Assistants and support workers: workforce flexibility to boost productivity – Summary report

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Key definitions

Throughout this report ‘assistant’ is used as a generic term to cover all groups nominated in the scope of this analysis, including those key roles below.

The general principles and issues of this analysis are applicable to all workers who assist or support. It does not denote any industrial term or condition or attachment to a professional discipline, sector, setting or training.

**Assistant:** Assistants work to and under the delegation and supervision of a health professional; take on less-complex treatment or care tasks; and perform administrative or other tasks that would otherwise reduce the time available for more complex direct care by more highly trained practitioners (Health Workforce Australia 2013). For the purpose of this analysis ‘delegation’ means assignment of responsibility to another person (normally from a manager to a subordinate) to carry out specific activities and tasks.

**Support worker:** Support workers undertake a broad range of health or care roles within defined service plans, reporting to a supervisor. They provide person-centred support and consumer-directed care to people in community and residential settings. Work may be carried out under regular direct or indirect supervision or be autonomous (self-directed recovery-oriented support). Support worker may be used interchangeably with assistant in some contexts.

**Personal care worker:** Personal care workers are those workers other than registered or enrolled nurses and hospital orderlies who provide personal care, general household assistance, emotional support and companionship for aged persons and those with disability.

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1 For example, Aboriginal health workers have common issues such as delegation and supervision. See HWA 2012, Growing our future, [https://www.hwa.gov.au/sites/uploads/ATSI_HWA_FINAL_REPORT_IN1_SML.pdf](https://www.hwa.gov.au/sites/uploads/ATSI_HWA_FINAL_REPORT_IN1_SML.pdf)
Analysis of assistant and support workforce in Australia

This paper is a brief summary of the key issues and recommendations covered in the full report Health Workforce Australia 2014, Assistants and support workers: workforce flexibility to boost productivity (2014). The full report can be accessed at www.hwa.gov.au

Purpose

Assistants and support workers have always been an important part of the workforce. They contribute to health, ageing, disability, mental health and social care in the public, private and non-government sectors.

“These workers represent the largest part of the health care and social assistance workforce, at 50 per cent of the total (CSHISC 2013).”

There is significant potential for this workforce to help meet the challenges posed by workforce shortages, escalating costs and increasing demand and systemic barriers. To date, this potential has not been met.

This paper seeks to establish how the introduction and expansion of assistant roles can assist health care and teamwork and contribute to wider workforce reform to boost productivity.

Scope

‘Assistant’ is a broad term used to cover all workers who assist or support, and includes:

- allied health assistants (AHA)
- nursing support workers and assistants in nursing (AiN)
- personal care workers (PCW) and patient care attendants (PCA)
- medical practice assistants
- peer workers (although the lived experience component is different for this group, many of the issues are similar).

For the purpose of this paper, the analysis includes all workers defined under the Australian and New Zealand Standard Classification of Occupations (ANZSCO) codes 4231 and 4233.²

These assistants work across the range of community to acute care, assisting with basic care through to more complex needs. While this analysis primarily focuses on assistant roles in health, its findings can also be applied to other areas such as aged care and disability care and, indeed, draws on evidence from these areas. The paper does not address industrial or regulatory issues pertaining to assistants and support workers.

² All allied health assistants may not be captured under the therapy aides code 42331 but are included in this analysis.
Methodology

This paper examines assistants’ contribution to and fit with healthcare teams and the broader workforce reform agenda.

It analyses the available evidence relating to the assistant workforce, including:

- the characteristics of the Australian assistant workforce
- current Australian assistant workforce roles, scopes of practice and models
- tested models for the most efficient and effective use and skills mix in healthcare teams
- the barriers and enablers to large-scale and consistent uptake of this workforce.

The information is investigated against:

- the contribution and validity of the assistant role in services and teams
- the appropriateness of assistant roles and functions
- the feasibility of introducing and expanding assistant roles in terms of cost, supply and training.

The analysis then explores how assistants contribute to:

- boosting productivity and flexibility
- delivering more effective, efficient and accessible services
- building workforce capacity and skills development.

Context

Skills shortages, cost pressures and changing demand are driving new thinking on how health and social care are managed. Addressing workforce issues is a critical part of this new thinking. Larger numbers of health workers alone will not solve the existing problems of poor distribution of providers and skills across underserved communities (Health Workforce Australia 2011b).

