Australian Vocational Education and Training (VET) Engagement in India’s Emerging Aged Care Sector

A study commissioned by the Australian Government Department of Education and Training

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December 2018
AUSTRALIAN VOCATIONAL EDUCATION AND TRAINING (VET) ENGAGEMENT IN INDIA’S EMERGING AGED CARE SECTOR
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Note
The views expressed in this study are of the authors and do not reflect the views of the Department of Education or the Australia India Institute.
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# List of Acronyms

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<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
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<tr>
<td>AII</td>
<td>Australia India Institute</td>
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<tr>
<td>ASTP</td>
<td>Association of Skilled Training Providers (India)</td>
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<tr>
<td>Austrade</td>
<td>Australian Trade and Investment Commission</td>
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<tr>
<td>ASQA</td>
<td>Australian Skills Quality Authority</td>
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<tr>
<td>CAGR</td>
<td>Compounded Annual Growth Rate</td>
</tr>
<tr>
<td>CII</td>
<td>Confederation of Indian Industry</td>
</tr>
<tr>
<td>CSR</td>
<td>Corporate Social Responsibility</td>
</tr>
<tr>
<td>DET</td>
<td>Department of Education and Training (Australian Government)</td>
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<tr>
<td>DFAT</td>
<td>Department of Foreign Affairs and Trade (Australian Government)</td>
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<tr>
<td>DWSSC</td>
<td>Domestic Worker Sector Skills Council (India)</td>
</tr>
<tr>
<td>FICCI</td>
<td>Federation of Indian Chambers of Commerce and Industry</td>
</tr>
<tr>
<td>HSSC</td>
<td>Health care Sector Skills Council (India)</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communication Technologies</td>
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<tr>
<td>ITI</td>
<td>Industrial Training Institute (India)</td>
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<tr>
<td>MSDE</td>
<td>Ministry for Skill Development and Entrepreneurship (Government of India)</td>
</tr>
<tr>
<td>NOS-QP</td>
<td>National Occupational Standards – Qualification Pack (India)</td>
</tr>
<tr>
<td>NSDA</td>
<td>National Skills Development Agency (India)</td>
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<tr>
<td>NSDC</td>
<td>National Skills Development Corporation (India)</td>
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<tr>
<td>NSDF</td>
<td>National Skills Development Fund (India)</td>
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<tr>
<td>NSQF</td>
<td>National Skills Qualification Framework (India)</td>
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<tr>
<td>NSW</td>
<td>New South Wales</td>
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<tr>
<td>PoCA</td>
<td>Proof of Concept Analysis</td>
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<tr>
<td>Roi</td>
<td>Return on Investment</td>
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<tr>
<td>RPL</td>
<td>Recognition of Prior Learning</td>
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<td>RRTC</td>
<td>Regional Resource Training Centre (India)</td>
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<tr>
<td>RTO</td>
<td>Registered Training Organisation (Australian Private VET Provider)</td>
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<tr>
<td>SRoi</td>
<td>Social Return on Investment</td>
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<tr>
<td>SSC</td>
<td>Sector Skills Councils (India)</td>
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<tr>
<td>TAFE</td>
<td>Technical and Further Education (Australian public VET Provider)</td>
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<tr>
<td>TNE</td>
<td>Trans-National Education</td>
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<tr>
<td>VET</td>
<td>Vocational Education and Training</td>
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<tr>
<td>VTP</td>
<td>Vocational Training Provider (India)</td>
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Glossary of Indian VET Acronyms

**ASTP**
Association of Skill Training Providers is a registered non-government, not-for-profit society, formed as a national alliance of skill training provider companies. The ASTP is a membership-based organisation and represents the concerns and interests of the skills sectors.

**DWSSC**
Domestic Worker Sector Skills Council is a not-for-profit company under the National Skill Development Corporation that focuses on critical roles and improving associated skills gaps for key sectors where domestic workers are employed.

**HSSC**
Health care Sector Skills Council is a not-for-profit company and certifying organisation under the National Skill Development Corporation, with representation of the public and private health care sectors and industry leaders.

**ITI**
Industrial Training Institutes are post-secondary schools that provide training in various trades. These come under the Government of India’s Directorate General of Employment & Training (DGET) and Ministry of Skill Development and Entrepreneurship.

**MSDE**
Ministry for Skill Development and Entrepreneurship is a Government of India department responsible for promoting skill development across all industry sectors with the aim of improving youth employability and employment outcomes.

**NOS-QP**
National Occupational Standards describe best practices by bringing together performance criteria, knowledge and skills pertaining to a job role. A set of NOS related to a specific job role is called a Qualification Pack.

**NSDA**
National Skills Development Agency is a registered society and autonomous body within the MSDE, created with the mandate to co-ordinate and harmonise the skill development activities in the country.

**NSDC**
National Skills Development Corporation is a Public Private Partnership (PPP) Company with the primary mandate of catalysing the skills landscape in India.

**NSDF**
National Skills Development Fund is a public trust set up by the Government of India for raising funds from government and private sectors and other donors for skill development in the country.

**NSQF**
National Skills Qualification Framework is a competency-based framework that organizes all qualifications according to a series of levels of knowledge, skills and aptitude.

**RRTC**
Regional Resource Training Centres provide multidisciplinary training materials for health and child care, evaluation tools and outreach materials.

**SSC**
Sector Skills Councils are autonomous industry-led bodies by NSDC for setting National Occupational Standards and developing Qualification Packs. SSCs develop competency framework, conduct Train the Trainer Programs, conduct skill gap studies, and Assess and Certify trainees on curricula aligned to NOS-QPs.

**VTP**
Vocational Training Provider or Skills Training Provider is a private service provider that offers skills training courses.
This research project investigates opportunities for Australian VET providers (TAFE colleges and RTOs) to engage with India’s emerging aged care sector. A 2017 Austrade market assessment for health care in India identified senior health care and living as an emerging sector with opportunities for first mover advantage in skills development, specialist management, consulting services and facility design. A previous Australia India Institute study of India’s skill agenda suggested opportunities for Australian VET providers were likely to be highest in niche or emerging sectors where India’s VET system capacity was low.

Australia is globally renowned for its high-quality, universal health care system and quality provision of aged care services. Its health care industry relies on a well-trained and highly competent workforce produced by the Australian VET system. India’s health and aged care sectors have expanded rapidly over the past decade, outstripping the capacity of the country’s VET system to provide a well-trained workforce to meet their needs. This study outlines the key features of the aged care sector and related VET in India and identifies factors that can enable Australian VET providers to establish competitive market presence and long-term, mutually beneficial modes of engagement with Indian partners.

India’s senior/elderly population (defined as aged 55+) comprises 9% of the total population. It is projected to grow from 116 million in 2018 to 158 million in 2025. Average life expectancy is projected to increase from 68.3 to 71 years in this period, while the dependency ratio is projected to decline from 13.7% to 12.1%. The elderly urban population is expected to more than double between 2018 and 2025 (from 30 million to 67 million). The demand for aged care is being driven by an expanding middle class with higher expectations for retired life and skilled care provision in their old age.

The aged care sector in India has expanded rapidly since 2008 with the entry of property developers involved in building retirement villages/estates and the emergence of home health care service companies. The home health care services segment is growing faster at a CAGR of 18%, and is projected to increase from US$ 3.2 billion to US$ 6.2 billion by 2020. It is becoming more formally organized and technology-led with standards and protocols and attracting many new entrepreneurs and investors.

Although new corporate players and wealthier households are driving demand for employment in the aged care sector, there is low motivation among young people to pursue training in this field due to perceptions of aged care work as being low status with poor pay and limited scope for career progression. Students are more attracted to health care job roles in medical establishments because these are associated with higher status and possibilities for career progression compared to home-based aged care.

Key stakeholder perspectives and reflections indicate that:

- Australia’s world-leading reputation in universal health and aged care delivery carries a high value premium for Australian health sector VET. This reputation can be mobilised as the key selling point and motivating factor for vocational training and career pathways in an increasingly sophisticated and ‘smart’ personalised health care-related industry. Australian VET providers can establish significant competitive edge in India by approaching aged care via engagement with the larger health care industry and training partners.

- Australia’s quality and delivery approach in VET is valued by government agencies and skill training providers in India. Indian stakeholders would like Australian VET providers to highlight their value proposition and brand advantage for attracting students and enhancing prestige for health and aged care sector training.
Indian stakeholders would like Australian VET providers to think beyond adapting and delivering existing courses, and consider wider business opportunities and training solutions for the health care sector with Indian partners.

International migration for employment offers significant motivation for students to train as health aides and aged carers due to prospects of higher wages and remittances.

There may be a larger market for mid- to high-level courses in broader health care job roles designed for overseas markets, rather than exclusively in aged care.

There may be valuable opportunities for Australian VET providers to partner with Indian corporations in the rapidly growing home health care industry segment to design mid-to high-level care courses in chronic disease management, post-operative support and rehabilitation.

The Australian government could follow the example of competitor countries like Germany, Japan, Switzerland, UK, and USA, and provide upfront funding and in-country assistance for Australian VET consortia entering the health and aged care market in India.

VET providers from UK and Switzerland have tackled the economics of scalability in India by investing in long-term relationships with Indian training providers and industry employers, with in-country support from their governments. They have worked with Indian partners to co-design products, delivery approaches, learning, assessment, and quality assurance systems. They have secured commitment at different levels of government and industry, built stable partnerships, and developed strong reputation and brand recognition for their skills training.

Australian VET providers need Austrade assistance with negotiating partners and investors to secure and promote the value premium of Australia’s VET across the health and aged care industry.

The commonly-accepted ‘low-cost/high-volume’ formula for scalable product delivery in India will not work in the current context due to low student demand for VET aged care. Research and stakeholder perspectives suggest that despite industry involvement in the Health care Sector Skills Council (HSSC) and design of training products, there is little indication that formal sector employers in health and aged care recognise skills training and aged care qualifications through higher wage premiums. Although aged care job training is heavily subsidised by the Indian government, there is little uptake among students.

India’s rapidly expanding health care industry sector including niche segments such as home health care and aged care offer early mover opportunities for Australian VET providers to establish partnerships, high visibility and reputational leadership in health care TNE. In order to do so, they require the following critical support factors for successful engagement:

- The active role of Austrade in helping identify potential Indian partners with strong business credentials, financial and technological capacity to scale up operations and training delivery.
- Austrade to assist in negotiations with Indian central and state governments, industry bodies, potential partners and investors to secure and promote Australia’s global brand value in health care and VET aged care.
- Strong connections with Australian companies operating in India, including connections facilitated through Australian Indian diaspora relationships and business networks.
- Australian Government support for VET providers to develop cost-effective operating models that can be piloted with health care partners in India and potentially deployed in Australia and other offshore VET contexts.
- A ‘whole of system’ approach to offshore skills training in India facilitated by state-to-state forums for establishing consortia arrangements between Australian VET providers.
- Australian Government support with in-country assistance, capacity building, and professional development for Australian VET providers to establish competitive advantage and long-term presence in India’s health and aged care sector.

The report offers six recommendations for Australian VET providers seeking to engage with India’s rapidly expanding health and aged care sector.

1. Australia’s world-leading reputation in high-quality, universal health and aged care relies on a well-trained, professionalised, and highly competent workforce produced by the Australian VET system. Austrade and Australian VET providers should highlight the value proposition of this expertise and high-quality training for strengthening India’s rapidly expanding health and aged care industry sector.

2. Australian VET providers should collaborate to offer a suite of health care-related training products, with aged care as one entry point for students to progress their career in India’s growing and diversifying health care industry. This collaborative approach will enable them to be flexible, take advantage of their expertise and multiple offerings in health, aged and community
care, and expand training in India as demand for higher quality personalised health care emerges in the coming decade.

3. Australian VET providers should pursue partnerships with different players in India’s health and aged care industry. This will enable them to gain market knowledge of training demand, access to training facilities and infrastructure, student recruitment, and employment placement. The diverse partnerships may provide new models for increasing student recruitment, scaling up and maximising value beyond the ‘low-cost/high volume’ formula for product delivery.

4. Australian VET providers should explore joint venture arrangements to develop mid-to high-level skills courses and services with home health care companies, retirement estate developers, established vocational training providers, higher education institutions, social enterprises and NGOs. This will enhance brand visibility and prestige for the wide range and high quality of Australian health and VET aged care.

5. Australian VET providers should pursue consortia arrangements between VET providers for maximising the impact of Australia’s brand and expertise in health and aged care training in India. The consortia should adopt a whole-of-network approach and seek in-country support from the Australian Government for establishing reliable partnerships and scaling up their health and aged care training ventures.

6. Depending on their capacity, experience and diversity of offerings in health and VET aged care, consortium members could potentially explore the following partnership or joint venture models of engagement within the health and aged care sector in India.

   vii. Large TAFE colleges or RTOs could partner with large retirement estate developers or large home health care companies to co-design courses for training and upskilling in various types of health- and aged-care services. Scalability of product and delivery approaches would develop in conjunction with the partner company’s expansion strategy and include assessment and quality assurance.

   viii. Small- or medium-sized RTOs could partner with well-established Indian Vocational Training Providers to co-design mid- to high-level health and aged care courses for trainees seeking third country employment. Such courses, with guaranteed job placements in the third country, may command higher price points than equivalent courses for the domestic market. Scalability may be achieved in both situations through sophisticated use of technology for simulations, demonstrations, flexible learning and assessment.

   ix. TAFE consortia could partner with larger public and private Indian higher education institutions and new Skills Universities being set up in different states to offer B. Voc. degrees. They could bring their Australian expertise in curriculum design for student progression from lower certification levels to B. Voc. specialisation in geriatric health care and management.

   x. TAFE consortia or large RTOs could partner with well-recognised NGOs and social enterprises working in informal sector skilling, and seek for RPL and upskilling of informal sector workers who are home-based aged caretakers or health care assistants in hospitals, residential aged care institutions, or senior living estates. Scalability may be achieved by partnering with online marketplace companies that provide hyperlocal on-demand services, and enabling informal/self-employed carers to post their health and aged care services along with evidence of work experience, skills qualifications, refresher courses, and upskilling certifications.
This research project has been commissioned by the Commonwealth Department of Education and Training to investigate the viability of Australian Vocational Education and Training (VET) providers in delivering skill development products and services targeted at the niche, but rapidly growing, aged care industry sector in India. By focusing on one industry – aged care – as a test case for deeper examination, the project explores the deeper practicalities for viability of VET engagement and findings for broader application to other industries for TNE engagement in India.

