Balancing risk and safety
for our community

unlicensed health workers in the
health and aged care systems

2009

Contents

1 Executive Summary

The impetus for this paper has come from the concerns expressed by nurses about unlicensed health care workers. These concerns relate to the lack of consistency in standards of educational preparation, competence and employment arrangements for workers who nurses share care responsibilities with and who they are often supervising and supporting. This group includes personal care (PC) assistants and nursing assistants in aged care and health settings who are providing direct nursing and personal care. This health care is being provided to people of all ages who are ill, frail, or injured and often with multiple co-morbidities as well as diminished independence of physical or psychological causation. This domain has long been recognised as 'nursing'. Consideration must be given therefore to the risks posed to the recipients of this health care in the same way that the risks are considered in relation to the nursing care provided by nurses. This paper's focus is on unlicensed health care workers providing direct health care.

Identifying these workers in terms of who they are, where they work and what they do is a challenge for researchers as there are no data bases that capture the full extent of this large but unstructured workforce. This workforce is scattered across numerous care environments; increasingly in all units of hospitals, residential aged care facilities, community health and welfare services, home care services, primary care settings, schools and disability services, to name but a few. There is no common title for these workers either and the difficulties this poses were raised in the National Review of Nursing Education where it was argued that: *without a common nomenclature it is difficult to count those contributing to nursing work and impossible to establish standards that cover their work* (Health 2002 p.46).

The authors of the National Institute of Labour Studies (NILS) research report on the residential aged care workforce found that:

> *…the existing level of knowledge about workers in aged care is remarkably limited. No single data source provides an accurate and detailed appraisal of direct care employment in residential aged care facilities in Australia, especially not of the kind that would inform complex workforce planning* (Richardson and Martin 2004 p.1).

Our estimates of employment in residential aged care homes show steady increases between 2003 and 2007. Total employment i aged care homes rose from about 157,000 to about 175,000, with direct care employees increasing from about 116,000 to about 133,000. Proportionately, the rise in equivalent full time (EFT) direct care workers was smaller, with an increase from about 76,000 in 2003 to about 79,000 in 2007. There has been something of a rebalancing of the workforce towards greater use of Personal Carers (PCs), and reduced reliance on Registered Nurses (RNs). Between 2003 and 2007, total employment of RNs fell by about 1,600 to 22,400, while PC employment rose by about 17,500 to nearly 85,000. Employment of Enrolled Nurses (ENs) and Allied Health workers rose slightly to just over 16,000 and nearly 10,000 respectively. (Martin and King 2008 p.i)

This paper looks at the many titles and the work that unlicensed health workers do. It also considers the issues around the skills and educational preparation of these workers. The paper goes on to discuss the major substitution of registered nurses and enrolled nurses by unlicensed health care workers and the reasons for this. It also addresses the issues raised when this group takes on work that has traditionally been recognised as 'nursing'. These include:

- Cost and productivity: direct care and nursing services being one of the primary costs in the provision of health and aged care services.

- Australia's population is ageing. In the most recent ABS projections, the proportion of Australians aged 65 or over will nearly double in the next 50 years, increasing from 13% in 2007 to between 23% and 25% in 2056. The proportion aged 85 and over will rise from less than 2% to between 5% and 7% over the same period. This ageing population has many implications, not least of which is a rising proportion of the population who will need care and assistance in daily living. At the same time, we face an ageing workforce. A declining proportion of the population will fall into the prime working ages of 18-65, and more of those who do will be in the older age groups. (Martin and King 2008 p.1)

- Policy and politics: the current focus of de-regulation, reducing the regulatory burden and anti-competition are embedded in National, State and Territory Government policy. There has been little political will to embark on further regulation where it can be avoided. Private sector employers in the health and aged care sectors have also been active in arguing for their right to run their organisations as they choose, without the burden of legislation that governments impose. The concerned voices of a community who are the health care recipients, their families and friends; and the nurses working in the care environment are largely being ignored.

Some of the counter intuitive issues in relation to the large scale substitution of registered health professionals by the unlicensed health and aged care workforce are:

- Case mix and care needs of client groups: the escalating care need profile of patients in hospitals and residents in residential aged care and those being provided care in the community has changed dramatically in the past two decades. The patients care needs are more acute and their admission to hospital is for much shorter periods. The notion of convalescence is long gone. Residents in aged care facilities now need higher levels of care which in the past would have been provided in hospital. Ironically, concurrent with the deskilling of the health and aged care workforce we are seeing a dramatic increase in the complexity and scope of the care needs of the consumer.

- Consumer expectations: an increasingly vocal community with rising expectation of the safety and quality of the services provided by the health and aged care systems is an important consideration when examining the impact of an increasingly less skilled workforce. We no longer have patients who traditionally were treated as passive recipients of care. Today health consumers, their families and friends have strong and strident opinions about care partnerships as well as about the safety and quality of care that is expected in the health and aged care systems.

The regulatory mechanisms for health workers from the currently registered health professional groups are also considered in the paper as well as the processes that have been established to review and make decisions in relation to what groups of workers should be regulated through the Australian Health Ministers Advisory Council (AHMAC) and under National Competition Policy. The paper also discusses briefly the opportunities that the current Council of Australian Governments' reforms coming from the Productivity Commission Report on the Health Workforce can provide for a review of the status quo. Some of the non-specific and largely disconnected regulatory mechanisms that create both obligations and rights for these unlicensed health workers and their employers are also reviewed.

The paper also looks at some of the initiatives that have been occurring in relation to unlicensed health workers in the United Kingdom and the United States of America where similar concerns to those raised in this paper have led to the development of different models of regulation being embarked on for these workers for the protection of the community. This section also looks at several Australian initiatives in this area that has relevance to the discussion.

The paper goes on to examine the existing models of regulation and then uses these to outline the options for the currently unlicensed health and aged care workforce. It also highlights the opportunity that the Council of Australian Governments (COAG) reforms in the regulated health workforce offer as a rational direction for the introduction of a comprehensive regime of regulation for currently unlicensed health workers.

Options for Regulation of Unlicensed Health Workers

There are a range of options for regulating currently unlicensed health workers providing direct care. The following options are outlined in more detail later in this paper.

OPTION 1: SELF-REGULATION

Self-regulation suggest no occupational licensing or registration legislation that requires members of the workforce to be registered with a statutory body, nor is there government oversight of educational and work standards development or a formal judicial process that makes up the disciplinary system for the group of workers.

This is the status quo and **NOT** *supported by ANF.*

OPTION 2: LICENSING

The licensing option requires there is a formal classification and naming of craft groups and their details are placed on a government oversighted register of persons who are working in specific industries. To be employed in that industry the person has to establish their credentials which can range from: minimal, eg not having had any serious criminal convictions that would impact on an assessment of their character in their area of work; to more onerous, eg having successfully obtained a basic qualification, being required to abide by a code of conduct and/or ethics, and/or practice standards.

*This option **IS** supported by the ANF with basic standards for education, practice and conduct being set as a baseline. The outcomes of the pilot project being conducted by the NHS Scotland should also inform the development of such a model.*

OPTION 3: NEGATIVE LICENSING

Any person is able to work in health and aged care unless they are placed on a register of persons who are ineligible to practise. It does not establish barriers to entry to the workforce, but allows those with poor practice records to be excluded from practising without the need for a full registration system. However it provides less protection to consumers and may be inappropriate when there is potential for serious harm.

*This option is **NOT** supported by the ANF as it does not adequately protect the community or set basic standards for education, practice or conduct.*

OPTION 4: CO-REGULATION

Regulatory responsibility is shared between government and the industry. For example, unions and professional groups set membership requirements and administer a disciplinary scheme to ensure practice standards. The government monitors and accredits these organisations to ensure they act in a way that protects members of the public. However workers who are not members of a co-regulated association or craft group are not legally prevented from practising or using the titles of the profession under such a system.

*This option is **NOT** supported by the ANF as it operates on the presumption that workers identify as a class of worker and have organised in formal collectives and developed codes and standards of education, practice and conduct which is not a feature of most of the currently unlicensed workforce in the health and aged care industries.*

OPTION 5: RESERVATION OF TITLE ONLY

This option, as with option 2, requires there is a formal classification and naming of craft groups eg health care support workers. Under this option particular titles of the craft group can only legally be used by those who are licensed by the relevant registration board. A statutory registration board establishes qualifications and character requirements for entry to the profession, develops standards of practice, and receives and investigates complaints of unprofessional conduct, poor health or performance and applies sanctions, if necessary, including deregistration. It is difficult for a deregistered worker to practise because if they advertise their services to the public or use the reserved title they can be prosecuted through the courts for committing an offence. This form of regulation assures consumers that workers are qualified to provide services and their practice is subject to the scrutiny of a registration board.

*This option **IS** supported by the ANF as it is consistent with the current system for the registration of health professionals which could be modified to add another level of health and aged care worker to an already established model of regulation that is understood by community and the health and aged care industries.*

OPTION 6: RESERVATION OF TITLE AND CORE PRACTICES

Certain risky and intrusive acts or procedures within the defined scope of practice of a profession are restricted through legislation to members of the registered worker group and others identified in legislation. Unregistered and unauthorised workers are not only prohibited from using reserved titles, but may be liable for prosecution for an offence if they carry out any of the reserved core practices for which they are not authorised. Exemptions are allowed for treatment provided in an emergency and where students perform core practices under the direction and supervision of an authorised member of the profession.

*This option is **NOT** supported by the ANF as it is an unnecessarily onerous regulatory system for most of the workers under discussion in this paper where less burdensome requirements can meet the safety and quality checks needed to protect the community.*

OPTION 7: RESERVATION OF TITLE AND WHOLE OF PRACTICE

This model is the most restrictive form of regulation and includes not only offences for unregistered persons to use reserved professional titles, but also a broad 'scope of practice' definition of the profession in legislation and it is an offence for unregistered persons to practise the profession.

*This option is also **NOT** supported by the ANF as it is an even more unnecessarily onerous regulatory system for most of the workers under discussion in this paper where less burdensome requirements can meet the safety and quality checks needed to protect the community.*

2 Introduction

On 19 November 1895, Dr James Graham, a Member of the Legislative Assembly and a medical practitioner addressed the NSW Lower House in support of a Midwifery Nurses Bill. If the Government required licences for people to operate as cab-drivers, plumbers, or gasfitters, he said, then those carrying out the more important task of midwifery nursing should be at least similarly regulated.

NSW Nurses Registration Board 1998 p.9

2.1 The legal obligation of duty of care

2.1.1   In most cases, the law does not prescribe who may perform a particular health care task or role. However the law does insist there is a standard of care in relation to each task or role that will apply generally irrespective of who is performing it. For people working in a health or aged care setting there is no doubt that a duty of care exists. Therefore, it is imperative that they and their employer are confident they have the knowledge, skills and experience to perform their role, at the requisite moral, ethical and legal standard (Cox 2006 p.17).

2.1.2   Because of the vulnerability of the people who are cared for in the health and aged care systems and the inherent potential for harm in delivering their care. A comprehensive regulatory framework has evolved to manage this risk for most groups of health workers, especially those responsible for direct care and treatment. The role of this regulation has been primarily to achieve particular goals. These include:

   • the establishment of registers (databases) of all licensed health workers that can be searched by employers, community members and other persons seeking to establish the credibility of a person claiming to be qualified to provide a health service;

   • the setting of standards of education and practice to ensure that health care providers have the necessary job entry knowledge, skills, experience, health and character to provide safe and competent care;

   • providing a more and more robust method for routine review of a person's ongoing capacity to provide safe and competent care; and

   • providing a reporting and disciplinary system so action can be taken when a health worker's practice has the potential to place people under their care at risk, whether the cause is related to their inadequate ongoing professional development, health or conduct.

2.1.3   However there is an increasingly sizable proportion of the health workforce who work outside these comprehensive regulatory safeguards and who have the potential, because of their roles, to place the care and treatment of people in these systems at risk.

2.2 The health workforce

2.2.1   Table 1, though containing data from 2001, provides an abbreviated snapshot of the categories of registered health workers in Australia. The registration status remains similar in 2007.

Table 1: Numbers of health professionals by occupation

Occupation	Number of workers in 2001	Proportion of health workforce %	Percentage change between 1996 and 2001
Registered nurses/midwives *	174,000	38.7	7.3
Enrolled nurses *	19,000	4.3	2.7
Nursing assistants/personal carers ^	51,000	11.2	18.8
Medical professionals *	52,000	11.5	12.6
Dentists *	8,000	1.9	7.9
Dental technicians/prosthetists/assistants +	18,000	3.9	12.5
Pharmacists *	14,000	3.0	13.0
Other allied health workers • Podiatry + • Occupational therapy + • Speech pathology + • Aboriginal health work + • Chinese medicine + • Optical dispensing + • Chiropractic * • Physiotherapy * • Psychology * • Optometry * • Osteopathic *	39,000	8.6	26.5
Complementary health workers +	9,000	1.9	29.6
Radiotherapy and medical imaging, radiation and nuclear medicine workers +	8,000	1.8	25.0
Medical scientists ^	11,000	2.6	16.8
Ambulance officers/paramedics ^	7,000	1.5	12.5
Other ^	41,000	9.1	30.2
Total	**451,000**	**100.0**	**11.6**

Source: Productivity Commission 2005d p.xvi

* Registered or enrolled in each State and Territory
+ Some categories are registered in some State and Territories
^ Not registered in any State or Territory

2.2.2   The Productivity Commission Report on Australia's Health Workforce defines the health workforce in the following way:

The study adopts an expansive definition of the health workforce, with the term 'health workforce professional' defined to cover 'the entire health professional workforce', from a number of education and training backgrounds, including vocational, tertiary,

post-tertiary and clinical. ….examples of relevant occupations covered include: doctors, nurses, midwives, physiotherapists, podiatrists, pharmacists, psychologists, occupational therapists, dentists, optometrists, radiographers, Aboriginal Health Workers, ambulance officers and paramedics. Generally, people must be registered before they can practise in most of these occupations. (Productivity Commission 2005d p.2)

2.2.3   Despite this 'expansive definition' of the health workforce, the Productivity Commission's definition excludes a large proportion of the health and aged care workforce. Those health workers who are providing health care to often vulnerable client groups are generally not quantifiable or classified into health professional or other worker groups such as those listed above. These workers who have a plethora of titles ranging from 'personal care workers', 'direct care workers' 'paraprofessionals' and many other iterations, are not currently regulated or licensed under any comprehensive government sponsored framework.

2.2.4   Researchers who attempt to identify these workers, where they work and what they do, currently have enormous difficulty as there is no system that captures the full extent of this large and unstructured workforce scattered across numerous health care environments. The comprehensive 2002 report on the nursing profession, the National Review of Nursing Education: *Our Duty of Care,* argued that: …*without a common nomenclature it is difficult to count those contributing to nursing work and impossible to establish standards that cover their work* (Health 2002 p.46).

