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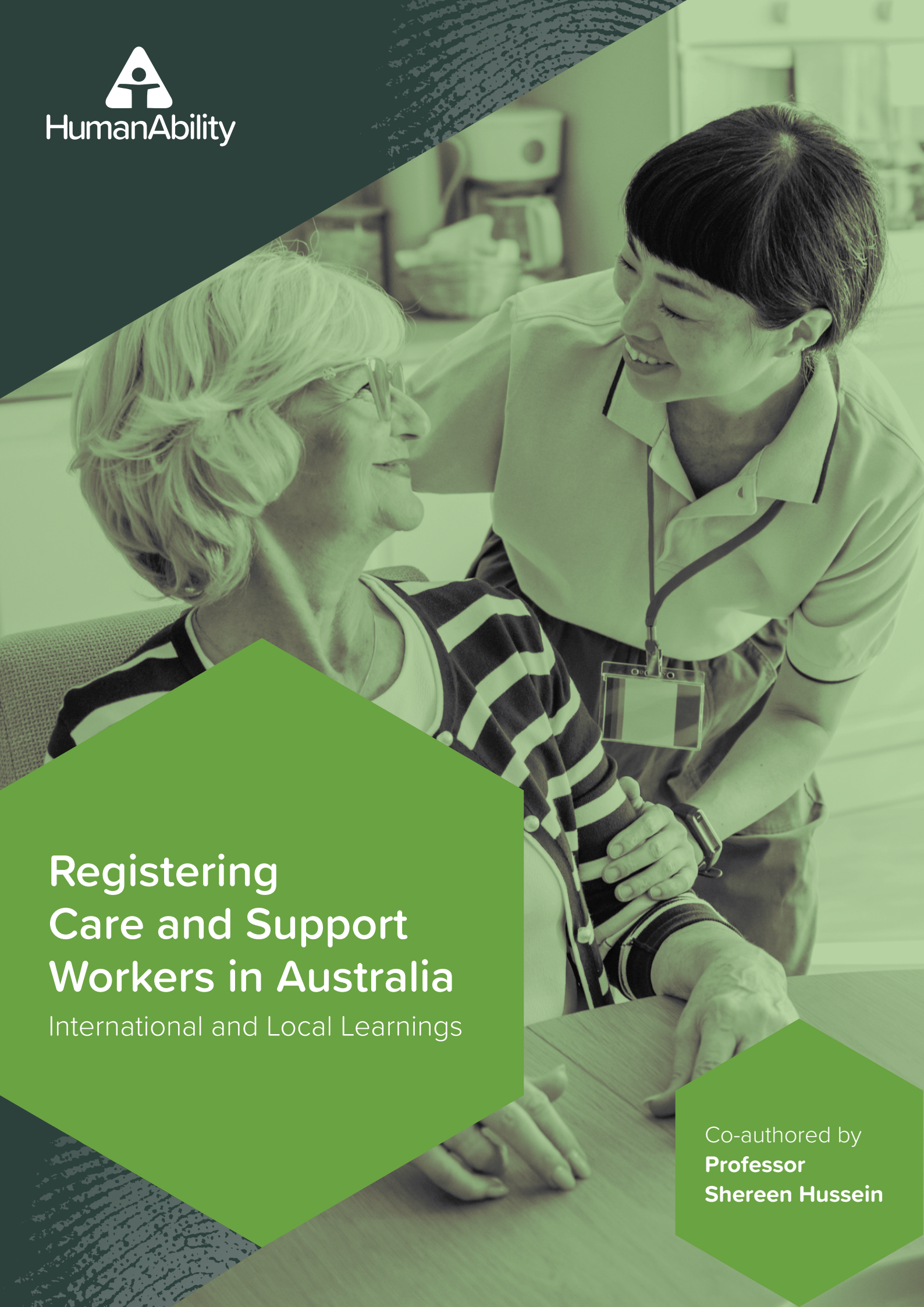

Registering Care and Support Workers in Australia

International and Local Learnings

Co-authored by
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Authorship Acknowledgement

Professor Shereen Hussein conducted the international comparative research, literature review, expert interviews, and an overview of the Australian context with a particular focus on the Victorian registration scheme, with HumanAbility contributing additional content and analysis on the broader Australian policy landscape and early childhood education and care registration scheme. Shereen is a professor of Health and Social Care Policy at the London School of Hygiene and Tropical Medicine (LSHTM). She is the Founder and Director of the LSHTM Centre for Care Research and Policy.

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Executive Summary

Australia is considering introducing a national registration scheme for personal care and support workers in response to recommendations from two Royal Commissions. The evidence, both in Australia and overseas, shows that positive workforce registration and accreditation schemes have the potential to improve career pathways, safety and safeguards, and support better workforce data and clarity of roles.

The challenge for Australia is designing a personal care and support workforce registration scheme, that can professionalise the workforce, improve safety and outcomes for clients, while remaining practical, inclusive and sustainable.

Experiences overseas demonstrate both the benefits of registering, accrediting, and professionalising the personal care and support workforce, and lessons that can be learned from the implementation of such schemes. The case studies discussed in this paper highlight that workforce registration and accreditation schemes require phased implementation, clear regulatory application, fit-for-purpose qualifications, and additional investment in training and support to avoid inadvertently burdening the workforce.

These international examples, alongside case studies and local experiences with registering the Victorian disability, early childhood education and care (ECEC), and Aboriginal and/or Torres Strait Islander Health Practitioner workforces, also show the value of phased approaches to registration. They offer examples of how different registration pathways and clear scopes of practice can be developed, including how systems of provider and worker registration can be linked.

Australia's tripartite skills system and modern Awards frameworks position the aged care and disability sectors well to harness the potential benefits of workforce registration and accreditation, and align safety, training, career pathways and remuneration.

Stakeholders emphasise the importance of the careful implementation of a workforce registration and accreditation scheme. There are clear opportunities to learn from the case studies below to define the scope of practice of a registered worker, different pathways to registration, and support harmonisation across the broader care and support economy.[1]

In designing a workforce registration scheme, HumanAbility, as the Jobs and Skills Council for the aged care, disability and community services, health, children's education and care, and sport and recreation sectors, can play a supportive role, including through the review of Aged Care, Disability, Leisure and Health qualifications, and research work on issues concerning the VET workforce and completions, opportunities to "Earn While You Learn", and recognition of prior learning.

The challenge for Australia is designing a personal care and support workforce registration scheme, that can professionalise the workforce, improve safety and outcomes for clients, while remaining practical, inclusive and sustainable.

Introduction

Globally, care and support workers face persistent issues of low pay, poor job quality, and workforce shortages, leading to recruitment and retention problems.[2] Aged care work has long been treated as "low-wage, low-trust, low-skill" despite its complexity and social value.[3] Similarly, disability support work is subject to low wages and conditions, reflecting poor societal perceptions of the work and its value.

Professionalisation of these workforces, including through standardised training and qualifications is promoted by overseas government bodies and industry as a structural response to improve job quality, elevate workforce status, and stabilise the sector. [4] Professionalisation is described as a "bundle" of policy measures, including registration and regulation; accredited and standardised education, training and Continued Professional Development (CPD); improved pay and working conditions; and stronger vocational identity.[5]

Together, these elements define "positive" models of workforce registration, which move beyond regulatory mechanisms to encompass accreditation, i.e. training and education standards with links to professional development pathways. Workforce registration and accreditation schemes that set these requirements serve as a symbolic and practical mechanism to acknowledge care and support work as skilled, socially essential, and ethically significant.[6] They help redefine care and support work from an unregulated service role to a semi-professional role with codified standards, responsibilities, and a recognised public role.[7]

While workforce registration can be a safeguarding *mechanism* to protect vulnerable service users from harm through frameworks for accountability, codes of conduct, and improved workforce data collection, when it goes further to set standards around the workforce and its skill, it can also be a professionalisation *strategy* to lift the status, quality, and sustainability of care and support work.[8]

Countries such as Scotland, Japan, and Canada have implemented different models of worker registration and accreditation, each shaped by the unique characteristics of their local labour markets, social policies, and care system structures. These international examples provide insight into how a positive worker registration and accreditation scheme can promote professionalisation while avoiding unintended barriers to workforce participation. They also highlight the importance of implementing registration requirements carefully, in alignment with investment in training, career pathways, and fair employment conditions. The existing evidence shows that without appropriate support for the workforce; registration alone can have an exclusionary or punitive effect. In a time when population care and support needs are increasing globally, registration and accreditation schemes must be designed and implemented in ways that support workforce attraction and retention, including through skills development.

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This paper seeks to examine international care and support registration and accreditation schemes and place them in the Australian context. Australia's care and support workforces and policy landscape are at a critical juncture, having been subject to significant public inquiries, such as Royal Commissions, which identified the connections between regulation, safeguarding, public trust and meaningful workforce development. Additionally, Australia's care and support sectors are governed by a unique industrial relations system and funding settings. Both present challenges, and opportunities, for designing a registration and accreditation scheme(s) that meets the shared objectives of safety and sustainability for and workers and the people they support.