Austrade’s market assessment of health care in India identifies senior health care and living as an emerging sector with opportunities for first mover advantage in skills development (Austrade, 2017; 2018a). A previous Australia India Institute (AiI) study on Australia’s Engagement with India’s Skill Agenda signalled that opportunities for Australian VET providers were likely to be highest in niche sectors where India’s existing VET system capacity is low, or only emerging (Freeman, 2017a).

Aged care – referred to as elderly, senior, or geriatric care in India – is a niche market sector that is growing rapidly at an annual CAGR of 18+% (CII, 2018). The current level of vocational training across the aged care-related sectors is low, but changes in demography, upward mobility and aspirations of middle-class urban Indians have generated new expectations for improved quality of aged care provision (Rajan, 2006; Vijayakumar, 2013; Dhillon, 2018). India’s health and aged care sectors have expanded rapidly over the past decade, outstripping the capacity of the country’s VET system to provide a well-trained workforce to meet their needs.

Australia is world-renowned for its high-quality universal health care system that is underpinned by a robust framework for accreditation, quality and regulation, cutting edge research, education and training (Austrade, 2015). Its health care industry relies on a well-trained and highly competent workforce produced by the Australian VET system (ASQA, 2013). The Aged Care Workforce Strategy Taskforce has outlined fourteen strategic areas of action for shaping the industry and workforce into the future, including VET and higher education (Department of Health, 2018).

Australia has well-established expertise and capacity in VET which is internationally regarded as being of high quality. All Australian states and territories have TAFEs and private RTOs offering broad-based and specialised VET programs, and some have expanded their markets to offshore locations in the Asia-Pacific region and in India. Although Australian VET providers have well-recognised capacity in aged care training (KPMG, 2016), including international experience in delivering aged care training and skills development (Liu, 2017), they have not yet entered the Indian market for VET in aged care.

The objectives of this project are to:

1. Determine the key features of VET in the aged care sector in India;
2. Identify factors that can enable Australian VET providers to establish competitive market presence in India’s health and aged care sectors;
3. Suggest modes of VET engagement with Indian partners that are mutually beneficial and sustainable over the longer term, and which can have broader application for TNE engagement in other industries in India.

1.1 PROJECT CONTEXT

The Indian Government has set up the ambitious Skill India Program with the aim of “meeting the challenge of skilling at scale with speed, standard (quality) and sustainability” (MSDE, 2015). The National Policy for Skill Development and Entrepreneurship has identified an enormous need for VET in India. It estimates that only 3.6% of the 487 million people comprising the country’s total workforce have been formally trained in their occupations. The policy estimates that there will be over 100 million fresh entrants in the country’s workforce by 2022, and that 298.25 million existing workers across the farming (128.25 million) and non-agricultural (170 million) sectors will need skilling, reskilling and upskilling to work in a rapidly changing economy (MSDE, 2015).
The market demand for formal VET in India is very low when compared with the demand for higher education (Agrawal, 2012). This is due to three key cultural and economic factors: 1) vocations involving manual labour or care work are associated with lack of dignity and low social status; 2) a largely poor population that does this work without formal skills training; and 3) private industries that use casual, short-term or informally skilled workers and do not offer wages that match skill premiums gained from formal training (Tilak, 2002). As a result, most skill development remains informal. Trades and vocational employment are mostly characterised by low wages, with limited opportunities for formal upskilling, career advancement, or improvement in income/socio-economic status (Jagannathan, 2013).

Despite the low demand for formal VET, the Indian Government’s Skill India Mission has incentivised significant numbers of Indian Vocational Training Providers (VTPs) to enter the space and deliver training ‘at scale and speed’ (EY, 2013; KPMG-FICCI, 2014). Many Indian VTPs are keen to partner with foreign/international VET providers to build capacity in delivering high quality training at low cost and high volume, and place VET graduates in jobs in industry.

The standard assumption prevailing the context of India’s burgeoning skills sector is that successful VET product delivery requires a low-cost/high volume model (Varghese, 2018, p. 66). The research investigates this hypothesis in the context of the project brief requirement to explore viability questions for Australian VET engagement in India’s aged care industry and its broader application to other industries for TNE engagement in India.
Information and data were gathered from four sources: desk research, stakeholder consultations in India, focus group discussions with Australian VET providers in aged and health related care, and a consultative group representing key bodies and expertise of the Australian VET sector.

**Desk research** pulled together information about India’s Skills Policy and VET initiatives from Ministry of Skill Development and Entrepreneurship reports, industry body reports, and online sources. Data on growth and characteristics of India’s emerging aged care sector were obtained from published academic research, industry reports and websites. Australian VET certificates, diplomas, and skill sets related to care sector provision were obtained from www.myskills.gov.au

Skills Think Consulting was engaged in June 2018 to undertake **stakeholder consultations** in India and with ACPET providers. Paula Johnston (Project Consultant, Skills Think Consulting) led consultation meetings and interviews with stakeholders in New Delhi, Hyderabad, Bangalore, Kochi, and Thiruvananthapuram (Trivandrum), with Surjeet Dhanji (Aii Project Team Researcher). The selection criteria for consultation targets in India was determined by Skills Think Consulting based on its past market research on TNE opportunities in India for Australia’s skill sector.

Stakeholder consultations by Skills Think Consulting in India and Australia included representatives from:

1. Government – Indian Central and State agencies, and Australian agency representatives based in India with active interest or involvement in the skills and trade sector: DET, Austrade and state trade commissions.
2. Indian Sector Skill Councils (SSC) – Health care SSC and Domestic Workers Skills Councils
3. Peak Bodies – Confederation of Indian Industry (CII), Association of Skilled Training Providers (ASTP)
4. Indian Skills and Training organisations – mostly ASTP members, providing training in the aged care, health and allied health care sectors. These organisations were:
   - Affiliated with India’s National Skills Development Corporation (NSDC) and/or Sector Skills Councils
   - Members of India’s peak provider body, ASTP, and
   - Offering courses in health, community or aged care, as part of India’s formal skills system
5. Australian stakeholders – including senior staff of a small group of public and private RTOs and representatives of their peak bodies.

Skills Think Consulting’s consultations in India were based on structured questions for consistency and were complemented with open discussion. The interviews covered the following aspects:

- Characteristics of the Indian aged care industry relevant to skill development: Types of Indian vocational training providers in care (i.e., health care and domestic work): National, state, public/private; role of regulatory bodies for provision of national occupational standards (NOS) qualification packs (QPs), quality assurance, compliance, assessment, etc.
- Relevant issues for Australian VET providers interested in TNE for VET in aged care in India: Compatibilities in training provision in care sector, Indian providers student recruitment strategies, delivery of NOS QP components, funding regulations, costs of delivery, work placements, funding, regulations
- Challenges, opportunities and options for Australian VET providers to deliver aged care training products and services in India: partnerships, value addition to existing NOS QPs in aged care, additional top-up products and services.
The initial project plan included a component for developing scalable models of Australian VET aged care products for the Indian market, costing these models, and discussing these options in a national workshop. Consultations in India, however, indicated that this exercise would not be possible due to significant differences in expectations for VET aged care in the Indian context, and inadequate information regarding the multiple variables influencing the cost/price relationship for scalability (Skills Think Consulting, 2018, p. 8).

Consequently, the Project Team decided to replace the costing exercise with focus group consultations with Australian VET providers on adapting and scaling their aged care products and services for the Indian market. This decision was approved by DET.

Focus group participants were identified by the Project Team through a search of the Commonwealth Department of Education and Training registry of Australian VET providers (https://www.myskills.gov.au). Criteria for invitation to the focus groups were:

- Providers should offer courses in aged care or other specialisations under a broadly defined ‘care’ provisioning sector;
- Providers may or may not operate internationally; operate in India; intend to expand capacity in course delivery.

Australian VET providers from Sydney and Victoria were invited to participate in the focus groups in Sydney and Melbourne. One TAFE college identified by TAFE Directors Australia from Tasmania, ACT and South Australia were also invited to participate in either the Sydney or Victorian focus group.

The participants self-selected for the focus group consultations. Several key participants who could not attend the focus group consultations held in Sydney and Melbourne were interviewed over the telephone.

Consultations centred on the following questions:

- What are your capabilities, experience, and systems for TNE delivery of VET aged care products and services?
- How do you view India as a market for your aged care products and services?
- How might your VET products, services and operating models be adapted and scaled to succeed in India’s low-cost/ high volume market?

The key findings from Indian and Australian stakeholder consultations and focus groups were presented to the project’s Consultative Group for comments and inputs to incorporate in the report. The consultative group membership included senior staff of a small group of TAFEs and RTOs, representatives of peak bodies, and researchers from the National Centre for Vocational Education Research (NCVER). Follow-up conversations were held with a few individual members for further clarifications of discussions.
According to estimates in the Confederation of Indian Industry (CII) Report on the Senior Care Industry (2018), India’s senior/aged (defined as age 55+) population comprises 9% of the total population. It is projected to grow from 116 million in 2018 to 158 million in 2025. Average life expectancy is projected to increase from 68.3 to 71 years, while the dependency ratio is projected to decline from 13.7% to 12.1%. Although the elderly rural population is larger (77 million in 2018 and projected to rise to 91 million by 2025), the elderly urban population is expected to more than double between 2018 and 2025 (from 30 million to 67 million).

Joint- and extended-families have traditionally been the primary support for the elderly in India, with institutionalisation often being seen as a failure of children to bear their responsibilities of caring for family elders (Datta, 2017). However, traditional family structures have changed with increased urbanisation and employment related mobility. Some studies estimate that 20% of people above 60 years of age in India live alone or solely without a spouse due to not having children or children living in other locations for their education or employment. There is growing recognition that urban families are less able or equipped to take care of their elderly parents and kin (Alam et al., 2012; Ponnuswami and Rajasekaran, 2017).

The burgeoning demand for aged care in India is also driven by increased life expectancy and an expanding middle class that has higher expectations for retired life compared to older generations (Rajan, 2006; UNFPA, 2017). A significant proportion of the urban elderly population have higher levels of education and social networks, are more well-travelled, financially stable, and better prepared for independent living after retirement (Dhillon, 2018). Also, family remittances from India’s large diaspora population mitigates the issue of affordability for parents who continue to live and remain behind in India, or for Non-Resident Indians (NRIs) returning to retire in India (Dewan, 2010). Having lived in countries that provide higher levels of amenity and institutionalised aged care, these groups have higher expectations for skilled care provision for their parents (Agarwal et al., 2016).

The aged care sector has expanded rapidly since 2008 with the entry of property developers involved in building retirement communities/estates and home health care service companies (Jones Lang LaSalle, 2011; EY-FICCI, 2013; Vijayakumar, 2013). The home health care services segment is growing faster, at a CAGR of 18% and projected to increase from US$ 3.2 billion to US$ 6.2 billion by 2020 (CMR, 2016; Economic Times, 2018). It is becoming more formally organized and technology-led with standards and protocols and attracting many new entrepreneurs and investors. This growth is outstripping the capacity of the country’s VET system to provide a well-trained workforce to meet the needs of these industry segments.

### Table 1: Aged care formats

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<tr>
<th>AGED CARE FORMATS</th>
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<tr>
<td><strong>Senior Living</strong></td>
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<tr>
<td>Independent Living community (IL)</td>
<td>Apartment complexes, retirement communities, housing cooperatives offering private residences designed for senior citizens on a lease or ownership basis. These may be standalone facilities or part of a larger residential development complex or exclusive/gated community.</td>
</tr>
<tr>
<td>Assisted Living Community (AL)</td>
<td>Assisted living provides help with non-medical support for daily activities for seniors living independently.</td>
</tr>
<tr>
<td>Skilled nursing facilities (SNF)</td>
<td>Skilled nursing facilities provide intensive levels of short-, medium- or longer-term care for post-operative recuperation, complex medical care demands, or chronically ill seniors who can no longer live independently. These facilities may be free standing or part of an existing senior living community complex.</td>
</tr>
<tr>
<td>Continuing Care retirement community (CC)</td>
<td>This offers a combination of housing, services and facilities for Independent and Assisted Living and Skilled Nursing.</td>
</tr>
<tr>
<td><strong>Home and Day Care</strong></td>
<td></td>
</tr>
<tr>
<td>Memory care facilities (MC)</td>
<td>These provide increased levels of care and safety for individuals with dementia.</td>
</tr>
<tr>
<td>Senior day care facilities (SD)</td>
<td>Day centres provide activities, rehabilitation and medical care for seniors.</td>
</tr>
<tr>
<td>Home care (HC)</td>
<td>Seniors are offered clinical and non-clinical support in their homes, ranging from medical monitoring, assistance for daily activities, nutrition management, and housekeeping.</td>
</tr>
<tr>
<td><strong>Institutional care</strong></td>
<td></td>
</tr>
<tr>
<td>People with special needs dependents (PWD)</td>
<td>Seniors with dependents who have disabilities or special needs are looked after together.</td>
</tr>
<tr>
<td>Palliative Care (PL)</td>
<td>These facilities provide specialised medical and psychological care for people with terminal illnesses and their families.</td>
</tr>
</tbody>
</table>

Source: Adapted from CII, 2018
3.1 Key features of the senior/aged care sector

The CII’s industry report (2018) on senior/aged care identifies nine formats that are relevant for the Indian context. Brief descriptions of these formats are provided in Table 1.

Retirement estates

The most common format provided by retirement estate developers are Independent Living (IL) and Assisted Living (AL). The largest proportion of retirement estate projects is in South India (54%), followed by West (19%), North (18%), East (6%), and Central (3%) (CII, 2018). The retirement estates cater largely to middle class and wealthy seniors. The costs of units may range between INR 5 million and INR 10 million (approximately AUD 100,000 to 200,000). The majority of developments are in Tier 1 and Tier 2 cities or in close proximity to them. The following table provides a summary of current and new projects of major retirement estate developers.