Demand

The changing burden of disease related to preventable long-term chronic and complex conditions and of population ageing has driven an increase in demand for health services.

An illness-oriented health system is largely relied upon as the first point of care. This is reflected in a 7.4 per cent rise in hospital separations for people aged 85 and over in 2011-12, compared with the average overall increase of 4 per cent in the same period.

The drivers of demand will continue to make the health workforce the largest employment industry in Australia (CSHISC 2012). The emphasis on primary healthcare, the increases in home care packages
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(Commonwealth of Australia 2013) and the National Disability Insurance Scheme will increase demand for personal care workers and disability support staff (DEEWR 2012). The design of the future workforce must be based on client needs. The challenge is to use scarce resources well and identify and streamline supply options across all sectors (CSHISC 2013).

Assistants and support workers are projected to have one of the largest increases in employment of any occupational group. There are estimates of the need for ‘an additional 750,000 direct care givers within just one generation’.3

There is therefore a need to both recruit more assistants and ensure they have the most appropriate skills to contribute to the whole-of-workforce reforms. In the case of assistants, increasing reliance will be placed on VET-qualified workers and generalist roles to meet growing demand. This demand outstrips growth in the registered workforce, compounded by a constraint on public health and community spending (CSHISC 2013).

Supply and distribution

Health Workforce 2025 (HW2025) projected distributional shortfalls in doctors and overall shortfalls in nursing numbers, particularly in aged care and mental health. There is also a mismatch between the location and deployment of the workforce and where the growing need for care exists (HWA 2012a). This is driven by the trend towards increasing specialisation to manage the most complex but relatively lower volume populations.

Assistants make up a significant proportion of the health and community services workforce: these sectors employ 1,375,000 health and social assistance workers (12 per cent of the population). This is predicted to increase to 1,778,000 workers by 2016-17. A conservative estimate predicts a further increase of 427,000 workers by 2025 (CSHISC 2013).

Most assistants are women who work part-time. The median age is between 47 years and 50 years in aged care (National Institute of Labour Studies 2012), although the median age is lower in the health sector. An increasing number of assistants are born overseas (35 per cent in residential aged care and 28 per cent in community services) (National Institute of Labour Studies 2012). The assistant workforce is generally looking for flexible working conditions and enjoys the caring aspect of the work.

Assistants are covered by the VET sector, the relevant educational attainments including certificates II, III and IV. These are attained under the Australian Qualifications Framework (AQF), designated:

- HLT in health – allied health and nursing
- CHC in aged care and health and community services.4

4 CSHISC is the body responsible for standards and relevance of available training <http://www.cshisc.com.au>.
In reality, there is no minimum entry educational requirement to employment. People enter the assistant workforce from a variety of backgrounds, including degree-qualified or higher-education students.

The retention and turnover rates of assistants vary according to location, sector and discipline (United Voice 2013). Overall, the aged care workforce is relatively stable, with generally long tenure (a third of residential direct care workers and a quarter of community direct care workers have been in the sector for 15 years or more). However, workers frequently move between aged care organisations (National Institute of Labour Studies 2012). In health the turnover seems to be higher, particularly in rural and regional areas (CSHISC 2013).

The ageing profile of the assistant workforce, as well as poor remuneration and recognition, will create a supply issue. Sixty per cent of aged care workers, for example, will retire in the next 10 years and volunteer numbers are declining. Active recruitment of a younger cohort and reform of employment conditions are urgently needed.

**The case for reform**

Worldwide skills shortages and a need to contain costs and manage increasing and changing demand are driving a major rethink of how care is organised, delivered and sustained. Health Workforce Australia (HWA) is focusing on how to use the total health workforce to its full potential to meet the current challenges.

Increasing productivity is a key to delivering and sustaining a nationally self-sufficient health workforce. Among other things, this requires greater flexibility, capacity, efficiency and effectiveness. It also demands improvements in access, responsiveness and safety of services. Reduction in acute and chronic demand can be delivered through such mechanisms as prevention and early intervention.

The future health and care workforce will require more generalist skills and shared competencies for cross-sector care and improved ways of using clinician experience to best effect.

A priority for government, non-government and private organisations is to use the total workforce to its full potential for both depth and breadth of services, and to address increasingly costly systemic barriers and impediments to workforce change.