The Australian context

2.1 Aged care and disability services in Australia

Australia's aged care and disability sectors are undergoing significant national reform to improve safety, quality, and workforce sustainability, especially following significant public inquiries, namely Royal Commissions, in both sectors. Both sectors are primarily funded through federal expenditure and regulated by federal departments and statutory agencies.

Despite a similar reform background and trajectory, it is important to note that in Australia, the two sectors retain distinct identities, settings, funding and models of service delivery.

Aged care has a focus on restorative and re-enabling care for older Australians to age and retire with dignity. Increasingly, aged care services are delivered in the home and community, reflecting policy and community preferences to avoid entering formal residential aged care facilities. Disability supports are grounded in empowerment, the social model of disability and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

Disability support workers work alongside participants to overcome barriers to access, social and economic participation.

This distinction between care and support between the two sectors is evidenced in models of care and support. While other countries might refer to social care workers across both sectors, in the Australian context, a personal care worker is commonly understood to work in aged care, and a support worker is commonly understood to work in disability services.

In residential aged care, minimum staffing levels for personal care workers through reported and regulated care minutes are accompanied by ratios for nursing staff, and personal care workers operate under the supervision of a Registered or Enrolled Nurse, which are both regulated titles under the Australian Health Practitioner Regulation Agency (AHPRA). Reflected in their inclusion in contributing to nursing ratios in residential aged care, personal care workers are required to support residents with increasing instances of, and growing complexity in, chronic illness and disease, dementia, palliative care, mental ill-health and disability.

The disability sector, by contrast, has seen a shift away from institutional nursing models towards individual or smaller community and placed-based support delivery. The disability support workforce is now large and varied. In contrast to personal care work in larger aged care teams, support workers might be engaged in a wide variety of tasks, from mealtime support and personal care to employment skills and social outings, with much greater independence.

The variations in job role, settings, changing care and support needs, and differences in scopes of practice are reflected in how each sector's policy inquiries approached the topic of workforce registration and accreditation.

2.2 Royal Commission into Aged Care Quality and Safety

Considerable reform of the aged care sector has taken place since the publication of the final report of the Royal Commission into Aged Care Quality and Safety (2021), undertaken by the Aged Care Royal Commission (ACRC). In its Federal Budget 2021-22, the then-Federal Government accepted, or supported subject to further consideration, the 148 recommendations of the ACRC, the first of which called for a new rights-based Act.[9]

It is important to reflect on the significance of the new Act, as the ACRC was clear that it would reset the foundation for aged care reform, including the regulation of service delivery and the aged care workforce.

In 2024, the Australian Parliament passed the *Aged Care Act 2024* (Act), which the Government describes as a framework that "places older people at the centre of the aged care system" and aims to make care safer, fairer, and more respectful. The Act introduced new requirements for funding, quality assurance, and provider registration – including conditions relating to workforce training, whistle-blower safeguards, and workforce screening.

These reforms represent a broader shift toward improving the integrity and equity of the aged care system and promoting the rights of older people.

The ACRC also made five recommendations directly relating to registration and accreditation of the aged care workforce. The recommendations centred on a national registration scheme with a code of conduct and criminal history screening; mandatory qualifications, training and English requirements; standardised and contemporary certificate courses with specialist content and pathways; scope of practice; and CPD requirements.[10] Commissioners also recommended that existing personal care workers who do not meet the minimum qualification requirements should be supported by transitional arrangements that allow them to apply for registration based on their experience and prior learning.[11] Commissioner Briggs further recommended that personal care workers be registered under AHPRA, however this recommendation has been rejected.[12]

Consultation and implementation on registration of the personal care workforce

Of these five recommendations, the two most pertinent to registration and accreditation have been noted as "substantially progressed" but not fully implemented. In December 2022, the Aged Care Code of Conduct was introduced. The Act and its subsequent *Aged Care Rules 2025* introduced a new rights-based complaints process, with significant penalties for workers found to have breached the Code of Conduct. Additionally, criminal history and worker screening checks are now recognised in both the National Disability Insurance Scheme (NDIS) and aged care. These changes implement the regulation aspects of the ACRC recommendations.

They can be broadly characterised as a "negative licensing" approach to workforce for the prevention of harm and the punishment of malpractice. By contrast, the Inspector-General notes that minimum training requirements, yet to be implemented, "signal the importance and value that should be afforded to care workers and positively reflects on the professionalism of the sector."[13]

In early 2025, the Australian Government launched a public consultation seeking views on the design of a national registration scheme to support personal care workers employed in aged care, including the implementation of minimum qualifications. The Government states that the proposed scheme is intended to strengthen and grow the aged care workforce, improve working conditions and opportunities for professional development, and enhance professional standards, quality and safety of aged care.

The consultation received broad support from the sector, including clear preference for a Certificate III in Individual Support as the mandatory qualification, a clearly defined scope of practice for personal care workers, 10 hours of funded professional development, and some harmonisation of registration requirements across aged care, disability support and veterans' care.[14] In the transition to workforce registration, sector leaders highlight the importance of provisional registration pathways, and reducing administrative and financial costs to workers.

Consultation showed broad sector support for a "positive" workforce registration and accreditation scheme. Trade unions, including the Health Services Union (HSU) and the Australian Nursing and Midwifery Federation (ANMF), and peak bodies and consumer representatives, argue that a minimum qualification requirement (namely, a Certificate III in Individual Support requirement for personal care work) is fundamental to professionalising the care and support workforce and improving quality of care.[15] Other stakeholders agree that registration has the ability to attract and retain workers by reframing aged care as a career of choice.

The proposed scheme is intended to strengthen and grow the aged care workforce, improve working conditions and opportunities for professional development, and enhance professional standards, quality and safety of aged care.

Palliative Care Australia calls for registration to define a clear professional scope for personal care workers and recognise their role in end-of-life care by ensuring the Certificate III in Individual Support includes core palliative care content. Similarly, Dementia Australia calls for training to align with the National Dementia Education and Training Standards Framework.

There remains debate over the efficacy of a police check system alone to ensure that workers are "fit and proper" to deliver safe care to clients.

2.3 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability and NDIS Review

In 2023, the final report of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission (DRC)) was tabled. The Federal Government holds responsibility for 172 of the 222 recommendations in the DRC and accepted 13 recommendations in full and 117 in principle.[16]

Notably, Recommendation 10.8 of the DRC called for a national disability support worker registration scheme to be implemented following additional consultation on the scope and elements of any such scheme. The recommendation identified priority considerations including: a standard definition of 'disability support worker'; a code of conduct applicable to defined and registered roles; mandated screening checks; recognition and accreditation of qualifications, experience, capabilities and skills with CPD requirements; cross-sector and agency registration; portable training and leave entitlements; and dedicated First Nations workforce pathways.[17]

It is important to note a clear distinction between the two Royal Commissions regarding worker registration. Unlike the ACRC, which proposed a specific minimum qualification as part of the accreditation component of the aged care personal care workforce, the DRC was not this explicit, both in qualification level, mandating it, or scope of application. This reflects the difference between the sectors, where in aged care, minimum qualifications are viewed as important to quality assurance and safeguards, while in disability, there are different views about whether a mandated and standardised qualification could serve to limit the choice and control of people with disability.[18]

Discussion of workforce registration was continued through an independent review of the NDIS, commissioned by the Federal Government. The Review's final report called for a mandatory "risk-proportionate" registration of service providers (Recommendation 17), underpinned by a "provider risk framework", as well as mandatory worker registration, including universal and streamlined screening of NDIS workers.[19] Worker screening and provider registration were introduced in aged care in response to the ACRC.

Following the Review, a Registration Taskforce was appointed in 2024 to consult further on the detail of mandatory registration of NDIS providers and workers. In its final advice, the Taskforce recommended a set of requirements to underpin a disability worker registration scheme. As with the DRC's recommendation 10.8, this included a call for further consultation and co-design; an agreed definition of NDIS provider and worker; a publicly searchable register; cost controls for workers; professional development, and safety training requirements; a worker training and qualifications framework; and obligations on registered providers to provide training plans for workers, dependent on the service and workforce size.

While the Taskforce reached consensus on some elements of the DRC and Review's worker registration recommendations, such as calling for 10 hours of professional development for workers and minimum training requirements, it was unable to establish a definition of a registered disability support worker and to whom the minimum training requirements would apply. It called for the Worker Training and Qualifications Framework to be "co-designed by the disability community and disability sector, including employers, unions and HumanAbility".[20]

The Taskforce also proposed a set of obligations and regulatory requirement for registered providers proportionate to risk, including advanced registration requirements for daily living requirements in closed settings (e.g. group homes) and general registration for medium-risk supports. This graduated risk framework[21] recommended for regulating disability services has potential to provide "scaffolding" for a future disability worker registration scheme with tiered qualification requirements, particularly where a disability worker registration scheme is linked to an NDIS provider registration scheme.

