Catholic Health Australia

2026

OUR POSITION
A more connected, efficient approach to address workforce shortages in the care economy

BACKGROUND

Catholic Health Australia (CHA) is Australia's largest non-government, not-for-profit group of health, community, and aged care providers. Our members operate over 80 hospitals in each Australian state and in the Australian Capital Territory, providing around 30 per cent of private hospital care and 5 per cent of public hospital care, in addition to extensive community and residential aged care. CHA Members also provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care services.

CHA not-for-profit health, community and aged care providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care. CHA champions reforms aligned with the healing ministry of Christ and the work of Catholic congregations around the country.

The aim of our position statements is to outline CHA's policy and advocacy priorities on key issues that are essential to the mission and values of its members.

A more in-depth analysis of our policy positions is available through our government submissions.

POSITION

Workforce shortages across Australia's health, aged care, and disability sectors are placing increasing pressure on the delivery of essential services.[1] Despite growing demand driven by an ageing population and rising care needs, the supply of workers is not keeping pace.[2] This misalignment undermines the sustainability and effectiveness of the care economy.[3]

Without coordinated national action, these shortages — projected to reach approximately 285,000 workers by 2049–50, particularly among aged and disability carers, nursing support, and personal care workers — will continue to escalate.[3] The abolition of Health Workforce Australia in 2014 left a critical gap in national oversight and strategic workforce planning. While some data is being collected, it is fragmented and underutilised, limiting the ability to respond to current and future workforce needs.

A cohesive, system-wide approach to strategically invest in our care workforce is urgently needed. Such reforms must address structural barriers to workforce attraction and retention — including housing affordability, cost of living, pay and conditions, and competition from adjacent sectors and international markets. This approach is aligned with our broader commitment towards upholding the principle of the common good.

The care economy is undergoing significant reform,[4] but without integration across health, aged care, and disability, these efforts risk being piecemeal. A connected approach focused on systems and processes is essential to building a sustainable, skilled, and satisfied workforce capable of addressing the issues facing our fragmented care landscape.[4]

CHA calls on the Government to:

- Fund innovation to enable sector investment in new workforce models across the care economy
- Align reform agendas across the care economy to ensure cohesive and sustainable workforce development
- Design funding and incentive structures that address structural barriers to workforce attraction and retention

How would funding innovative workforce models help address these shortages?

Australia's care sectors lack a unified, long-term workforce strategy. Fragmentation forces these sectors to compete for the same workforce, undermining sustainability and limiting our ability to meet growing care needs. These sectors are not only competing with each other for the same workforce but also with other countries facing similar challenges.[5,6]

To uphold the common good, we must move beyond identifying shortages and invest in a coordinated approach that prioritises collaboration over competition. Catholic Social Teaching calls for solidarity and human dignity, guiding us to create a system that serves all, especially the vulnerable.

This requires a well-resourced mechanism to design, implement, and evaluate innovative workforce models, supported by dedicated funding. Such investment will enable sector-wide collaboration, trial new approaches, and scale successful models — improving attraction, retention, and mobility, and building a resilient care economy for the future.[6]

A coordinated strategy, supported by innovation funding, is critical to building a sustainable, skilled workforce capable of meeting Australia's evolving care needs.[7] Importantly, this strategy articulates an understanding of what the future workforce should – and could – look like.[7]

Modernisation of key system components is required. As a starting point, this refers to:

- **Regulation:** Risk-proportionate, adaptive regulatory models that support care quality and workforce mobility.
- **Funding:** Integrated, outcomes-based funding models aligned with emerging care delivery approaches, including virtual care and multidisciplinary teams.
- **Technology**: Technology as an enabler of participation and retention, with tools designed for workforce needs rather than retrofitted.

One practical action within this strategy could be integrating the various workforce planning initiatives currently underway across government departments and portfolios — such as the Health Workforce Taskforce[8] and Jobs and Skills Australia[9] — into a single, coordinated framework. This would reduce duplication, align priorities, and leverage shared data insights to inform evidence-based decisions. By joining up these efforts, Australia can create a unified approach that accelerates innovation and ensures reforms are implemented consistently across the care economy.[7,10]

Above all, this strategy must include multi-year funding commitments to modernise these components and support the change management and capability-building required to embed new ways of working. Investment at this scale is essential to address current and future workforce shortages and secure the sustainability of Australia's care and support economy.[6,10]

Why is risk-proportionate, adaptive regulation needed to address barriers to workforce mobility?

