to accelerate.[93] An authoritative evidence review by the UK organisation, Skills for Care, identified the following digital skills for frontline adult social care workers, many of which would be exercised by community care workers whose employers have already digitised their operations:[94]

a) Handling and managing information and content
b) Problem solving and communication
c) Ethics and service delivery involving digital technology
d) Understanding the needs of others in using and supporting access
e) Cyber security including data sharing and data protection
f) Safety and safeguarding

5. Work value issues in home care and support

To deliver home care and support that meets community standards and government-mandated quality requirements, community care workers carry out care work that:

a) demands a variety of technical and interpersonal skills
b) gives them responsibility for the safety and well-being of vulnerable older people, and
c) requires them to exercise judgement about clients' condition, priorities within their work, and ethical courses of action when the principles of new models of aged care compete.

Yet the exercise of these skills, responsibilities and judgement are undervalued in the industrial instruments that cover their work. Please refer to the main report for discussion of work value issues in home care and support. That section dealt with the general problem of undervaluation of care work, which applies to both residential care work and work in home care and support.

[92] Prgomet, Douglas, Tariq, Georgiou, Armour et al. (2017)
[93] Barnett, Livingstone, Margelis, Tomlins, Gould et al. (2020).
[94] Skills for Care (2021). Skills for Care is an independent charity that works as a delivery partner for the UK Department of Health and Social Care to 'create a well-led, skilled and valued adult social care workforce'; see https://www.skillsforcare.org.uk/About/About-us.aspx.

Conclusion

Several policy changes on the horizon that mean it is very timely to recognise the value of work in aged care. The Home Care Packages program and the Commonwealth Home Support Program are slated for unification into a Single In-Home Care Program.[95] Another policy under discussion is alignment of regulation across Australia's care and support sectors, which takes in aged care, disability support and veteran's care. Announced in the 2021-22 Budget, the government's aim is to:

> align regulation to improve quality and safety for participants and consumers and remove unnecessary duplication of obligations for service providers and *workers to work more seamlessly across different types of care*.[96] (emphasis added)

In the context of these reforms, it is desirable to have the problems of the undervaluation of care work in aged care resolved.

[95] https://www.health.gov.au/health-topics/aged-care/aged-care-reforms-and-reviews/reform-to-in-home-aged-care-to-create-a-single-system.
[96] https://www.health.gov.au/initiatives-and-programs/aligning-regulation-across-the-care-and-support-sectors

References

Aged Care Financing Authority (2013). *Inaugural report on the funding and financing of the aged care sector*, Canberra: ACFA.

Aged Care Financing Authority (2021). *Annual report on the funding and financing of the aged care sector – 2021*. Canberra: ACFA.

Australian Institute of Health and Welfare (1993). *Australia's welfare 1993: services and assistance.* Canberra: AGPS.

Australian Institute of Health and Welfare (2000). *Community care packages in Australia 1998–99: A statistical overview*. Canberra: AIHW (Aged Care Statistics Series no. 8), Section 2.1.

Australian Institute of Health and Welfare (2021). *Dementia in Australia.* Cat no. DEM 2 Canberra: AIHW.

Backhouse, T., & Ruston, A. (2021). Home-care workers' experiences of assisting people with dementia with their personal care: A qualitative interview study. *Health & Social Care in the Community*. Early view: https://doi.org/10.1111/hsc.13445.

Baird, C., Woolford, M. H., Young, C., Winbolt, M., & Ibrahim, J. (2019). Chronic disease management and dementia: a qualitative study of knowledge and needs of staff. *Australian Journal of Primary Health*, *25*(4), 359-365.

Baker, J. R., Harrison, F., & Low, L. F. (2016). Development of two measures of client engagement for use in home aged care. *Health & Social Care in the Community*, *24*(3), 363-374.

Barken, R., Denton, M., Sayin, F. K., Brookman, C., Davies, S., & Zeytinoglu, I. U. (2018). The influence of autonomy on personal support workers' job satisfaction, capacity to care, and intention to stay. *Home Health Care Services Quarterly*, *37*(4), 294-312.