2.2.5   The authors of a National Institute of Labour Studies (NILS) research report: The Care of Older Australians: A picture of the residential aged care workforce, agreed that:

…the existing level of knowledge about workers in aged care is remarkably limited. No single data source provides an accurate and detailed appraisal of direct care employment in residential aged care facilities in Australia, especially not of the kind that would inform complex workforce planning. (Richardson and Martin 2004 p.1)

2.2.6   The survey was conducted as part of the NILS study referred to above estimated there were 133,000 direct care workers employed in aged care facilities in 2007, of whom:
- 84,750 were unlicensed personal care workers,
- 22,400 were registered nurses,
- 16,300 were enrolled nurses, and
- 9,875 were allied health workers (primarily diversional and recreational officers) (Martin and King 2008 p.9).

2.2.7   The impetus for this paper has come from the concerns expressed by nurses in relation to the lack of consistency in standards of educational preparation, competence and character for colleagues they share work with and whom they are often required to delegate work to, supervise and support. This paper focuses on the

unlicensed health workers such as the personal care workers in aged care, health and disability settings who are providing direct nursing and personal care to people of all ages who are ill, frail, injured or with multiple co-morbidities an/or diminished independence due to physical or psychological causation. This domain has long been recognised as 'nursing'.

2.2.8   There is little doubt when examining the work done by the many unlicensed personal care and health workers in Australia that what they do requires a level of knowledge, skill and judgment that traverses the needs and condition of the people in their care and that they are not merely automatons working solely at the behest of a registered or enrolled nurse. However there is an alternative and quite pervasive view that argues that these workers should not be caught up in the rubric of the profession of 'nursing'.

2.2.9   This opposing force is arguing that there should be minimal regulation for these workers and is particularly evident as coming from employer organisations who cite the difficulties that they have complying with the stringent limitations and requirements of the organised health professional groups. Employer groups contend that the traditional practices of these professional groups prevent innovation and flexibility necessary for better models of care. This group contends that the current legislative and common law safeguards that include: employer obligations to employ appropriate personnel; their common law duty of care to clients; the third party accreditation and review processes that most engage in; almost compulsory criminal record checking on recruitment of staff; the current stringent occupational health and safety obligations on employers; and the oversight of aged, health and disability complaint agencies; are a more than adequate range of mechanisms to protect the community from harm.

2.2.10   A more cynical view of this attitude is that the less organised and neglected that the workforce is, the more control, influence and power is vested in the employer. Also, an individual without a strong regulatory framework for their educational preparation, practice, conduct and ethics is more biddable and less likely to 'rock the boat' than a worker with professional obligations that are well known and consistent across the group.

2.2.11   In the current political climate, particularly at a federal level, this minimalist regulation or de-regulatory view has ascendancy over the arguments for a more cogent regulatory framework.

2.3   The protection of the public through licensure

2.3.1   The interest in regulating currently unlicensed health and aged care workers is not unique to Australia. Research is currently being conducted in the United Kingdom into the need for different and more comprehensive models of regulation for currently unlicensed health and aged care workers in order to protect the community, especially those who are vulnerable to exploitation and abuse (Duffin 2006; NHS Scotland

2006a, 2006b). There is also evidence that many of the states in the United States of America have broadened their regulatory role to include the licensing of support and assistant health and aged care workers. It has been recognised that the nature of this work has the potential to cause harm to people if the workers do not have an acceptable level of skill, knowledge, and experience to do the work (USA Department of Labor 2006).

2.3.2   It could be argued that registered and enrolled nurses in advocating licensing for the currently unlicensed workers are attempting to protect 'their patch'. However, as close observers with a very real professional interest and investment in the work being done by unlicensed health workers, nurses have an obligation and a responsibility to put forward their views which should not be ignored.

2.3.3   Reviews of the regulation of health professionals that have been conducted in each State and Territory as part of the application of the National Competition Policy have all determined that existing regulation of workers in the health industry, while anti-competitive, was in the best interests of the community. The work of personnel working in the health and aged care industries is identifiably capable of harm and therefore warrants a robust framework of regulation in order to minimise and manage harm if it occurs. This position was supported in the Productivity Commission's research on the regulation of the health workforce which is seen in their recommendation that regulation should be conducted at a national level in the interests of the community's safety, economic good sense, consistency and to enable greater mobility and flexibility in the workforce (Productivity Commission 2005a; 2005b; 2005d). This position has subsequently been endorsed by the Council of Australian Governments (COAG). National frameworks for regulation and the accreditation of educational courses for currently registered health professionals are to be introduced by 2008 (Council of Australian Governments 2008, 2006b, 2006c, 2006d).

2.3.4   Traditionally licensed health and aged care workers are being replaced by unlicensed workers. Since these workers are providing nursing care, for safety and quality reasons, an argument that unlicensed workers should not be licensed is unsustainable.

2.3.5   This paper argues there are a number of models for developing a more comprehensive regulatory framework for currently unlicensed workers in the health and aged care sectors. Models discussed include:
- that which will be introduced as part of the Productivity Commission recommendations for the currently regulated health professional workforce;
- a model that is being pilot tested in UK, Scotland; and
- other licensing models such as those that exist in the United States of America (USA).

2.3.6   Whatever the final outcome, the regulatory system must reflect the critical requirement of any regulatory system for health and aged care workers, which is to protect the community from harm.

3 Unlicensed Health Workers in Australia and Substitution of Regulated Workers

3.1 Unlicensed health workers and where they work

The HSU (Health Services Union) noted that 80 per cent of the people who directly look after residents in aged care are carers, not nurses. The level of training of carers varies significantly. The HSU stated that providers can and do use staff who have no training in aged care, with some even working alone at night. One carer stated:

'Personal carers come in and I cannot understand how on earth they got their certificate. Their basic English is not very good and nor is their understanding of looking after somebody. When you orientate them, although they have just got their PC 3 certificate they do not even know how to shower a person, how to wash them properly, how to toilet them properly or how to transfer them properly. Yet these people are being put into aged care to look after elderly people. There needs to be some sort of training outside before you enter them into aged care.

Senate Community Affairs Committee 2005 p.19

3.1.1   Unlicensed care workers are employed across a wide range of health and aged care settings in Australia and have a plethora of titles. They work in acute clinical care settings - in hospitals, day procedure centres and in primary care centres. They also work in the slow stream rehabilitation sector of the health system. They work in the residential aged care sector and residential disability care sector. They are also working in the community in home care, public health and aged care. They work with ambulance services and they are privately contracted by individuals to work in homes.

3.1.2   A 2004 workforce study by Health Professions Wales UK identified 147 titles for the role of a health care support worker in Wales alone (Robertson 2006 p.22). Some of the titles identified in the research for this paper are listed in Table 2.

3.1.3   There are undoubtedly many more titles and roles for people working as care workers in the health and aged care systems that are not represented on this list. This in itself highlights the challenge posed when there is no universal classification system or census process for being able to track or understand the specific issues in relation to the role, education and conduct of these individuals.

Table 2: Titles and terms for currently unlicensed health and aged care workers

- Aged person carer
- Allied health assistants and aides – physiotherapy, diversional therapy
- Anaesthetic technicians
- Assistants in nursing
- Assistive or support nursing personnel
- Care assistants
- Direct carers, workers or assistants
- Disabled person carer
- Health care - workers or assistants
- Health care support workers
- Home health aides
- Medical technicians
- Nurse aides
- Nurse assistants
- Nursing – aides, assistants, orderlies or attendants
- Long term care workers
- Para-professional long term care workers
- Paraprofessionals
- Para-medical health worker
- Patient care technician
- Personal - carers, workers, attendants or assistants
- Psychiatric aides
- Physician's assistants
- Residential care - workers or assistants
- Scientific support staff
- Scout and scrub – assistants or technicians
- Surgical dressers
- Surgical assistants
- Therapy assistants

> *Unlicensed healthcare workers are employed across the majority of health care settings, under a variety of titles*

3.2 The work these workers do

The ratio of staff to residents is said to be 2 to 11. All of those persons are employed as residential care workers. Some of these residential care workers possess the formal qualification of Advanced Certificate of Residential Services. Others possess no

formal qualifications, other than experience of life and empathy with disabled persons. None of the carers have any medical, paramedical or nursing qualifications or experience. They apparently accept full responsibility for their charges, who have complicated medical histories, and for reasons not fully understood by themselves follow certain routines which were put in place when the 'X' Residential Services was a nursing home. Being mature persons they know that the residents with complicated medical histories and physical problems could, if not properly cared for, become seriously ill. The care workers are very admirable women, performing an enormously difficult task in caring for the residents, but to my mind they have had placed on them a level of responsibility, for which their training is inadequate and in respect of which medical support or backup is again, totally inadequate.

State Coroner of Victoria 1994 p.3

3.2.1   The work that unlicensed workers 'do' ranges from domestic and maintenance tasks such as:

- housekeeping,
- laundry,
- gardening,
- household maintenance,
- social companionship,
- diversional activities,
- shopping, and
- transport;

through to assisting people with intimate personal care, including:

- hygiene,
- continence,
- skin problems and wounds,
- medications,
- assessing and monitoring health and capacity,
- mobility, and
- many other aspects of daily living for frail and dependent people;

and working and supporting health professionals working in operating theatre settings, outpatient clinics, and other acute care units.

3.2.2   Of the latter groupings, it is evident that the work that the greatest proportion of these unlicensed health workers 'do' is what has been traditionally identified as 'nursing'.

3.2.3   Whether the work is as a personal care assistant providing care to residents of a high care residential aged care facility or as an anaesthetic technician engaged in the assessment, ongoing observation and management of the person sedated or

anaesthetised during a therapeutic, surgical or diagnostic procedure; the clinical assessment, clinical judgment and actions that are required of the person in intimate contact with the care recipient is 'nursing'.

3.3 What is nursing?

3.3.1   A succinct and identifiable definition of 'nursing' has proved notoriously difficult to uncover. The Report of the recent project conducted by the Royal College of Nursing in the United Kingdom (UK) attempting to define nursing captures its illusory nature:

Nursing is experienced at some time by almost everybody. It is done by millions of nurses across the world, yet is still difficult to describe and is poorly understood. In 1859 Florence Nightingale wrote: the elements of nursing are all but unknown (Royal College of Nursing 2003 p.4).

3.3.2   The International Council of Nursing definition states:

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing role (http://www.icn.ch/definition.htm).

3.3.3   Nursing and other scholars however still struggle to capture the essence of 'nursing' in their work and there is constant frustration and confusion when governments commission inquiries into health and aged care that nursing work is not easily identified and described. *Our Duty of Care,* the final report of the 2002 National Review of Nursing Education was not able to come up with a convincing definition and retreated to making the statement:

Nursing is defined by its practice which, in turn, is characterised by distinctive traditions, skills, knowledge, values and qualities - that is, it forms a discipline. One of these values is 'caring'. Defining this intrinsic nursing value is part of the development of the discipline of nursing as it evolves to meet the emerging needs of the community. Articulating that value to the community is one of the challenges nursing faces as it evolves to respond to very different practice environments (Health 2002 p.45).

3.3.4   At the front line of health care (and extrapolated from that, aged care and disability services) there will always be the need to have a worker with a suite of skills, knowledge and experience that are recognisably to be found within the rubric of 'nursing':

There is little doubt that health services will always need a generic worker who is client-focused, possesses multidisciplinary skills, manages the care environment, delivers all but the most highly specialised services to the client, humanises the

system at the point of contact, and acts therapeutically as the experience is lived by the client. This is historically the broad, flexible role ascribed to those titled 'nurse' (Chiarella 2005 p.41).

3.3.5   The Public Health Regulations of the Code of Federal Regulations in the USA define a 'nursing facility' as:

§1396r (1): *'Nursing facility' means an institution (or a distinct part of an institution) which -*

i. *is primarily engaged in providing to residents -*

    a) *skilled nursing care and related services for residents who require medical or nursing care,*

    b) *rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or*

    c) *on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases* (USA Code Collection 2007).

3.3.6   This same regulation defines a 'nurse aide' as:

§1396r (5)(f): *…….any individual providing nursing or nursing-related services to residents in a nursing facility, but does not include an individual -*

i. *who is a licensed health professional …. or a registered dietician, or*

ii. *who volunteers to provide such services without monetary compensation* (USA Code Collection 2007).

3.3.7   The important distinction here that is critical to the issues being dealt with in this paper is in the description of: *health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board)* (Centres for Medicare Medicaid Services and Department of Health and Human Services 2007).

3.3.8   This same Code is explicit that anyone *providing nursing or nursing-related services to residents* (ie a nurse aide) must be adequately trained.

§1396r (5)(a): *- a nursing facility must not use on a full-time basis any individual as a nurse aide in the facility on or after October 1, 1990, for more than 4 months unless the individual,*

i. *has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A) of this section, and*

ii. *is competent to provide nursing or nursing-related services* (USA Code Collection 2007).

3.3.9   The Code took this regulatory safeguard one step further when in 1987 new conditions for regulating nursing homes introduced a requirement for each State to establish a nurse aide registry. Now referred to as Certified Nursing Assistants (CNAs), there is a major push on in the USA to improve the training and competency evaluation program for these certified nursing assistants (Rehnquist and Office of Inspector General 2002; USA Department of Health and Human Services 2004; Hernandez-Medina et al 2006).

3.3.10   In this Code it is unequivocal that most persons providing care in high care residential care and aged care facilities are providing 'nursing care'.

3.3.11   In a recent decision in the Australian Industrial Relations Commission, Senior Deputy President Williams says:

….I confirm my view that the terms 'nursing care' and 'nursing service' encompass any care or services provided in the course of the provision of care to persons either in need of medical or health care and/or in need of assistance with daily living. I am also of the view that the work performed by persons who are employed to provide or assist in the provision of nursing care or nursing services or both, to persons in, or receiving services from, private and/or not for profit residential aged care facilities… is work that falls within the term 'nursing industry' (Australian Nursing Federation 2004 p.16).

3.3.12   This decision was in response to a phenomenon that has been insidiously creeping into the dialectic around aged care in Australia, notably over the last decade, that older people requiring residential care because they are unable to live independently in their own homes because of their frailty, health and mental state do not require highly skilled personnel, *but instead would be looked after by people who simply 'care' in a cosy, yet 'home-like' environment* (Dulhunty 2002 p.6).

3.3.13   A view has developed that if a role is re-named, eg 'personal care assistant', it takes the nursing out of the role. This has led to a fallacious distinction being made between nursing and 'meeting lifestyle needs', 'personal care support' and many other euphemistic references to what has traditionally been recognised as nursing work, requiring a level of skill, knowledge and experience to undertake. The community identifies the work as nursing, hence the need for nursing organisations such as the Australian Nursing Federation to seek judicial recognition of the role as nursing. The next step is to ensure that this 'nursing' is performed by adequately educated personnel with safeguards available to the community if the worker's conduct, performance or health comes into question.

Unlicensed health care workers are doing nursing work

3.4 Skills and educational preparation for the unlicensed care workforce

Training care workers - particularly those who provide home care - becomes more important as medical advances permit more persons with complex needs to live in the community rather than in specialised institutions. Training - whether in the classroom or the workplace - also is necessary to provide the horizontal and vertical career mobility that will keep workers in the profession.