2.4 Cross-sector regulatory developments

In both sectors, efforts to improve quality standards in care, including through workforce training, have focused on requirements for providers. This reflects the Federal Government's role as the primary funder and regulator (via the Aged Care Quality and Safety Commission and the NDIS Quality and Safety Commission) of care and support services, and the aspiration to remove barriers to workforce mobility across funded sectors.

The move to harmonise regulation is consistent with recent proposals from the Productivity Commission for a unified, regulatory ecosystem across the care and support economy, through greater alignment of provider regulation across the NDIS, aged and veterans' care, and early childhood education and care sectors. Further reforms to support harmonisation recommended by the Commission include designing the proposed national registration scheme for personal care workers in aged care with sufficient flexibility to allow for any future expansion to the NDIS, the veterans' care sector or other care professions, as well as a single registration portal, and a national system of credit transfer and recognition of prior learning (RPL).[22] These recommendations provide a potential roadmap for joining up different Royal Commissions and establishing the infrastructure to register the workforce.

2.5 Australia's vocational education and training system

Significant shifts have also impacted Australia's vocational education and training (VET) system. An increasing emphasis on workforce planning, improving data, and better aligning qualification reform with industry need saw the creation of the 10 Jobs and Skills Councils (JSCs) in 2023, replacing the former Skills Service Organisations.

In addition to developing training products (including the units of accredited qualifications), JSCs have been given an expanded remit compared to their predecessors, including implementation, promotion and monitoring, as well as broader workforce planning and industry stewardship. This broadened role reflects an intent to join up skills policy with workforce planning, and position qualification reform within workforce strategy.

Tripartite engagement – centring employers, unions and governments in skills reform – has also become a corner piece of VET reform and ensures workforce changes are genuinely sector-led. As industry stewards, JSCs are required to demonstrate tripartite engagement in qualification reform and workforce planning, and in their governance, and prioritise workforce mobility and career pathways.

HumanAbility is the Jobs and Skills Council for the health care and social assistance industry. Its role, including in developing the qualifications potentially subject to a worker registration scheme, leaves it well placed to influence thinking on, and develop strategies for implementation, through deep insights that cut across the training sector, industry and workforce. This includes supporting sector readiness for regulatory change and increasing quality requirements, mandatory child safety training and minimum qualifications in the ECEC sector, and addressing barriers to vocational course enrolments and completions.[23]

The VET system has also seen exceptional investment in training access and innovation, with a focus on essential care services and the TAFE system. This includes the introduction of the Federal Fee-Free TAFE Program in 2023, which saw the Certificate III in Individual Support become tuition free for many learners, and the establishment of several TAFE Centres of Excellence to lead cutting-edge approaches to care and support training and workforce development.

This joined up approach to workforce development, combining jobs and skills policy and improving the accessibility and quality of training, points to broader investments in training and career pathways that are sector-led, and can support transitions to workforce registration and accreditation.

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Case studies in Australia

3.1 Victorian Disability Worker Commission

Victoria operates a voluntary registration system for disability support workers through the Victorian Disability Worker Commission (VDWC) and Disability Worker Registration Board of Victoria (DWRBV). Victoria's disability support worker registration scheme, established following a state parliamentary inquiry, has been operating for five years and is regarded as a pilot for potential national implementation. At present, the VDWC and DWRBV make Victoria the only jurisdiction in Australia with a dedicated registrar and regulator for disability support workers.

The VDWC's primary aim is to prevent abuse and ensure the safety of people with disability by promoting accountability and workforce professionalism. It has the authority to investigate complaints and notifications against any Victorian disability worker. Through its mandatory notifications scheme, Victorian disability workers and their employers are required to report unsafe behaviour by colleagues. Its Code of Conduct applies to all disability workers delivering disability services in Victoria, regardless of their funding source.

A 'disability worker' is defined as "a person who either directly provides a disability service to a person with disability or supervises or manages another person" doing so. In response to complaints, the VDWC may ban workers found to have engaged in misconduct, and maintains a public Prohibited Workers Register.

The registration scheme provides two streams, but with multiple pathways:[24]

1. Disability Support Workers may qualify for registration by:
    a. Applying with a qualification – must hold a Certificate III or higher in Individual Support, Disability, Aged Care Work or a related field (or training equivalent to) and have relevant work experience providing disability services in the past 10 years; OR
    b. Applying with professional experience – must have at least 1,440 hours of relevant work experience providing disability services over at least 2 years in the past 10 years; OR
    c. Applying with combination of both – relevant qualification related to practice as disability worker plus at least 120 hours of relevant work experience in the last 10 years.

2. Disability Practitioners may qualify for registration by:

a. Applying with a qualification at a diploma level or higher – must have relevant tertiary qualification in a professional discipline at diploma level or higher, such as allied health or social work, and have relevant professional experience and hold professional registration with a relevant professional body.

While the VDWC regulates the conduct of all Victorian disability workers, registration with the VDWC is voluntary. Disability worker registration with VDWC is different to the NDIS Worker Screening Check. Registered workers must comply with three practice standards: criminal history checks; completion of at least ten hours of professional development each year; and English language competency at a vocational level.

The Commission also educates workers about their obligations under the Code of Conduct and provides an online training and development catalogue to support continuing professional learning. Registration with the Victorian Disability Worker Commission is free, including police and criminal history checks. Workers are encouraged to register, including through their employers in higher-risk settings, appear on a public register, and are issued a badge to demonstrate their registration.

The VDWC has publicly expressed its support for a national statutory registration scheme for disability support workers through its submission to the NDIS Review and DRC, noting that a consistent, nationwide framework would improve the quality of supports provided to people with disability, strengthen public trust, and raise professional standards across the care and support economy.

3.2 Registration of Aboriginal and/or Torres Strait Islander Health Practitioners (AHPRA)

Registration and accreditation of the Aboriginal and Torres Strait Islander Health Practitioner workforce points to the importance of well defining the scope of practice of registered workers alongside other professions, investing in the workforce transition, and the potential for registration and accreditation to support workforce development and career pathways.

From 1986 until the 2010s, the Northern Territory was the only jurisdiction with a registration board for Aboriginal and Torres Strait Islander Health Workers (AHWs). The workforce, both in and beyond the NT, provided supplementary (largely non-clinical) healthcare services to First Nations community members. AHWs' scope of practice, informed by the vocational qualification level held by most in the workforce, was meant to sit alongside, but below, that of allied health practitioners, nurses, and medical practitioners.

Increasingly, however, it became clear that localised community needs and worker shortages, and informal practices around skill acquisition, had blurred these lines. In regional areas, AHWs were expanding their scope of practice, but at times with limited supervision, or the standards to ensure consistency and safety for workers and patients. As Health Workers crossed jurisdictional borders to Queensland, there was an increasing appetite for recognition, standardisation of skills and scope of practice, alongside other regulated health professionals (nurses, doctors, allied health professionals).

In response, the Aboriginal and Torres Strait Islander Health Practice Board of Australia ('National Board') was set up under the Australian Health Practitioner Regulation Agency (AHPRA) to regulate and register a new profession from 1 July 2012: Aboriginal and Torres Strait Islander Health Practitioner.

The resultant national registration scheme created a distinct, protected title for many workers who are Certificate IV or Diploma qualified in Health Care Practice, promoting professional recognition and enhancing community confidence, and awareness of the Aboriginal Health Practitioner role as distinct from Aboriginal and Torres Strait Islander Health Workers.

Under the scheme's requirements, registered Practitioners must hold a Certificate IV of Aboriginal and Torres Strait Islander Primary Health Care (Practice) and also meet requirements around Aboriginal and/or Torres Strait Islander status, English language proficiency, recency of practice, CPD, and professional indemnity insurance (typically held by employer).

While the National Board is responsible for regulating and registering Aboriginal and Torres Strait Islander Health Practitioners, registration itself is recorded on the single national system for the regulation of health professionals, the National Registration and Accreditation Scheme. AHPRA itself is responsible for approving programs of study for the workforce, applying accreditation standards to ensure programs of study, and the training providers who deliver them, are suitable.

Although the now-registered Aboriginal and Torres Strait Islander Health Practitioner workforce is considerably smaller– the profession's journey to registration reveals several key learnings and takeaways behind the successful design of and transition to workforce registration and accreditation:

- **Clarity of role and scope of practice**
  Developing national recognition of the scope of practice of an Aboriginal and Torres Strait Islander Health Practitioner, and awareness of the workforce's role, required policymakers to consider its role alongside other professions. To define a scope of practice for the registered workforce, policymakers mapped which workers would be captured by registration, which other workers would be affected, and what the role of services would be. This process ensured, on the one hand, that parameters of the role would not clash, nor compete, with other health system occupations. On the other, it allowed clinical governance standards to be developed, that outlined how a standardised scope of practice is supported in different settings, under differing models of supervision.