The care economy is inherently complex, with variations in regulations, processes, and expectations across states and sectors.[7,11] These inconsistencies create barriers to workforce mobility and undermine efforts to place qualified professionals where they are most needed.[7] For example, worker screening requirements differ significantly between jurisdictions, slowing workforce movement despite a shared goal of improving care quality. Such fragmentation limits flexibility and responsiveness at a time when workforce shortages demand agility.[11,12]

Excessive or poorly targeted regulation can also have unintended consequences. In aged care, for instance, associated providers face a heavy administrative burden, completing multiple iterations of similar forms to engage with registered providers.[12] Registered providers, in turn, must register all associated providers in the Government Provider Management System (GPMS) and ensure their staff meet screening requirements, comply with the Aged Care Code of Conduct, and maintain training standards — even when these obligations may not be proportionate to the services provided. This complexity adds cost and responsibility, creating a significant risk to workforce retention, and dampening workforce satisfaction.

To address these challenges, a national alignment of reform priorities is critical.[9] A unified framework would support consistency in standards and processes, making it easier for workers to transition across settings and jurisdictions.[10] Risk-proportionate, adaptive regulation ensures that compliance measures are tailored to actual risk, reducing unnecessary administrative burden while safeguarding care quality. This approach would enable a more agile, responsive workforce and help achieve the overarching goal: having the right people in the right roles at the right time.

Why is outcomes-based funding for innovative workforce models important for addressing ongoing workforce shortages?

Outcomes-based funding models shift the focus from activity and volume to measurable results,[13] creating incentives for providers to invest in workforce strategies that deliver better care and efficiency. Insights from the Payment by Outcomes trial highlight the potential of these models in strengthening employment supports, demonstrating how linking payments to results can drive innovation and better long-term outcomes for jobseekers.[14]

Aligned with the Department of Social Services' Outcomes Measurement Initiative,[13] this approach underscores the need for consistent, transparent, and evidence-based frameworks to define and track outcomes. Embedding robust measurement practices enhances accountability, supports data-driven decision-making, and ensures that social investments deliver meaningful benefits for individuals and communities.

Why is outcomes-based funding for innovative workforce models important for addressing ongoing workforce shortages? (cont.)

By linking funding directly to workforce outcomes — such as retention, skill development, and team-based care in the health care context — these models encourage employers to adopt innovative approaches, including multidisciplinary teams, to address workforce maldistribution and better align services with population needs.[14] This not only improves productivity but also helps address chronic workforce shortages by:

- Attracting and retaining talent through recognition of quality and collaboration rather than throughput.[10,16]
- Aligning incentives for education, migration, and workforce planning to ensure a responsive pipeline of skilled workers.[7,9]
- Driving accountability across system actors, fostering shared responsibility for workforce sustainability and care quality.[7,13]

Integrating these principles into funding frameworks ensures workforce policy is proactive, adaptive, and equipped to meet future challenges in the care economy:

- Funding frameworks should reward providers that implement **integrated, team-based approaches** involving allied health, nursing, and social care professionals. Recognising the value of collaborative care is critical to improving patient outcomes, reducing duplication, and enhancing system efficiency.[14]
- Funding should be linked to a **national skills system** that is connected, coordinated, and responsive to labour market needs. This alignment must promote coordination between education, migration, and workforce planning to address skill shortages and enable inclusive participation across the economy.[9,10]
- **Shared accountability and outcome indicators** across system actors —such as workforce sustainability, patient outcomes, and productivity improvements — should underpin funding frameworks to drive transparency and provide a basis for future funding decisions.[17]
- Dedicated funding for **continuous development, ongoing training and upskilling**, particularly in areas such as digital transformation, leadership and supervision, is essential to maintain a future-ready care workforce.[6,9]
- **Formalised partnerships** between health, education, and workforce stakeholders should be incentivised.[7] Targeted funding can support joint governance and decision-making processes that deliver shared workforce outcomes.[14]
- Funding models must be **adaptable** to changing labour market conditions and demographic shifts. Mechanisms for rapid response to emerging skill gaps will ensure resilience and continuity in care delivery.[5,6]

How can technology be used as an enabler of workforce participation and retention?

It is known that technology can reduce workload and improve job quality when appropriately embedded within existing workflows. Generative AI (GenAI) tools can significantly reduce administrative and planning burdens, freeing up time for higher-value tasks.[6,10] This reduction in workload can alleviate worker stress and improve job satisfaction – key factors in retaining workers in high-pressure sectors like health and aged care.[10]

Additionally, technology can support skill development and career mobility. Digital tools and AI-enabled platforms can provide personalised learning and adaptive training, making upskilling more accessible and efficient.[6]

Technology to support skill development will be critical in a labour market where 90% of new jobs will require post-secondary qualifications and workers are expected to change occupations multiple times over their careers.[9,18] Technology-enabled learning pathways help workers stay employable and engaged, reducing attrition and supporting long-term participation.[6,19]

Well-designed technology solutions can remove barriers for underrepresented cohorts — such as people with disability, First Nations Australians, and those in remote areas — by enabling flexible work arrangements, remote service delivery, and accessible learning tools (e.g., text-to-speech, translation, adaptive interfaces).[18,19] Inclusive technology adoption helps employers tap into underutilised talent pools, addressing shortages and improving workforce diversity, which is linked to better retention and productivity outcomes.[19] However, key considerations and safeguards should be in place to ensure equity of access.[18]

What can genuine collaboration look like when strengthening workforce sustainability, mobility and stability?