Moreover, the care worker's frontline role needs to be recognized in service delivery. A better paid and better trained workforce will provide better care, which should be the ultimate goal of workforce policies.

Care work is often 'invisible' work. Care workers may be low-paid, part-time, or temporary workers, and in the case of home care workers, may not have a usual workplace where they can receive professional supervision, collegial support, and training. But these workers are not invisible to their growing ranks of clients. The findings of this report suggest that improving the economic and professional status of these workers is likely to improve the quality of care as well.

Korczyk 2004 p.v

3.4.1   The educational level of much of the unregulated health workforce is difficult to pinpoint as there are so many different titles, roles and work settings. In most settings there are no specific levels of educational preparation required to do the work, including working in aged care, an area where there is a large unregulated health workforce with essentially well understood roles. While vocational education at Certificate 3 or 4 level in aged care for unlicensed care workers is supported by many providers, there is evidence that this support is not industry wide; and that it may not be adequate for the role these care workers have.

3.4.2   Professor Rhonda Nay, a recognised expert in aged care said while giving evidence in a coronial hearing into the death of a resident of a residential aged care facility:

The current international nursing shortage has not been avoided in Australia; typically aged care faces greater difficulties in attracting and retaining qualified nurses. Because of the long-held general perception that aged care did not require specific skills the majority of staff currently working in the field have less than ideal educational preparation (State Coroner of Victoria 2004).

3.4.3   This is supported by the research reported in workplace training practices in the residential aged care sector:

The majority of workers employed in aged care bring a wealth of life skills to the job. An assumption that life experience and an attitude of commitment is sufficient for these workers to be effective and efficient in the workplace has prevailed, although increasingly, more personal care workers have undertaken training to Certificate 3 level (Booth et al 2005 p.16).

3.4.4   The changing profile of residents in the aged care sector demands that care workers in aged care have training in areas such as manual handling, communication and negotiation skills; dealing with challenging behaviour; and assisting with medication. The major vocational education qualification for personal care workers in the industry is the Certificate 3 in Aged Care Work (Booth et al 2005 p.6). In the high level review of training packages it was mooted that aged care workers will require *the acquisition of new interpersonal and highly context bound skills as well as those more readily transferred'* (Australian National Training Authority 2003 p.30). Personal care workers are currently covered by the educational standards and qualifications set out in the revised Community Services Training Package CHC02 (Booth et al 2005 p.17) (http://www.cshisc.com.au/load_page.asp?ID=23) and the Health Training Package HLT07 (http://www.cshisc.com.au/load_page.asp?ID=234).

3.4.5   The research conducted by NILS showed that 64.4% of personal care workers have a Certificate 3 in aged care and 13.3% have a Certificate 4 in aged care (Martin and King 2008 p.16). On the face of it, this is an impressive record. However, another recent study challenges this, finding only 35.66% of personal carers had vocational training; with 33.55% of personal carers reporting they had not completed year 12 (making their highest educational level year 10). This study also brings into question quality and adequacy of the education received by personal carers (Jones et al 2006 p.8).

Table 3: Post-school qualifications of the residential aged care workforce, by occupation (per cent)

Post-school qualification	Nurse		PC		Allied Health		Total	
	2003	2007	2003	2007	2003	2007	2003	2007
No post-school qualifications	5.6	11.8	16.4	23.7	17.1	17.9	12.8	19.8
Certificate III in aged care	7.1	9.7	65.9	64.6	25.5	36.9	42.9	46.6
Certificate IV in aged care	4.9	5.2	7.9	13.3	9.3	17.5	7.0	11.3
Certificate IV/diploma in enrolled nursing	26.6	35.1	2.9	3.4	2.9	2.5	11.0	12.5
Bachelor degree in nursing	23.6	28.3	1.7	1.6	3.9	0.6	9.3	9.3
Other basic nursing qualification	34.6	21.4	7.3	3.8	8.3	4.6	16.7	9.0
Post basic nursing qual in aged care	13.2	10.0	2.8	0.7	3.4	0.8	6.4	3.4
Post basic nursing qual not in aged care	16.2	15.1	1.9	1.1	2.4	0.2	6.8	5.1
Other	9.0	12.3	9.8	13.7	49.2	44.7	12.4	15.6

Source: Martin and King 2008, p.16.

Note: Because staff can have more than on qualification, the totals do no sum to 100. Figures for 2003 have been adjusted to use same weighting principles as 2007

3.4.6   In the report of a *Study into the Demographics, Training and Workplace Experience of Personal Carers in Residential Aged Care Facilities* in the Australian Capital Territory, the authors found that due to the combination of the very limited specialist services for aged care residents with mental health issues and the declining numbers of registered and enrolled nurses, the education and training of front line care workers in these facilities was critical. The study focused particularly on the problems of cognitive decline and functional mental illness for an increasing number of older people who live in residential aged care facilities and the challenges this posed for the majority of the workforce in those facilities - the personal care workers. In the study the researchers identify the primary care activities carried out by these care workers as those physical tasks usually identified as nursing, but they also identify their important roles as the conduit between resident, the resident's family, friends or significant others; as well being the main line of communication between the responsible nurse or manager of the facility:

That is, personal carers convey vital information to those in charge in relation to the mental, physical and psychological state of the resident. Personal carers clearly spend most of their working day with residents, so they are strategically placed to observe changes in the latter's presentation. With regard to disorders of cognitive functioning it is vital that any changes in behaviour are identified and brought to the attention of more senior staff. These behavioural changes may be indicative of a worsening dementia, a depression or an anxiety state or, of greater concern, a delirium or a psychotic illness. Personal carers are strategically placed to identify such changes. Timely intervention and good outcomes for residents depend on swift and accurate identification of changed mental status by those who provide direct care to elderly residents in aged care facilities (Jones et al 2006 p.4).

3.4.7   However in their research the authors found:

… personal carers receive very little training in either mental illness or dementia care on commencing work at a residential aged care facility. In the current study only 17.48% received training in mental illness and 32.16% received training in dementia care. Given the frequency of mental health problems encountered in residential aged care, particularly problems of depression but also, to a lesser extent, mood disorders, anxiety states and even psychotic illnesses such as schizophrenia and paranoid disorders, this is especially cause for concern. Once having begun work, however, the reported training in both mental illness and dementia care, decreases so that only 11.18% reported ongoing training in mental illness and 23.07% reported ongoing training in dementia care. (Jones et al 2006 p.10-11).

3.4.8   In dementia specific facilities where the most profoundly cognitively impaired residents live, the findings are even more concerning:

Within dementia specific units problems such as delusions, hallucinations, verbal and physical aggression, agitation, wandering, pacing, hoarding, and sexual disinhibition,

compound with the physical deterioration that accompanies the dementia profile, to create a particularly confronting caring environment. However, and paradoxically, carers who identified a dementia specific unit as their primary work location reported (for the most part) even less education and training in both mental illness and dementia care than those who worked in other areas of the residential care environment. In the current study only 16.6% received training in mental illness and 31.25% received training in dementia care at the commencement of work. Again, as with those in other areas of residential care, once having begun work, the reported training in both mental illness and dementia care, decreased so that only 6.25% reported ongoing training in mental illness and 29.16% reported ongoing training in dementia care (Jones et al 2006 p.11).

3.4.9   The study found that personal carers reported a high level of verbal and physical abuse from residents and as well, they were also subjected to a level (although to a lesser extent) of verbal abuse from the relatives or friends of residents. Most concerning are the findings that, after an incident involving verbal or physical abuse from residents, family or friends of residents, it was rarely reported to management (8.39%) or a direct supervisor (4.89%). The most prevalent action was to tell a colleague (27.27%), although 16.78% of carers reported they took no action. Incident forms were completed in only 23.78% of incidents.

3.4.10 The capacity for any health workers to deal with and appropriately report such challenging behaviour requires a strong foundation of knowledge, skill and experience that is part of specialist educational programs. Registered and enrolled nurses who have the educational preparation to equip them to work with people with mental health illnesses, dementia and in psycho-geriatric care settings report that working in these settings is physically, emotionally and psychologically taxing. The risks for both the cared for, and the carer, when the carer is not skilled in this highly specialised area are profound. Subjected to physical and verbal aggression without the portfolio of skills to manage such behaviour the researchers found that:

Apart from impacting negatively on the physical and emotional wellbeing of individual carers, resulting in a deterioration in physical and psychological health, absenteeism and high staff turnover, there is evidence to suggest that carer burnout can lead to reduced levels of care for those, not only with challenging behaviours, but those in care generally (Jones et al 2006 p.12).

3.4.11 The example this study provides highlights the disconnect between the assumption that to provide care in a residential aged care facility minimal skills are required and the high risk and the extremely challenging care environment that exists in aged care where it is clear that higher level skills are required for personal care workers to manage the dementia and psychiatric disorders that afflict many residents.

3.4.12   Booth et al identified other factors specific to the aged care workforce that impact on the need for training. The first of these is in relation to the areas of culture and language. They note the census data from the NILS study in relation to workers in aged care that shows that 19% of personal care/nursing assistants are from non-English speaking ethnic or cultural groups, while only a very small proportion of workers identify themselves as Indigenous (Healy and Richardson 2003 p.22). They also identify that some of the workers from non-English speaking backgrounds are likely to have quite specific training needs, eg if their English level is not adequate in terms of reading drug administration information or specific procedures (Booth et al 2005 p.16).

3.4.13   Another issue that emerged from the NILS study relates to the turnover of workers within the industry (Martin and King 2008). The study reflects on the effects of a quarter of the personal care workforce having to be replaced each year. In their study, Booth et al say:

It is difficult to determine the ramifications of this 25% annual turnover in the personal care workforce, particularly as a large number of these workers leave the industry, while many others leave one facility to work in another, or move to a different sector or role within aged care.

There is a high proportion of workers identified through the same survey (about 48%) who have been employed for between one and five years. Another group of long-term employees (26%) have worked in the industry as personal carers for more than six years. However, the mobile high turnover segment of the workforce means that new training programs will have to be provided on a continuous basis (Booth et al 2005 p.16).

Table 4: Tenure in current job of the residential aged care workforce, by occupation (per cent)

Tenure in current job	Registered Nurses		Enrolled Nurses		PCs		Allied Health		Total	
	2003	2007	2003	2007	2003	2007	2003	2007	2003	2007
Less than 1 year	21.4	21.4	17.5	18.8	26.0	27.8	23.5	22.6	23.7	25.2
1 to 5 years	41.2	43.8	39.4	39.3	48.1	48.5	45.9	47.6	45.3	46.5
6 or more years	37.4	34.8	43.1	41.8	26.0	23.7	30.6	29.8	30.9	28.4

Source: Martin and King 2008, p.20.

3.4.14   A third area for concern identified by Booth et al is the increased sophistication in the documentation required to meet the accreditation standards and to provide the necessary evidence to claim funding from the Australian Government through the Aged Care Funding Instrument (formerly the Resident Classification Scale). This has necessarily placed additional demands on personal care workers, many of whom have been identified as having literacy difficulties (Booth et al 2005 p.17).

3.4.15   Another critical area cited by Booth et al relates to the training that is:

... required to meet increased quality service standards and good business practice. Aged care, like all successful businesses, needs to provide responsive and flexible solutions to customer needs. In service organisations such as aged care, this provides particular challenges, where the quality of service in individual transactions between 'servers' and customers is inherently subjective and personal and not as easy to measure as tangible indicators such as waiting lists (Booth et al 2005 p.18).

3.4.16   Finally Booth et al note that: *approaches to 'ageing well' and 'healthy ageing' require workers to have skills in planning and facilitating recreation activities* (Booth et al 2005 p.17).

3.4.17   The challenges that providing services within this changing environment pose: calls for a fluid, multi-skilled workforce with flexible, broadly applicable skills which equip them to work effectively in multi-disciplinary and/or multi-cultural teams where the focus of their work is on prevention and early intervention (Booth et al 2005 p.17).

3.4.18   A sound risk management perspective requires direct links between this education and training; the code(s) of worker conduct and ethics; and the obligations of employers to ensure the standards of education and training are adhered to rigorously in order to ensure competent care for consumers. However there is currently no such framework for care workers in the aged and health industries if they are not registered. The commitment to consistent educational preparation and ongoing training and development is not an embedded obligation for employers and the evidence shows that this is at best, patchy.

3.4.19   A number of social, economic, political and professional issues have been identified as contributing to the increasing use of unlicensed workers in the health and aged care systems providing care that has traditionally been provided by registered and enrolled nurses. These include:

- cost and productivity,
- workforce supply and demand, and
- political leverage.

> ## *Currently unlicensed health care workers require limited training and preparation to undertake their role*

3.5 Cost and productivity

3.5.1   In most organisations, the cost of providing direct, nursing or personal care has traditionally been the greatest expense in the annual budget. Therefore it has been the most identifiable target for cost savings and rationalisation. While efficiency drives,

work transformation initiatives, pushes for 'working smarter not harder', skill mix reviews, and other such strategies are a feature of many contemporary industries, the focus in health and aged care has been more on reducing the labour costs of direct care without the countervailing attention to the quality and safety of the care being provided. Productivity and improving care and treatment should always be a priority for any health, aged care and disability service, but the safety, appropriateness and effectiveness of care must always balance the efficiency of treatment and care. Each is a significant indicator of the value that the community places on safe, ethical care.

3.5.2   Supporting a skilled and organised workforce with consistent standards of education, practice and conduct comes at a cost, however the concomitant cost of the risk to community safety must be factored in. The reputation and financial costs of community outrage when frail, vulnerable, injured and ill people are harmed, neglected, exploited or dealt with improperly; and those resulting from damages awarded in a legal action for breach of duty of care; can ultimately be significantly higher.

3.5.3   These cost and productivity initiatives have been an obvious cause for the gradual replacement of higher cost professionals with lower cost workers. The health professional workforce shortages that are manifest across the health and aged care industries have provided an additional catalyst and excuse for this transition, as it can also be justified on the grounds of necessity.

> ## *Cost of the care giver versus risk to the care recipient*

3.6 Workforce supply and demand

3.6.1   The challenge of ensuring there is a sustainable health and aged care workforce in the future is a national and international concern. There is strong evidence the population's need for a sizeable health workforce is likely to rise as the 'baby boomers' age and their health needs increase (Productivity Commission 2005a; 2005b; 2005c; 2005d). However the evidence is that the required health workforce is not, or will not, be available to meet this challenge. Health care workers are representative of the same population and many are also heading toward retirement age. Even if the traditional retirement milestones shift, the burden of the physical and emotional nature of much direct care work is such that few staff can sustain it beyond a certain age. Indeed, the workforce data shows that this workforce is already primarily part-time, particularly in the aged care sector because of its physical and mental demands (Richardson and Martin 2004 p.20).