Barnett, K., Livingstone, A., Margelis, G., Tomlins, G., Gould, G., Capamagian, L., Alexander, G., Mason, C., & Young, R. (2020). *Aged Care Industry Innovation - driving care systems capability: Final report*. Aged Care Industry Information Technology Council. Retrieved from http://www.aciitc.com.au/wp-content/uploads/2020/11/ACIITC-Care-IT-Report-FINAL-13112020.pdf.

Batchelor, F., Savvas, S., Peck, A., Dang, C., Wade, C., Goh, A.M.Y, Dow, B. (2020). *Inside the system: home and respite care clients' perspectives.* National Ageing Research Institute: Parkville, Victoria. Report for the Royal Commission into Aged Care Quality and Safety. Research Paper 14, October. Retrieved from https://agedcare.royalcommission.gov.au/sites/default/files/2020-10/research-paper-14.pdf.

Bony, H., Lloyd, R. A., Hotham, E. D., Corre, L. J., Corlis, M. E., Loffler, H. A., ... & Suppiah, V. (2020). Differences in the prescribing of potentially inappropriate medicines in older Australians: comparison of community dwelling and residential aged care residents. *Scientific Reports*, 10(1), 1-8.

Browne-Yung, K., O'Neil, D., Walker, R., Smyth, A., Putsey, P., Corlis, M., ... & Cations, M. (2021). 'I'd rather die in the middle of a street': Perceptions and expectations of aged care among Forgotten Australians. *Australasian Journal on Ageing*, *40*(2), 168-176.

Burton, E., Lewin, G., O'Connell, H., & Hill, K.D. (2018). Falls prevention in community care: 10 years on. *Clinical Interventions in Aging*, 13, 261.

Burton, E., Boyle, E. J., O'Connell, H., Lewin, G., Petrich, M., & Hill, K. D. (2021). Community care staff attitudes towards delivering a falls prevention exercise intervention to community care clients. *Health & Social Care in the Community*, *29*(2), 416-424.

Charlesworth, S., & Malone, J. (2017). Re-imagining decent work for home care workers in Australia. *Labour & Industry*, *27*(4), 284-301.

Department of Health (2019a). *Home Care Packages Program Data Report 4th Quarter 2018-19*, retrieved from https://www.gen-

agedcaredata.gov.au/www_aihwgen/media/Home_care_report/HCPP-Data-Report-4th-qtr-2018-19.pdf.

Department of Health (2019b). *Home care packages – reform.* Retrieved from https://web.archive.org/web/20190304204416/https://agedcare.health.gov.au/aged-care-reform/home-care/home-care-packages-reform

Department of Health (2020a). *Commonwealth Home Support Programme Data Study*. Canberra: DoH. Retrieved from https://www.health.gov.au/sites/default/files/documents/2021/06/commonwealth-home-support-programme-data-study_0.pdf.

Department of Health (2020b). Home Care Provider Survey – analysis of data collected. Canberra: DoH. Retrieved from https://www.health.gov.au/sites/default/files/documents/2020/06/home-care-provider-survey-analysis-of-data-collected.docx.

Department of Health (2021a). *2020 Aged care workforce census report*. Canberra: DoH. Retrieved from https://www.health.gov.au/sites/default/files/documents/2021/10/2020-aged-care-workforce-census.pdf.

Department of Health (2021b). *Home Care Packages Program – Data Report: 3rd Quarter 2020-21*. Retrieved from https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Home_care_report/Home-Care-Data-Report-3rd-Qtr-2020-21.pdf.

Department of Health (2021c). *Home Care Packages Program Operational Manual – A guide for home care providers.* Version 1.2 – September 2021. Retrieved from https://www.health.gov.au/sites/default/files/documents/2021/09/home-care-packages-program-operational-manual-a-guide-for-home-care-providers.pdf.

Dow, C., & Phillips, J. (2009). 'Forgotten Australians' and 'Lost Innocents': child migrants and children in institutional care in Australia. *Background Note.* Parliamentary Library. Canberra: Parliament of Australia. Retrieved from https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BN/0910/ChildMigrants.