A range of policy options can enable the care economy to collaborate effectively in designing funding and incentive structures that address structural barriers to workforce attraction and retention. As previously noted, some of these barriers include housing affordability, cost of living, pay and working conditions, and competition from adjacent sectors and international markets. Additional challenges include inconsistent regulation, high rates of burnout, limited career progression, and inadequate supervision or support. Several potential options to address these barriers are outlined below.

Implement a National Skills and Capability Matrix

Unlocking full scope of practice across the workforce is essential for productivity.[10] This includes expanding access to prescribing, referrals, diagnostics, and care coordination for qualified non-medical professionals, and removing funding siloes that privilege some roles over others to enable equitable utilisation of skills. [10]

The development and implementation of a National Skills and Capability Framework and Matrix would:

- Provide a clear understanding of the skills and capabilities of health and aged care professionals.

What can genuine collaboration look like when strengthening workforce sustainability, mobility and stability? (cont.)

- Support a coordinated approach to workforce planning across sectors.
- Address barriers that prevent professionals from working to their full potential and delivering contemporary, integrated care.

This work is already underway and will require strong sector collaboration and support to ensure effective implementation across the care economy.[20] Additionally, ensuring that a national workforce planning body, equipped with oversight of the care economy, has a mandate to lead the implementation of this matrix.[7,10]

Funding to trial new medical and nursing workforce models

The Commonwealth Government should directly fund pilot programs for new workforce models under the oversight of the Health Workforce Taskforce.[8] This initiative is timely as findings from the Scope of Practice Review identified significant barriers and opportunities for health practitioners to work to their full potential.[10]

These pilots should focus on developing models where care is delivered by medical professionals with less training or experience, under the supervision of appropriately credentialed clinicians, to maximize the scope of practice. CHA members, operating across health, aged, and community care settings, are well-positioned to provide a sandbox environment for these pilots.

Key considerations include:

- Pilots must be designed with scalability in mind to ensure benefits extend across the entire care economy.
- Embedding monitoring and evaluation functions from the outset is essential for measuring impact and informing broader implementation.
- Strong sector collaboration and support will be critical to success.

Integrating housing and infrastructure policy to support workforce participation

Genuine health and wellbeing for all people begins with access to secure, affordable housing that meets the care needs of its residents. In line with CHA's ethos, Catholic organisations, civil society, and governments share a moral imperative to address the housing crisis and rising homelessness, with a particular focus on supporting the most vulnerable in our communities. CHA's position on housing and homelessness policy is available here.

To build a resilient care workforce, government must better integrate health and housing policy — particularly as rental unaffordability for care workers continues to rise.[21]

The Commonwealth Government should urgently explore and implement rental support measures for essential health and aged care workers,[22] including:

- Exemptions from salary packaging caps and
- Rental deductions up to a defined limit for properties located within a specified proximity to workplaces.

What can genuine collaboration look like when strengthening workforce sustainability, mobility and stability? (cont.)

This investment would:

- Provide a pay advantage for a workforce currently lagging behind market rates for comparable graduate roles, improving attraction and retention.
- Support not-for-profit healthcare providers overcome a critical recruitment barrier in high-cost regions.
- Incentivise nurses to remain in local care settings, reducing reliance on costly agency roles.

Clear eligibility criteria must be established so that these rent subsidies and exemptions target those most in need.

Enhancing supervision and accreditation for junior doctors to expand hospital capacity and capability

Current models for the supervision and accreditation of junior doctors act as a structural constraint on hospital capacity, limiting the system's ability to meet growing service demand. Several interrelated factors contribute to this bottleneck:

- Training numbers are capped rather than demand-driven. Junior doctor training cohorts are determined by fixed allocations, with little flexibility to respond to workforce shortages or local service needs.
- Supervision and accreditation requirements are unfunded. Hospitals face significant barriers to employing junior doctors — and international medical graduates (IMGs) in particular — because supervision obligations and accreditation limits are not matched by dedicated funding. This has created a clear unmet demand for accredited training positions.
- Visa pathways are slow and resource-intensive. Delays in visa processing for IMG recruitment impose substantial operational and financial pressure on health services, undermining workforce planning and continuity of care.
- System-level focus is skewed toward entry rather than progression. Policy attention has concentrated on expanding medical graduate numbers, with comparatively little investment in supporting their transition into accredited training programs and stable, long-term career pathways.