3.6.2   This demographic profile is particularly evident in the nursing profession. For example between 1995 and 2001, the number of full-time equivalent nurses per head of population declined markedly. Data from 2005 indicate this decline has slowed and there has been an increase from 1031 full time equivalent nurses per 100,000 population in 2001 to 1133 in 2005 (Australian Institute of Health and Welfare 2008 p.viii). However the data also indicate a continued ageing of the employed nursing labour force that is alarming, with the average age increasing from 42.2 years in 2001 to 45.1 years in 2005 (Australian Institute of Health and Welfare 2008 p.viii). The proportion of nurses who are over 50 years old was 35.8% in 2005 up from 24.4% in 2001 (Australian Institute of Health and Welfare 2008 p.viii). This represents a serious and growing threat to the capacity of Australia's health system to meet the future health care needs of the population.

3.6.3   The ageing nursing workforce is compounded by data showing that almost half of the nursing workforce (49.8%) is working part time (Australian Institute of Health and Welfare 2008 p.viii). It is no surprise that nurses are seeking to achieve a better balance between high stress nursing work and family commitments by working fewer hours, either by working shorter work days or by working fewer days in a week. With the existing shortfall and the propensity for part time work there is a need to significantly increase the number of students entering nursing education to maintain the existing number of nurses in the workforce.

3.6.4   The average nurse in Australia in 2005 was over 45 (Australian Institute of Health and Welfare 2008), working part-time and contemplating retirement at age 55. This paints an alarming picture for the future of the nursing workforce. Unless urgent action is taken to educate more nurses, it is clear there will not be enough to provide for Australia's ageing population in the future.

3.6.5   Over the next ten years, Australia will require up to13,500 new registered nurses each year to meet the increasing demand for nursing services that the ageing population will bring (Australian Health Workforce Advisory Committee 2004; Hogan 2004). However figures from the Council of Deans of Nursing and Midwifery (CDNM) demonstrate that this target is unlikely to be met. According to the CDNM, 9,675 domestic students commenced undergraduate nursing courses in 2005; 10,246 in 2006 and 12,356 in 2007 (Council of Deans of Nursing and Midwifery 2007 p.10). In 2005, 6103 students completed their course, 6814 in 2006, and 7299 are expected to complete in 2007 (Council of Deans of Nursing and Midwifery 2007 p.13).

3.6.6   It is well recognised that aged care workers such as registered and enrolled nurses and other licensed health workers are being replaced by unlicensed health and aged care workers for a number of reasons, including nursing workforce shortages. Given the reasons, it is difficult to sustain the argument that alternative workers should not also be licensed for safety and quality reasons. The National Institute of Labour

Studies' (NILS) unique research into the residential aged care workforce demonstrates the vast majority of workers in these settings are unlicensed health care workers:

…staff who provide direct care in aged care facilities are predominantly personal carers (PCs) and it is likely that their share of all jobs is rising: 57 per cent of all staff and 64 per cent of recent hires are PCs. The next most numerous group is registered nurses at 22 per cent. Enrolled nurses comprise 13 per cent. The proportion of both types of nurse is lower amongst the recently hired. Diversional therapists and recreation officers are the other sizeable group, comprising the bulk of the allied health group and about 8 per cent of all direct care staff (Richardson and Martin 2004 p.19).

Table 5: Distribution of aged care workforce, and new hires by occupation (%)

OCCUPATION	DATA FROM EMPLOYEES		DATA FROM FACILITIES	
	Whole workforce	New hires	Number of persons	Equivalent full-time
Registered nurse	21.6	18.0	21.0	21.4
Enrolled nurse	13.0	11.0	13.1	14.4
Personal carer	57.1	64.0	58.5	56.5
Allied health	8.2	5.7	7.4	7.6
Total number			**115,660**	**76,006**

Source: Martin and King 2008 p.19

3.6.7 The study estimates that only 8% of personal care workers are permanent full-time workers with the highest proportion being permanent part-time employees. The same study shows that 94% of aged care workers are women and 57% are over 45 years. This figure is commensurate with the age of nurses and midwives but high when compared with 33% of workers over 45 years across the broader Australian workforce (Booth et al 2005 p.15).

3.6.8 The set of goals developed by Australia's health ministers that underlie the vision for the Australian health workforce for the first part of the 21st century has been developed to ensure Australia has an available and appropriate health workforce into the future. Table 4 below outlines these seven goals.

Table 6: Goals for the Australian health workforce

1. **Population and health consumer focused**

   able to deliver safe, appropriate, quality care that maximises health outcomes, improves the health and well being of the Australian community and accommodates community expectations, all within a population health framework;

2. **Sustainable**

   in terms of service and financial sustainability and ensuring there is adequate workforce supply, both now and into the future;

3. **Distributed to achieve equitable health outcomes**

   to ensure equitable access to health care regardless of location;

4. **Suitably trained and competent**

   appropriately educated with continuing maintenance and improvement of professional competence;

5. **Flexible and integrated**

   able to undertake multiple tasks, work in community and/or institution based settings and in multidisciplinary teams, but that work-life balance is respected;

6. **Employable**

   optimal use can be made of available skills and new skills taught;

7. **Valued**

   career satisfaction is maximised and work is undertaken within a supportive environment and culture.

Source: Australian Health Ministers' Conference 2004 p.13

3.6.9   Currently it is difficult to place the unregulated health workforce clearly within these goals as it is hard to identify so many different classifications as a defined class of worker and there are few drivers to ensure their integration into the broader health workforce is achieved. Their education and training is erratic and as Booth et al identified: *… in some parts of the industry, these workers are disparagingly referred to as 'blue collar' workers, 'people off the streets', 'unregulated' and 'untrained'.* Far from being a 'valued' part of the health workforce Booth et al go on to suggest that: *…this could be a factor in retention of staff within the industry. Training is therefore an essential feature of a strategic human resources approach to workforce development, one which seeks to create a workplace culture capable of delivering the range of quality services needed by the ageing population* (Booth et al 2005 p.18).

> ## *Unlicensed health care workers are replacing nurses*

3.7 Policy and politics

3.7.1   At a time when de-regulation, reducing the regulatory burden and an anti-competition ethos are embedded in national, state and territory government policy, there has been little political will to embark on further regulation where it can be avoided. Private sector employers in the health and aged care systems have been activists in arguing for minimal encumbrance on their rights to run their organisations as they desire, without the burden of legislation that governments impose.

3.7.2   However there has been a constant and increasing body of consumer concern and professional disquiet in relation to areas of the unregulated health workforce, particularly the aged care sector. Largely reported through the conduit of the media and websites such as: http://www.agedcarecrisis.com; the reports of the Aged Care Standards and Accreditation Agency; as well as the individual stories of older persons, their families and friends (Davies 2004; Aged Care Crisis Team 2006; Paine 2006a; Stafford 2006; Strutt 2006).

3.7.3   Examples appearing at regular intervals include:

- *Under-trained staff didn't recognise when residents were nearing death - meaning loved ones weren't contacted until just before or after death …*

- *The home was found to be 'non-compliant' in medication management, pain management, palliative care, nutrition and hydration, behavioural management, skin care, staff education, leisure activities and fire and emergency plans.*

- *The home does not have sufficient levels of skilled staff to deliver basic care that is consistent, individualised … and reflects quality service.*

- *There is one registered nurse to provide staff supervision and specialised nursing care to 66 residents, 49 of whom require a high level of care during the afternoon and night shift.*

- *Documentation in eight of 22 incidents reviewed from December to March 2006 clearly infers resident blame for the incident.*

- *Dying residents do not have their palliative care needs assessed or documented.*

- *Staff knowledge of the dying process, changes in behaviours and experience of pain is limited* (Paine 2006b p.1-2).

- *… another inspection team audited the hostel and found it to be in breach of 13 standards, finding that … none of the personal care staff had been assessed for competency in relation to safe drug management. There had been a number of instances, the auditors noted, where either wrong medications or incorrect dosages had been given* (Davies 2004 p.6).

3.7.4   As well as these examples relating to the lack of education, skill and experience are the sad cases of assault and abuse that have finally led the Australian Government to take action to check the criminal records of staff, contractors and volunteers in the aged care industry (Australian Government Department of Health and Ageing 2006).

3.7.5   It is a sad indictment of policy planning that scandal and crisis have to be the imperatives that drive policy change and political action.

3.7.6   Some of the impetus for the work being done by the Australian Nursing Federation (ANF), the Australian Nursing and Midwifery Council (ANMC) and the state and territory nursing and midwifery regulatory authorities in relation to unlicensed health workers and the scope of nursing practice can be traced back to the concerns of licensed nurses having to supervise often large teams of under educated, unlicensed health workers (Australian Nursing Federation 2007a, 2007b, 2005; Paine 2006a; Nursing Board of Tasmania 2006; Nurses Board of South Australia 2006, 2005, 2003a, 2003b, 2002; Queensland Nursing Council 2005; Nurses Board of Western Australia 2004; Ellis 2003). As yet this voice has been largely unheeded at the level of government, labelled anti-competitive, and dismissed by employer organisations in the aged care industry.

> ## *A policy of deregulating the health care workforce risks reducing the standards of care*

3.8 Case mix and care needs of client groups

3.8.1   In hospitals, both the decline in the length of stay and the higher acuity of people who are hospitalised has changed the nature of the work for most health workers, increasing the workloads as well as the physical and mental stressors for most. From 2001-2002 to 2005-2006 the number of admissions to hospitals increased from 6.4 million to 7.3 million (Australian Institute of Health and Welfare 2007). Another example is that in 1990 the average length of stay for someone having coronary artery bypass surgery was 8-10 days. However today a person is in hospital for 3-5 days and the intensity of their care is high for the entire time they are there (Krapohl and Larson 1996 p.101). Hospitals are no longer places for convalescence. They are places where a high level of competence, including knowledge, skills and experience are essential to care for very ill people in a highly technologically enhanced environment where a failure of clinical judgement can have dire consequences.

3.8.2   The profile of residents entering aged care facilities has also changed. As a result of the policy of 'ageing in place', introduced under the Aged Care Act 1997, residents entering aged care facilities are now older and more dependent when they enter facilities and require more intensive care. There are also tensions created by providers who seek to maximize government funding by increasing their intake of high care residents. This changes the casemix for residential aged care facilities considerably, increasing the workloads for residential aged care workers. Increasingly residential aged care facilities are occupied by residents with very high care needs

related to their chronic and numerous physical illnesses, the disabilities of ageing, or advanced dementia. These people require competent, safe care from educated, skilled and experienced care givers.

3.8.3   Even the profile of people being provided with care in the community is changing. Hospital in the home initiatives, Community Aged Care packages (CACPs), Extended Care at Home packages (EACH) and an increasing demand by the community to remain at home as their independence diminishes and care needs increase has meant a dramatic increase in the provision of home care services of all types.

3.8.4   Together with the fact that people are living longer and consuming more acute health and aged care resources in the last years and months of their life, there is a growing demand for both the amount and sophistication of nursing type care (Krapohl and Larson 1996 p.101).

3.8.5   In recent years, while there has been an increase in registered and enrolled nursing numbers in the acute care sector, the acuity of care required and provided has also risen exponentially. However in the aged care sector where there has been a notable decrease in the number of registered and enrolled nurses, resident acuity levels are also increasing alarmingly. This means the burden on nurses remaining in the aged care workforce has increased significantly. This has been exacerbated by the responsibilities that they have to carry in relation to supervising and delegating responsibilities to a lesser skilled and knowledgeable workforce.

> *The increasing acuity of older Australians is in direct contrast to falling skill levels of their care givers*

3.9   Consumer expectations

3.9.1   The Australian community has become increasingly knowledgeable and discriminating about the health care they require and many are playing a more active role in the decision making about their health care (Krapohl and Larson 1996 p.101). This is reflected in health policy at a government level across all jurisdictions in Australia. There is now a recognised need for consumer participation in health and aged care service planning, policy and evaluation as well as partnerships between consumers and health and aged care providers. This is apparent in the multiple layers of health and aged care policy from the highest level to the local service level.

3.9.2   Health professionals no longer have 'patients' who traditionally were treated as passive recipients of care. Today, health consumers, their families and friends have strong and strident opinions about the safety and quality of care that is expected in

the health and aged care systems. Over the past 15 years independent health and aged care consumer watchdog agencies have been set up in every jurisdiction in Australia to deal with complaints from the community about the quality of care and services they receive. The federal, state and territory governments have all invested significantly in improving the relationships between health and aged care services and the consumers of those services. This is demonstrated by the creation of the Consumer Focus Collaboration; the inclusion of consumers on quality and safety committees and councils; and the increasing focus on consumer satisfaction (Draper and Hill 1995; Draper 1997; Flinders University 2000; National Resource Centre for Consumer Participation in Health 2000; Global Learning Services Pty Ltd 2000a; 2000b; Consumer Focus Collaboration 2001; NSW Department of Health 2001a; Australian Council for Safety and Quality in Health Care 2003).

> *Consumers of health care services are becoming increasingly involved in the care that is provided to them*

4 Current Regulation of Health and Care Workers

4.1 Frameworks for the regulation of health professionals

4.1.1 Across Australia, the regulatory framework in which the health and aged care workforce operates is extensive, complex and ranging across a number of systems and jurisdictions.

4.1.2 A number of health professional groups have been brought into a comprehensive professional registration system over the last century and a half, as seen in this description by the Productivity Commission:

...in broad terms registration is the process of legally recognising practitioners' qualifications, experience, character and fitness to practice. Its purpose is to provide assurances of quality and safety, helping to overcome the information asymmetry between health professionals and patients' (Productivity Commission 2005d p.134).

4.1.3 In NSW the first statute for the registration of medical practitioners was passed in 1838 but it was not until 1924 that the NSW Parliament passed the Nurses' Registration Act, also covering midwives. Tasmania and Western Australia legislated to regulate midwives in 1910. Queensland established the first nurses' registration board in Australia in 1912 (NSW Nurses Registration Board 1998 p.6-7). The impetus for the establishment of the system of regulation in NSW is described as:

Patient death, which had been the catalyst for setting up a registration system for medical practitioners, also played a part in achieving regulation for nurses. It was fear of a shrinking population in NSW, a falling birth-rate and high levels of maternal and infant mortality that prompted concerned citizens to seek governmental control of midwives (NSW Nurses Registration Board 1998 p.8).

4.1.4 The evolution of the enrolled nurse in Australia is a useful parallel to the issues relating to the unlicensed direct care workers in this paper. In NSW, assistants in nursing were originally introduced to fill a perceived temporary shortage of registered nurses. A debate relating to the regulation of this category of health worker continued from 1944 when the Kelly Committee on the Status of the Nursing Profession met to discuss the need to regulate assistants in nursing until the legislation to enrol assistants in nursing commenced in February 1958 (NSW Nurses Registration Board 1998 p.72). In 1960 the legislation was amended and the title for these workers changed to nursing aides. The transition to the title of enrolled nurse occurred under legislation commencing in 1958 (NSW Nurses Registration Board 1998 p.114). This second level nurse is titled 'enrolled nurse' (Registered Nurse Division 2 in Victoria. This register is currently transitioning to become part of the Register of Health Practitioners under the Health Professions Registration Act 2005).

4.1.5   This form of regulation for health professionals is enshrined in statute (legislation) and is administered by State and Territory Governments through statutory registration boards or councils. Professions subject to registration are outlined in Table 1 and include nurses, midwives, medical practitioners, dentists, pharmacists, physiotherapists, optometrists, osteopaths, chiropractors and psychologists. Across Australian there are nine registered health profession occupations and approximately 90 registration bodies for health workers (Productivity Commission 2005d p.358).