Franzosa, E., Tsui, E. K., & Baron, S. (2019). "Who's caring for us?": Understanding and addressing the effects of emotional labor on home health aides' well-being. *The Gerontologist*, *59*(6), 1055-1064.

Gibson, D. (2020). Planning the supply of aged care services: It's time to talk denominators. *Australasian Journal on Ageing*, 39(4), e515-e521.

Gibson, C., Crockett, J., Dudgeon, P., Bernoth, M., & Lincoln, M. (2020). Sharing and valuing older Aboriginal people's voices about social and emotional wellbeing services: a strength-based approach for service providers. *Aging & Mental Health*, *24*(3), 481-488.

Gill, L., McCaffrey, N., Cameron, I. D., Ratcliffe, J., Kaambwa, B., Corlis, M., Fiebig, J. & Gresham, M. (2017). Consumer Directed Care in Australia: Early perceptions and experiences of staff, clients and carers. *Health & Social Care in the Community*, *25*(2), 478-491.

Hart, A., Bowman, D., & Mallett, S. (2021). Time for Good Care and Job Quality: Managing Stress among Older Workers in the Aged Care Sector. *Journal of Aging & Social Policy*, Early View, https://doi.org/10.1080/08959420.2021.1926202.

Hsu, B., Korda, R. J., Lindley, R. I., Douglas, K. A., Naganathan, V., & Jorm, L. R. (2021). Use of health and aged care services in Australia following hospital admission for myocardial infarction, stroke or heart failure. *BMC geriatrics*, *21*(1), 1-10.

Hsu, B., Korda, R., Naganathan, V., Lewis, P., Ooi, S. Y., Brieger, D., & Jorm, L. (2021). Burden of cardiovascular diseases in older adults using aged care services. *Age and Ageing*, *50*(5), 1845–1849

Inacio, M. C., Lang, C. E., Khadka, J., Watt, A. M., Crotty, M., Wesselingh, S., & Whitehead, C. (2020). Mortality in the first year of aged care services in Australia. *Australasian Journal on Ageing*, *39*(4), e537-e544.

Inacio, M. C., Lang, C., Bray, S. C., Visvanathan, R., Whitehead, C., Griffith, E. C., ... & Wesselingh, S. (2021). Health status and healthcare trends of individuals accessing Australian aged care programmes over a decade: the Registry of Senior Australians historical cohort. *Internal Medicine Journal*, 51(5), 712-724.

Jayatilaka, A., Ranasinghe, D. C., Falkner, K., Visvanathan, R., & Wilson, A. (2020). Care workers' voices in designing assistive technologies for preventing malnutrition in older people with dementia: Innovative Practice. *Dementia*, *19*(2), 505-511.

Khadka, J., Lang, C., Ratcliffe, J., Corlis, M., Wesselingh, S., Whitehead, C., & Inacio, M. (2019). Trends in the utilisation of aged care services in Australia, 2008–2016. *BMC Geriatrics*, *19*(1), 1-9.

King, A. I., Parsons, M., Robinson, E., & Jörgensen, D. (2012). Assessing the impact of a restorative home care service in New Zealand: a cluster randomised controlled trial. *Health & Social Care in the Community*, *20*(4), 365-374.

Lam, J., & Baxter, J. (2020). "Friend-ish": Home Care Workers,'Social Labour'and Managing the Boundaries of the Carer Relationship. *Life Course Centre Working Paper*, (2020-17).

Lee, W. S., McNamara, P., English, J., & Meusemann, R. (2020). Ocular trauma associated with falls in older people: A 10-year review from a state trauma service. *Injury*, *51*(9), 2009-2015.

Leverton, M., Burton, A., Beresford-Dent, J., Rapaport, P., Manthorpe, J., Mansour, H., ... & Cooper, C. (2021). 'You can't just put somebody in a situation with no armour'. An ethnographic exploration of the training and support needs of homecare workers caring for people living with dementia. *Dementia*, Early view, https://doi.org/10.1177/14713012211023676.