Table 2: Retirement estates by region

<table>
<thead>
<tr>
<th>REGION</th>
<th>STATE-URBAN AREA/CITY</th>
<th>RETIREMENT ESTATE DEVELOPERS</th>
<th>NUMBER OF DEVELOPMENTS</th>
<th>MAIN FORMATS FOR AGED CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NORTH INDIA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delhi-National Capital Region</td>
<td>The Golden Estate UCC Care; Epoch Elder Care; Panchvati</td>
<td>4</td>
<td>IL, AL, Panchvati and Epoch offer SNF, MC, PW, PL, SD, OT</td>
<td></td>
</tr>
<tr>
<td>Haryana</td>
<td>Greater Gurgaon</td>
<td>Age Ventures</td>
<td>2</td>
<td>IL</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>Kasaul</td>
<td>Aamoksh One Eighty</td>
<td>1</td>
<td>IL, AL, MC, SD</td>
</tr>
<tr>
<td>Punjab</td>
<td>Ludhiana</td>
<td>Heavenly Palace</td>
<td>1</td>
<td>IL</td>
</tr>
<tr>
<td>Uttarakhand</td>
<td>Dehra Dun</td>
<td>Antara Senior Living</td>
<td>2</td>
<td>IL</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>Lucknow, Vrindavan</td>
<td>Age Ventures; Infinity Group</td>
<td>2</td>
<td>IL</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>Jaipur, Bhiwadi</td>
<td>Ashiana Senior Living</td>
<td>2</td>
<td>IL, AL</td>
</tr>
<tr>
<td><strong>EAST INDIA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Bengal</td>
<td>Kolkata</td>
<td>Shrachi; Godhuli Retirement; Rukmani Amar Aangan</td>
<td>3</td>
<td>IL, AL</td>
</tr>
<tr>
<td><strong>CENTRAL INDIA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>Bhopal, Jabalpur</td>
<td>Oasis Senior Living; Age Ventures</td>
<td>3</td>
<td>IL, AL CC offered by Oasis</td>
</tr>
<tr>
<td><strong>SOUTH INDIA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>Vishakhapatnam</td>
<td>Delhi-National Capital Region</td>
<td></td>
<td>Delhi-National Capital Region HCI Group, 597-599</td>
</tr>
<tr>
<td>Telangana</td>
<td>Hyderabad-Secunderabad area</td>
<td>Delhi-National Capital Region</td>
<td></td>
<td>TAFE Directors Australia, ACT 2601</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>Chennai, Coimbatore, Kanchipuram, Kodaikanal, Trichy</td>
<td>Delhi-National Capital Region</td>
<td></td>
<td>Delhi-National Capital Region P O BOX 42, Holmesglen, VIC 3148</td>
</tr>
<tr>
<td>Pondicherry</td>
<td></td>
<td>Delhi-National Capital Region</td>
<td></td>
<td>EQUALS Group, 81 Currie St, Adelaide SA 5000 SA 5001</td>
</tr>
<tr>
<td>Kerala</td>
<td>Kochi - Kakkanad</td>
<td>Paradise Senior Living; Verandah Gardens-Infra Housing</td>
<td></td>
<td>Open Colleges, Level 4, 1 Richmond</td>
</tr>
<tr>
<td>Karnataka</td>
<td>Bangalore, Mysore</td>
<td>Mantri Primus; Athashiri, Serene Senior Care; Coval Care; Brigade; Epoch Elder Care; Tata Housing; Riva; Bahri Estates; Suvidha; Golden Age Retirement Homes and Hospitals; Age Ventures</td>
<td></td>
<td>HCI Group, 597-599Upper Heidelbeights Victoria 3081, Australia</td>
</tr>
<tr>
<td><strong>WEST INDIA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maharashtra</td>
<td>Mumbai, Pune, Lavasa, Nagpur</td>
<td>Silver Inning; Ashiana Senior Living; Oasis Senior Living; Athashiri; Coval Care; Golden Age Retirement Homes and Hospitals; Age Ventures</td>
<td>14</td>
<td>IL, AL; See above for Coval Care, Athashri additional services</td>
</tr>
<tr>
<td>Gujarat</td>
<td>Ahmedabad, Vadodara</td>
<td>Athashiri, Age Ventures</td>
<td>4</td>
<td>IL, AL; See above for Athashiri</td>
</tr>
</tbody>
</table>

Source: Based on data from CII, 2018
Home health care services

While senior living has steadily expanded since 2008, the home health care market in India has grown dramatically within the last five years. This growth reflects the broader global trends of technological innovations in health care for better integration between hospital and home care, chronic disease management and support (McKinsey-CII, 2012). The current focus of Indian home health care players is on clinical home-care support, but the drive for market expansion is bringing a blend of clinical and non-clinical service providers to deliver customised care services for post-operative treatment, chronic disease, physical rehabilitation and elderly patients (CMR, 2016).

The CII Report estimates the total current demand for senior home health care services at Indian Rupees INR 9.13 billion (AUD 1.83 billion), projected to INR 14.84 billion (AUD 2.97 billion) in 2025. Current market demand in urban areas for home health care is nearly 4 times higher than in rural areas, and projected to be nearly 6 times higher in 2025.

Clinical services offered by home health care companies and affiliates may include teleconsultation, medical appointments, pharmacy delivery, lab & diagnostics, physiotherapy, medical equipment delivery, and home-based nursing. Non-clinical services may include housekeeping, home attendant, nutritional support, wellness and fitness, and facilitating social activity.

Home health care companies are developing business models based on combinations of high technology systems for health monitoring and personalised support that are capable of large volume service delivery with improved efficiency. The following table profiles the major players in this emerging sector.

Figure 1: Estimated market demand for senior home health care services

![Market demand for senior home healthcare services 2018 and 2025 (AUD million)](image)

Source: Based on data from CII, 2011
Key features of India’s aged care sector

- The senior/aged care sector has expanded rapidly since 2008 with the entry of property developers building retirement estates and home health care service companies.
- The home health care services segment is growing faster at a CAGR of 18% and projected to increase from US$ 3.2 billion to US$ 6.2 billion by 2020.
- Home health care is becoming more formally organized and technology-led with standards and protocols. It is now attracting many new entrepreneurs and investors.

Table 3: Major Home Health care players in India

<table>
<thead>
<tr>
<th>ENTITY</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care 24</td>
<td>Founded in Dec. 2014 by IIT alumni Vipin Pathak, Abhishek Tiwari, Garima Tripathi and Pranshu Sharma. Services (Mumbai-based): home care visits by nurses, physiotherapists and attendants. Aegis Care Advisors Private Limited that runs Care24 is one of India’s first venture-backed start-ups in the home health care space.</td>
</tr>
<tr>
<td>Critical Care Unified</td>
<td>Critical Care Unified started in New Delhi and has been in operations for about 16 months, with about 600 home-based patients. The firm is in discussions for raising further funding for expansion.</td>
</tr>
<tr>
<td>India Home Health Care</td>
<td>Established in 2009, India Home Health Care (IHHC) provides home health care and home nursing services in Chennai, Bangalore, Hyderabad, Pune &amp; Mumbai in India. Its 800 employees comprise registered nurses, associate nurses and medical caretakers across cities. In July 2013, BAYADA Home Health Care, USA acquired a 26% stake in India Home Health Care and formed a partnership to ensure quality home health care in India. Bayada employs over 18,000 nursing support staff in 250 offices throughout the United States and India. Bayada and India Home Health Care announced a $10 million investment geared towards creating a pan India presence by 2016 with 3000 care workers and revenue of $12 million.</td>
</tr>
<tr>
<td>Max@Home</td>
<td>Max@Home offers patients an extension of the Max Hospital quality health care in the patient’s home. While the group has been offering home care services for several years now, it has recently increased focus on this vertical and offers a range of health care services and products through this channel. Max@Home currently has over 1000 care workers.</td>
</tr>
<tr>
<td>Nightingale Home Health Services</td>
<td>Having started in 1996, Nightingale has grown into a specialized home health care company with expertise in treatment of chronic diseases, geriatrics, and post-operative rehabilitation. The firm has operations in Bengaluru, Chennai, Hyderabad, Mumbai and Pune and plans to establish presence in 10 Indian metro clusters. After being acquired by Medwell Ventures in 2014, and a Series A financing of USD 10 million by Eight Roads Ventures in May 2015, it recently raised USD 21 million in Series B funding led by Mahindra Partners, a private equity arm of the Mahindra Group.</td>
</tr>
<tr>
<td>Portea</td>
<td>Bengaluru-based Portea Medical, which is owned by Healthvista India Pvt. Ltd, ex UK promoters K Ganesh and Meena Ganesh, raised $37.5 million (around Rs 247 crore) in a Series B round of funding led by existing investor Accel Partners and IFC, among others in September 2015. Subsequently, it raised Series C funding of $26 million led by Sabre Partners and MEMG CDC Ventures. Started in 2013, Portea does 120,000 home visits a month, offering services such as chronic disease management, post-operative care, cancer care, geriatric as well as orthopaedic care at home. It has a workforce of 5,000 care workers and a presence across 16 cities and estimates to reach 15,000 care workers by 2025.</td>
</tr>
<tr>
<td>Tribeca Care</td>
<td>The founding team Tomojit Dutta started Tribeca Care at Kolkata in 2013. The firm has taken a lead in adding non-clinical services such as arranging maids and specialist help through trusted partners. Since its inception in 2014, it has served more than 5,000 customers and provided more than 200,000 bedside visits. It provides employment to more than 500 care workers every month in Kolkata alone.</td>
</tr>
<tr>
<td>HelpAge India</td>
<td>Set up in 1978, HelpAge is a leading charity in India working for the disadvantaged elderly for more than 40 years. It runs one of the largest Mobile Health units to render services to this segment of Indian populace.</td>
</tr>
<tr>
<td>Heritage Foundation</td>
<td>The Sishrusha Health Management Trust – formed in 1994 is now known as Heritage Foundation. It provides wide range of health care services including nursing, diagnostics, physiotherapy, bedside assistance, meals, and doctors on call in Hyderabad.</td>
</tr>
<tr>
<td>Apollo Home Healthcare</td>
<td>Apollo Home Healthcare Ltd was set up in 2015 as a new delivery segment beginning with 500 homecare professionals offering services across Hyderabad, Chennai and Delhi.</td>
</tr>
</tbody>
</table>

There are currently no dedicated statistics available for total numbers of aged care workers across hospitals, senior retirement estates, and home health care segments. The CII Senior Care Industry Report (2018) projects the demand for aged care workers in the formal sector to more than double by 2025. However, stakeholder consultations and industry surveys indicate that aged care has largely been carried out by self-employed informal sector workers in family-based home contexts, and hence classified as domestic work. Alternatively, aged care assistants in hospitals are likely to be classified as health care employees. The CII Report indicates that in the case of retirement estates, carers are likely to be classified as hospitality service workers. Consequently, projections of demand for aged care workers are likely to be highly varied.

As Figure 1 illustrates, the greatest projected demand for aged care in urban settings is for home attendants, followed by lab and diagnostics, and home nursing. The CII Report estimates that between 60 and 80% of formally skilled care workers are currently employed in the emerging home health care segment, mostly in clinical services such as nursing, physiotherapy, lab and diagnostics. Senior living establishments have fewer skilled care workers in clinical services, and more in hospitality, housekeeping, domestic services, building and property maintenance.

### Training in Aged care

As a VET category, aged care reflects the current dual categorisation and comes under both the Health care Sector Skill Council (HSSC) and the Domestic Worker Sector Skill Council (DWSSC), with the following job roles and schooling levels for admission into training and gaining qualifications. The job role of aged caretaker features minimally within the formal training context and is mostly carried out by informal sector workers.

### Training and qualification needs

Table 4: Indian VET qualification levels for job roles in aged care

<table>
<thead>
<tr>
<th>QUALIFICATION LEVEL</th>
<th>JOB ROLE WITHIN QUALIFICATION PACK</th>
<th>CANDIDATE ENTRY LEVEL</th>
<th>INDIAN SECTOR SKILLS COUNCIL (SSC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSQF 3</td>
<td>Aged caretaker</td>
<td>Class/Year 5</td>
<td>Domestic Workers</td>
</tr>
<tr>
<td>NSQF 4</td>
<td>General Duties Assistant</td>
<td>Class/Year 10, possibly also Class/ Year 8</td>
<td>Health care</td>
</tr>
<tr>
<td>NSQF 4</td>
<td>Home Health care Aide</td>
<td>Class/Year 10, possibly also Class/ Year 8</td>
<td>Health care</td>
</tr>
<tr>
<td>NSQF 5</td>
<td>Geriatric Aide</td>
<td>Class/Year 10 or NSQF 4 and 21 years of age</td>
<td>Health care</td>
</tr>
</tbody>
</table>

Source: DWSSC and HSSC, 2018
There are public and private higher education institutions that provide geriatric care training ranging from specialised degrees in geriatrics, geriatric medicine, counselling, and geriatric care management to diploma and short certificate courses in geriatric care. An indicative sample of key institutions is provided in Table 6.

Most accounts of India’s VET ecosystem focus their attention of government ministries, regulatory, and implementing bodies (EY, 2013; KPMG-FICCI, 2014; MSDE, 2015), rather than on the larger ecosystem of economic activities within which VET is embedded. Viewing VET within the larger ecosystem is critical because it enables a clearer identification of players, products, delivery, and key factors influencing scalability.

The ecosystem for aged care is largely defined within the context of health care, which includes both clinical and non-clinical support services provided in hospitals and senior living facilities, and by home health care companies. Figure 2 maps the main features of the VET health care–aged care ecosystem.

NSDC: The NSDC is the government-funded umbrella organisation under which the Health care and Domestic Worker SSCs are located. The SSCs develop National Occupational Standards – Qualification Packs (NOS-QPs) according to industry requirements and the National Skills Qualification Framework (NSQF) which are delivered by public and private vocational training providers (VTPs).

Investors: Delivery of the NSDC-Health care and Domestic Worker SSCs accredited NOS-QPs is funded by the National Skill Development Fund (NSDF). Other funders for skills training include private equity investors in small-medium-large companies and employers in the health care industry, venture capital, foreign government and private investors, large companies with Corporate Social Responsibility (CSR) obligations, and philanthropic trusts and charities.
Training providers: Hospitals and home health care companies may provide in-house training tailored to their specialised requirements with their own trainers or through contracted external training providers. Public institutions and private VTPs may seek NSDF or other government funds to offer NOS-QPs in health care and aged care, and also conduct quality assurance and trainer training programs. Other private VTPs may offer training not funded by the NSDF but which conform to high standards for overseas employment migration. Informal sector providers may offer low-level training based on their work experience in home-based aged care.