4.1.6   This regulation is primarily aimed at protecting the community by determining who can work in specific health occupations; by establishing standards of educational preparation and professional conduct and practice; and by monitoring the conduct, health and performance of individual practitioners within these occupations.

4.1.7   For some professions, requirements vary across jurisdictions. For example occupational therapists are only required to be registered in Queensland, Western Australia, South Australia and the Northern Territory. Those wishing to work in the other States or Territories, particularly in the public health system, would simply be expected to have qualifications acceptable to OT Australia, the professional association for occupational therapists. In the case of Chinese medicine, only Victoria requires practitioners to be registered (Productivity Commission 2005d p.358).

4.1.8   Those professions (such as occupational therapists in the jurisdictions where they are not subject to statutory registration) are generally subject to self-regulatory arrangements administered by the peak health professional organisations. While these systems do not have the same legal mandate of the statutory systems, they do have strong credibility across the industry and members of the community are urged to ensure that any health professional they contemplate consulting who does not come under the auspices of a statutory registration scheme is a member of their professional body.

4.1.9   This form of self regulation tends to mirror the statutory registration systems. It is also primarily aimed at protecting the community by setting requirements for who can work in the specific health professional groups by establishing standards of educational preparation and professional conduct and practice and to some extent, having a role in over sighting the roles and responsibilities of those within these occupations (Productivity Commission 2005d p.358).

4.1.10   These self-regulatory arrangements also provide another layer to the registration processes for registered health professionals with speciality qualifications through their peak professional bodies, such as in the case of specialist medical colleges, where the specialist qualification is regulated through policy of the professional organisation (Productivity Commission 2005d p.358).

4.1.11   However for an increasing number of unregulated health and care workers there is no such professional or occupation based regulatory framework or worker collective such as an association that can be identified as pertaining to their distinct group. As with the professionally regulated professions, these workers are also subject to the safeguards provided by other protective checks and balances of the service delivery environment. These include occupational health and safety legislation; governance arrangements and employer obligations; funding requirements; education and training initiatives; third party safety and quality review standards (such as those used by the Australian Council on Health Care Standards and the Aged Care Standards and Accreditation Agency); criminal law; the Coronial systems; and the common law, as examples of the more well known protective mechanisms. Some of these checks and balances will be dealt with more fully below. However it is important to note that these mechanisms do not provide the more holistic capacity of the professional regulatory models to set specific educational and practice standards, oversight the conduct, health and performance of individual care workers, and take action when they are placing the health and safety of clients at risk.

4.1.12   For those health and aged care workers who are not registered it has been notoriously difficult for the consumer protection agencies (such as the health complaint bodies in each of the jurisdictions) to be able to take effective action when a serious complaint they receive pertains to the conduct, health or performance of an unregistered health or aged care worker. This issue was the subject of an inquiry by the Joint Committee on the Health Care Complaints Commission of the New South Wales Parliament in 1998 (Joint Committee on the Health Care Complaints Commission NSW Legislative Assembly 1998) which subsequently led to some legislative changes in that state in relation to unregistered health practitioners, although the focus of that was primarily on de-registered health professionals setting themselves up as alternative health practitioners outside the confines of a registration system (for example a number of deregistered psychiatrists established themselves as 'counsellors' and there was no provision for potential patients to be advised of their de-registered status).

4.1.13   Traditionally it has been those organised and identifiable professions where service provision can carry a high degree of risk and where a requirement for the protection of the public interest is greatest, that were more likely to be subject to statutory registration requirements (Productivity Commission 2005d p.358). This is not out of step with the Productivity Commission's recent focus on the higher level health professional end of the health workforce. Before 1992, the array of health worker groups regulated through a statutory registration system had largely evolved serendipitously, for the most part dependent on the political response to the 'squeaky wheel'. In a number of cases the 'squeaky wheel' was the community responding to a very real risk by exercising their democratic right to appeal to their elected representatives to take appropriate action. Although in many cases the political influence was more likely to come from the members of the worker group defending

their area of practice, usually from the incursions of uneducated and unskilled people (and sometimes charlatans) who claimed to have the skills, knowledge and experience to provide the same service as those who had been more rigorously prepared. This latter situation has given rise on occasion to accusations of anti-competitive conduct against the worker group concerned which may have some merit in some, although not all, instances.

> ## *A registered health care workforce provides consumers of health and aged care services with assurances relating to their skill and training*

4.2 Australian Health Ministers' Advisory Council agreements

4.2.1   The Australian Health Ministers' Advisory Council (AHMAC) includes all heads of state, territory and Australian government health departments. Its terms of reference are to provide effective and efficient support to the Australian Health Ministers' Conference (AHMC)[1] by advising on strategic issues relating to the coordination of health services across the nation and operating as a national forum for planning, information sharing and innovation.

4.2.2   With the introduction of the legislation relating to mutual recognition of registered health professionals across State and Territory boundaries in Australia in 1992–93, AHMAC:

Identified and agreed on those professions that should continue to be regulated via statute in all Australian States and Territories; and established a process (via an AHMAC Working Group) for jurisdictions to jointly assess the case for statutory registration of the 'partially regulated' health occupations (that is, those that had statutory registration legislation in some jurisdictions but not others) (Victorian Government Department of Human Services 2003 p.12).

4.2.3   After acceptance of the recommendations made by the AHMAC working group, statutory registration arrangements were repealed in a number of jurisdictions, including for: naturopaths, speech pathologists and social workers in the Northern Territory and dietitians in Victoria. Not all jurisdictions fell in line with the recommendations and repealed legislation. For example, there are still jurisdictions that register speech therapists and occupational therapists, contrary to the AHMAC position (Victorian Government Department of Human Services 2003 p.12). However that debate has been reopened with the acceptance by the Council of Australian Governments (COAG) of the 2005 Productivity Commission recommendations concerning national registration and accreditation of some groups of professionals in the health workforce (Productivity Commission 2005d; Council of Australian Governments 2006a).

4.3 Criteria for assessing the need for statutory regulation

4.3.1   The recommendations of an AHMAC Working Group: Advising on Criteria and Processes for Assessment of Regulatory Requirements for Unregulated Health Occupations, accepting its recommendations in April 1995, established an agreed process for determining whether to regulate any currently unregulated health occupation. This process aimed to ensure that statutory registration for a health profession is introduced only: if agreed to by a majority of jurisdictions; if it could be demonstrated that the practice of the workers presents serious risks to public health and safety; and that these risks can be minimised by regulation (Victorian Government Department of Human Services 2003 p.12).

4.3.2   Six specific criteria, summarised in Table 5 below, were agreed on to provide a basis for regulatory assessment. This agreed process allows for unregistered health professions to make a submission to any state or territory government requesting that their case for statutory registration be considered. Any participating jurisdiction may then bring this case to AHMAC for consideration. AHMAC may then establish a working group to examine and make recommendations to all jurisdictions as to whether statutory registration is required (Victorian Government Department of Human Services 2003 p.12).

4.3.3   The last submissions from professions to be assessed in this way by the AHMAC Working Group were for traditional Chinese medicine and hypnotherapy in 1996 (Victorian Government Department of Human Services 2003 p.12; 1997). Traditional Chinese medicine practitioners are now registered in Victoria and will be affected by the decisions currently being made in relation to the national health registration of health professionals.

Table 7: AHMAC criteria for assessing the need for statutory regulation of unregulated health occupations

Criterion 1: Is it appropriate for health ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another ministry?

Criterion 2: Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?

Criterion 3: Do existing regulatory or other mechanisms fail to address health and safety issues?

Criterion 4: Is regulation possible to implement for the occupation in question?

Criterion 5: Is regulation practical to implement for the occupation in question?

Criterion 6: Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

Source: Australian Health Ministers Advisory Council 1995 cited in Victorian Government Department of Human Services 2003 p.12

4.3.4   The irony in relation to most of the unlicensed direct care workforce is that they are not organised into a collective that can meet AHMAC's pre-condition of having the necessary collective of health 'professionals' to make a submission to any state or territory government requesting that their case for statutory registration be considered; however presumably one of those governments could put up such a case to AHMAC if community activism and other impetus made it an imperative. This paper argues that such an imperative does exist for consideration of the case for regulation of this workforce.

4.3.5   It is interesting to note that, like the Productivity Commission, AHMAC sees the health work force as primarily organised health professionals, not in terms of the very large number of health workers who would not meet the criteria for classification as a 'professional'.

> ## *Unlicensed health care workers generally lack an organised worker association to protect their interests or seek statutory registration*

4.4 National Competition Policy (NCP) agreements

4.4.1   The AHMAC criteria and process have been reinforced by the introduction of NCP. In 1995, the Australian Government, States and Territories signed the Competition Principles Agreement and the Conduct Code Agreement, based on the recommendations of the National Competition Policy Review Committee chaired by Professor Fred Hilmer (Hilmer et al 1993). The aim of establishing a national approach to competition policy was to improve Australia's economic competitiveness in the international market place (Victorian Government Department of Human Services 2003 p.13).

4.4.2   Under these agreements, all jurisdictions agreed to:

- extend the application of Part IV of the Trade Practices Act 1974 (Cwth), which deals with anti-competitive practices, to individuals within the areas of state and territory constitutional powers, including the statutory regulation of individual health practitioners,

- review their legislation and remove all anti-competitive provisions, unless on balance such provisions could be demonstrated to have public benefit and the purpose of the restrictive provisions could not be achieved without legislation,

- implement competitive neutrality, that is the elimination of any competitive advantage benefiting significant business enterprises within the public sector, unless retention of the competitive advantage could be demonstrated to have public benefit (Victorian Government Department of Human Services 2003 p.13).

4.4.3   Proposals for legislative reform in Australia have to comply with NCP Principles. The guiding Principle to be applied to these reviews is that legislation should not restrict competition unless it can be demonstrated that:

- the benefits of the restriction to the community as a whole outweigh the costs; and
- the objectives of the legislation can only be achieved by restricting competition (Victorian Government Department of Human Services 2003 p.13).

4.4.4   Also, any proposals to amend legislation under the NCP policy must consider:

- the objectives of the legislation,
- the nature of the restriction on competition,
- the likely effect of the restriction on competition and on the economy generally,
- the costs and benefits of the restriction, and
- any alternative means for achieving the same result, including non-legislative approaches (Victorian Government Department of Human Services 2003 p.13).

4.4.5   All jurisdictions have now reviewed their legislation in relation to the regulation of health professionals to consider the implications of these agreements. While there have been some amendments to some of the legislation in order to remove anti-competitive provisions that were deemed to not relate to the protection of the public, the regulation is seen as central to protecting the health and safety of the community in areas where the risks to them can be high. It is therefore argued in this paper that the extension of some form of regulation to currently unlicensed health workers is essential as the risks posed to the community outweigh the benefits of having a large and growing, unregulated health workforce.

> ## *Do the risks of an unlicensed and competitive health care workforce outweigh the benefit to the community?*

4.5   Other legal safeguards outside the regulatory framework

4.5.1   There are other regulatory processes that control the conduct of employers and individual workers in the health and aged care sectors, other than the statutory and self regulatory frameworks for health professionals described above. These protective checks and balances of the service delivery environment include those represented in Figure 1 below and are more completely outlined in Table 6.

Figure 1: The jigsaw of regulatory mechanisms in the health and aged care sectors
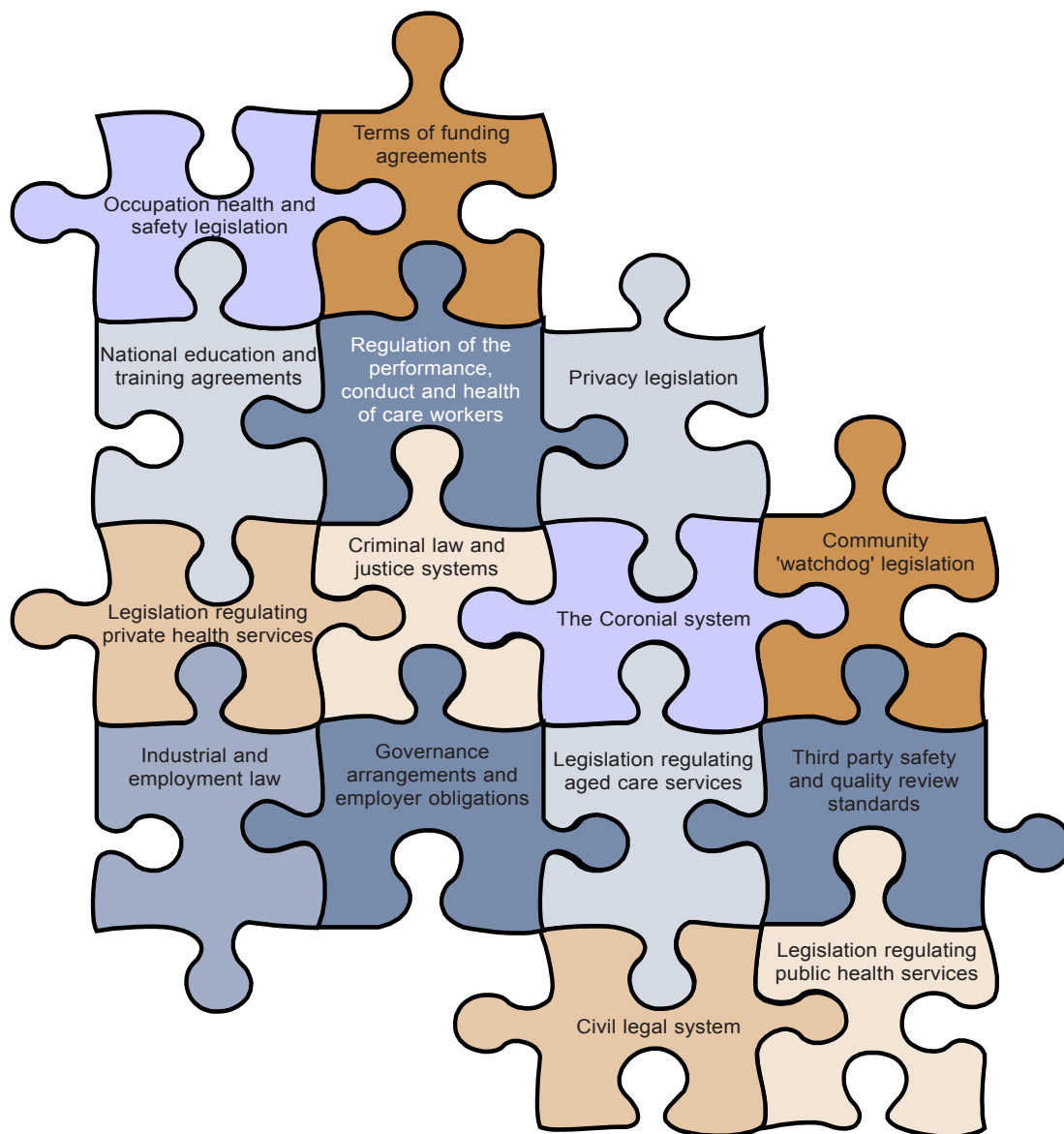
4.5.2   Each of the providers has a specific focus and powers but a critical piece of the jigsaw is missing without the licensing and regulation of individual workers. Unless these workers in health are regulated, a significant gap in safety for the community exists.