  Critically, this analysis spanned jurisdictional borders, noting that (as with the original AHWs) similar work can often be done by staff with varying levels of skills and training, depending on the locations. An important aspect of registering the role was that it would support vocational identity by making Aborignal and Torres Strait Islander Health Practitioner a protected title, claimable only by those who demonstrated they had met the minimum requirements.
- **Qualification and skill set mapping**
  Against the mapping of scopes of practice, training and career pathways were better defined for Practitioners. Registration and accreditation allowed already qualified workers to be recognised for their advanced skills in health practice, and opened a pathway to Enrolled, and Registered Nursing, and into registered Allied Health work. Instead of creating regulatory duplication and workforce fragmentation, in connection to the vocational training system, registration improved pathways to career progression.

- **Fair and proportionate requirements of, and transition to, registration**
  The transition to workforce registration took considerable time and investment, and points to the important of phased and funded workforce transition. While many Aboriginal Health Workers were qualified, not all possessed the required qualification for Practitioner registration. In the beginning, workers who wished to transition to registration could meet qualification requirements over 18 months, either by completing the revised Certificate IV qualification in its entirety, or by demonstrating prior learning and skill acquisition to count towards a reduced number of units needing to be completed.
- Government investment in RPL was critical to a smooth workforce transition, with only a small proportion of costs shared by Aboriginal Community Controlled Health Organisations (ACCHOs). Financial assistance was provided to AHWs seeking to transition to the newly registered role, with the bulk of expenses covered by government. Crucially, support for this training workload was provided in logistical terms too: with trainers and assessors sent to regional communities, a far more cost-effective process than expecting workers to travel to metropolitan training centres.
- **The value of registration and accreditation to existing workers**
  Regardless of whether they continued onto work as Practitioners, the opportunity to progress to Practitioner work and develop extra skills was valuable for Aboriginal and Torres Strait Islander Health Workers.
  For Practitioners, a regulated scope of practice provided the guardrails to safely, confidently and competently carry out work. For other professions, it was an opportunity to better understand the skills of colleagues and how they can support them as part of collaborative models of care. This demonstrates how registration and accreditation can be embraced as an opportunity to expand career pathways, workforce attraction and retention.

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3.3 Registration of Early Childhood Educators and Care Workers

Australia's early childhood education and care (ECEC) sector presents as a case study in how a fragmented patchwork of worker requirements can give way to a unified, national model. The sector's experience highlights how connecting provider registration and access to funding support with strong, nationally consistent workforce standards, including mandatory minimum qualifications, has raised service quality, governance, and professionalised the workforce. This framework has, in recent months, allowed the sector to respond swiftly to concerns around child safety, with a new National Early Childhood Worker Register, and mandatory child safety training, having been implemented quickly. The Register builds upon the steps already undertaken to introduce various elements of a registration and accreditation scheme for ECEC workers by blending existing screening measures, provider and workforce standards and mandatory minimum qualifications, with a single national register, ongoing training to reflect contemporary sector needs and professional recognition.

The National Quality Standard – Linking workforce enhancement with quality service provision

Prior to 2012, states and territories had different workforce standards applying to ECEC settings. The National Quality Framework (NQF), which started on 1 January 2012, covered a range of elements that reshaped and standardised the sector across the country.

Staffing arrangements (namely, minimum qualifications and staff-to-child ratios relating to different ECEC settings) represented one of seven new overarching expectations for ECEC services, collectively comprising the National Quality Standard (NQS). Other NQS areas cover pedagogy and practice, children's health and safety, and how services connect with families. At the provider level, meeting NQS requirements was (and is) connected to eligibility for the Federal Government ChildCare Subsidy – crucial to their ongoing sustainability and appeal to workers.

The NQS mandated minimum ratios of staff to children at the service level, at various qualification levels (Certificate III and Diploma-qualified educators, and Bachelor's-qualified teachers). While implementation occurred progressively from 2010, providers were granted a transition period from the start of the NQF in January 2012 to fully meet the new workforce standards, ending the inconsistencies that had existed across borders.

Noting the relative training workloads needed to formally qualify staff at different levels in the sector, transition periods for providers to meet associated ratios differed. For instance, providers with over 80 children in attendance at any one time were granted two years (to 1 January 2014) to have 50% of educators at, or working towards, a Diploma level qualification. That same cohort of provider, however, had a full eight years (to 1 January 2020) to meet the requirement of having sufficient numbers of Bachelor's-qualified teachers.

The Australian Children's Education and Care Quality Authority (ACECQA) was established to support state and territory regulatory authorities to transition to the new national framework (which continue to this day to regulate the sector and ensure compliance with the NQS). ACEQA effectively absorbed the duties and responsibilities of its predecessor, the National Childcare Accreditation Council (NCAC), which had been responsible for assessing and maintaining states' and territories' different Quality Assurance Systems (QASs). During the transition periods discussed above, providers operated under the existing staff-to-child ratios that had been mandated by the earlier QASs.

The NQS's reforms significantly reshaped the sector's workforce. Between 2004 and 2019, the proportion of ECEC workers holding a qualification increased from around two-thirds to essentially 100% (including those actively working towards a qualification).[25] The enhanced professionalisation of the workforce has had clear impacts on service quality. Whereas a little over half (55%) of services had met or exceeded the NQS in the year after its introduction, by 2020 that percentage had grown to 82%.[26]

At the same time, the ECEC sector's experience highlights that the benefits of qualification requirements in terms of workforce professionalisation and can take a long time to realise.[27] Despite increasing qualification rates, wages have remained relatively depressed until recently. It is possible that the growing gap between the workforce's skill and its remuneration has provided momentum for broader industrial reform to rectify gendered undervaluation, including support for multi-employer bargaining. However, this shows that the impact of registration on workforce valuation and retention is more indirect, and longer term.

The National Early Childhood Worker Register

In response to reporting on unsafe actors in ECEC settings, the National Early Childhood Worker Register was introduced by federal regulation and commenced on 27 February 2026. It provides ACECQA and state and territory regulatory authorities with point-in-time visibility of all workers in the sector, including their current roles and employers, qualifications and training statuses. The National Register leverages existing national structures introduced by the NQF, including ACEQCA's National Quality Agenda IT System (NQA ITS), through which providers have had to report required information about their workforces since 2012.

The National Register currently only serves to allow for a 'bird's eye' view of the sector from a safety and screening perspective. However, it is being framed as potentially a first step towards a national registration and accreditation scheme for all ECEC staff, across qualification levels. While these updates and additions will need to be agreed upon by all governments, given the sector has demonstrated its capacity to introduce national regulation, qualification and provider and workforce standards, it would not be difficult to add to the Register:

- registration/licencing of all staff (currently, only early childhood teachers with a qualification at Bachelors' level or higher must hold registration with some states' education departments. In Victoria, for example, this cohort makes up only around 17% of all ECEC staff with regular contact with children); and
- record keeping of staff members' professional development and further training, building on the existing qualification and staffing standards already existence and acknowledging the introduction of mandatory child safety training on 27 February 2026, which will be nationally regulated.

Lessons from international experience

A review of comparative experiences in three jurisdictions – Scotland, Canada, and Japan – provides valuable insight into how registration systems can balance safeguarding with workforce sustainability. To complete this analysis, desktop-based research of publicly available data and reports was undertaken, complemented by discussions with stakeholders from Australia, Canada, Japan and Scotland.

These were chosen to illustrate a diverse range of approaches to workforce professionalisation and regulation. The Canadian case study offers an example of a scheme originally intended to serve as a transitional step toward full statutory registration, but which ultimately did not progress in that direction.

The Scottish case study provides the closest comparison to the regulatory model proposed for Australia. Scotland's Scottish Social Services Council (SSSC) oversees a statutory registration system that has substantially improved accountability, data collection, and quality assurance.[28] Yet, the Scottish experience shows that regulation without sufficient investment can create unintended barriers.

Mandatory qualifications such as the SVQ have become expensive and time-consuming, leading to attrition among older and migrant workers and increasing administrative burden on employers.[29]

The Canadian case study offers an example of a voluntary registry for personal support workers (PSWs), which intended to promote recognition and workforce transparency, but saw limited uptake. The case demonstrates that without mandatory participation or a tangible connection to improved wages or conditions, registration offers limited value to workers or employers.[30] Moreover, Canada's fragmented regulatory environment has left the PSW registry disconnected from broader workforce planning and safeguarding systems.

The Japanese case study represents the world's oldest and most established system of regulation for care and support workers. Japan's statutory model demonstrates how professionalisation can be embedded into social welfare policy. Since 1987, the Certified Care Worker system has defined a national curriculum, standardised qualifications, and improved public confidence.[31]

Yet, even in this mature model, structural issues, such as low pay, long hours, and high turnover, persist. Japan's experience reinforces that registration alone cannot overcome deeper workforce challenges.

Several other jurisdictions have moved to register and accredit their social care workforces in 2022 and 2023, reflecting a desire to professionalise the workforce by phasing in registration requirements:[32]

- Social Care Wales now requires registered social care workers to complete Level 2 or Level 3 qualifications within specified timeframes and adhere to a national *Code of Professional Practice*.[33]
- The Northern Ireland Social Care Council (NISCC) announced plans to register the workforce in 2015, and recently introduced qualification and conduct standards similar to Scotland's and Wales'.
- Late last year, the Republic of Ireland's Social Care Registration Board, CORU, has regulated the protected title of 'Social Care Worker'.