Employers: Employers range from large hospitals and home health care companies, senior living communities, employment placement companies, to families with elderly dependents living at home. NSDF funding includes requirements and conditions for final payments based on placement of graduates in employment.

Training delivery: Skills training delivery may take place in dedicated training facilities located in hospital or health care company premises. Most public institutions and private VTPs deliver training through classroom-based instruction with simulation exercises at their centres or hubs. Some collaborate with NGOs to provide training at Regional Resource Training Centres (RRTCs). Additional ICT-based training packages may be provided online or downloaded on tablets and smartphones for offline study. Recognition of Prior Learning (RPL) and upskilling programs for informal sector workers are fairly limited and may be provided by NGOs in urban or rural training centres.
4.1 Student demand for VET

As is well recognised, the number of people in India holding formal VET qualifications is small: only 3.6% of the 487 million people comprising the country’s total workforce have received formal skills training (MSDE, 2015). A further 6-7% have received skill training via early age apprenticeship with family/kin members in artisanal, traditional and hereditary occupations (Mehrotra & Saxena, 2014: 247).

The low demand for VET is due to a mix of factors which include low youth education levels, poor awareness of employment pathways, the low social status attributed to vocational jobs, and limited formal employment opportunities. Around 200 million students drop out from secondary school (Years 9-12) due to social and economic constraints borne by their families. Most of them are then unable to go on to gain industry-aligned employability skills for formal sector manufacturing or services. Those who do finish secondary schooling are largely unaware of how vocational training courses can improve career prospects because most Indian VET courses are narrowly job role-defined and are not linked to career pathways and outcomes (KPMG-FICCI, 2014).

Vocational jobs are often stigmatized because of “inherited prejudices ... against working with one’s hands”, something that is generally associated with poor, low caste, and educationally disadvantaged groups (Tilak, 2002). Among the Indian youth who graduate from secondary school and pursue further education, most seek to enrol in university-level undergraduate courses that offer prospects for white-collar jobs rather than take up vocational training for blue-collar jobs (Singh, 2013; Freeman, 2017b).

Finally, formal sector employment is extremely limited. More than 90% of the working population in India is employed in the informal and unorganised sector where wages are low and formal skill premium is not financially incentivised or rewarded by higher wages. The requirement for skilled workers also varies within the formal sector. For example, manufacturing industries in steel, automotive, and textiles have well-established skilled workforce recruitment through Industrial Training Institutes (ITI). In electronics and capital goods industries where technology changes rapidly, companies usually plan and provide for in-house training (Ruthven, 2017). In the case of construction or other labour services sectors, there is very little formal skills training required or provided by employers, and most workers develop their skills from on-the-job experience.

Demand for VET aged care

Despite projections of need and growing demand from India’s aged care industry, student demand for VET aged care is low. This is due to extremely low wages for these roles in both formal and informal sector employment in hospitals, senior living and residential aged care, and in family-based aged care. Formal vocational qualifications in aged care neither result in higher wages or improved employment conditions, nor prospects for career advancement.

Viewed from a global perspective, the problems faced by the aged care sector in India are similar to those in developed countries. There is growing demand for aged care services, combined with a shortage of skilled aged care workers, and high employee turnover due to low wages, stressful and difficult work, and limited career development opportunities. Even in Australia, aged care is considered a relatively unattractive sector despite significant investment in high quality residential facilities, health care infrastructure, training, and effort to attract, recruit, retain workers in this sector (Dhakal et al. 2017).

The problems of VET aged care in India are more acute due to the additional social, cultural, and economic factors associated with vocational jobs. Stakeholders consulted in India reiterated the problem of low student demand for VET in aged care and the difficulties of student recruitment for skills training because of poor aspirational status, low wages and lack of career progression. Aged care work in family-based settings was particularly unappealing for students because of the very high probability of being treated like a domestic worker. One Australian stakeholder experienced in the India skills market observed,

“Theoretically, aged care skills training should be possible. But low wages, low respect, and low take up of skill development means it’s not yet well enough valued by employers in India” (Skills Think Consulting, 2018, p.12).

Stakeholders in India noted that in contrast to aged care, vocational training for health care roles at medical institutions is more appealing to students because it invokes higher status through association and work with doctors, nurses and other medical professionals.

Stakeholders also highlighted the importance of international migration as a strong incentive for students to pursue health care and other care-related job training. The main attraction of international employment is higher wages and the potential for remittances to family. The Gulf Cooperation Council countries are well-known destinations for higher level skilled health workers and lower-level skilled care and domestic workers from India. New destinations for trained aged care workers include Germany, Belarus, and Japan. In the case of Japan, the Technical Intern Training Program (TITP) requires students to gain NSQF Levels 4 and 5 qualifications for aged care and Japanese language training for fixed term employment placements in country. These training schemes receive NSDF funding and Japanese government support (Murthy, 2018).
5. Prospects for Australian VET Providers in India

Australia’s VET system has been pursuing TNE opportunities in India in different ways, most actively in the last five to seven years. Understanding of the market has been informed by the practical business experience of VET providers, their peak bodies and government assisted research of the Indian skills sector from a market and academic perspective (Skills Think Consulting, 2018, p. 3; Freeman, 2017a; Freeman, 2017b).

This section combines information from stakeholder consultations in India by Skills Think Consulting with the data from the literature review, focus group and consultative group discussions conducted by the Aii Project Team.

5.1 Key lessons from previous engagement

As the Skills Think consultations (2018, p. 3) indicate, the experience of Australian VET providers in India over 5-7 years highlights the importance of:

- Maintaining presence in India, especially in the initial stages as opportunities are being scoped and secured
- Tailoring products to client’s needs
- Employment/self-employment outcomes for students
- Involving local partners in recruitment, delivery, provision of facilities, and securing employment outcomes
- Recognising that the cost/price relationship is complex, and that this needs to be addressed through a long-term investment strategy that builds in scalability factors to address cost and appropriate price issues
- Establishing ‘success metrics’ related to quality and commercial outcomes
- Determining risk appetite and mitigation strategies

The focus groups and consultative group discussions concurred with and reiterated these lessons.

5.2 Capabilities and TNE experience of Australian VET providers

Australia has longstanding expertise in VET that is internationally recognised and well respected. The Australian VET system has quality standards and assurance built into courses and training packages. ASQA regulates courses and training providers to ensure nationally approved quality standards are met. Stakeholder consultations indicate that Indian policy makers greatly value the Australian VET philosophy and pedagogical approach for its underlying quality processes and integration of on- and off-the-job training.

Although many stakeholders in India expressed support for Australia’s efforts to enter the Indian VET market, they also expressed disappointment on the limited progress made so far. Representatives from Indian central and state government agencies noted the limited number of Australian VET providers in the Indian market and that more Australian providers should participate in their tender processes. Several stakeholders pointed out that India’s own capacity for meeting its skills market needs was growing and there would be fewer opportunities for Australian VET provider engagement in the coming years (Skills Think Consulting, 2018, p. 11).

The critical point of comparison for Australian VET in India is with countries like Germany, Switzerland, UK, Japan, Korea and Singapore which also have well-respected VET systems. They have made strategic government investments over several decades to help their VET providers to successfully establish their presence in India (Skills Think Consulting, 2018, p.11; Freeman, 2017b).

Both focus group and consultative group participants endorsed the need for the Australian Government to provide funding for establishing a competitive presence alongside foreign VET providers with long-term presence and commitment in India. The focus groups highlighted the need for the Australian government to adopt a ‘whole of system’ approach to offshore skills training by providing in-country assistance to VET providers for establishing their presence and promoting the value of the Australian VET brand.
Some consultative group members offered the example of the Victorian TAFE Offshore model as an approach that could be pursued by the Australian Government. This initiative was launched by the Victorian Government with the aim of expanding business opportunities for Victorian TAFEs in Indonesia. Rather than operating independently, the Victorian TAFEs work together to develop a comprehensive TNE strategy for VET in selected sectors. The Victorian Government assists TAFE Victoria in securing Indonesian government support, identifying in-country training partners and sources of Indonesian government funding. It funds TAFEs for upskilling, capacity building, and professional development to enable successful engagement in Indonesia (Consultation with DEDJTR representative, October 2018).

Australian expertise in aged care and health care VET

Focus group participants noted that Australian VET providers have strong capabilities and expertise in delivering broad-based and specialised AISC accredited health care, aged care, allied health, and other care products and services. Their training packages and skill sets typically include both off and on the job training, and can accommodate blended learning. At least some AISC accredited care-related training packages require completion of on-the-job training in Australian workplaces.

African care-related VET products can be very broadly aligned to the Indian NOS-QPs and courses developed by the Domestic Worker SSC and Health care SSC (see below). Both the consultative group and focus groups shared the view that the relevant Australian VET products could be modified according to Indian contexts and needs and offered as value-added ‘top-ups’ alongside relevant NOS QPs.

Table 6: Australian – Indian aged and health care VET product comparison


Some Australian VET providers have made significant investments in developing integrated technology platforms with business analytics and bandwidth that can handle up to 100,000 users at the same time. Participants indicated that these have been tested and can be readily used for delivering online training components of VET courses in aged care and health care.

With regard to TNE experience, participants referred to the delivery of Australian Skills Quality Authority (ASQA) accredited VET courses in health care in Pacific Island nations through the DFAT funded Australian Pacific Technical College (APTC) program (DFAT, 2018). Some had experience in delivering non-accredited courses with partners in Pakistan, Sri Lanka, Myanmar, Thailand, Malaysia, Indonesia, Philippines, Korea, and China (Liu, 2017; Austrade 2018b). Participants referred to the International Skills Training (IST) program managed by the Department of Education and Training, which has granted licences to ten Australian VET providers to deliver IST courses in India pending Indian government approval.

5.3 India as market for Australian VET aged care products and services

Previous sections of this study show that despite increased market demand for skilled aged care workers, there is low demand for skills training in aged care work. Industry demand for skilled aged care workers in hospitals, retirement living establishments and home health care companies may be high, but this is not reflected in the valuing of trained aged care workers in terms of wage premiums or improved working conditions. Stakeholders pointed out that this is particularly visible in home-based aged care. Although many families want good, skilled carers for their elderly parents, they do not associate quality care with formal skills qualifications. They usually employ people from rural areas and lower socio-economic and educational backgrounds on low wages to look after their parents, and often treat them like domestic workers (Skills Think Consulting, 2018, p. 6).

Table 6: Australian – Indian aged and health care VET product comparison

<table>
<thead>
<tr>
<th>AUSTRALIAN CARE-RELATED VET PRODUCTS: CERTIFICATES, DIPLOMAS, SKILLS SETS</th>
<th>INDIAN VET PRODUCTS: NOS QPS AND COURSES</th>
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<td>Health Care</td>
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The stakeholders in India suggested that there might be greater student interest in training for health care job roles that lead to employment in hospitals or other ‘medicalised’ institutional settings. They felt there were limited prospects for Australian value-addition for skills training specifically targeted at aged care, but better prospects in other areas of health related care where higher quality was more valued. The health related care training was specially emphasised as an option for offshore employment, where delivery of Australian AQF qualifications might be valued as a benchmark of quality (Skills Think Consulting, 2018, p. 8).

Opportunities

Australian VET providers are aware of the complexities of the Indian VET market, and the parity of esteem issues that affect student demand. Focus group participants acknowledged that low student demand for VET aged care was not unique to India, and that student recruitment was similarly difficult for aged care courses in Australia.

However, the focus group saw opportunities for tapping the emerging market potential in delivering a combination of health care and aged care training. Participants pointed out that Australian providers have developed leading expertise in a wide range of ‘care-related’ areas including health care, residential aged care, home-based care, and disability care. They observed that by bringing Australian experience in high-quality training and delivery methods across health care and aged care, they would be able to deliver higher value for students, and establish a strong reputation and brand value in India’s rapidly expanding aged care and home health care sectors.

Some focus group participants highlighted their capabilities in data-driven solutions and integrated technology platforms that could target and attract students from different demographic backgrounds to a broader range of health care and aged care courses.

Additional points of advantage noted by the focus groups was the possibility of building partnerships with Indian health care companies to develop products and services that could grow as these companies expanded their market presence in third countries. A few stakeholders in India expressed confidence that students could be recruited for aged-care training with the right partnerships, investments, and guarantee of better wages and opening of other career pathways in the broader health care sector.

Challenges

In addition to student recruitment and attrition issues, some stakeholders in India spoke about wide variations in the quality of training delivery of NOS-QPs by VTPs. They pointed out that in order to secure government funding, many VTPs were mainly concerned about meeting mandatory training hours to secure their NSDC funding1. Indian stakeholders felt that Australian VET providers engaging in India needed to be backed by strong bilateral interactions and business-to-business networks to establish stable relationships and sustainable outcomes.

The focus groups were concerned about three issues for Australian VET providers: partnerships, curricular quality and outcomes, and technology capacity for high volume delivery. They highlighted the need for Austrade to play a strong facilitating role in establishing links with the right Indian business partners who would share commitment to due diligence and quality assurance in curriculum and on and off the job training for students. Some focus group participants raised the issue of technology access and internet capacity that would be needed for delivering multiple courses in health care and aged care at scale.

Both focus groups and the consultative group expressed the need for additional support from government to develop capacity and strategies for maintaining Australian VET quality reputation in courses designed for delivery with Indian partners.

Adapting VET products for the Indian market

The stakeholder consultations in India revealed important differences in the way Australian providers and Indian VTPs think about VET ‘products’. Australian providers tend to use examples of their existing courses offered in Australia, rather than thinking of ‘product’ as something that is co-designed and developed with Indian partners. The widely-held view among Indian stakeholders is that Australian VET providers come with a preconceived idea of the product or service they will offer with minimal adaptations to suit the Indian environment. While this attitude of VET providers may have been so in the past and is no longer valid, the opinion prevails (Skills Think Consulting, 2018, p. 5).