4.5.3   Table 6 below is a summary of the current regulatory safeguards that exist in Australia and their applicability to unlicensed health workers.

Table 8: Examples of current regulatory safeguards and their applicability to unlicensed health workers

Safeguard	Focus	Examples of responsible agencies	Unlicensed care workers
Civil legal system	Enabling individuals to bring actions when they have suffered a wrong, for example in the tort of negligence when an individual or organisation has breached their duty or care and harm has ensued.	• Courts in each of the jurisdictions.	An individual unlicensed health worker may be identified as a defendant in a civil action. However the 'shallowness of their pockets' (ie their capacity to pay the damages) would limit their attractiveness to a plaintiff and limit the likelihood of proceedings. The employing organisation may be the nominal defendant in those jurisdictions such as NSW where the doctrine of vicarious liability for employees operates. The employing organisation would usually be the preferred defendant as they should have appropriate insurance to cover such situations.
Community 'watchdog' legislation	Providing consumers and other interested parties with an appropriate complaint resolution mechanisms when an issue arises concerning the services they receive that they cannot resolve at the local level. Most of these organisations have effective relationships with health professional registration authorities should the complaint require referral if it relates to the conduct, performance or health of a registered health worker.	• Health Services Commission (VIC) • Health Care Complaints Commission (NSW) • Complaints Resolution Scheme (Cwth – aged care) • Health Complaints Commissioner (TAS) • Human Rights Commission (ACT) • The Health and Community Services Complaints Commission (NT) • Health Quality and Complaints Commission (QLD) • Office of Health Review (WA) • Health and Community Services Complaints Commissioner (SA)	There is no capacity for the complaint agency to refer a matter pertaining to an individual health worker to a licensing body when a complaint relates to an individual unlicensed health worker. Remedies include: the employer taking action (eg performance management, education, suspension, dismissal); civil action; criminal charges (if it relates to a criminal issue).
Coronial system	Investigation into the manner and cause of death in cases where a person dies in unusual, unexpected, violent and unnatural circumstances.	• Coroners' Court and Coroner in each jurisdiction.	If the Coroner finds in the course of their investigation that the person died as a result of a criminal act committed by an unlicensed health worker they are likely to be charged with murder or manslaughter which, if convicted will affect their capacity to work in the health and aged care industry in the future.
Criminal law and justice system	Criminal record checks (police checks) conducted on employment and at defined points during employment to identify people who have convictions for offences that are regarded as inappropriate for workers in the health and aged care industries – convictions such as murder, sexual assault or any other form of assault resulting in a prison sentence will preclude a person from employment in much of the health system and aged care.	• Police departments in each jurisdiction	Will identify any potential or currently employed unlicensed care worker who has been convicted of a serious criminal offence eg murder, sexual assault or any other form of assault resulting in a prison sentence and is likely to preclude that person from employment in much of the health and aged care systems, but only after the event.

Table 8: Examples of current regulatory safeguards and their applicability to unlicensed health workers *continued...*

Safeguard	Focus	Examples of responsible agencies	Unlicensed care workers
Governance arrangements and employer obligations	Governance is how an organisation is set up and administered. It covers its corporate and other structures, cultures, policies and strategies and the way it deals with its various stakeholders. Governance principles include: accountability, transparency and openness, integrity, stewardship, leadership, efficiency, effectiveness, fairness; flexibility and consistency.	• Government audit offices in the public sector • Government Departments eg health, aged care, Veterans Affairs • Government and non-Government funding agencies	An organisation with robust governance systems and a commitment to providing a safe, quality service will ensure that all staff: are adequately prepared to undertake the work they do and have ongoing education; conduct themselves in an appropriate manner; and are adequately supported and supervised.
Industrial and employment law	Deals with the relationship, usually through an employment contract, between the employer and employee. The aim is: *'to achieve a harmonious working environment and maximum benefits to the employer and the employee at the workplace'* (Staunton and Chiarella 2003 p.137-138). Obligations on the employer can be summarised as duties to: • pay wages and provide other conditions agreed on or expressly provided for, • provide a safe system of work, • not discriminate against people in employment on various grounds (Staunton and Chiarella 2003 p.137-138).	• Industrial commissions in most jurisdictions • Industrial organisations representing workers	Many unlicensed health workers are are not members of an industrial organisation that can protect their collective working rights, ensuring they have appropriate conditions in their place of work eg appropriate training, support and supervision to do the work safely. With the introduction of 'WorkChoices' the safety net of strong industrial safeguards including unfair dismissal has diminished significantly.
Legislation regulating aged care services	Broad framework legislation designed to provide for funding of aged care and accommodation that takes account of: quality of the care; type of care and level of care provided; access to care that is affordable by, and appropriate to the needs of, people who require it; appropriate outcomes for recipients of the care; accountability of the providers of the care for the funding and for the outcomes for recipients.	• The Department of Health and Ageing (Cwth) • The Aged Cares Standards and Accreditation Agency • Complaints Resolution Scheme (Cwth – aged care)	Recently introduced amendments to the Aged Care Principles in the Aged Care Act 1997 (Cwth) require police checks for all aged care workers – people will be precluded from employment in aged care if their police check shows a conviction for murder or sexual assault, or a conviction for any other form of assault which has resulted in a prison sentence. These checks must be less than three years old however a lack of probity is sometimes found after the event. The new Minister for Ageing in the Rudd Government, Justine Elliot, has announced an extension of police checks from people with unsupervised access to older people receiving care to those with supervised access.

Table 8: Examples of current regulatory safeguards and their applicability to unlicensed health workers *continued...*

Safeguard	Focus	Examples of responsible agencies	Unlicensed care workers
Legislation regulating public health services	Regulatory framework that establishes a system of public health services for the whole of the jurisdiction to provide a basis for the planning and delivery of public health services within that jurisdiction.	• State and Territory Departments of Health • Government audit offices in the public sector • Health complaint agencies	In most cases the legislation is silent in relation to specificity staffing except for contracting with visiting medical officers and other contractors.
Legislation regulating private health services	Licensing frameworks to regulate private hospitals and day procedure centres with controls primarily relating to ensuring quality and safety of private health services	• State and Territory Departments of Health • Government audit offices in the public sector • Health complaint agencies	Most legislation has some requirements about staffing arrangements but they are generally very high level and have no specificity around requirements for unlicensed health workers (Productivity Commission 1999).
National education and training agreements	Consistency in the preparation for workers across jurisdictions and in keeping with international standards and appropriate to the work that they are employed to undertake.	• Department of Education Science and Training • Industry Skills Councils • Registered Training Organisations • Organisations such as the Australian Nursing and Midwifery Council and Australian Medical Council • University sector	Standards for the different levels of courses developed by the Industry Skills Councils. Authorisation of education and training providers and the registration of vocational educational and training (VET) providers as registered training organisations (RTOs). Examination of the competencies for Certificate 3 and 4 in the health and aged care sectors however reveals these standards do not educate to the level of 'basic' nursing care.
Occupational health and safety legislation	Physical and psychological safety in the workplace for workers.	• Occupational health and safety statutory authorities in each jurisdiction	A safe system of work requires employees to be adequately educated, supported and supervised to ensure they are safe at work.
Privacy legislation	Personal information collected by organisations concerning clients and employees. Covers the collection, maintenance and disclosure of personal information.	• Commonwealth, State and Territory privacy agencies or other agencies with responsibility for privacy eg the Health Services Commissioner in Victoria	No specific requirements but the nature of day to day work and the documentation of care carries high risks for workers at the front line of care and there is a need for good local procedures and training for staff.

Table 8: Examples of current regulatory safeguards and their applicability to unlicensed health workers *continued...*

Safeguard	Focus	Examples of responsible agencies	Unlicensed care workers
Regulation of the performance, conduct and health of care workers	Ensuring that individual workers are: • appropriately prepared for their roles and continue to maintain their skills and knowledge; • are of good character and conduct themselves ethically and appropriately during the course of their work and daily life if it impinges on their work; and • are physically and mentally healthy enough to undertake the required work. Providing mechanisms for reports to be made by the community, colleagues and others, and action taken when a health worker's performance conduct and health come into question. Establishing competency standards and codes of conduct and ethics. Reviewing and authorising course curricula and educational providers appropriate for the worker group.	• Health professional registration authorities in each jurisdiction • National professional organisations eg Australian Nursing and Midwifery Council and Australian Medical Council • Health professional associations eg Australian Association of Social Workers and OT Australia – the Australian Association of Occupational Therapists	There is no framework of regulation that applies to health workers not currently registered or members of a professional association that has a certification process.
Terms of funding agreements	Setting conditions for funding to be paid for services eg relating to level of care, care environment, documentation etc. Increasingly terms relating to quality and safety are being introduced.	• Department of Health and Aged Care • Increasingly the private health insurance organizations	At a global level - the quality and safety of services are contingent on the skill, knowledge and experience of staff providing the care and the level of accountability that the funding body institutes to ensure the funding terms are being met.
Third party safety and quality review standards	*The granting of recognition for meeting designated standards for structure, process and outcomes, where outcome is the status of an individual, group of people or population which is wholly attributable to an action, agent or circumstance* (Australian Commission on Safety and Quality in Health Care 2006 p.4).	• Australian Council on Health Care Standards • The Aged Care Standards and Accreditation Agency	At a global level - the quality and safety of services are contingent on the skill, knowledge and experience of the staff providing care and the success of this process depends on how well embedded the standards are in the governance and operations of the organisation. It also depends to some extent on the level of scrutiny that a third party review agency institutes to ensure that standards are actually being met.

5 An Issue of Quality and Safety for Consumers - Regulation of Health Care Workers

When convicted rapist Yuen How Choy, from East Sussex , was struck off the nursing register in 1986, he took a job as a care assistant at a nursing home looking after people with mental illness. His case highlighted two key issues: there was no register for support workers and no one oversaw their conduct. Today, Choy would be barred from working as a care assistant because the Nursing and Midwifery Council (NMC) would forward his name for inclusion on the Protection of Vulnerable Adults (POVA) list. If a prospective employer made a mandatory criminal record check it would find his name on the list. The case highlights an ongoing problem. Support workers fired from one care assistant job for serious misconduct can take up a similar post without anyone knowing. Unlike registered nurses, they are not added to the POVA list unless an employer reports them.

Duffin 2006 p.18

The challenges posed by unregulated health workers are not new and they are not isolated to Australia. The above example highlights the danger inherent in an unregulated workforce providing services through which there is significant risks and potential for harm to result.

5.1 International initiatives – the United Kingdom

5.1.1   In the United Kingdom there has been significant activity in reviewing the roles and regulation of currently unregulated health care support workers (HCSWs). A project commenced in 2001 with the objective to: *provide a co-ordinated national approach to the development of health care support workers across Scotland* (Cowie 2002 p.1). Core competencies for health care support workers were subsequently negotiated on a national basis in Scotland in the same year and this work has informed the latest development work on the regulation of health care support workers.

5.1.2   In 2004 a consultation paper was issued on 6 May and closed for comment on 20 September. It targeted professional and regulatory bodies as well as employers and employees of the health and social care sector and invited comments on proposals for extending regulation to a wider group of health and social care staff; health care assistants, assistant practitioners in a wide range of care settings, allied health support staff, health care scientist workforce, social care support staff, pathology assistant practitioners (Scottish Government 2004).

5.1.3   The aims of the consultation paper were to:

- establish whether regulatory arrangements should be extended to include specified assistants and support staff,

- consider how to regulate groups of staff who move across or work outside of traditional boundaries,

- establish how quality can be assured,

- determine the most appropriate form of regulation,

- establish who should regulate these groups of staff, and

- consider whether there are alternatives to statutory regulation (Scottish Executive 2004).

5.1.4   One hundred and twenty two (122) responses were received. Key respondents were: The Nursing and Midwifery Council, The Health Professions Council, Scottish Social Services Council, The Council for Healthcare Regulatory Excellence, National Health Service (NHS) Education for Scotland, The Royal College of Nursing and UNISON Scotland, NHS Scotland Operating Divisions/Boards (Scottish Government 2004).

5.1.5   A summary of the findings from the 2004 consultation found:

- 93% of responses indicated that regulatory arrangements should be extended to cover health and social care assistants and support staff.

- 81% of responses felt that health care support staff should be accountable for their own practice but that this should be dependent on their level of training and/or scope of practice.

- 70% of responses felt that setting standards for assistants and support staff should be the responsibility of the manager or employer, done in consultation with support staff.

- The consensus was that 'preferably' assistants and support staff should be regulated as a single group within a single framework. However it was also felt that, to avoid multiple registration and to facilitate transferability of staff between the four UK countries, it would make sense for existing regulators to work together to develop core common standards, with some discipline specific standards.

- 90% of responses indicated that statutory regulation was the most appropriate way to ensure public protection.

- 64% felt that Scotland should follow any decision that might be taken in England.

- There was no general consensus over which of the regulatory bodies should regulate these staff; 33% indicated it should be the relevant professional organisation.

- 60% indicated that if the Health Professional Council (HPC) was selected to regulate this group of staff, then it should be done by statutory committee.

- 85% of responses felt that regulation would not lead to problems such as a second class workforce, that it would raise the profile of health care support workers and lead to an enhanced workforce.

- The majority were content that statutory regulation is the most appropriate way to ensure public protection. The Council for Healthcare Regulatory Excellence remained to be convinced that statutory regulation was appropriate and encouraged the consideration of employer led regulation (Scottish Government 2004).

5.1.5   In May and June 2005, the National Scotland Strategy Group of key stakeholders (including health care support workers) developed a model as a preferred option and agreement was reached that Scotland would continue to lead the initiative on behalf of the UK (Cowie 2007; Scottish Government 2006b). In October 2005 a Project Initiation Document was approved by the four country steering group.

5.1.6   The key elements of this preferred option were:

- develop a model of employer-led regulation for health care support workers (HCSWs),
- hold a centralised list or register,
- negotiate nationally agreed standards for:
    - safe recruitment and induction,
    - a code of conduct for healthcare support workers, and
    - a code of practice for employers.

5.1.7   The consultation paper: *National Standards Relating to Healthcare Support Workers – Consultation Document* was issued on 31 May that outlined the preferred model, and closed for comment on 31 August 2006. It targeted professional and regulatory bodies, employers and employees of the health sector across the UK, and invited comments on draft standards relating to health care support workers employed by NHS Scotland. Standards outlined in the document related specifically to:

- a Code of Conduct and Practice for Employees,
- a Code of Practice for Employers, and
- Induction Standards (Cowie 2007; Scottish Government 2006b, 2006c).

5.1.8   A summary of the standards for safe induction are outlined in Table 7. Under each standard are a comprehensive set of relevant performance criteria.