These schemes are noteworthy, but have only recently been launched, and only limited data is available. This paper therefore focuses on lessons from more established workforce registration schemes.

Together, the experiences of Scotland, Ontario and Japan indicate that statutory registration can deliver stronger safeguards and data visibility, but without investment in workforce support, accessible pathways to qualification, and genuine sector engagement, it risks exclusion and workforce loss. Voluntary systems, while easier to implement, struggle to achieve meaningful impact.

4.1 Scotland

4.1.1.1 Overview and Regulatory Framework

Scotland has instituted a national statutory registration scheme for social care workers, managed by the Scottish Social Services Council (SSSC). Registration has been mandatory since 2015 for staff in care homes and since 2020 for domiciliary care workers. Even though the title "Social Care Worker" is not legally protected, registration serves as a regulatory baseline for practice oversight.[34] The SSSC was established in 2001 under the Regulation of Care (Scotland) Act as a non-departmental public body with authority over education, training, fitness to practice, codes of conduct, and workforce data for Scotland's social services workforce.

All individuals undertaking roles with direct care or support responsibility are expected to register under the SSSC's scheme, and employers must assess whether a role requires registration (SSSC registration rules). The SSSC publishes quarterly registration data, capturing the number of registered workers and those with qualification conditions (i.e. registered but subject to acquiring qualifications).[35]

Interviews with Scottish Care also highlight how registration legislation was shaped through consultation with provider organisations and people with lived experience. The Care Inspectorate was established alongside the SSSC to oversee quality assurance and provider registration. This has improved accountability and reduced exploitation, including human trafficking among migrant care workers, but also resulted in "provider duplication": providers are subject to overlapping regulatory requirements, meaning incidents must be reported to multiple bodies, such as the SSSC, Care Inspectorate, local health partnerships, and Disclosure Scotland. A series of policy and practical challenges has also emerged around training, funding, and qualification delivery.

The SSSC is exploring further regulation: in 2025, it began consultations on expanding registration to include day centre supervisors, support staff, and other roles, indicating that the current register covers about 176,500 of approximately 213,000 workers in the sector.[36]

4.1.1.2 Education and Qualification Requirements

Registration under the SSSC requires workers to either hold or work toward qualifications relevant to their role. For many, this means obtaining the SVQ (Scottish Vocational Qualification) in Social Services and Healthcare (SSH) at SCQF Level 6. Workers lacking the required qualification can register conditionally and must meet the qualification within a set timeframe, traditionally up to five years.[37]

However, demand for SVQ SSH Level 6 greatly exceeds supply. The Scottish Government reports that approximately 55,000 registered adult social care workers require this qualification, but only about 25,000 training places are available annually, a capacity shortfall more than double the training provision. This mismatch constrains many workers' ability to comply with registration conditions.

Some roles deliver learning via blended or online courses, though feedback suggests that online modules are often seen as "tick-box" exercises done in workers' own time, sometimes on mobile phones, and with limited support. Because of this, training quality suffers, and some service providers fail to comply with industrial obligations: "*care providers may not always pay workers for study time*."[38]

Despite some improvements in accountability, challenges remain. Issues relating to low pay, poor working conditions, and public perception continue to affect the social care sector. According to the Scottish Government,[39] only 52 per cent of adult social care workers hold the required qualification for their role. Housing support workers and domiciliary carers were found to be the least qualified groups.

Some roles deliver learning via blended or online courses, though feedback suggests that online modules are often seen as "tick-box" exercises done in workers' own time, sometimes on mobile phones, and with limited support.

The same 2022 Scottish Government survey found that most care managers viewed current qualifications positively: approximately 90 per cent agreed that they met service needs, and more than 80 per cent believed they supported professionalisation. However, managers also identified persistent skills gaps in areas such as infection control, digital skills, trauma-informed practice, and quality improvement.

Discussions with Scottish Care indicate that fewer than half of the workforce have held the required qualification for over a decade. Most staff work part-time, and around 80 to 85 per cent are women. For the many who also have other caring responsibilities, completing formal qualifications while working is increasingly difficult.

The mandatory SVQ qualification is widely viewed as outdated and poorly aligned with the real demands of care work. It has been criticised as overly academic and expensive, costing between £1,200 and £1,500 per learner. Many care workers complete training online, often on their phones and in their own time, resulting in poor learning quality and potential non-compliance with minimum wage rules.

In June 2025, the SSSC reduced the qualification completion window from five years to three, further heightening concerns about staff retention and service continuity. The new rules apply to all unqualified registered care staff, except those requiring two qualifications, who retain a five-year limit.[40]

4.1.1.3 Workforce Context and Implementation Challenges

Scotland's social care workforce is predominantly female, part-time, and faces multiple pressures. Many workers feel undervalued, citing low pay and limited social recognition, despite the demand for significant specialist training.[41]

Scottish Women's Budget Group surveyed care workers, who often report that mandatory training (infection control, manual handling, dementia, communication) must be completed in their own time, contributing to stress and fatigue.

Vacancy rates in the social care sector are markedly high. The 2020 Staff Vacancies in Care Services report showed an overall vacancy rate of 43%, with home care and housing support services reporting even higher rates (60% and 59%, respectively). In more recent data, the Staff Vacancies in Care Services 2023[42] report confirms that many services continue to struggle to fill posts.

Pay disparity remains a persistent issue. Social care workers commonly receive significantly lower pay than NHS clinical staff performing analogous support roles. While real living wage policies have been introduced in Scotland via government funding programs, uptake depends on whether providers accept contract variations to increase pay.

Research by the Scottish Women's Budget Group shows that social care workers feel undervalued and perceive their work as low status despite the extensive training and registration required. Workers reported high workloads, administrative burdens, and limited pay progression. Pay disparities remain stark compared with equivalent NHS roles. For example, NHS Band 3 support staff earn between £26,869 and £28,998, whereas care workers on the Real Living Wage earn around £24,570 per year. Senior staff in social care often earn only marginally above the minimum wage, despite their experience.[43]

Scottish Care argues that while the implementation of qualification requirements in Scotland was intended to professionalise the sector, they have become a barrier to workforce sustainability. The drive for universal registration has not been matched by adequate financial investment, leaving providers struggling to fund staff qualifications. The Scottish Government previously subsidised training but withdrew this funding in 2022. This has led to retention pressures, with vacancy rates reported as 43 to 48 per cent, compared with 11 per cent across the general economy. Older workers and internationally recruited staff face particular difficulties in accessing or completing qualifications, with risks of workforce attrition as a result.

4.1.1.4 Impact and Lessons Learned

The Scottish registration system has delivered improvements in safeguarding, standard-setting, and public confidence. The Regulation of Care (Scotland) framework incorporates human rights principles and care standards, and codes of practice are embedded within required qualifications and regulatory oversight. Stakeholders report that abuse incidence is lower in Scotland's regulated sector compared to less regulated jurisdictions (e.g. England).[44] Many care facilities are now rated "good" or above by the Care Inspectorate as a consequence of these regulatory reforms.

A key strategic benefit has been data and workforce visibility. The SSSC's registration data supports long-term workforce planning, monitoring qualification compliance, and responding to policy changes. Hemmings et al note that registration yields valuable workforce intelligence, useful during crises such as COVID-19, when regulators used registration data to identify staff lacking infection-control training.[45]

Similar registration data in Wales was used to identify and target infection control training among care workers.[46] This demonstrates the broader strategic value of registration in managing workforce capability and public health risks.

Overall, the Scottish case demonstrates that statutory registration plays an important role in safeguarding, accountability, and professional standards, but limited financial investment and implementation challenges have constrained its success. Without sufficient funding for training and qualification pathways, the system has placed significant pressure on both care providers and workers.

Managers report that regulatory oversight has become burdensome, with inspectors expecting detailed evidence of compliance and due diligence. As a result, many care managers spend substantial time on administrative tasks rather than on workforce development or service delivery. Some care workers also report that the growing volume of documentation and reporting requirements leaves them with less time to provide direct care. Similar issues have arisen in the Republic of Ireland's registration scheme, which has created ambiguity for registered practitioners and organisational leaders, who have assumed responsibility for ensuring compliance among their teams. Research points to the necessity of training to navigate these dual responsibilities effectively and sustain quality standards during implementation.[47]

While registration enjoys broad support across the workforce as a mechanism for quality assurance and public protection, it has also created barriers for staff. The most significant of these is the requirement to complete the SVQ qualification, which remains costly, time-consuming, and often poorly aligned with real workplace needs. Combined with workforce shortages and high vacancy rates, these qualification pressures have made recruitment and retention increasingly difficult.