1. On 10 October, 2018, PM Modi’s Cabinet approved the merger of two regulatory institutions, the NCVT (which regulated the older, long-format vocational system) and the NSDA (which regulates the newer, short-format VET) into the National Council for Vocational Education and Training (NCVT). The government envisages NCVT as driving quality improvement and market relevance of skill development programs and thereby encouraging greater private investment and employer participation in VET. The NCVT will house the regulatory functions of the NSDC and the SSCs (Government of India PIB, 2018).

The government’s has three aims for this institutional reform. The first is to provide greater credibility to VET via a single regulatory body that establishes standards for training, assessment, and qualifications approval. Second, it expects that having a single regulator of India’s skill system will, in turn, increase its credibility and the aspirational value of formal vocational education, and encourage more youth to undertake skill-based educational courses. The third aim is to facilitate the ease of doing business by providing a steady supply of skilled workforce for industry and service sectors (Government of India PIB, 2018).
The most important message from stakeholder consultations in India is that Australian VET providers need to be flexible and client-focused when embarking on business opportunity discussions with potential Indian partners. Indian VTPs are more likely to opt for partnerships with Australian VET providers for co-development of courses, curriculum content and training methods, and less likely to partner to deliver modified versions of Australian ‘products’ (Skills Think Consulting, pp. 4-5).

**Scalability and price issues**

According to Skills Think Consulting, scalability, i.e., “being able to modify products, delivery approaches, learning methodologies etc. readily as student numbers increase, is less topical in discussions about India TNE as in previous years. This may relate to less focus now being on ‘low cost, high volume’ as the only possible solution for Australian RTOs in India. Identification of niche areas where higher price points exist, also contributes. However, some Australian RTOs may still struggle to plan for a large volume of learners.” (2018, p. 8).

Stakeholders in India felt that Australian providers tend to assume Australian input costs and a cost-plus approach for product pricing. This leads to the conclusion that Australian VET products are too expensive and uncompetitive for the Indian market. The focus groups, in contrast, felt that Australian providers could offer VET courses in India at competitive prices if the Indian partners could guarantee large volume of student recruitment.

The commonly quoted price point for VET courses in India is roughly AUS 200, pegged in relation to the price of government funded, lower-level NSDC courses. Depending on the course recognition and levels of government funding for the VET course, prices could vary between AUS80 and AUS300. However, the key point emphasised by stakeholders is that the courses should be designed with Indian partners with an understanding of the student market. Premium prices could be charged for VET courses if value is clearly articulated in terms of labour market destinations and outcomes (Skills Think Consulting, 2018, p. 9).

An important dimension of scalability highlighted by stakeholders in India, focus groups, and the consultative group was the need for consortia arrangements among Australian providers. This was seen as a way for Australian providers to pool their capabilities and expertise across a range of VET in health care and aged care and seek Indian partners with capabilities and expertise to deliver training at scale and appropriate price points.

**5.4 Scaling up Australian VET in health and aged care in India**

The low-cost/high-volume model for VET remains the conventional wisdom offered to Australian providers seeking market entry in India (Varghese, 2018). In theory, it seems convincing on the principle that large numbers of customers will be attracted to buy the product because of its low price. However, this principle only works if there is already a large demand for the product, or if sufficient resources have been invested beforehand to create large demand for the product in the marketplace. The low-cost/high volume model for VET in India has been adopted from the National Skills Development Policy agenda of “meeting the challenge of skilling at scale with speed, standard (quality) and sustainability” (MSDE, 2015). It is an expression of intent driven by government targets rather than market realities.

It is important to reiterate that although the NSDC and SSCs were set up as industry-led and governed bodies for establishing demand-driven approaches to VET (i.e., skilling people according to industry demand), the implementation of the Skills Agenda has been predominantly supply-driven with the primary aim of deploying NSDF funds to provide training to large numbers of students (Mehrotra and Pratap, 2018; CAG Report No. 45, 2015). Some stakeholders in India also pointed out that despite the fact that industry-led SSCs have developed NOS QPs and set standards for certification, the quality of training delivered has been highly variable. There continue to be significant gaps in job placements for trainees, a key requirement of the skilling programs (Srivas, 2017, 2018; MSDE, 2018).

The low-cost/high-volume model is inappropriate for VET aged care. As several Indian stakeholders noted, student recruitment for aged care courses is difficult and plagued by high levels of attrition, despite being highly subsidised by the Indian government. Since aged care job roles in India are both poorly valued in social terms and poorly paid, the critical success factor for scalability is not to aim for low-cost/high-volume delivery, but focus on building a market strategy that enhances the value and respectability of aged care jobs within the larger ambit of health related industry. Australian providers would need to develop a market strategy that demonstrates how starting a vocational path in the health care and aged care industry can lead to greater value for qualified staff, better wages, and dignified, professional treatment in the workplace.

Australian VET providers could work with Indian partners in the health care industry to co-design courses that demonstrate premium value by ‘upgrading’ diverse health care related job roles and showing pathways for further qualification and career advancement in a highly sophisticated and rapidly evolving care industry in India.

The viability of Australian VET provider engagement in the health and aged care industry will depend on the relationships established between Australian VET providers, types of investors, Indian VTPs, and employers in various health care industry segments to recognise quality training and employee skill development in terms of improved wages.

Figure 2 builds on the health care and aged care ecosystem mapped in Figure 1, and identifies the key scale and scope factors and relationships influencing the strategic choices for TNE engagement of Australian VET providers in India’s health care industry.
Depending on their own characteristics in terms of size, courses and services offered, technological capacity, and funding sources, Australian TAFE institutes and RTOs could seek Indian partners that may be:

- Home health care service companies, retirement estate developers and management companies, or employment marketplace platforms offering a range of on-demand care-related services;
- Private VTPs with a pan-Indian footprint;
- Private VTPs that are expanding their training presence in African countries, the GCC, and the Indian Ocean region;
- Private VTPs that offer guaranteed third country placements;
- Public or private higher education institutions that offer training progression through different certification levels toward a B. Voc. degree.

Australian providers and their Indian partners could jointly mobilise funding for VET in health care and aged care from:

- Indian private equity investors
- Indian and foreign venture capital investors
- Indian and Australian government start-up grants
- CSR funding from large Indian companies or Australian companies with operations in India
- Indian charities, trusts, and Indian diaspora foundations

The time frame for scaling up operations would depend on the terms of agreement that the partnership establishes for expectations of financial returns on investment (RoI), and what it is able to jointly negotiate with investors. Venture capital investors and private equity may have short time frames and expectations for financial RoI. CSR funding or charitable trusts may not seek financial RoI, but may have short to medium timeframes for delivering Social RoI (SRoI).

Based on these scale and scope factors, the partnership can conduct Proof of Concept Analysis (PoCA) to determine the market scope for their jointly developed VET product and services, operational and revenue sharing models. The PoCA should clearly and explicitly focus on achieving two objectives, namely, i) enhancing the partnership’s reputation within the Indian VET ecosystem and care industry, and ii) guaranteeing improved job status for qualified students, i.e., delivering the ‘respectability dividend’. The aims and expectations for RoI between partners and investors should be set and managed according to these two priority objectives.

In order to benefit from early mover advantage in innovative VET for health and aged care, the partnership may need to spend more resources and time at the initial stages of product and market development for testing, quality assurance, and managing different risks. This should be factored into negotiations between partners and investors in terms of timing and scale of funding at different stages of business development.
6. Modes for engagement in VET aged care and home-health care in India

Following on from the strategic considerations outlined above, Australian VET providers could explore opportunities for engagement in India’s health care, home-health care, and aged care sectors through different kinds of partnerships or joint venture arrangements with industry, VTPs, and higher education institutions.

Depending on their capacity, experience, and diversity of products and services in VET for health care and aged care, Australian VET providers could potentially explore the following types of partnership or joint venture models of engagement either individually or as a consortium.

Table 7 presents some examples of the types of VET products or services that could be offered by Australian providers, the value premium for their products, the scalable delivery features, and benefits for students acquiring skills qualifications.

The companies and institutions mentioned in the table and in the examples represent well recognised, established and emerging players in the health care and aged care sector. They are illustrative of the potential types of partnerships for Australian VET providers and not intended to be prescriptive. The information about these organisations have been obtained from websites and freely available online resources listed in the reference section.

<table>
<thead>
<tr>
<th>AUSTRALIAN VET PROVIDERS</th>
<th>POTENTIAL INDIAN PARTNER</th>
<th>TYPE/S OF AUSTRALIAN VET PRODUCT OR SERVICE</th>
<th>APPROPRIATE PRICE POINT – VALUE PREMIUM FOR AUSTRALIAN PROVIDER</th>
<th>SCALABLE DELIVERY FEATURES</th>
<th>BENEFITS FOR STUDENTS ACQUIRING SKILLS QUALIFICATION</th>
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<tbody>
<tr>
<td>TAFE Consortium or Large RTO</td>
<td>Home Health care company (e.g., Nightingale Medical Trust, Portea, Max@home)</td>
<td>Special package as top up with Health care NOS-QPs</td>
<td>Negotiated with company</td>
<td>Built-in periodic upskilling for maintaining certification</td>
<td>Secure employment, scope for career progression in company</td>
</tr>
<tr>
<td>Individual RTO or TAFE</td>
<td>Indian VET providers with guaranteed third country employment placements (e.g., Orion Edutech; HCI)</td>
<td>Health care NOS-QPs + Australian quality assured non-accredited package</td>
<td>Premium for Australian quality assured package</td>
<td>Built-in periodic upskilling and professional development</td>
<td>Higher wages, international mobility and remittances</td>
</tr>
<tr>
<td>TAFE Consortium</td>
<td>Higher education institutions offering B.Voc and VET courses in Health care and Geriatric care (e.g., TISS)</td>
<td>Health care NOS-QPs + Australian expertise in curriculum progression through to higher certification levels</td>
<td>Negotiated with higher education partner</td>
<td>Regular Curriculum upgrade; training trainers</td>
<td>Career progression towards specialisations in health care fields</td>
</tr>
<tr>
<td>TAFE Consortium or Large RTO</td>
<td>Online marketplace companies offering hyperlocal on-demand services (e.g., UrbanClap, Housejoy, Lifeasy); NGO working with informal sector labour; Venture capital; CSR or charitable foundation, Indian higher education institution</td>
<td>Co-develop RPL methodology + level 2 and 3 training modules in health care and soft skills for informal sector care workers</td>
<td>Low, but significant scope for Venture Capital and CSR funding, plus long-term collaboration with educational institution</td>
<td>Development of e-learning components that can be updated on the platform</td>
<td>Ability to charge higher prices for aged and home health care-related services via the marketplace platform on the basis of formal VET qualifications</td>
</tr>
</tbody>
</table>
Partnering with Indian home health care services companies

TAFE consortia and large RTOs could seek to partner with some of the large Indian home health care companies listed in Table 4. All are growing rapidly and attracting substantial private equity investment and venture capital funding for expansion of their services across major metropolitan centres.

For example, Nightingales Home Health Services (NHHS) is a large and specialised home health care company with more than US$30 million investment through private equity and venture capital funding. The company’s charitable arm, the Nightingales Medical Trust (NMT), offers training in geriatric and dementia care. It has developed telemedicine capabilities and operates several residential- and day-care centres for the elderly in five cities.

An Australian VET provider could consider partnering with such a well-established company to develop tailored packages for different components of home health and aged care services that could be offered as top-ups to existing HSSC designed NOS-QPs. The training package could build in requirements for periodic upskilling for maintaining certification.

Example 1 – Home Health Care Services Company: Nightingales Home Health Services

Nightingales Home Health Services (NHHS) was set up in 1996 in Bangalore by co-founders Dr Radha S. Murthy and Mr S. Prem-kumar Raja. While both were working in a private hospital in Bangalore, they realized that they shared a vision for finding a solution for elderly patients who needed home care after leaving the hospital. They started by providing all possible medical care to patients, mostly elders, who had difficulty in visiting hospitals and waiting in long queues for medical consultations and treatment.

NHHS soon became one of the pioneering home health care organisations in India to provide comprehensive 24 hours care that included handling emergencies, and offering personalized and affordable medical services at home with qualified nurses and medical staff.

Two years later, they founded the Nightingales Medical Trust (NMT), a non-governmental, secular, and charitable organisation with the aim of alleviating the non-medical problems faced by the elderly. Dr Murthy and Mr Raja realised that many elderly people were living alone because their children were employed elsewhere. In addition to health problems, they also had to deal with loneliness and emotional issues. They set up centres to cater to physical, emotional, financial and social needs of elders and help them cope with the ageing process with dignity.

In the following decade and a half, NHHS grew into a specialising home health care company with expertise in treatment of chronic diseases, geriatrics, and post-operative rehabilitation. In 2014, NHHS was acquired by Medwell Ventures, a specialty-focused home health care company by Vishal Bali, former Group CEO of Fortis Healthcare, and Ferozan Engineer, Chairman of Cytespace Research, a health care research firm. At the time of its acquisition by Medwell, Nightingales had a subscriber base of 5,000 families under its annual care plans, and provided 53,000 patient bedside nursing days per year.

A year later, Nightingales raised US $10 m in Series A financing from Eight Roads Ventures, and in 2017 raised a further US $21 m in Series B financing from Mahindra Partners, the private equity arm of India’s Mahindra Group.

Sources: https://www.nightingales.in/about-us ; http://nmteldercare.org/index.php/training

The Nightingales Medical Trust continues to function as NMT ElderCare. It runs advocacy programs for dementia awareness, regulatory bodies for residential aged care facilities, and mobile outreach programs. It provides dementia residential care, dementia day care, respite care, and elders enrichment activities in Bangalore.

NMT offers vocational training in geriatric care, dementia care, and other aged care-related services in its training facilities and Regional Resource Training Centres.

NMT has developed India’s first telemedicine enabled Dementia Care Facility at the ETCM Hospital in Kolar, a city near Bangalore. The facility has 35 beds and provides short- and long-term stay along with memory screening. The clinical core team of Nightingales Centre for Ageing & Alzheimer’s including geriatric psychiatrists, neurologists, psychologists and therapists monitor residents at the centre using specially designed Teledementia Management Software. Teleconferencing facilities have been set up to connect people with family members in dementia care.