Lewis, A., Harvey, G., Hogan, M., & Kitson, A. (2019). Can oral healthcare for older people be embedded into routine community aged care practice? A realist evaluation using normalisation process theory. *International Journal of Nursing Studies*, *94*, 32-41.

Low, L. F., Baker, J. R., Harrison, F., Jeon, Y. H., Haertsch, M., Camp, C., & Skropeta, M. (2015). The lifestyle engagement activity program (LEAP): implementing social and recreational activity into case-managed home care. *Journal of the American Medical Directors Association*, *16*(12), 1069-1076.

Macdonald, F., & Charlesworth, S. (2021). Regulating for gender-equitable decent work in social and community services: Bringing the state back in. *Journal of Industrial Relations*, Early view, https://doi.org/10.1177/0022185621996782.

Mackay, T., & Goodwin-Smith, I. *Quality jobs and best practice care: improving homecare staff engagement within a consumer directed care environment.* A research report prepared by the The Australian Alliance for Social Enterprise for Anglicare Australia.

Maxwell, H., Bramble, M., Prior, S. J., Heath, A., Reeves, N. S., Marlow, A., ... & Doherty, D. J. (2021). Staff experiences of a reablement approach to care for older people in a regional Australian community: A qualitative study. *Health & Social Care in the Community*, *29*(3), 685-693.

Meagher, G. (2021). *Changing aged care, changing aged care work: workforce and work value issues in Australian residential aged care.* Research report. Macquarie University.

Palesy, D., & Jakimowicz, S. (2020). Health literacy support for Australian home-based care recipients: A role for homecare workers?. *Home Health Care Services Quarterly*, 39(1), 17-32.

Payne, G., & Fisher, G. (2019). The service triangle and power: the role of frontline home support workers and consumer-directed care—an Australian context. *Industrial Relations Journal*, 50(2), 197-213.

Poulos, R. G., Harkin, D., Poulos, C. J., Cole, A., & MacLeod, R. (2018). Can specially trained community care workers effectively support patients and their families in the home setting at the end of life?. *Health & Social Care in the Community, 26*(2), e270-e279.

Prgomet, M., Douglas, H. E., Tariq, A., Georgiou, A., Armour, P., & Westbrook, J. I. (2017). The work of front line community aged care staff and the impact of a changing policy landscape and consumer-directed care. *The British Journal of Social Work, 47*(1), 106-124.

Rahman, M., Efird, J. T., Kendig, H., & Byles, J. E. (2019). Patterns of home and community care use among older participants in the Australian Longitudinal Study of Women's Health. *European Journal of Ageing, 16*(3), 293-303.

Royal Commission into Aged Care Quality and Safety (2021). *Final Report: Care, Dignity and Respect Volume 2: The current system.* Retrieved from https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-volume-2_0.pdf.

Skills for Care (2021). *Digital skills in adult social care: rapid evidence review*. Retrieved from https://www.skillsforcare.org.uk/Documents/Misc/Digital-Skills-in-Adult-Social-Care-Rapid-Evidence-Review-Mar21.pdf

Teshuva, K., Borowski, A., & Wells, Y. (2021). Holocaust survivors' perspectives on using community aged care and support services. *Ageing & Society, 41*(2), 231-246.

Welberry, H. J., Brodaty, H., Hsu, B., Barbieri, S., & Jorm, L. R. (2020). Impact of prior home care on length of stay in residential care for Australians with dementia. *Journal of the American Medical Directors Association, 21*(6), 843-850.

Welberry, H. J., Jorm, L. R., Barbieri, S., Hsu, B., & Brodaty, H. (2021). The impact of dementia on aged care service transitions in the last five years of life. *Age and Ageing, 50*(4), 1159-1165.

Wise, S. (2020). Staffing policy in aged care must look beyond the numbers. *Australian Health Review, 44*(6), 829-830.

Yeh, I. L., Samsi, K., Vandrevala, T., & Manthorpe, J. (2019). Constituents of effective support for homecare workers providing care to people with dementia at end of life. *International Journal of Geriatric Psychiatry, 34*(2), 352-359.

MACQUARIE
University