Professionalisation would have been more effective if accompanied by greater financial support, flexible training delivery, and stronger engagement with frontline workers and providers.[48]

Nonetheless, the Scottish case also highlights significant limitations and risks. Insufficient financial investment has hindered the viability of mandatory qualifications for many workers. Overregulation and administrative burden are commonly criticised, with care managers spending considerable time documenting registration compliance rather than managing care. The SVQ qualification has become a bottleneck, viewed by some as outdated, overly academic, and misaligned with practical training needs. Some workers may leave the sector as a result.[49]

High vacancy rates compound the problem, where a thinner workforce increases pressure on existing staff, making qualification progression harder and retention more fragile. Professionalisation initiatives would likely have more success if accompanied by greater flexibility in qualification pathways, sustained funding, and stronger engagement with the workforce.[50]

Ultimately, the Scottish model shows that registration can act as a foundation for professionalising social care, but only when resources, sector capacity, and administrative design are aligned. The lessons suggest that any national registration scheme should minimise regulatory duplication and ensure workers and service providers are supported in the transition to registration, such as through investment in training, workforce support, and pragmatic pathways.

4.2 Canada (Ontario)

4.2.1.1 Overview and Regulatory Framework

Ontario operates a voluntary registry for social care workers known as the *Personal Support Worker* (PSW) Registry. The registry functions as a database of certified PSWs who have completed approved training programs and met the requirements to work in Ontario. Applicants must demonstrate successful completion of accredited educational courses and exams, proficiency in English or French, and clearance to work safely with vulnerable people. The registry is managed by the Health and Supportive Care Providers Oversight Authority (HSCPOA) under the oversight of the Ontario Ministry of Health and Long-Term Care.[51]

The registry was launched in June 2012 following advocacy from sector organisations seeking formal recognition of PSWs and improved employment standards.[52] At the time, the PSW workforce was expanding rapidly, playing an increasingly central role in delivering care in residential and community settings. The registry was created to increase transparency and enhance the credibility of the PSW occupation. It was established with three main objectives:

1. To highlight and raise awareness of the work that PSWs do in Ontario.
2. To create a platform for PSWs and employers to connect more easily within the labour market.
3. To provide the government with reliable workforce data to inform planning and policy.

Although the registry was initially envisioned as a precursor to a mandatory registration system, this has not been implemented. The Ministry of Health decided to keep registration voluntary, citing concerns about possible disruptions to the health care system and the PSW supply. The Ministry stated that registration "may become mandatory in the future," but only following further policy review.[53]

4.2.1.2 Education and Qualification Requirements

In 2014, Ontario introduced the PSW Program Standard, developed by the Ministry of Training, Colleges and Universities (MTCU), to standardise education across disparate PSW curricula. Rather than prescribing specific courses, the standard defines 14 vocational learning outcomes and essential employability skills, to which all PSW programs must conform.[54]

This standard emerged to reduce variability across the many educational options previously available to PSW students, which had differing requirements and inconsistent quality. The policy was designed in response to a workforce increasingly characterised by unregulated PSWs performing more complex community-based care tasks.[55]

While the standard brought greater coherence to PSW qualification pathways, critics warn it may pose barriers for workers without prior formal education, and does not by itself resolve structural workforce challenges.

Kelly's qualitative research (involving 35 PSWs and students) highlighted several educational barriers: labour market casualisation, misalignment between curriculum and real work demands, limited recognition of home-and community-based roles, and variability in educational quality.[56] Participants also asserted that structural issues, such as poor pay and job insecurity, undermine retention more than curriculum design.

4.2.1.3 Workforce Context and Implementation Challenges

Ontario's PSW workforce is highly diverse, with a substantial proportion of immigrant workers. Some PSW training programs are delivered in multiple languages (e.g., Mandarin, Cantonese) to support non-English speaking trainees (sector discussions).[57]

While the standard brought greater coherence to PSW qualification pathways, critics warn it may pose barriers for workers without prior formal education, and does not by itself resolve structural workforce challenges.

Despite the registry's existence, uptake among PSWs has been low, as registration offers few direct incentives (e.g. pay increases or career advancement). Employers also typically do not require registry membership, limiting the practical impact of workforce regulation.[58]

Community-based PSWs report dissatisfaction with training opportunities: in a survey of PSWs, many expressed that their organisations offered limited support for job-related professional learning. [59] Moreover, some home care workers and allied professionals report concerns about the technical complexity of tasks being shifted to PSWs without adequate supervision or assessment.[60]

Critiques from sector stakeholders note that the registry has not sufficiently addressed broader systemic problems, such as low wages, lack of standardised training across provinces, and regional disparities in access to education or support.[61]

Ontario's health regulatory landscape is complex: there are over 260 regulatory colleges overseeing 292 health professions, but oversight of non-regulated practitioners like PSWs is relatively weak, highlighting jurisdictional gaps in workforce accountability.[62]

Research by Chamberlain and others provides further context. Analysis of 91 nursing homes found that in western Canada, where most care workers are unregulated, working conditions have stagnated or worsened, and the long-term care system was unprepared to meet the needs of an ageing population.[63] Although this study did not directly examine Ontario's PSW registry, it underscores that regulation alone cannot resolve deeper structural challenges without broader workforce and funding reforms.

4.2.1.4 Impact and Lessons Learned

Laporte and Rudoler highlight both the strengths and limitations of the Ontario model.[64] On the positive side, registration has increased public recognition of PSWs and their contribution to society. It has also provided the government with data for human resource planning and created a mechanism to screen out workers with a history of misconduct. The registry's flexible design and minimal administrative burden made it easier to implement than a full statutory regulation. Some stakeholders viewed it as a possible stepping stone toward future self-regulation of the occupation.

However, several drawbacks were also identified. PSW unions and advocacy groups expressed privacy concerns, arguing that the public availability of registry information could expose personal data. They also noted that the registry fails to address systemic workforce issues such as low pay, poor working conditions, and inconsistent training standards. Critics warned that registration could create additional barriers for capable workers who lack formal education, while offering few tangible benefits to those who enrol. Moreover, because the registry does not carry the authority to enforce education, discipline, or professional standards, unlike statutory professional regulators, it has a limited impact on practice quality or workforce development.

Stakeholder discussions further highlight distinctive features of the Canadian care landscape. In Ontario, a limited "cash-for-care" allowance exists primarily within the disability sector. People with disabilities may use government payments to hire personal care workers directly, while older adults typically access care through publicly funded services coordinated by care managers. These managers help service users navigate care options within allocated (time-based) budgets, though coverage is often insufficient to keep older people living at home. Private, unqualified care workers are sometimes employed informally as a lower-cost option, particularly where public provision falls short. In contrast, provinces such as Nova Scotia have broader personal budget arrangements, while Ontario maintains a more centralised, publicly funded model.

The Canadian care workforce is also highly diverse, with a large proportion of immigrant workers. As indicated earlier, in Ontario, PSW training programs are available in multiple languages, including Mandarin and Cantonese, to support the integration of Chinese-speaking migrant workers serving a large community of older Chinese Canadians.[65] Policy development in Canada is described as "bottom-up": educational institutions often pilot initiatives that are later formalised by government, contrasting with more "top-down" policy models seen in countries like Japan. Despite these efforts, the voluntary PSW registry has seen low uptake among workers and limited engagement from employers, primarily because registration offers few direct incentives such as improved pay or career advancement.

The COVID-19 pandemic further exposed vulnerabilities in the Canadian care workforce. Severe staff shortages and infection risks placed immense strain on the sector, highlighting the consequences of fragmented regulation and underinvestment. International qualifications are generally not recognised, limiting workforce mobility and the ability to attract qualified migrant workers. Some private agencies in Ontario have responded by hiring internationally trained nurses and supporting them through bridging programs to qualify as PSWs.

In summary, Ontario's experience illustrates the limitations of a voluntary registration system. The registry has enhanced workforce visibility and provided valuable data for planning but has had limited impact on job quality or professional recognition. Without mandatory participation or enforcement powers, registration alone has not improved retention, pay, or public assurance. Efforts to standardise education have strengthened training consistency but failed to resolve the deeper structural and cultural issues affecting the care sector. The Canadian case underscores that registration can contribute to professionalisation only when supported by complementary reforms, such as funding, fair pay, clear career pathways, and stronger institutional commitment to valuing care work as a skilled and essential profession.

4.3 Japan

4.3.1.1 Overview and Regulatory Framework

Japan operates one of the world's most established systems of statutory registration for social care workers, centred on the role of the *Certified Care Worker (Kaigo Fukushishi)*. The title *Certified Care Worker* has been legally protected since 1987 under the Certified Social Worker and Certified Care Worker Act.[66] To obtain this qualification, individuals must either complete approved education or demonstrate sufficient work experience, pass a standardised national examination, and register through an organisation authorised by the Ministry of Health, Labour and Welfare (MHLW).

The *Certified Care Worker* qualification was introduced in response to Japan's demographic transformation and the rapid ageing of its population during the 1980s. It marked the beginning of a broad professionalisation movement within the care sector, aimed at building a qualified workforce to meet the growing demand for elder care.[67] In 2000, this framework was strengthened through the creation of the Long-Term Care Insurance (LTCI) system, which made care services universally accessible to older people and embedded the role of qualified care workers within the national social insurance structure.