5.1.9   The primary outcomes of the 2006 consultation on the standards and codes were:

- overwhelming support for the principle of public protection in some form of regulation,
- a positive response to standards with strong views that all three sets of standards should be mandatory (Cowie 2007; Scottish Government 2006c).

Table 9: Draft Induction Standards

CORE DIMENSION	PUBLIC PROTECTION STANDARD
Health, safety, security	• Protect service users from harm and abuse • Be personally fit at work • Maintain health and safety at work • Assess risk associated with work • Report incidents at work
Communication	• Practise within confidentiality and legal frameworks
Personal and people development	• Personally develop – in terms of knowledge and practice • Reflect on practice to enhance knowledge
Quality	• Contribute to team work • Build 'customer' relationships • Manage self as a resource • Work within own limits
Equality and diversity	• Practice in accordance with the equality, diversity, rights and responsibilities of individuals • 'Whistle-blow' in cases of harm and abuse

Source: Scottish Government 2006b p.20

5.1.10 The objectives of the project have now been amended to accommodate a pilot phase which was to commence in three NHS Board areas in January 2007. The latest update on project and status is the intention to:

- develop a model of service-led regulation with the addition of a centralised, non-statutory, 'occupational' register, on behalf of, and with input from, the four UK countries - this has been achieved.

- introduce, under existing staff governance arrangements, a formal system (ie under cover of a Scottish Government Executive Health Department letter) of registration for support workers employed within the health sector in Scotland (to include NHS Standards; independent and voluntary sectors as appropriate) through an 'occupational register' held by an independent Scottish body - *the pilot phase of the project will test out a 'list' of health care support workers in NHS Scotland only.*

- set up a national records function for the generation and maintenance of a register - *a decision on this will be delayed until the pilot phase is complete.*

- negotiate nationally agreed frameworks for competence; conduct; scope of practice and induction/educational preparation - *consulted 31 May - 31 August 2006.*

- develop systems for monitoring compliance with standards in line with existing governance arrangements (such as Staff and Clinical Governance frameworks) - *it is planned that this will be tested during the pilot phase in 2007.*

- ensure articulation with any career frameworks in existence - *a Career Framework for NHS Scotland is currently being consulted on* (Cowie 2007).

5.1.11 Under the Scottish model, employers are likely to be responsible for monitoring the conduct and training of HCSWs locally. Alongside this, a centralised list of HCSWs will be set up. The two national codes of practice have already been drawn up – for

employers and HCSWs. The health department, NHS Scotland will hold the list and ministers will be responsible for keeping it up to date and possibly for removing people. Employers would not be obliged to place people on the list.

5.1.12   The NHS Scotland's professional advisor for regulation and workforce standards and the leader of the project from its inception, argues that the approach is 'proportionate' to the risks posed by HCSWs to consumers (Duffin 2006. p.19).

5.1.13   In this model, there was a need to define the class of worker that it covers, because as in Australia, these workers had numerous titles for their roles. The definition that was agreed to in the Project was:

Health care support workers' are defined as those who provide a direct service – that is, they have a direct influence/effect on patient care/treatment/relationships - to patients and members of the public in the name of NHS Scotland. This would include those in support roles to the healthcare professions (such as care assistants) and those who provide ancillary services (such as porters and mortuary attendants). For ease of definition, any support worker who 'is in contact with a patient in the name of NHS Scotland' and who is not already statutorily regulated, or due to be, would be included. Standards could also be voluntarily adopted by those working in independent or voluntary health care settings (Scottish Government 2006 p.1).

5.1.14   This will be a useful model to follow through its pilot phase to determine what applicability it may have for Australia. The catalysts for the UK initiative are very similar to the issues raised in this paper relating to the lack of framework for the regulation of currently unregulated health workers in Australia. The model also demonstrates some sensitivity to the concerns of those who do not just want to see a duplication of or an add-on to the existing infrastructures for the regulation of health professionals.

5.2 International initiatives – the United States of America

5.2.1   The US took the step of requiring that nurse aides be certified in 1987. The registries of certified nurse aides (CNAs) are largely a creation of Federal legislation that directly addressed nursing home reform in the Federal *Nursing Home Reform Act* with subsequent Federal refinements of this law in 1989 and 1990 (USA Department of Health and Human Services 2004 p.131). However this has not been the ultimate solution.

5.2.2   The CNA Registries operate in a variety of ways. State agencies manage and maintain some. Some are under contract to a national consultant who works directly with the state supervisory agencies to maintain and update registry files. These Registries have various configurations depending on the controlling state's legislation and the purposes for which they exist. Some registries maintain only certification and demographic data about nurse aides, while others also contain criminal background

information. Some registries list and track a more expansive group of paraprofessional workers including home health aides, medication aides, and, in some states, all direct care workers (USA Department of Health and Human Services 2004 p.131).

5.2.3   As in Australia at this time, the 'fickleness of Federation' manifests itself in a lack of consistency in rational quality and safety risk management initiatives across the different jurisdictions. Also similar are the problems that the USA is confronting with the proliferation of direct care and paraprofessional health workers and 'nurses by any other name' that do not come under a comprehensive workforce policy strategy or regulatory framework and licensing system. Key findings from a study conducted in 2004 by the National Center for Health Workforce Analyses, Bureau of Health Professions in the USA Department of Health and Human Services, Health Resources and Services Administration titled: *Nursing Aides, Home Health Aides, and Related Health Care Occupations: National and Local Workforce Shortages and Associated Needs* were that:

- *"Nurse aide registries collect data on certified nurse aides in every state;*

- *There are great variations in the structure and content of registries across states;*

- *With some limited modifications, nurse aide registries could be an excellent source of data on the paraprofessional workforce. Key modifications that would increase the usefulness of the registries include:*

  - *more consistent, core data elements,*

  - *greater consistency in the types and definitions of workers included in the registries,*

  - *regular updates of the files on current activities, and*

  - *maintenance of some historical data for active and inactive paraprofessionals.*

  - *Several states have registries that collect data on all direct care paraprofessionals in a manner that protects patients, assists providers, and contains valuable data for planning and policy making. These states could be models for other states"* (USA Department of Health and Human Services 2004 p.63).

5.2.4   These findings are consistent with the Scottish project's recognition that some form of a list or registry is an imperative in scoping the workforce for a number of reasons - but primarily in the interest of the community to ensure they receive safe services of a consistent quality.

5.3 Australian initiatives

5.3.1   There have been specific initiatives in Australia over time in relation to reviewing the regulatory arrangements around unregulated health care workers as indicated in the section of this paper on the Australian Health Ministers Advisory Council criteria for

the registration of health practitioners. However several of these are particularly relevant for the purposes of this paper and warrant further comment.

5.3.2   The first is the Review of Traditional Chinese Medicine (TCM) undertaken by the Victorian Department of Human Services on behalf of all State and Territory governments.

The first stage was a major research project to collect information on the risks and benefits of TCM and to consider the need, if any, for registration of TCM practitioners and regulation of Chinese herbal medicines. The researchers published their results in the report: *Towards a Safer Choice: the practice of Traditional Chinese Medicine* (Victorian Government Department of Human Services 1996) in November 1996, which recommended to the Australian Health Ministers Advisory Council (AHMAC) and to all State and Territory governments that occupational regulation of the profession of TCM proceed as a matter of urgency (Victorian Government Department of Human Services 1997 p.3).

5.3.3   The key findings of the research have strong resonance to the outcomes of research that has been conducted into other unregulated health workers such as the care assistants in the health care industry:

"The practice of acupuncture and Chinese herbal medicine carries both inherent risks and risks associated with poor practitioner training. The risks relate primarily to the practice of acupuncture and Chinese herbal medicine, which have resulted in a significant number of adverse events and at least five deaths in Australia.

A number of factors are likely to contribute to increasing public health risks, including a dramatically increased use of TCM, increasing demands on practitioners to use Chinese herbal medicine in a wide range of clinical presentations, difficulty in controlling the importation of Chinese therapeutic goods, widely varying levels of TCM training, and the impact of National Competition Policy in undermining efforts at self-regulation by TCM professional associations.

There is a link between length of training in TCM and self-reported adverse incident rates. However while there is general agreement among non-medical professional associations on the length and content of TCM courses, the profession has been unable to enforce such a standard under a self-regulatory system.

There is significant black market activity in the importation of unlisted and/or unregistered patent medicines, and there are deficiencies in the Commonwealth's ability to address this problem. Tighter regulation of importation of raw herbs and patent medicines are needed in order to protect the public adequately.

There is considerable fragmentation within the TCM profession, with 23 separate professional associations existing. Given such fragmentation and vested interests, a self regulatory approach to setting standards of practice will continue to be unsuccessful" (Victorian Government Department of Human Services 1997 p.4).

5.3.4   Practitioners of Traditional Chinese Medicine are now registered in Victoria, however the debate continues to rage in each of the other jurisdictions in Australia, although this may well be derailed by the COAG's response to the Productivity Commission's recommendations in relation to the national registration of health professionals (Productivity Commission 2005d; Council of Australian Governments 2008).

5.3.5   In 1998 the Parliament of NSW Legislative Assembly, Committee on the Health Care Complaints Commission (the Joint Committee on the HCCC) undertook an inquiry into unregistered health practitioners. This was as a result of the Health Care Complaints Commission (HCCC), both in its annual reports and during meetings with the Committee, raising ongoing problems with respect to its limited ability to deal adequately with complaints about unregistered health practitioners (Joint Committee on the Health Care Complaints Commission 1998 p.9).

5.3.6   The Terms of Reference for that Inquiry were:

"That the Committee examine the experience of consumers in dealing with unregistered health practitioners (including those practising in alternative health care fields) with a view to establishing:

a) *what complaint mechanisms exist for consumers;*

b) *whether these complaint mechanisms are effective;*

c) *whether there is scope for strengthening voluntary codes of behaviour or conduct;*

d) *whether the provisions in the Health Care Complaints Act 1993, relating to unregistered health practitioners are appropriate or whether they need strengthening;*

e) *any other related matters"* (Joint Committee on the Health Care Complaints Commission 1998 p.9).

5.3.7   In the Chairman's Foreword of the *Report on Unregistered Health Practitioners: the adequacy and appropriateness of current mechanisms for resolving complaints,* he says:

"The Committee's most important recommendation, at least in the long term, relates to the establishment of umbrella regulation of unregistered practitioners.

Many of the problems the Commission presently faces in regard to dealing with these practitioners stem from the fact that the Health Care Complaints Act 1993 operates on the premise that there will be a professional disciplinary board to which the Commission can take a complaint after investigation. In order to fit in with the existing system and to best ensure standards of education, good character, clinical care and discipline, the Committee believes that registration is a preferred option. It does not however advocate individual registration of unregistered professions, considering this to be too problematic. What it would like to see is a generic uniform approach to the issue, bringing all unregistered professions under the one Act. It would also like to see such legislation establish an Advisory Board to the Minister to give the unregistered professions a voice" (Joint Committee on the Health Care Complaints Commission 1998 p.6).

5.3.8   Recommendation 6 of that Report was the specific proposal that flowed from this view:

"That the Minister for Health examine the feasibility of establishing umbrella legislation to cover unregistered health care practitioners which establishes a generic form of registration, generic complaint and disciplinary mechanisms, a uniform code of conduct, entry criteria agreed amongst the relevant professions and an Advisory Board to the Minister" (Joint Committee on the Health Care Complaints Commission NSW Parliament Legislative Assembly 1998 p.8).

5.3.9   This recommendation resembles the recommendations of the Productivity Commission that are being implemented in relation to health professionals currently registered jurisdiction by jurisdiction in Australia. The undertaking of COAG at this stage is:

"…The COAG Communiqué of 14 July 2006 confined the first tranche of national registration to the nine health professions currently registered in all jurisdictions. However, it was envisaged that other health professions would be added over time. The Ministerial Council will determine those additional professions that should enter the scheme, but this will not occur prior to the commencement of the scheme on 1 July 2010 (Council of Australian Governments 2008).

5.3.10   A third relatively recent initiative that warrants comment is the review and consultation of the Nurses Board of South Australia in 2002 and 2003 into the 'unregulated health worker' (Nurses Board of South Australia 2003a; 2003b; 2002). This work ultimately appears to have 'fizzled out' into the development of a standard: *Delegation by a registered nurse or midwife to an unlicensed healthcare worker* (Nurses Board of South Australia 2005).

5.3.11   Similar work was seen to be necessary and commenced by the Nurses Board of Victoria in 2001 however shortly after it was commenced, new management of the Board decided not to proceed.

6 Licensing and Regulation for Currently Unregulated Health Workers

6.1 Existing models of regulation

6.1.1   Different approaches to regulation of the health professions have been canvassed by most Australian jurisdictions in recent years, while conducting national competition policy reviews of legislation. The main models of regulation of the health professions are set out in Table 7 below. These include:

- Model 1: Self-regulation
- Model 2: Licensing
- Model 3: Negative licensing
- Model 4: Co-regulation
- Model 5: Reservation of title only
- Model 6: Reservation of title and core practices
- Model 7: Reservation and whole of practice restriction

Table 10: Models for regulation of the health professions

Model 1: Self-regulation
Under this model, there is no occupational licensing or registration legislation that requires members of the workforce to be registered with a statutory body, nor is there government oversight of standards development and a formal judicial process that makes up the disciplinary system for the group of workers. Consumers rely on other non specific regulation (eg OHS legislation) and a person's voluntary membership of a professional or craft group association (if there is one) as an indication that the practitioner is suitably qualified, safe to practise and subject to a disciplinary scheme. Where the practitioner is an employee, their employer also has responsibility for ensuring their safe and competent practice.
- *This model applies to all health and aged care workers that are not subject to statutory registration.*

Model 2: Licensing
Under this model, any person is able to practise in a self-regulated profession or craft group and their details are placed on a government oversighted register of persons who are working in certain industries. To be employed in that industry the person has to establish their credentials which can range from: minimal, eg not having had any serious criminal convictions that would impact on an assessment of their character in their area of work; to more onerous, eg having successfully obtained a basic qualification, being required to abide by a code of conduct and/or ethics, and/or practice standards. This model is usually linked to a negative licensing model as described below. This model is a less complex version of the co-regulatory model described in Model 4.
- *The Scottish Pilot Project involving the regulation of healthcare support workers generally fits within this model.*

Model 3: Negative licensing
Under this model, any person is able to practise in a self-regulated profession unless they are placed on a register of persons who are ineligible to practise. This is a more targeted and less restrictive form of regulation than Models 5-7 because it does not establish barriers to entry to the profession, but allows those with poor practice records to be excluded from practising without the need for a full registration system. However it provides less protection to consumers than Models 4-7 and may be inappropriate when there is potential for serious harm.
- *The child care and protection legislation introduced for people working with children and the police check requirements currently being introduced into the aged care sector essentially create this model of regulation.*

Table 10: Models for regulation of the health professions, *continued...*

Model 4: Co-regulation
Under this approach, there is a range of models where regulatory responsibility is shared between government and industry: for example, professional associations or craft groups set membership requirements and administer a disciplinary scheme to ensure professional or practice standards. The government monitors and accredits these professional associations to ensure they act in a way that protects members of the public. However workers who are not members of a co-regulated professional association or craft group are not legally prevented from practising or using the titles of the profession under such a system.