Addressing these structural issues is essential to unlocking the latent capacity within the existing medical workforce. During COVID, workforce pressures eased temporarily through visa flexibility, emergency funding, and relaxed supervision arrangements — measures since wound back, exposing long-standing weaknesses that current policy has yet to address.

Closing this gap requires Commonwealth, state, and territory governments, colleges, and health services to jointly fund and design supervision and accreditation pathways that reflect actual service demand — moving beyond capped allocations toward co-invested, demand-responsive models that share supervision costs, streamline IMG recruitment, and build transparent progression from graduation into accredited training and long-term careers.

What can genuine collaboration look like when strengthening workforce sustainability, mobility and stability? (cont.)

Leverage migration policy to strengthen workforce sustainability

Immediate Action

International students on visas studying qualifications in the care economy — particularly aged care — should be exempt from the current fortnightly working hour cap. This measure would serve as an interim solution to address the acute shortfall of direct aged care workers and meet growing demand driven by Australia's ageing population.[23] This exemption aligns with previous temporary measures introduced during the COVID-19 pandemic to alleviate critical workforce shortages.

Long-Term Strategy

Migration must be treated as a strategic lever, not a short-term fix.[18,24] Australia faces intense global competition for a limited pool of skilled health and care professionals.[6]

To remain competitive, migration settings must:

- Be streamlined and prioritised for high-need roles.
- Coordinate with domestic training pipelines to ensure system resilience.
- Include reforms to visa pathways, faster recognition of international qualifications, and improved onboarding and retention supports for internationally qualified workers.

Genuine collaboration is critical to making migration policy more effective in addressing regional workforce challenges such as housing affordability, maldistribution of skills, lack of access to childcare, transport barriers, high levels of non-attendance rates, limited specialist supervision and/or teaching and others.[6,18]

A national workforce planning body exemplifies what this collaboration could look like — bringing together governments, industry, training providers, and regional stakeholders to align migration settings with real-time labour market data and local needs. By integrating regional insights into a coordinated national approach, as outlined in the *Jobs and Skills Roadmap for Regional Australia*,[24] migration policy can become a strategic lever to support sustainable workforce development across rural and remote communities.[18]

Importantly, migration should complement, not replace, domestic upskilling and training initiatives; both are essential for a sustainable and resilient care system.[18,24]

What policy settings are needed to build a workforce fit for the future of care?

Building a stable and sustainable care workforce also demands coordinated action across two interconnected fronts: reforming agency labour dependency and navigating the complexities of industrial relations reform. Several options to achieve this are outlined below.

Address the casualisation of the care workforce

The growing reliance on agency labour within health and aged care services presents significant risks to both care quality and financial sustainability.

What policy settings are needed to build a workforce fit for the future of care? (cont.)

Unlike staff formally employed by a health service, agency workers are less likely to be embedded in the organisation's culture, trained to its specific protocols, or aligned with its service delivery standards — factors that collectively undermine consistency and quality of care outcomes. In aged care, for example, average agency hourly rates of $50–$70 can translate to costs exceeding $50 million annually for providers, and this figure does not account for the substantial ancillary expenses associated with maintaining a high proportion of agency staff, including accommodation, transport, and onboarding and offboarding requirements.

This problem is particularly acute in regional, rural, and remote areas, where workforce shortages and a lack of available staff accommodation can leave aged care and health service providers with little choice but to rely on agency staff or fly-in/fly-out workers to meet care minutes targets and minimum staffing obligations. Rather than representing a flexible staffing solution, over-reliance on agency labour in these contexts has become a structural cost burden and a material risk to care quality — one that demands a systemic policy response.

Two regulatory options warrant consideration. The first is the introduction of a cap on the number of workers that any single agency staffing organisation can place within the care sector. This approach recognises that while some cohorts of care workers do benefit from agency-based employment, the role that agency organisations play as a systemic contributor to the care economy requires recalibration. The second option is the introduction of restrictions on the fees that agency organisations can charge service providers — a measure that would significantly reduce the cost burden on providers in locations most affected by workforce shortages, without removing access to the flexible staffing arrangements that some services genuinely require.

Any regulatory response must also grapple with a broader equity concern: where agency employment is significantly more financially rewarding or flexible than direct employment — such as nursing roles within a hospital or aged care setting — it creates a structural incentive for workforce drift that undermines sector stability. This matters beyond cost alone, as a consistent, committed workforce is the foundation upon which safe, person-centred care is built.

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