Although the title *Certified Care Worker* is protected, the law does not prevent unqualified staff from working in social care. Unqualified workers can still undertake day-to-day personal care tasks such as feeding, bathing, and cleaning. However, certified care workers hold broader responsibilities that include providing psychological and social support, tasks that in other countries might fall within the domain of social work. According to the Japanese Association of Certified Care Workers (JACCW), a certified care worker is "a person with expert skills and knowledge who engages in the business of providing care for people with physical, mental, or intellectual disabilities that make daily life difficult, and provides instruction on caregiving to the person and their caregivers." Over time, the role has evolved from personal assistance to a more holistic model of supporting independence and wellbeing for older people and people with disability.[68]

4.3.1.2 Education and Qualification Pathways

Training for certified care workers is offered through both university and non-university routes. Nagata and Kanda compared these pathways and found that most non-university institutions provide two-year programs, the minimum duration required by law, while universities offer four-year degrees with approximately twice as many hours of social work education.

It marked the beginning of a broad professionalisation movement within the care sector, aimed at building a qualified workforce to meet the growing demand for elder care.[89]

University programs also devote more attention to the theoretical and social aspects of care, including family systems, ageing, and community welfare. The authors concluded that the growing number of university-trained care workers could enhance workforce capability and improve care quality.[69]

As of 2012, roughly one-third of Japan's social care workforce held certified care worker status, while the remainder were either unlicensed or held *Home Helper* qualifications at Level 1 or Level 2, which are not nationally certified. The *Home Helper* role was introduced in 1991 as a flexible, part-time occupation primarily targeting women returning to work. However, it became less popular over time, as pay and career progression were limited comparedto structured positions in residential care. To simplify the workforce structure, the government discontinued the training of new home helpers in 2006, focusing instead on consolidating the *Certified Care Worker* qualification.[70]

The Certified Care Worker curriculum has undergone several revisions in response to legal and demographic changes. Lanfang and others describe three major stages of curriculum development between 1988 and 2012:[71]

1. Early Stage (1988–1999) – Focused on foundational subjects such as care, social welfare, home economics, medical science, and psychology.
2. Middle Stage (1999–2008) – Revised following the 1997 Long-Term Care Insurance Act to include care management, long-term care insurance, mental health, respect for human dignity, and nutrition.
3. Later Stage (2008–2012) – Introduced after the 2007 revision of the Certified Care Worker Act, establishing three domains: *Human Beings and Society, Care, and Mind and Body*. These domains covered communication, practical care processes, life support, dementia care, and end-of-life care.

The 2007 revision placed particular emphasis on dementia care and independent living, reflecting rising rates of dementia and the increasing number of older people spending their final years in residential care facilities. The curriculum thereby evolved into a comprehensive, evidence-informed educational system aligned with Japan's social welfare priorities. Certified care workers are formally recognised as part of the social welfare workforce, highlighting their dual social and clinical responsibilities.

The Japanese care system integrates regulation, education, and workforce management. Government policy requires at least one qualified care worker to be on duty in every residential care facility at all times. For domiciliary care, which involves one-to-one service delivery, care workers must hold relevant qualifications to work independently (Ministry of Health, Labour and Welfare). These regulations ensure quality but also contribute to staffing shortages in rural regions.

In recent years, the Japanese government and professional bodies have promoted continuing education and specialist training to strengthen the professional status of care workers. New specialisations, such as *Certified Dementia Care Worker and Certified Cancer Care Worker*, are being developed.[72]

Research by Okada explored the continuing training and educational needs of care managers, 34.2 per cent of whom also hold the certified care worker qualification.[73] His survey of 42 care managers revealed strong demand for advanced training in dementia care (78.6 per cent), practical caregiving techniques (61.9 per cent), and medical knowledge (54.8 per cent). The study highlights the workforce's appetite for career-long learning and structured professional support. Okada recommended that the Japan Association of Certified Care Workers develop continuous education programs to maintain workforce competence and career motivation.

4.3.1.3 Workforce Context and Implementation Challenges

Before 1987, Japan's care workforce was largely unregulated and shaped by traditional family caregiving. As birth rates declined and women entered the formal workforce, the extended family model of care weakened, increasing demand for organised social care.[74] The government responded with a series of legislative and policy reforms that expanded and formalised elder care provision. These included the 1963 Social Welfare Service for the Elderly Act, the 1966 Standards Concerning Maintenance and Management of Nursing Homes, and the 1970 Five-Year Plan for the Urgent Maintenance of Social Welfare Facilities. These policies led to rapid growth in institutional care and created the foundation for the modern long-term care system.

During the 1970s and 1980s, specialised training programs proliferated across Japan. Institutions such as the Welfare Medical Helper School at Hamamatsu Health Junior College offered courses ranging from six months to two years, with training hours between 168 and 2,400. The Certified Social Worker and Certified Care Worker Act (1987) consolidated these disparate initiatives into a unified national qualification system. By 1988, 25 institutions, both public and private, were authorised to deliver formal education in elderly care.[75]

Despite a highly structured framework, the sector faces persistent challenges of low pay and demanding working conditions. Domiciliary care workers are not compensated for travel time between clients, substantially reducing their income. A class action lawsuit challenging this practice was unsuccessful. Consequently, residential care employment remains more attractive than community-based work. By 2024, approximately two million certified care workers were registered in Japan, but only about 60 per cent were actively employed in the sector.[76]

Attrition is particularly high among newly qualified workers who leave the field shortly after certification due to long hours, low pay, and limited advancement opportunities.

While professionalisation has elevated care work in Japan, it is not universally welcomed by the workforce. Some care workers resist being compared to medical professionals, fearing that the increasing formalisation of the role could erode the relational, community-based ethos of caregiving. Many view their work as socially distinct from medicine and resist being absorbed into a "medicalised" care model. Persistent issues of low wages, labour shortages, and high turnover continue to undermine the sector's sustainability, despite strong institutional and policy support.[77]

4.3.1.4 Impact and Lessons Learned

Japan's system demonstrates both the strengths and limitations of long-standing statutory registration. The Certified Care Worker qualification has enhanced professional identity, standardised education, and improved public trust. The integration of registration, education, and welfare policy provides a coherent framework for workforce development and quality assurance. However, structural issues such as pay, working conditions, and limited career progression persist.

The Japanese experience underscores that professionalisation through registration can significantly strengthen workforce capability and public confidence, but it must be accompanied by adequate financial support, attractive career pathways, and measures to retain skilled workers. While regulation alone cannot resolve labour shortages or social undervaluation, Japan's model illustrates how a national framework, embedded in law and linked to long-term social policy, can sustain quality standards and legitimise care work as a recognised profession within society.

Contextualising lessons from overseas

Drawing on both global and domestic insights, Australia appears well-placed to progressively implement a positive care and support workforce registration and accreditation scheme over time. While small differences in views were expressed, HumanAbility and stakeholder consultations consistently highlight the following design elements:

- ***Phased implementation***, beginning with provisional registration for experienced but unqualified workers, allowing three to five years to transition to full qualification.
- ***Minimum qualification*** requirements – such as a Certificate III in Individual Support requirement for personal care work, as recommended in the Aged Care Royal Commission, with wrap-around supports for workers to meet requirements.
- ***Recognition of Prior Learning (RPL)*** options for experienced workers, including cultural knowledge and language skills.
- ***Continuing Professional Development (CPD)*** obligations for workers to undertake at least ten hours annually to ensure skills currency, with providers resourced to support compliance.
- ***Earn While You Learn (EWYL)*** pathways, including paid traineeships and placements, to reduce attrition during training and mitigate the effects of placement poverty.
- ***Equity provisions***, including low to no fees for registration, and addressing cost barriers for workers in regional, rural and remote areas, and by workers from migrant backgrounds.
- ***Alignment with Closing the Gap priorities:*** including growing the First Nations vocational education and training (VET) workforce and Aboriginal Community Controlled Organisation (ACCO) sector, including on-job training provided on Country, and co-designing culturally safe pathways to registration[78] These pathways should form part of targeted consultation led by First Nations' peoples and communities.

The case studies, both international and domestic, provide lessons around the importance of careful policy framing and phased implementation of workforce registration schemes. However, Australia's skills reform agenda also offers opportunities to bridge the workforce gaps and create a smooth transition to a registered care and support workforce.

Considerations for the Australian context include:

- **Australia's Modern Awards framework**
  The international case studies in this paper show registration schemes can have limited impact on pay and conditions when not directly linked with, or underpinned by, wage-setting structures. Australia has an industry-based Modern Awards framework, which sets minimum pay rates for different classifications of work (frequently connected to qualification attainment).

  By linking improvements in workforce support to enhancements in quality, safety and safeguards, and noting the recent findings of gender undervaluation across various care and support Awards, this provides a key contextual distinction to registration settings overseas.