Model 5:- Reservation of title only
Under this model particular titles of the profession or craft group can only legally be used by those who are registered by the relevant registration board. A statutory registration board establishes qualifications and character requirements for entry to the profession, develops standards of practice, and receives and investigates complaints of unprofessional conduct, poor health or performance and applies sanctions, if necessary, including deregistration. It is difficult for a deregistered practitioner to practise because if they advertise their services to the public or use the reserved title, they can be prosecuted through the courts for committing an offence. This form of regulation assures consumers that practitioners are qualified to provide services and their practice is subject to the scrutiny of a registration board. If there are risky and intrusive practices that should be restricted to certain registered health professionals, then these are generally contained in other forms of legislation, such as drugs and poisons Acts, radiation safety regulations and so on.
- *Some health professional registration systems in Australia are currently based on this model, eg legislation regulating nurses and midwives in NSW, Queensland, SA, Victoria.*

Model 6: Reservation of title and core practices
Under this model certain risky and intrusive acts or procedures within the defined scope of practice of a profession are restricted through legislation only to members of the registered profession and other registered health professions identified in legislation. Unregistered and unauthorised practitioners are not only prohibited from using reserved titles, but may be liable for prosecution for an offence if they carry out any of the reserved core practices for which they are not authorised. Exemptions are allowed for treatment provided in an emergency and where students perform core practices under the direction and supervision of an authorised member of the profession.
- *This model has been implemented in Ontario, British Columbia and Alberta in Canada, and is currently being implemented in Queensland and WA for medical practitioners and for nurses and midwives in ACT, NT and WA.*

Model 7: Reservation of title and whole of practice
This model is the most restrictive form of regulation and includes not only offences for unregistered persons to use reserved professional titles, but also a broad 'scope of practice' definition of the profession in legislation and it is an offence for unregistered persons to practise the profession. The main criticism of this form of regulation is that it allows monopolistic practices by the health professions and leads to demarcation disputes between the professions and increased fees and costs, with little if any added public benefits in terms of greater protection.
- *In Victoria, the Dental Practice Act 1999 contains a broad definition of dentistry and an offence for unregistered persons to practise dentistry. The Dental Practice Board or Victoria Police can prosecute, through the courts, unregistered persons for practising dentistry.*

Adapted from Regulation of the Health Professions in Victoria (Victorian Government Department of Human Services 2003 p.20) which in turn was adapted from the NSW Health Report of the Review of the Nurses Act 1991 (NSW Department of Health 2001b pp.27-36)

6.2 Opportunity knocks - COAG and a cogent framework of regulation

6.2.1 A major finding of the Productivity Commission review of the health workforce after reviewing the operations of more than 90 health professional regulatory authorities was that:

"Diversity in these state-based systems leads to variations in standards across the country, results in administrative duplication and can impede the movement of health workers across jurisdictions not withstanding the operation of mutual recognition" (Productivity Commission 2005d p.xxv).

6.2.2　The National Nursing and Nursing Education Taskforce Project in reviewing the legislation and other regulatory mechanisms used to regulate the nursing and midwifery professions in Australia across the eight state and territory jurisdictions inevitably reached the same conclusion (National Nursing and Nursing Education Taskforce 2006a; 2006b).

6.2.3　The Productivity Commission's solution was a radical one. The Commission made the recommendation that a single national registration board for all currently registered health workers should be established. They dismiss the notions of *"seeking to achieve greater uniformity within the current regime, or to introduce profession by profession registration at the national level, outside of an overarching registration framework"* (Productivity Commission 2005d p.xxv). The role of the professions would be significantly curtailed in relation to the full range of functions and powers currently vested in each regulatory authority but the single national registration board mooted by the Commission, *"would have a series of supporting professional panels to advise on specific requirements, monitor codes of practice and take disciplinary action"* (Productivity Commission 2005d p.xxv).

6.2.4　A discrete but associated recommendation related to the creation of a national accreditation board which would be charged with setting uniform national standards for health workforce education and training which would also have the effect of reducing the scope of functions and powers currently held by the various health professional regulatory authorities (Productivity Commission 2005d p.134).

6.2.5　Recommendation 6 of the Our Duty of Care Report outlined above is not far removed from Recommendation 7.1 of the Productivity Commission's Research Report: *Australia's Health Workforce in 2005:*

- *"When a health professional is required to be registered to practice, it should be on the basis of uniform national standards for that profession:*

- *Education and training qualifications recognised by the national accreditation board should provide the basis for these national registration standards.*

- *Any additional registration requirements should also be standardised nationally.*

- *Flexibility to cater for areas of special need, or to extend scopes of practice in particular workplaces, could be met through such means as placing conditions on registration, and by delegation and credentialing"* (Productivity Commission 2005d pp.140-142).

6.2.6　These recommendations formed the basis for the current considerations of the Council of Australian Governments (COAG) in relation to national registration and national accreditation of courses leading to registration. In responding to the Productivity Commission inquiry, COAG said:

> *"COAG recognises the challenges facing Australia regarding the health workforce and the need for national systemic reform to workforce and health education structures. COAG welcomes the Productivity Commission's report on Health Workforce released in January 2006 and supports its key directions. COAG has endorsed the National Health Workforce Strategic Framework. Given the significance of the recommendations of the Productivity Commission's Report, COAG has asked Senior Officials to undertake further work on the recommendations and related issues and report to it in mid-2006. This work will include, but not be limited to, the number and distribution of training places, the organisation of clinical education and training, and accreditation and registration"* (Council of Australian Governments 2006a p.13).

6.2.7   At a more general level the COAG national reform agenda is also focusing on reducing the regulatory burden imposed by the three levels of Government which sits compatibly with the Productivity Commission's recommendations and undoubtedly had resonance in their consideration of possible reforms in relation to the regulation of health professionals:

> *"COAG agreed that all governments will::*
>
> * *establish and maintain effective arrangements to maximise the efficiency of new and amended regulation and avoid unnecessary compliance costs and restrictions on competition;*
>
> * *undertake targeted public annual reviews of existing regulation to identify priority areas where regulatory reform would provide significant net benefits to business and the community;*
>
> * *identify further reforms that enhance regulatory consistency across jurisdictions or reduce duplication and overlap in regulation and in the role and operation of regulatory bodies; and*
>
> * *in-principle, aim to adopt a common framework for benchmarking, measuring and reporting on the regulatory burden"* (Council of Australian Governments 2006a p.9).

6.2.8   The centralisation or harmonisation of regulatory frameworks and establishing national instrumentalities that have power to execute their roles is no easy feat. It is controversial and complex in a federated nation. However it is a rational response and one that is generally supported by the nine currently registered health professions.

6.2.9   The Productivity Commission Report and the COAG response and agenda (Productivity Commission 2005d; Council of Australian Governments 2006a) reflect the general community and health system's dissatisfaction about the way that the health workforce has been educated, organised and regulated in Australia, largely due to our colonial heritage and the fierce determination of States to maintain their independence and autonomy. The Productivity Commission Report boldly and clearly put a strong case for the imperative for change.

6.2.10   After eighteen months of negotiation and consultation with the various health professional groups, COAG signed an intergovernmental agreement (IGA) on national registration and the national accreditation of courses leading to registration on 26 March 2008 (http://www.coag.gov.au/meetings/260308/docs/iga_health_workforce_pdf). The intergovernmental agreement outlines the principles and structures on which the scheme will be based and the process for implementation (NSW Nurses and Midwives Board 2008).

6.2.11   COAG clearly states that the first tranche of national registration will be confined to the nine health professions currently registered in all jurisdictions, however envisages that other health professions would be added over time. The Ministerial Council established under the IGA will determine those additional professions that should enter the scheme, but this will not occur prior to the commencement of the scheme on 1 July 2010. In the first instance, COAG will give priority to partially regulated occupations with a special case being made for podiatry and Aboriginal Health Workers. It is only after already partially registered occupational groups are considered that COAG will consider any proposals for the inclusion of unregulated health occupations in the national registration scheme.

6.2.12   COAG, in the IGA, refers to the 1995 determination of the Australian Health Ministers' Advisory Council which established a process for determining whether to regulate any currently unregulated health profession, involving assessment against six criteria (see Table 5: *AHMAC criteria for assessing the need for statutory regulation of unregulated health occupations)*. COAG considers these criteria are still appropriate for assessing the inclusion of partially regulated and unregulated health professions in the national registration and accreditation scheme. Professions seeking inclusion in the scheme must meet all six criteria and will also be required to develop their own nationally consistent registration proposal for consideration by the Ministerial Council.

6.2.13   Under this process, statutory registration would only be introduced where:
   • it was supported by a majority of jurisdictions; and
   • it could be demonstrated that the occupation's practice presents a serious risk to public health and safety which could be minimised by regulation.

6.2.14   COAG noted that while occupational regulation may have a number of benefits, both for the occupation and for its individual practitioners:
   • *the sole purpose of occupational regulation is to protect the public interest; and*
   • *the purpose of regulation is not to protect the interests of health occupations.*

7 Conclusion

7.1   The number of unlicensed workers in the health and aged care systems is growing at an exponential rate that has the potential and increasingly real likelihood of impacting on the quality and safety of care provided to the community through those systems. Increasingly replacing skilled, professional, regulated health professionals and workers, these workers are caring for progressively more older, more acutely frail people with multiple physical and mental health co-morbidities without the requisite support, supervision, skills, knowledge and experience.

7.2   The challenges that the increasing workforce of unlicensed health workers pose are not unique to Australia. While the USA has some lessons for Australia, they have not yet tackled the issue in a holistic way, which is why the initiatives in Scotland are particularly interesting and deserve watching closely.

7.3   With the COAG work in relation to the nationalisation of registered health professionals and the national approach to establishing the funding and standards of care and services in the aged care sector, there is an opportunity and timeliness to 'get it right' across the breadth of the health and aged care workforces for the sake of the community.

7.4   Protecting the community – rational regulation for safety and quality.

  7.4.1   Reframing these regulatory options for the equivalent of the health care support worker provides some different options for Australia and represents an important supplement to the work being undertaken by COAG in relation to the currently licensed health workforce in the name of community protection; safety and quality; workforce flexibility and mobility; and economic good sense. These options are:

OPTION 1: SELF-REGULATION

No occupational licensing or registration legislation that requires members of the workforce to be registered with a statutory body, nor is there government oversight of educational and work standards development and a formal judicial process that makes up the disciplinary system for the group of workers.

Consumers rely on other non specific regulation (eg OHS legislation) and in some very limited cases where a collective of some sort has evolved - a person's voluntary membership of a craft based association or industrial organisation (where there is one) as an indication that the worker is suitably qualified, safe to practise, and perhaps subject to a disciplinary scheme.

Where the practitioner is an employee, their employer also has responsibility for ensuring their safe and competent practice under obligations as outlined in Table 6 in this paper.

*This is the status quo and **NOT** supported.*

OPTION 2: LICENSING

This option requires that there is a formal classification and naming of craft groups eg health care support workers (as in Scotland) and their details are placed on a government oversighted register of persons who are working in specific industries. To be employed in that industry the person has to establish their credentials which can range from: minimal, eg not having had any serious criminal convictions that would impact on an assessment of their character in their area of work; to more onerous, eg having successfully obtained a basic qualification, being required to abide by a code of conduct and/or ethics, and/or practice standards.

As with the Scottish model there would need to be a reciprocal code of conduct for employers to proved guidance and ensure they comply with their obligations in relation to educational support and reporting requirements. This option gives employers more power and responsibility than the statutory registration processes currently in existence for registered health professionals.

*This option **IS** supported by the ANF with basic standards for education, practice and conduct being set as a baseline. The outcomes of the pilot project being conducted by the NHS Scotland should also inform the development of such a model.*

OPTION 3: NEGATIVE LICENSING

Any person is able to work in health and aged care unless they are placed on a register of persons who are ineligible to practise. It does not establish barriers to entry to the workforce, but allows those with poor practice records to be excluded from practising without the need for a full registration system. However, it provides less protection to consumers and may be inappropriate when there is potential for serious harm.

The bar is usually very high eg a criminal conviction is the level of conduct that is required for a person to be placed on such a register as there is no other robust system for the examination of conduct, health or performance other than performance management by an employer which would be somewhat questionable in establishing consistent benchmarks for acceptable conduct, health and performance.

*This option is **NOT** supported by ANF as it does not adequately protect the community or set basic standards for education, practice or conduct.*

OPTION 4: CO-REGULATION

Regulatory responsibility is shared between government and the industry. For example, worker associations or craft groups set membership requirements and administer a disciplinary scheme to ensure practice standards. The government monitors and accredits these organisations to ensure they act in a way that protects members of the public. However, workers who are not members of a co-regulated association or craft group are not legally prevented from practising or using the titles of the profession under such a system.

*This option is **NOT** supported by ANF as it operates on the presumption that workers identify as a class of worker and have organised in formal collectives and developed codes and standards of*

education, practice and conduct which is not a feature of most of the currently unlicensed workforce in the health and aged care industries.

OPTION 5: RESERVATION OF TITLE ONLY

This option, as with Option 2, requires that there is a formal classification and naming of craft groups eg health care support workers. Under this option particular titles of the craft group can only legally be used by those who are licensed by the relevant registration board. A statutory registration board establishes qualifications and character requirements for entry to the profession, develops standards of practice, and receives and investigates complaints of unprofessional conduct, poor health or performance and applies sanctions, if necessary, including deregistration. It is difficult for a deregistered worker to practise because if they advertise their services to the public or use the reserved title, they can be prosecuted through the courts for committing an offence. This form of regulation assures consumers that workers are qualified to provide services and their practice is subject to the scrutiny of a registration board.

*This option **IS** supported by ANF as it is consistent with the current system for the registration of health professionals which could be modified to add another level of health and aged care worker to an already established model of regulation that is understood by community and the health and aged care industries.*

OPTION 6: RESERVATION OF TITLE AND CORE PRACTICES

Certain risky and intrusive acts or procedures within the defined scope of practice of a profession are restricted via legislation only to members of the registered worker group and others identified in legislation. Unregistered and unauthorised workers are not only prohibited from using reserved titles, but may be liable for prosecution for an offence if they carry out any of the reserved core practices for which they are not authorised. Exemptions are allowed for treatment provided in an emergency and where students perform core practices under the direction and supervision of an authorised member of the profession.

*This option is **NOT** supported by ANF as it is an unnecessarily onerous regulatory system for most of the levels of workers under discussion in this paper where less burdensome requirements can meet the safety and quality checks needed to protect the community.*

OPTION 7: RESERVATION OF TITLE AND WHOLE OF PRACTICE

This model is the most restrictive form of regulation and includes not only offences for unregistered persons to use reserved professional titles, but also a broad 'scope of practice' definition of the profession in legislation and it is an offence for unregistered persons to practise the profession.

*This option is **NOT** supported by ANF as it is an even more unnecessarily onerous regulatory system for most of the levels of workers under discussion in this paper where less burdensome requirements can meet the safety and quality checks needed to protect the community.*

8 References

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