The Centre has led to increased access to services, improved functional outcomes, and high-levels of satisfaction, enhanced communication and continuity of care. Application of telemedicine technology has allowed NMT to cut down costs by 30%. NMT aims to expand this hub-and-spokes model and set up ten additional facilities in other locations to make dementia care affordable and accessible.
TAFEs and RTOs with expertise in new technologies of personalised medical care could also seek partnership with highly-reputed private hospital groups such as Fortis Health care and Apollo Hospitals, which have large-scale facilities in major metropolitan centres. Such hospital groups require skilled personnel for providing advanced and personalised post-operative and rehabilitation care services to clients in their own homes or, in the case of foreign medical tourists, in dedicated health hospitality centres. India Home Health Care (IHHC) is an example of a care services provider and VTP which has partnered with large hospital groups to provide care training for their staff and offer skilled care for their clients.

**Example 2 – Provider for Home Health Care Services: India Home Health Care (IHHC)**

Based in Bangalore and Chennai, India Home Health Care (IHHC) is a service provider which also functions as a VTP offering health and aged care training programs. IHHC partners with large hospital groups and sources its patient clientele through customer care support desks at their hospitals and via physician recommendations.

IHHC’s investment partner is Bayada, a US-based home health care company providing medical and clinical services and support for the elderly. Bayada has also invested in home health care service partnerships in Germany, Ireland, and Korea.

IHHC offers both HSSC NOS-QP training and its own in-house care training programs which include personal care assistance, emotional support, health monitoring, physical therapy and dementia care. The training is delivered through a combination of classroom instruction, online components, and practical exercises in an US-style simulation lab on its premises. IHHC uses US terminology for job roles in home health care and geriatric services. Clients are provided non-clinical support by home health aides and medical caretakers, while clinical support is provided by nurses.

IHHC offers other services that are linked to Bayada’s expertise in home health care, such as home environment safety assessment, home modifications for fall prevention and ease of movement. The company is aiming to set up its own retirement home facilities in Bangalore.

Source: https://www.indiahomehealthcare.com/

**Partnering with VTPs offering guaranteed in-country and third-country employment placements**

Over the past decade, several VTPs in India have successfully scaled their operations by expanding their training courses across many sectors and locations within and outside India. Some have developed partnerships with third country employers that offer guaranteed, fixed-term placements for qualified trainees, while others have established partnerships for vocational training in third countries. Australian TAFEs and RTOs could partner with these firms to develop care-related curriculum and courses guaranteed to deliver Australian

**Example 3 – VTP offering training for domestic and foreign employment: Orion Edutech**

Set up in 2005 in Kolkata, Orion started off with skills training for the hospitality sector and expanded its skills training portfolio to cover 44 job roles across 18 skill sectors. The company has training centres in most Indian states. It is an NSDC partner for skill development and provides HSSC NOS-QPs in health care.

In 2010, Orion received investment from the VC fund manager Venture East to expand its capacity and operations as Orion Edutech, as an integrated vocational training provider and education counsellor. Its subsidiary company, Content Grill, develops online, classroom and blended teaching content combining lab training, hands-on experience, and soft skills development. Orion Edutech offers upskilling courses for corporate clients, and has recently partnered with Tata Consultancy Services (TCS), a global ICT solutions company, to offer skill development courses through the TCS platform.

Internationally, Orion Edutech offers vocational training in seven countries in West Africa and South Africa. It has also set up vocational training ventures in Indonesia and Oman with local partners. Orion also runs a division which recruits and places graduates in international employment, mainly in GCC countries, and more recently in Japan via the Japanese government’s Technical Intern Training Program.

Since Indian vocational health care qualifications are not recognised in the GCC countries, Orion Edutech is establishing a training centre in Oman to provide additional training that meet GCC standards. Orion is seeking international partnerships or collaborations for developing curricular content benchmarked to international best practice in health care. Its aim is to market these improved health training programs to employers in third countries and make them more aspirational for Indian students seeking global employment mobility.

Orion has set up an education counselling division which mentors and assists Indian students seeking to pursue international higher education. Through its integrated suite of divisions and operations, Orion Edutech hopes to become one of India’s leading global skills training and employment provider

quality and standards of health and aged care training. One such example is Orion Edutech, a well-established Indian VTP providing integrated vocational training and international employment and education opportunities.

Some Australian RTOs have established their presence in skills training in India via subsidiary companies. The following examples illustrate experiences of Indian-Australian enterprises in India.

Example 4: Australian-Indian health care VTP offering training for domestic and foreign employment: HCI India

Health Careers Institute (HCI) India is a VTP company based in Kochi, Kerala, and is a wholly owned subsidiary of an Australian company, HCI Holdings, set up by an Indian-Australian entrepreneur. HCI Holdings operates across the health care sector – from skill development, training and employment - domestically and overseas - to consultancy services in the health care sector.

HCI India in Kochi provides comprehensive education in health care through its affiliate partnership with EduSystems Australia. It offers HSSC health care skill development training in Kochi and Mumbai and job placements for qualified trainees in Indian hospitals. In conjunction with the State Government of Maharashtra, HCI India offers bedside assistant; nursing assistant, and English-language proficiency courses for government medical hospitals. HCI India is the first VTP in Kerala recognised by the NSDC as an India International Skills Centre. It aims to set up an additional 50 Indian International Skills Centres across India by 2022. HCI India partners with the Kerala Academic for Skills Excellence (KASE) for employment placements in GCC countries.

HCI India also offers additional health and aged care training benchmarked to Australian quality standards. Training is offered through flexible learning packages that blend online, classroom and practical experience and enable students to maintain a study-work commitment. The HCI Group is currently completing a market feasibility study to set up an elite 100-bed residential aged care and training facility in Kottayam, Kerala, that meets Australian standards and regulatory requirements.

The HCI Group is seeking to expand its operations into Southeast Asia and the Gulf Cooperation Council (GCC) region. It has established training centres in Philippines and Malaysia, and is finalising its training facility in Dubai. It intends to use the Dubai facility to offer 1-year online Graduate of Nursing Program on behalf the Edith Cowan University as well as training Indian trainers. Through this Dubai operation, the HCI Group plans to develop industry networks with hospitals for both internships and employment outcomes in the GCC region.


Example 5: Australian Indian VTP company offering HSSC NOS QPs: UDAY

UDAY is an Indian vocational training company founded by a dynamic Australian-Indian entrepreneur in 2013. Having previously run a successful RTO in Australia, UDAY’s founder was well-versed with the Australian VET system, and been part of Austrade and DFAT delegations on numerous ACPET missions to India and Indonesia.

UDAY invokes as its core values the Australian ethos of fairness and dignity of labour and consciously promotes this in marketing its skills training in rural areas. This has been very successful in attracting rural youth, farmers, and women in the state of Punjab to pursue vocational training and skills education in entrepreneurship with UDAY. It has also ventured into technology-assisted solutions for the farming sector. One of its award-winning initiatives is Project Mooo, which has leveraged ICT to build a mobile application which solves some key challenges in herd productivity and milk traceability for farmers in Punjab.

Having established a strong reputation in the agri-tech and vocational training in the farming sector, UDAY expanded its course offerings to include skills training in hospitality, business management, IT, construction, and English-language proficiency. UDAY was awarded a grant from the NSDC to launch 14 training centres as part of NSDC’s SkillsCONNECT projects. It has set up a Centre of Excellence at its base in Faridkot, Punjab, and has branches across eight Indian states.

UDAY delivers NOS-QPs for the different skills sectors, but also does in-house design and development of content for train-the-trainer and master training programs. Training is mainly delivered face-to-face in classrooms along with practical application of learning. Online learning components are not offered as yet due to the special support required at the initial stage for rural students with very basic computer skills.

UDAY is has been awarded a contract to offer skill development training in Nigeria. It hopes to capitalise on its distinctive Australia-India VET experience and advantage to expand its operations in other locations across Africa.

UDAY’s health care training has limited progress when compared with its other skill training. It offers the HSSC NOS-QPs for bedside assistants and home health care assistants. Although most UDAY trainees are placed in jobs in government hospitals and homes, they tend to drop out after six months because wages are ‘too little to survive on.’ UDAY’s founder believes that both government and industry commitment is needed to improve pay scales for qualified health care workers.

Higher education institutions offering B.Voc and VET courses in health and geriatric care

There are over 200 colleges affiliated to universities and degree granting institutions and newly-established Skills Universities which offer Bachelor of Vocational Training (B.Voc) degrees. The B.Voc is a three-year degree program that can be taken up after Year 12, with multiple entry and exit levels. They comply with the NSQF and are financially aided by the Indian government’s University Grants Commission (UGC). The program curriculum comprises 40% general education (theory) and 60% practice components. Students get a Diploma Certificate after completing their first year, an Advanced Diploma after completing their second year, and the B. Voc degree after completing their final year.

Many colleges offering B. Voc degrees collaborate with industry partners in different sectors. Students work in the industry and attend general education classes in college. They are usually paid a stipend by the companies they work for, and often end up being employed by them when they complete their B. Voc degree (Murthy, 2017).

Australian VET providers could form a consortium for partnering with leading higher education institutions, colleges, or Skills Universities to co-design and develop higher level health and geriatric care courses. An example of such a leading higher education institution is the Tata Institute of Social Sciences (TISS), which was the first to develop and trial the B. Voc degree in India.

Example 5: B. Voc degree – School of Vocational Education, Tata Institute of Social Sciences

TISS was approached in 2011 by the Ministry of Human Resources and Development to incubate a National Vocational University. Not having prior expertise in setting up such an institution, TISS put forward an alternative proposal to set up a School of Vocational Education as a precursor to the National Vocational University. An MoU was signed between TISS and the All India Council of Technical Education (AICTE) in 2012 to establish the School of Vocational Education (SVE) and a work-integrated model for higher education.

The TISS-SVE currently offers courses in nineteen industry sectors across 90 locations in 22 states. It has trained over 20,000 students in the past six years through a unique and scalable delivery mechanism involving three types of institutional partners – Vertical Anchors, Hub Partners, and Skill Knowledge Providers (Wadia et al. 2018).

Social Enterprises/NGOs and online marketplace companies offering hyperlocal on-demand services

As mentioned in earlier sections of this study, the majority of home-based care services are provided by informal sector workers under poor wage and working conditions. Most cannot afford to spend time away from work or invest resources in formal training. RPL certification for these job roles are also poorly developed and deliver little benefit in terms of improved wages or career opportunities. However, there are several social enterprises and labour NGOs that work with informal sector associations to provide appropriate skills training and support to their members and improve their income and self-employment opportunities. These social enterprises are well-recognised and receive both NSDC funding and CSR funding from industry for their skills training programs.

A number of online marketplace companies such as Housejoy, UrbanClap, and Lifeasy have emerged in the past 5 to 6 years in India. These are gig-economy companies, similar to AirTasker in Australia, that offer hyperlocal on-demand home services, such as domestic care, cleaning, plumbing, electrical equipment repairs, beauty and wellness. These companies are backed by large corporate investors and venture capital funds and are expanding rapidly across many Indian cities. Major players like Lifeasy have adopted an end-to-end business model for their on-demand services and train their technicians to guarantee quality of work (Pradhan, 2018). Others like Housejoy and UrbanClap are moving towards building a subscriber base and putting in place quality assurance and guarantees for quality of work done by their technicians and service workers (Das, 2018).

Australian TAFE consortia and large RTOs could pursue an innovative three-way partnership with labour NGOs and on-demand home services companies to assist in RPL certification and develop small skills training programs for informal sector workers in health and aged care. They could co-develop systems for workers to post their skills certifications and endorsements via the company platforms, and link their skill and experience to different price levels for their home health care and aged care services. Such partnerships would provide substantial market visibility and brand credibility for Australian VET providers in India.
7. Conclusion and Recommendations

Australia is world-renowned for its high-quality universal health care system that is underpinned by a robust framework for accreditation, quality and regulation, cutting edge research, education and training (Austrade, 2015). Its health and aged care sectors rely on a well-trained and highly competent workforce produced by the Australian VET system (ASQA, 2013). The 2018 Aged Care Workforce Strategy Taskforce has outlined fourteen strategic areas of action for shaping the industry and workforce into the future, including VET and higher education (Department of Health, 2018).

Australia’s world-leading reputation in universal health and aged care delivery carries a high value premium for Australian health sector VET. This reputation can be mobilised as the key selling point and motivating factor for vocational training and career pathways in an increasingly sophisticated and ‘smart’ personalised health care related industry (Deloitte, 2018). Australian VET providers can establish significant competitive edge in India by approaching aged care via engagement with the larger health care industry and training partners.

India’s rapidly expanding health care industry including niche segments such as home-health care and aged care offer early mover opportunities for Australian VET providers to establish partnerships, high visibility and reputational leadership in health care TNE. In order to do so, they require the following critical support factors for successful engagement:

- The active role of Austrade in helping identify potential Indian partners with strong business credentials, financial and technological capacity to scale up operations and training delivery
- Austrade and DET assistance in negotiations with Indian central and state governments, industry bodies, potential partners and investors to secure and promote Australia’s global brand value in health care and VET in health and aged care
- Strong connections with Australian companies operating in India, including connections facilitated through Australian Indian diaspora relationships and business networks
- Australian Government support to develop cost-effective operating TNE models that can be piloted with health care partners in India and potentially deployed in Australia and other offshore VET contexts

- A ‘whole of system’ approach to offshore skills training in India facilitated by state-to-state forums for establishing consortia arrangements between Australian VET providers
- Australian Government support with in-country assistance, capacity building, and professional development for Australian VET providers to establish competitive advantage and long-term presence in India’s health and aged care sector.

The way forward

The study offers six recommendations for Australian VET providers seeking to engage with India’s rapidly expanding health and aged care sector.

1. Australia’s world-leading reputation in high-quality, universal health and aged care relies on a well-trained, professionalised, and highly competent workforce produced by the Australian VET system. Austrade and Australian VET providers should highlight the value proposition of this expertise and high-quality training for strengthening India’s rapidly expanding health and aged care industry sector.

2. Australian VET providers should collaborate to offer a suite of health care related training products, with aged care as one entry point for students to progress their career in India’s growing and diversifying health care industry. This collaborative approach will enable them to be flexible, take advantage of their expertise and multiple offerings in health, aged and community care, and expand training in India as demand for higher quality personalised health care emerges in the coming decade.