- **Increased access to qualifications and training**
  The overseas experience shows that attempts to implement worker registration can be complicated by declining funding for vocational education and training. Australia has, by contrast, invested record levels of funding in fee-free TAFE places. The Certificate III in Individual Support has the highest number of enrolments of any fee-free TAFE course;[79] highlighting that unqualified workers need not face financial barriers to pursue formal qualifications.

  Stakeholders note that other investment such as to facilitate in-service training within otherwise restrictive price settings or ensuring accessibility and diversity of training provider options would also be needed.

- **Improving relevance of qualifications**
  Scotland faced challenges implementing workforce registration with an enforced a minimum qualification equivalent to a Diploma, a relatively high level of training. In Australia, the entry level qualification for a supervised personal care or disability support worker is generally understood to be at the Certificate III in Individual Support.[80] This qualification has been substantially condensed over recent updates, which would reduce the barriers related to course duration and complexity experienced in the Japanese and Scottish examples.

  There nonetheless remains scope to make improvements to aged care and disability qualifications. Stakeholder feedback has highlighted the impacts of a shortage of training places, barriers imposed by mandatory work placement requirements on training providers and learners, gaps between course content (and its residential focus) to the reality of work in the sectors, and difficulties faced by teachers, trainers and assessors in maintaining industry currency. The registration of Aboriginal and Torres Strait Islander Health Practitioners demonstrates the opportunities for worker registration and accreditation to support better career pathways with multiple entry and exit points.

  HumanAbility's review of these qualifications, and its work on improving industry currency of the VET workforce, is therefore timely. The qualification review work, specifically, allows the different training modules and frameworks, developed by the sector regulators and peaks in absence of workforce registration, to be fed into the next release of the training products. HumanAbility's tripartite engagement allows the sectors to be deeply involved in the review, supporting industry readiness for potential registration requirements.

- **Broader skills, training, and workforce reforms**
  Overseas case studies point to the need for wider investment in skills, training and workforce support to ensure registration and accreditation enables professionalisation and minimises barriers to workforce entry.

Considerable investment has been made by the Australian Government in care and support workforce development initiatives.[81] National skills priorities, including improving gender equality, Closing the Gap (between First Nations and non-Indigenous outcomes), provide the rationale for expanding workforce support alongside registration.[82]

Areas for improvement, in alignment with these priorities, include VET completions – currently only 59% of students who commence a Certificate III in Individual Support complete the course within four years of enrolment.[83] Low completion rates are partly attributed to students' experience of placement poverty: the Certificate III in Individual Support involves 120 hours of placement that often goes unpaid.

The ECEC sector heavily utilised traineeships, including existing worker traineeships, to transition its workforce to a qualified one, and both the Aged Care Royal Commission and NDIS Review[84] discussed the importance of traineeships, especially in the context of phased registration requirements. However, traineeship commencements in the aged care and disability sector remain critically low, and only account for around 3% of total course enrolments.[85]

HumanAbility's research on Earn While You Learn is exploring this issue. Findings highlight that quality traineeship models are underpinned by wrap-around supports and fair pay for learners, tailored models of supervision, and mentoring, but that incentives need to be adequate.

- **Diverse and phased pathways to registration** The 2024 Aged Care Worker Survey highlighted that only a small proportion of the aged care workforce is unqualified, and most hold a Certificate III in Individual Support or Aged Care (58.3%).[86] In considering how qualification requirements for registered workers may be phased in, lessons can be learned around how those "actively working towards a qualification" are treated for registration purposes in Victoria's disability

Overseas case studies point to the need for wider investment in skills, training and workforce support to ensure registration and accreditation enables professionalisation and minimises barriers to workforce entry.

sector and Australia's ECEC sector. Abroad, Northern Ireland has also allowed employers to hire unqualified workers and support them to obtain qualifications while working, and Wales provides registered workers with six years to complete a mandatory qualification.[87]

Developing multiple pathways to registration may also be an opportunity to formally recognise "invisible skills" in an industrial context which equates pay with qualification levels. This includes recognising:

- *Adjacent care and support qualifications* – e.g. Community Services, Health Services Assistance, Mental Health, Aboriginal and/or Torres Strait Islander Primary Health Care, Leisure and Health.
- *Prior training and learning* – including individual units of competency and microcredentials.
- *Prior experience* – including sector employment, informal/unpaid care, and lived experience.

To support these registration pathways, the registration of Aboriginal and Torres Strait Islander Health Practitioners demonstrates the need to invest in gap training and mobile assessors, to reduce pressure on services and rosters, especially in rural and remote areas with limited access to training.

In addition, the Disability Royal Commission recommended a First Nations pathway for registration, which reflects the emphasis in the Closing the Gap strategy on shared decision-making.[88] A fit-for-purpose registration model that includes mandatory qualifications requires culturally safe ways of affirming and recognising the different systems of knowledge, skills and capabilities in the First Nations care and support sectors.

- **Harmonisation and regulatory infrastructure**
  Australian and overseas experiences with registration demonstrate the cost of duplicative regulatory schemes. There is an important balance that can be maintained in designing registration requirements that support both workforce mobility, and safety in each profession. Following the moves toward development of a national registrar of early childhood educators, the Productivity Commission last year proposed a workforce registrar to minimise fragmentation, spanning aged care, disability services and veteran's care, which could oversee streams of registration for different workforces.
- **Fragmented models of service delivery and regulation**
  The experience of jurisdictions like Canada highlights that care and support systems marked by consumer-directed pricing and access frameworks can create complex dynamics in a registration context. The NDIS, for instance, enables choice and control by providing individual funding to participants to engage support workers. This, however, disperses accountability across thousands of private employers and self-managed participants. In these complex markets, registration schemes need to be simple to navigate and accessible for both participants and workers.

  Service users may prefer to hire workers informally to maximise hours of support, while some qualified workers seek flexibility outside formal employment structures. Where support is directly purchased, traditional employer–employee relationships are fragmented and regulatory oversight becomes harder to enforce, especially when combined with registration schemes that are voluntary.

Fragmented markets and models of care, in these situations, undercut the ability of regulators to lift the public's confidence and perception of the workforce. In the context of learnings from the Ontario case study also, it is worth emphasising that neither of the Royal Commissions, nor the NDIS Review, call for workforce registration to be voluntary. While recommendations across both the DRC and NDIS Review point to further co-design on the scope of practice of a support work, recommendations consistently call for registration requirements to be applied based on risk. Recent efforts to enforce registration of all platform providers in the NDIS will also expand regulatory oversight of directly purchased supports and may facilitate better data collection around the NDIS's large, sole trading workforce to support disability workforce registration.

- **Clearly defined registration systems**
  The Ontario case study emphasises the need for registration schemes to be clearly defined to ensure consistent regulatory coverage. Comparisons across the Royal Commissions, and commentary from the Productivity Commission, suggest there is greater consensus and progression on design principles for registering and accrediting the aged care workforce than the disability support workforce. Overseas case studies demonstrate that carefully defining who registration requirements apply to is fundamental to ensuring that requirements are applied consistently and appropriately to the workforce.

  In this context, clear guidance will be critical on when and how qualification requirements apply to workers who, for example, might deliver personal care to an older person, but are employed with different titles and have different duties and scopes of practice (e.g. assistants in nursing, respite workers, residential aides, home care workers, personal care assistants).

  The registration of Aboriginal and/or Torres Strait Islander Health Practitioners demonstrates a structured approach to designing scopes of practice for registered workers. This included collaboratively mapping the roles of registered workers alongside other professions, including nursing, and linking the registration of providers to the registration of workers, by mapping a worker's scope of practice to clinical governance standards. However they are structured, qualification requirements should be designed to support harmonisation and career pathways, so that the same kinds of work in aged care are subject to the same requirements in the disability sector and require genuine co-design with people with disability.

- **Engagement and consultation on design and implementation**
  Considering the Disability Royal Commission recommendations and the Aboriginal and Torres Strait Islander Health Practitioner example included in this paper, effective consultation and engagement will have practical benefits in the designing and implementing of a workforce registration scheme.

Conclusion

The evidence, both in Australia and overseas, shows that positive workforce registration and accreditation schemes have the potential to improve career pathways, safety and safeguards, and support better workforce data and clarity of roles. The challenge for Australia is designing a personal care and support workforce registration scheme, that supports safety and professionalism while remaining practical, inclusive and sustainable.

Stakeholders emphasise that this challenge can be mitigated through careful design. Case studies domestic and abroad provide clear examples of how a workforce registration and accreditation scheme can be carefully implemented over time. They highlight that workforce registration and accreditation schemes require broader investment in workforce support and pathways registration to enhance, not inhibit, workforce attraction and retention.

Australia's modern Awards, which frequently reference qualifications, and tripartite skills system, leaves it well-placed to address these challenges. It can build on substantial investment in workforce training and work already underway to harmonise regulatory standards. In this work, in its industry stewardship and workforce planning roles, HumanAbility can support this transition, both through qualifications reform and future/ongoing research projects.

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