Assistants will be integral to these approaches. However, their roles in health have often been established in the absence of clear guidelines and tools; they are often under-utilised, and their value and contribution has not been sufficiently recognised. Their contribution to the future workforce has not been fully explored or supported.
Findings

Barriers and challenges to reform

Barriers and challenges exist to making the best use of assistants. These include:

- perceptions around their impact on quality and safety
- concerns about regulation
- concerns about supervision and delegation
- concerns about skill level and training
- lack of clarity around their roles and functions
- the unpreparedness of organisations and professionals to use assistants and at the same time review the roles of other team members
- supply issues, including recruitment, retention, and job satisfaction
- lack of evidence about the cost-effectiveness of using assistants as a single group
- a continuation of piloting assistant roles, where evidence of their use and impact is not shared.

Reforms to use and expand this existing workforce in the most productive way must address these barriers.

The value of the assistant workforce

Assistants should not just be a means to an end, but a group of importance and interest in their own right across health, aged care and disability services.

The evidence suggests that, within sound models of practice, when assistants are provided with appropriate training and support, they can enhance:

- service delivery and allow for a re-focus of delivery to areas of need
- workforce flexibility and team efficiencies
- client outcomes.

They bring important attributes that are valued by clients and carers. Their core attributes as helpers and enablers, companions, facilitators and monitors are specific to their practice and operate as a bridge between themselves, clients and professionals. These generalist skills can be used to create efficiencies and flexibility within and across teams, and community or acute care.

With appropriate training, skills development, governance and supervision they can take on a range of tasks and responsibilities from basic clinical work to support functions. They can work within single disciplines or in multidisciplinary teams.

In the community and home-care sectors, they can work with remote supervision to contribute to delivering primary health care and early intervention to reduce demands on the acute health system.
The role of assistants is feasible to implement in terms of cost, supply and training.

**Assistants’ critical role in reform**

Changing models of care and consumer need have driven changes in workforce roles. These more dynamic role boundaries (see Figure 1 below) have been typified as:

- diversification – new work or new ways of performing work or redistribution of tasks
- specialisation – adoption of increasing levels of expertise in a specific discipline by a select group of the profession
- horizontal substitution – role overlap with roles of another with similar training and expertise
- vertical substitution – profession delegation of tasks to others such as assistants (Nancarrow and Borthwick 2005).

The assistant workforce has always been an important part of healthcare delivery. Assistants are now being considered for their contribution in achieving whole-of-workforce reform as they:

- complement and supplement the work of professional staff, working alongside them to enhance or enlarge existing care and service
- carry out direct clinical care as a delegated activity, clinical care support, administration and coordination activities as the most appropriate choice of worker to deliver that level of care (in terms of cost, scope, routineness and capacity) (Imison and Bohmer 2013; Spillsbury et al. 2013; Centre for Workforce Intelligence 2013; SDO Network 2011)
- act as partial substitutes, taking on activities or tasks previously done by a professional that do not require that level of expertise, releasing or relieving professionals for more complex tasks (Spillsbury et al. 2013)
- function as a combination of all of the above (Dubois and Singh 2009).

The results, when assistants are clear about their roles and are well supported, can include:

- movement from profession-centred care to consumer-centred approaches
- creation of real efficiencies via interdisciplinary teamwork and making better use of clinicians’ time (supplementation and complementation)
- re-balancing who does what, at what cost and availability; this uses substitution or task redistribution for activities previously undertaken by others (role enhancement or role enlargement)
- provision of more direct services (with a range of levels of practice aligned with complexity of need)
- building workforce flexibility and adaptability to change, including use of new and generalist roles (innovation).
The proposed way forward

Assistants should be recognised and used as a:

- valued workforce that helps manage skill and time shortages, supports more effective use of professionals, enhances service breadth and depth, and enables more active participation by clients in their care and continuity of care
- safe workforce that is trained and actively supported by organisations and supervising professionals
- flexible workforce that offers the best choice of staff to deliver certain aspects of care, and provides an essential balancing role for more efficient and effective interdisciplinary teamwork
- cost-effective workforce that is affordable within the right skills mix, agreed governance, and leadership arrangements, and where untapped sources of supply can be supported.

It is recommended that reform should be pursued through six main aspects:

- support stronger local implementation
- invest in the assistant workforce
- promote recruitment and retention
- establish national training and education requirements
- share the evidence to shape and direct reform
- undertake evaluation and research.

1. Support stronger local implementation

Sound local implementation must be supported and consistently promoted at the national level.