3. Australian VET providers should pursue partnerships with different players in India’s health and aged care industry. This will enable them to gain market knowledge of training demand, access to training facilities and infrastructure, student recruitment, and employment placement. The diverse partnerships may provide new models for increasing student recruitment, scaling up and maximising value beyond the ‘low-cost/high volume’ formula for product delivery.
4. Australian VET providers should explore joint venture arrangements to develop mid to high level skills courses and services with home health care companies, retirement estate developers, established vocational training providers, higher education institutions, social enterprises and NGOs. This will enhance brand visibility and prestige for the wide range and high quality of Australian VET in health and aged care.

5. State-to-state forums should be used to facilitate consortia arrangements between VET providers for maximising the impact of Australia’s brand and expertise in health and aged care training in India. The consortia should adopt a whole-of-network approach and seek in-country support from the Australian Government for establishing reliable partnerships and scaling up their health and aged care training ventures.

6. Depending on their capacity, experience and diversity of offerings in VET health and aged care, consortium members could potentially explore the following partnership or joint venture models of engagement within the health and aged care sector in India.
   
   i. Large TAFE colleges or RTOs could partner with large retirement estate developers or large home health care companies to co-design courses for training and upskilling in various types of health- and aged-care services. Scalability of product and delivery approaches would develop in conjunction with the partner company’s expansion strategy and include assessment and quality assurance.

   ii. Small- or medium-sized RTOs could partner with well-established Indian Vocational Training Providers to co-design mid to high level health and aged care courses for trainees seeking third country employment. Such courses, with guaranteed job placements in the third country, may command higher price points than equivalent courses for the domestic market. Scalability may be achieved in both situations through sophisticated use of technology for simulations, demonstrations, flexible learning and assessment.

   iii. TAFE consortia could partner with larger public and private Indian higher education institutions and new Skills Universities being set up in different states to offer B. Voc. degrees. They could bring their Australian expertise in curriculum design for student progression from lower certification levels to B. Voc. specialisation in geriatric health care and management.

   iv. TAFE consortia or large RTOs could partner with well-recognised NGOs and social enterprises working in informal sector skilling, and seek CSR funding for RPL and upskilling of informal sector workers who are home-based aged caretakers or health care assistants in hospitals, residential aged care institutions, or senior living estates. Scalability may be achieved by partnering with online marketplace companies that provide hyperlocal on-demand services, and enabling informal/self-employed carers to post their health and aged care services along with evidence of work experience, skills qualifications, refresher courses, and upskilling certifications.
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https://www.sve.tiss.edu/index.php?p=courses-sep
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https://www.urbanclap.com/
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9. Appendix 1: Australian Stakeholder Consultations
### A. Focus Group Participants

**MEETING DATE: 19 SEPTEMBER 2018, UTS, SYDNEY**

<table>
<thead>
<tr>
<th>Name of Institution</th>
<th>Address</th>
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<tr>
<td>Linx Institute</td>
<td>Level 3, 25 George Street, Parramatta, NSW 2150</td>
<td>Attended</td>
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<tr>
<td>Evolve College Pty Ltd.</td>
<td>Unit 1101/2-4 Sterling Circuit, Camperdown NSW 2050</td>
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**MEETING DATE: 24 SEPTEMBER 2018, AUSTRALIA INDIA INSTITUTE**

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<tr>
<td>Stirling Institute of Australia Pty Ltd</td>
<td>51 Brady Street, South Melbourne, VIC 3025</td>
<td>Attended</td>
</tr>
<tr>
<td>FYI Training Pty Ltd.</td>
<td>Suite 5, 769 High Street, Epping, VIC 3076</td>
<td>Attended</td>
</tr>
<tr>
<td>Hays International College</td>
<td>15 Hay Street, Boxhill South, VIC 3128</td>
<td>Attended</td>
</tr>
<tr>
<td>Melbourne Polytechnic</td>
<td>77 St. Georges Road, Preston, VIC 3072</td>
<td>Attended</td>
</tr>
<tr>
<td>The Malka Group Pty Ltd.</td>
<td>29 Ellingworth Parade, Box Hill VIC 3128</td>
<td>Attended</td>
</tr>
<tr>
<td>Victoria Polytechnic</td>
<td>225 King Street, Melbourne, VIC 3000</td>
<td>Attended</td>
</tr>
<tr>
<td>Federation Training</td>
<td>P O Box 3279, Morwell</td>
<td>Attended</td>
</tr>
<tr>
<td>Philips Institute</td>
<td>Cnr. Princess Drive &amp; Monash Way, Morwell, VIC 3841</td>
<td>Attended</td>
</tr>
<tr>
<td>Canberra Institute of Technology Solutions Pty Ltd</td>
<td>75A Koornang Road, Carnegie, VIC 3163</td>
<td>Attended</td>
</tr>
<tr>
<td>TAFE SA</td>
<td>9:39 Carlton Parade, Port Augusta, SA 5700</td>
<td>Teleconference participation</td>
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<tr>
<td>Victoria University Polytechnic</td>
<td>Footscray Campus, Cnr. Nicholson and Buckley St.</td>
<td>Telephone interview</td>
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<tr>
<td>TasTAFE</td>
<td>Lower Ground Level, 75 Campbell Street, Hobart, TAS 7001</td>
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<td>Uday Skills Organisation</td>
<td>105 Institutional Area, Sector 44, Gurgaon, Haryana 122003</td>
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### B. Consultative Group Membership

**MEETING DATE: 2 OCTOBER 2018, AUSTRALIA INDIA INSTITUTE**

<table>
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<tr>
<th>Name, Position</th>
<th>Institution</th>
<th>Attend/Teleconference</th>
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<tbody>
<tr>
<td>Jen Bahen</td>
<td>TAFE Directors Australia, GPO Box 826, Canberra ACT 2601</td>
<td>Attended</td>
</tr>
<tr>
<td>David Saunders</td>
<td>Holmesglen TAFE, P O BOX 42, Holmesglen, VIC 3148</td>
<td>Attended</td>
</tr>
<tr>
<td>Katina Jones</td>
<td>EQUALS Group, 81 Currie St, Adelaide SA 5000</td>
<td>Attended</td>
</tr>
<tr>
<td>Alexis Watt</td>
<td>Open Colleges, Level 4, 1 Richmond Road, Keswick SA 5035</td>
<td>Attended</td>
</tr>
<tr>
<td>Bijo Kunnumpurath</td>
<td>HCI Group, 597-599 Upper Heidelberg Road, Heidelberg Heights Victoria 3081, Australia</td>
<td>Attended</td>
</tr>
<tr>
<td>Genevieve Knight</td>
<td>National Centre for Vocational Education Research (NCVER) Level 5, 60 Light Square, Adelaide, South Australia PO Box 8288, Station Arcade, SA 5000</td>
<td>Teleconference participation</td>
</tr>
<tr>
<td>Toni Cavallaro</td>
<td>National Centre for Vocational Education Research (NCVER) Level 5, 60 Light Square, Adelaide, South Australia PO Box 8288, Station Arcade, SA 5000</td>
<td>Teleconference participation</td>
</tr>
<tr>
<td>Laura Jackson</td>
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10. Appendix 2: Skills Think Consulting Report
A. Focus Group Participants

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</tr>
<tr>
<td>Bijo Kunnumpurath, Founder, Managing Director and Chief Executive Officer</td>
<td>HCI Group, 597-599 Upper Heidelberg Road, Heidelberg Heights Victoria 3081, Australia</td>
<td>Attended</td>
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<tr>
<td>Genevieve Knight, Acting National Manager Research, Knowledge Management and Communication</td>
<td>National Centre for Vocational Education Research (NCVER) Level 5, 60 Light Square, Adelaide, South Australia PO Box 8288, Station Arcade, SA 5000</td>
<td>Teleconference participation</td>
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10. Appendix 2: Skills Think Consulting Report
Report on
Aged Care TNE Skills Development Viability Project Consultations
For Australia India Institute (Aii)
September 2018

Prepared by
SkillsThink CONSULTING
1. Project purpose

The Aged Care Transnational Education (TNE) Skills Development Viability Project was developed by the Australia India Institute (Aii) to examine the viability of Australian vocational education and training (VET) providers delivering skills development products and services for the aged care industry within India.

Within the specific context of the aged care industry, factors likely to influence the viability of transnational education (TNE) business for Australian Registered Training Organisations (RTOs) within India were considered.

Issues for exploration relate to –

- Market - supply and demand, products, scalability, costs, price
- Business – relationships, opportunity identification
- Social – cultural and community issues for aged care in India
- Policy – government and key stakeholder settings

By focusing on one industry – aged care – as a test case for deeper examination, actual practicalities of viability questions can be more accurately considered.

The project forms part of Aii’s program of work funded under a grant from the Australian government Department of Education and Training (DET) from 2015-18. DET requested a practical approach to this project, resulting in market guidance to assist RTOs considering TNE opportunities in India in the aged care sector.

2. Involvement of Skills Think Consulting

Skills Think Consulting was engaged in June 2018 by Aii to undertake consultations for the Aged Care TNE Skill Development Viability Project.

Project Consultant Paula Johnston brings 25 years’ experience in VET policy, strategy and program management, many in senior roles in the public and private sector. She has spent most of the last decade specialising in international education with a particular focus on skill development in India.

Most recently Paula developed an India TNE Action Plan for Trade and Investment Queensland (TIQ), when seconded there part-time during her role as International Engagement Director for the Australian Council of Private Education and Training (ACPET).

See Appendix 1 - Project Plan for more details of intended methodology and break-up of activities between Aii and Skills Think Consulting, noting some changes were made to the plan as work progressed.

3. Project scope and limitations

In defining the meaning of ‘viability’ for RTOs working in aged care in India, the focus was on looking for conditions that warranted a joined-up, collective response, worthy of a broader effort, not narrow or isolated business opportunities for individual organisations. This was considered appropriate given the Australian government’s funding of the project.

Accordingly, the project was not looking for actual opportunities through extensive business development activities. Consultations in India were instead designed as early market research to explore prospects generally. Further investigation of pursuable business leads for RTOs will be needed if commercial agreements are to be realised in the future. Detailed client briefs would allow identification of the product details to be offered by RTOs and then enable accurate costings for proposals.

---

1 Delivery of education within another country for students who remain offshore.

Prepared by Skills Think Consulting – September 2018
Limitations impacting on consultations included that -

- Aii’s environmental scan of aged care skills was not available to inform the design of consultations
- Skills Think Consulting’s intended structured consultations with Australian RTOs were not done prior to India consultations. Limited informal conversations only occurred.

4. Background

Australia’s skills sector has been pursuing TNE opportunities in India in different ways, most actively in the last five to seven years. Understanding of the market has been informed by the practical business experience of RTOs, their peak bodies and government assisted research from a market or, less often, an academic perspective.

Widely acknowledged lessons to date include -

- RTOs need significant in-country presence, especially when developing and securing business opportunities
- Products must be tailored for client’s needs and the intended labour market, NOT an Australian approach transplanted to India.
- Course offerings should have an inbuilt employment or self-employment outcome.
- Local partners are well placed to recruit students, take a role in delivery, provide facilities and secure employment linkages.
- Cost/price is a complex value proposition. RTOs should build in long term investment and scalability.
- Success metrics need to be articulated for all partners including for quality and commercial outcomes.
- Risk appetite and mitigation should be well-articulated, requiring clear commitment from many levels throughout RTOs.

These and other known conditions influenced the selection of consultation targets within India.

Many training organisations consulted represented possible future partners for Australian RTOs, in that most were -

- offering courses in health, community or aged care, as part of India’s formal skill system
- members of India’s peak provider body, ASTP (no ITIs were identified as specialising in aged care)
- affiliated with India’s National Skills Development Corporation (NSDC) and/or relevant Sector Skills Councils.

Fewer aged care service providers were consulted. It was assumed that skills providers and sector skills councils were client focused, with the formal skills system in India already having built-in industry advisory arrangements, as in Australia. India’s qualification packs are developed via consultation with industry and so reflect their known needs.

5. Consultations

Consultations conducted within India resulted in engagement with -

- Indian Sector Skills Councils – Healthcare Sector Skills Council, Domestic Workers Skills Council
- Peak bodies – Council of Indian Industry (CII), Association of Skilled Training Providers (ASTP)
• Indian Skills and Training providers—ten education providers working in the aged care or allied health sectors, mostly members of ASTP, with both social and commercial priorities.

• Government - Indian agencies (Central and State) and Australian agencies with representatives in India involved in skills and trade eg. DET, Austrade and state trade agencies active in skills sector.

• Providers of aged care services within India – a small selection of established or new businesses.

Skills Think Consulting conducted more than twenty targeted meetings in India in late July 2018, with a member of Aii’s research staff observing at most. Structured questions were used for consistency, complemented by open discussion. Locations for consultations were Delhi, Hyderabad, Bangalore, Kochi and Trivandrum.

Discussions with Australian stakeholders included senior staff of a small group of private and public RTOs and representatives of their peak bodies. All were knowledgeable through their direct involvement in the Indian TNE market in some way.

Details of organisations consulted are not included in this report for commercial and privacy reasons, but have been provided to Aii and DET for accountability.

6. Analysis

Discussions with Indian and Australian stakeholders before, during and after the visit to India were complemented by existing knowledge of the India skills market. All contributions provided valuable input.

Following consultations, draft headline findings were provided to Aii in August 2018. These can be found at Appendix 3, noting they represent thinking at that point.

Further explanation and analysis is summarised below, categorised in the areas identified for exploration by the project plan - market, business, social and finally policy issues.

Market

Products

The key training courses relevant to aged care within the structured skills sector in India are -

<table>
<thead>
<tr>
<th>Qualification level</th>
<th>Job role within Qualification Pack</th>
<th>Candidate entry level</th>
<th>Sector Skills Council</th>
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<tr>
<td>NSQF 3</td>
<td>Elderly Caretaker</td>
<td>Class 5</td>
<td>Domestic Workers</td>
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<td>General Duties Assistant</td>
<td>Class 10 or possibly 8</td>
<td>Health</td>
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<tr>
<td>NSQF 4</td>
<td>Home Health Aide</td>
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<td>Health</td>
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<td>NSQF 5</td>
<td>Geriatric Aide</td>
<td>Class 10 or NSQF 4 and 21 years of age</td>
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Those consulted indicated that the most commonly studied of these courses are General Duties Assistant (GDA) and Home Health Aide (HHA) both at National Skills Qualification Framework (NSQF) level 4.