The step-by-step guide Support nationally, act locally incorporates the available evidence to help local employers to make decisions that deliver flexibility, good governance and workforce affordability – while managing the variations between jurisdictions.

Best-practice reform will:

- start from the local context and requirements for change
- determine the relevant model of care and evidence-based principles underpinning it
- determine current and future skills mix using a capability approach
- determine which contributions assistants are required to make and the subsequent changes in other roles to capture net productivity
- agree, document, orient and train the whole workforce in local governance arrangements
- use available case studies to ‘push the boundaries’ and support the change
- use team metrics to demonstrate whole-of-workforce change in productivity or service access and responsiveness
- harness the professional and distributed leadership capacity to actively address the barriers to introducing assistants
- ensure assistants are not required to undertake work for which they are not trained.
Reform, at the local and national levels, has the best chance of success when it includes initial service analysis and takes a structured approach to change, leadership and stakeholder engagement.

2. **Invest in the assistant workforce**

Reform must capitalise on the existing workforce and tackle uncertainty by:

- providing support to clarify roles and arrangements for governing safety and quality
- offering assistants access to continuous practice development
- authorising and acknowledging assistants as an integral part of the workforce design by:
  - using a mix of generalist and single-discipline roles, task allocation and assigned workloads
  - ensuring responsibilities are as important as roles
  - articulating different levels of assistant scopes of practice (full, expanded and advanced), aligned with the local context
  - using partial role substitution, complementation and supplementation to optimise care and resource use
- aligning workforce roles and placements with models such as consumer-directed care, the wellness (or active service) model and early intervention
- improving skills in delegation, supervision and confirmation of competency to practice, as well as in arrangements for supervision of generalist or combined roles
- investing in a team culture which values the development of assistant roles.

3. **Promote recruitment and retention**

A transparent and rewarding career structure must be developed to promote the assistant role as a valuable one and career choice in its own right.

This requires articulation into expanded roles as well as pathways into professional qualifications.

As a priority, work must be undertaken with relevant agencies to develop the supply pathways for recruitment and retention that:

- identifies relatively untapped sources that do not take from the existing health workforce, such as second-career seekers, volunteers wishing to formalise their expertise, and declining industries
- streamlines pathways and develops national benchmarks
- targets recruitment of assistants from overseas to match the increasing ethnic background of the ageing population
- ensures recruitment processes identify agreed attitudes and behaviours as the most important elements of competency for these roles.
4. **Establish national training and education requirements**

An industry-wide process should be facilitated to determine whether a certificate III is desirable as a minimum level of qualification for all assistants, together with the variety of pathways to achieve that.

National agreement on elements of the HLT and CHC qualifications should take into account:

- the best combinations of core and elective units for individual settings
- common pathways of competencies, so that workers can move across sectors and respond appropriately to comorbidity and complexity. This could be a common foundation certificate III, which is upgraded through a modular approach for additional technical skills for different sectors
- the assessment of certificates of attainment for local service needs and recruitment
- national data sets on modes of assistant deployment and training levels.

This is to ensure professionals know the scope of practice and capability of their assistant workforce, and what to delegate and authorise.

Delegation and supervision units should be part of core curricula in undergraduate clinical education. Simulated learning environments can be used to build acumen and adeptness in delegation, supervision and monitoring, and to adjust the appropriate responses to complex care needs.

Incentives for low paid workers should be determined that encourage them to engage in skills development (United Voice 2013).

5. **Use evidence to shape and direct reform**

Sectors and organisations must use the available evidence to promote and implement reform.

National repositories should be created to share the evidence, including:

- existing and tested implementation resources building on the work of jurisdictions and employer organisations
- case studies that demonstrate the benefits and uses of assistants
- case studies of the leadership and capability required to sustain the most productive use of assistants. These should be aligned with HWA Health LEADS Australia, the National Common Health Capability Resource and jurisdictional guides.
6. **Undertake evaluation and research**

Where assistants are introduced to a team or their role is enhanced to improve their contribution, team metrics should be used to:

- assess a whole-of-workforce baseline, ongoing productivity and client outcomes
- determine the cost-effectiveness of different types of skill mix and their impact on healthcare settings
- determine a threshold of optimal staffing mix below which care is compromised and above which there is no significant effect on quality outcomes.

Longitudinal studies should be conducted on where and how assistants are deployed to better understand their use and to measure the impact of retention strategies. National data sets specific to assistants should be created.
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