The highest level of these, the Geriatric Aide at NSQF level 5, is new and so not yet well adopted. Many skills organisations appeared unfamiliar with it, or without plans to add it to their offerings. While supportive of its intent, a number felt there was an unproven demand so far for such a high-level specialist aged care job role.

The lowest NSQF job role, elderly caretaker, does not appear to be well-known beyond the more socially driven skills providers. Accordingly, it did not seem to be widely offered.

When asked what would be most valuable input by Australian RTOs working in India, most of those consulted proposed product-based partnerships, particularly the purchasing of or co-development of content.
Interestingly, many struggled to articulate exactly what they meant by content, but appeared to be referring to learning materials. No consultees suggested delivery partnerships.

The value of Australia’s assistance in embedding our VET ‘philosophy’ and methodologies, particularly underlying quality processes, is recognised by policy makers in India. Some RTOs with experience in India believe this contribution is undervalued by potential commercial business partners, because it’s easily perceived as intangible. They feel its value as a ‘product’ is significant but finite, and may start to decline as India’s own skills system matures.

Notions of ‘product’ proved interesting and worthy of further exploration. Australian stakeholders often default to examples of delivering their course in India when discussing product, rather than a more a multi-faceted definition.

But product or service considerations are many – possibly as varied as types of business opportunities. Examples of issues to be explored include purchase/licensing of learning materials, consulting advice, online simulations, type and timing of delivery, number of learners, mentoring of local trainers, recruiting of students, facilities and practical materials supplied or not, and to what quality standard?

Meetings with Indian stakeholders indicated a widely held view that RTOs still come with a pre-conceived idea of the product/service they’ll offer with minimal adaptions to suit the Indian environment. While that may have been more common in the past, the opinion remains. Dealing constructively with many product variables is key if Australian RTOs are to be flexible and client focused. An existing Australian training course may not be the best starting point for many business opportunity conversations.

### KEY MESSAGES about products

1. ‘Product’ should be considered more broadly than course delivery, with many possibilities for innovative solutions to business opportunities for Australian RTOs in India.

2. Indian stakeholders consistently ask for Australian RTOs to be more client-focused and flexible in their product offering and design.

### Demand for skilled labour

Ai’s project proponents assumed a growing demand in India for skills suitable for the aged care industry. The project plan outlined this premise as -

Australia has an established aged care industry, and this sector has experience in training the aged care workforce. As Australia’s demand for an aged care workforce has increased, Australian VET providers have developed recognised capacity in aged care training (KPMG, 2016). This includes experience in delivering aged care training and skills development internationally, particularly in China (Liu, 2016).

India’s elderly population is projected to increase, in line with global trends. Despite this, India has inadequate healthcare infrastructure and training capacity in geriatric care. There is high demand for training in the healthcare sectors, particularly in aged care (e.g., home care, dementia care, palliative care). As such, there may be opportunities for Australian VET providers and businesses to engage with India’s aged care sector.

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1 KPMG (2016). The global demand for skills. KPMG.
A need within India for skilled workers to care for the elderly was certainly acknowledged by those consulted. It was also clear that demand from some types of potential employers is high. However, it became clear that understanding demand for aged care workers required a deeper appreciation of the intended labour market for students.

This can be summarised as -

- **Home based elderly carers** – employed within family homes.

  Consultees indicated that many families want to employ carers in-home, but generally don’t value structured skill development. If they do, short courses at low skill attainment levels, are favoured. Caring for family may be considered an ‘innate’ skill, so learning is typically more general, with less focus on specific aged care knowledge.

  The cost of these courses is low, as are wages of employees. Training may more likely be provided by socially driven organisations, and more often is not linked to qualification packs. Recognition/mobility of courses completed is therefore lower.

  Home based carers employed by families are often domestic migrants moving to the city from States and families of lower socio-economic and educational backgrounds. Many remain in these roles for short periods only, especially young females who feel vulnerable and miss their own families. Adjusting to an urban lifestyle within another family’s home can be difficult. They are often expected to perform various household duties typically performed by domestic workers, and are therefore valued similarly.

- **Institutional** – employed in medical facilities such as hospitals, aged care homes.

  Institutions specifically for live-in aged care, similar to retirement, aged care or nursing homes in Australia, are an emerging industry in India. High end establishments designed for wealthy older people in popular ‘retirement’ locations, or whose children reside overseas, are increasingly advertised. These were considered by many as a niche market, growing slowly and demanding more general health workers. Specialist geriatric knowledge is sought at highly paid levels such as doctors or senior nurses.

  Consultees reported that little geriatric specialisation for care workers occurs in hospitals. Post hospital care for elderly patients who return home may be undertaken by nurses or other allied health roles, such as physiotherapists engaged by the hospital or agencies.

  Accordingly, health qualifications designed for general care or specific job roles were offered by skills organisations consulted. One claimed high placement rates for vision technicians, diabetic educators, dialysis assistants, laboratory technicians and other para-medical roles.

  The need for higher-level specialist skills in elderly care is slowly being realised in Australia. With aged care being an emerging industry in India, this could likely take longer.

**KEY MESSAGES about demand for students/skilled labour**

3. Despite an apparent growing demand for care workers to assist the elderly within India, demand for skills development in aged care, does not seem to correspond.

4. Demand from employers appears more common for -
   - Firstly - mid to high level health care skills, for institution related care.
   - Secondly - low level generic care skills and some domestic abilities, for in-home care.
Supply of students

The most compelling message heard throughout consultations in India, particularly from skills and training providers, was a significant problem with the supply of students to study and work in aged care.

Student recruitment is reported as difficult, with insufficient numbers willing to consider these roles, with one clear exception.

Potential students’ motivations are reported to relate to -

- **Aspiration** –

  Just as in Australia, many young people in India may not be naturally motivated to take on aged care work, with poor prospects for high wages, security or career progression. This seems particularly true of home-based (family employed) caring positions, where the possibility of being treated like a domestic worker is unappealing to many.

  Existing domestic workers may aspire to upgrade their skills to focus more on aged care, if families recognise the greater value inherent in doing so. The elderly caretaker qualification pack from the Domestic Worker’s Sector Skills Council seems well designed for this.

  Employment in medical facilities, even at low skill levels, is much more aspirational according to those consulted. The status borrowed from working with nurses, doctors and other professional colleagues is appealing for many, whether the patient/client is aged or otherwise.

- **International migration/employment**

  International migration was consistently mentioned as the greatest motivator for study in a range of fields, including in health and care job roles. This confirms previous studies, including by Austrade suggesting a market in India for Australian standard qualifications for third country migration, such as to the Middle East/Gulf countries. Demand for skilled health staff in these and some other countries is reported to be high. The Indian State of Kerala is renowned for exporting higher level skilled health workers overseas over many years.

  The establishment of Indian International Skills Centres (IISC) with support from Indian government responds to this call for a labour outflow to other countries. The objective of providing skills training to benchmarked international standards is designed to facilitate overseas mobility for Indian citizens.

  Pilots have been undertaken, but progress in establishing the centres is reported by some to be slow. Interestingly only one stakeholder spoke of this during consultations, despite general duties assistant training within healthcare being included in IISC plans. This may be a promising development, although some confusion about the initiative appeared to exist amongst those consulted. Further exploration is needed to assess where it fits in the viability equation for Australian RTOs.

  Consultations unearthed recent schemes being developed for other countries, including carers for the elderly in Japan, where aged care qualifications at NSQF 4 or 5 level and Japanese language study were required for fixed term employment placements in country. These appeared to involve significant government support.

  Suitable candidates for international migration were expressed as needing sound educational background and English language skills, typically Class 10 finishers but with some work experience, preferably aged 20 years or above.
Negotiating and managing the placement of finishing students with overseas employers requires many important considerations. Students seeking migration outcomes require complex supports to avoid exploitation. To help mitigate these risks, some consultees proposed an Indian government regulated scheme, mandating high level, high quality qualifications, (possibly within the Australian Qualification Framework) be introduced for students seeking international mobility via health job roles.

The main attraction of international employment is of course higher wages, with the potential for remitting money back to family in India being a significant driver. This creates a better value proposition for courses of higher level, higher quality and higher cost.

The return on investment equation for courses with overseas employment outcomes was suggested as two to three times the starting salary. One consultee suggested for courses with employment outcomes offering a starting salary of 50 000rp per month in a hospital in Dubai, students are willing to pay up to $3000AUD.

**KEY MESSAGES about supply of students**

5. Student recruitment is difficult for aged care courses, with insufficient numbers to meet demand willing to consider these job roles.

6. Working in the health industry rather than ‘care’ industry is more aspirational because of higher status and career progression.

7. A promising market for exploration is mid to high level courses designed for overseas employment in broader healthcare job roles, with some but fewer possibilities for aged care. Possible links with India International Skills Centres should be explored.

8. Students seeking overseas employment require complex supports to avoid exploitation.

**NOTE – Very few discussions about Australian education providers working in India occur without the subject of migration to Australia being raised. This is a difficult subject that seems seldom well handled.**

**Scalability**

Scalability, that is being able to modify products, delivery approaches, learning methodologies etc. readily as student numbers increase, is less topical in discussions about India TNE as in previous years.

This may relate to less focus now being on ‘low cost, high volume’ as the only possible solution for Australian RTOs in India. Identification of niche areas where higher price points exist, also contributes. However, some Australian RTOs may still struggle to plan for a large volume of learners.

Online learning as a strategy to assist scalability is frequently mentioned. Sophisticated use of technology was seen in visits to some Indian skills providers working in health. This was in demonstrating techniques or processes, rather than online assessments or learning management systems. Some have invested significant resources in virtual simulation, and e-friendly instructional design. In some high-risk health areas, this outlay is understandable and takes advantage of India’s well developed capability in information technology.

Australian government agencies have encouraged RTOs to utilise consortia arrangements to tackle scalability in markets such as India. This was well supported and actively proposed in meetings with an Indian government agency known for its significant investment in skills development.
Efforts to date to form consortia in this area have been limited and faced many challenges. A structured program approach to building capability of RTOs to work in consortia arrangements may help. Implementation in partnership with government would seem more likely to result in the integrated efforts needed for success.

KEY MESSAGES about scalability

9. E-learning techniques offer possibilities to assist scalability in the healthcare industry in India.
10. Developing the capabilities of RTOs to work in consortia arrangements may also assist.

Cost/price

Great confusion over price points for TNE in India continues in Australia, with a multitude of factors to be taken into account.

Some Australian stakeholders still focus unhelpfully on comparing what a course costs/sells for in Australia to what it costs/sells in India. This perpetuates a narrow view that our primary product is the delivery of an Australian course with Australian input costs.

Cost/price is easier to explore when client parameters are more known and the nature of the right product solution becomes clearer between buyer and seller.

Business development is a lengthy process that requires many more steps than the early market research possible in this project. A sophisticated understanding of the intended labour market is needed to gauge the return on investment for a skills course.

Nonetheless, the well-quoted price point of 10000rp or $200AUD for lower level courses in India, seems largely driven by government pricing models. This is considered a constraint for RTOs if this is the market they are exploring. Home Health Aide courses were suggested by some to cost around 14 000rp ($280AUD) from an Indian skills provider. A three month healthcare course was discussed by a socially driven Indian provider as being 4000rp ($80AUD) or up to 15 000rp ($300AUD) depending on the level of government assistance provided and how the course is recognised in India.

It is suggested by many that an appropriate pricing strategy for RTOs is to start with the price point your market is willing to pay and design product inputs to meet that, taking into account all the outputs/outcomes needed. If a premium price is proposed then the value-add must be clearly matched and articulated to the market.

KEY MESSAGES about cost/price

11. It is not helpful to compare cost/price for TNE courses in India with cost/price of similar courses in Australia.

12. Cost/price is subject to so many variables it is not possible to estimate from afar without at least an early client brief.

13. A clear understanding of the labour market destination of the student needs to be taken into account in cost/price considerations.
Social
Indian family values are of great relevance to the nation’s emerging aged care industry. Extended family households and lifestyles are of course far more prevalent than in Australia. Deeply ingrained responsibility to care for aging family discourages outside assistance.

Many of those consulted acknowledged that attitudes are changing as a more ‘western’ approach to work and family is adopted in parts of India. But a number cautioned this is not as widespread as it may appear, with demographic complexities evident.

An assumption that many overseas citizens of India (OCI) will invest in high skill, high cost labour to care for their elderly parents remaining in India was challenged by some. They reported that in-home care was more favoured in these situations, but at what might be considered mid-range prices in overseas terms.

A number of interviewees seemed more uncomfortable talking about live-in institutions for the elderly when this was personalised. While acknowledging the broader need, one stated he couldn’t place his own parents in an institution or ask ‘outsiders’ to care for them at home as this was incompatible with his family’s values.

Some gender issues were raised in discussions about in-home care of the elderly. Concerns exist for a predominance of young ladies in these roles facing vulnerability to abuse and risk of injury if lifting patients without mechanical assistance.

Aged care is of course a difficult issue for families to navigate in many cultures, including Australia. Over time, and if family and social expectations continue to evolve, Indians may increasingly make different choices...if a range of culturally appropriate options are offered by the health/aged care industry.

KEY MESSAGE about social issues

14. Aged care is an emerging industry in India, but take-up faces challenges based on deeply held social values and family obligations to care for the elderly.

Business
Many have commented previously that Australian RTOs are risk adverse when considering business in India. There are additional risks inherent in skilling for a developing industry like aged care, but returns for creating an early foothold in emergent markets can of course be greater. Nonetheless, caution was sounded at the idea of creating a market for aged care skills in India, just because there is a perceived need for it. That task was thought by many to be beyond the influence of Australian RTOs.

Conversely one seemingly well-placed Australian RTO contended that viable demand for aged care skill development could be actively created in India. If they were able to achieve this, it may represent the ‘exception rather than the rule’. The manufacturing of demand in the type of market observed during consultations seems beyond the typical risk and investment appetite of individual RTOs.

Some RTOs experienced in the India TNE market consider that a large investor or employer, who is convinced of the return on investment for skills development, is needed for Australian input to be viable. One reported that after significant effort already expended exploring up to ten business leads for aged care skilling, none had eventuated.
Some of those consulted believed that a few aged care agencies, prominent recent entrants to the market, had got their model wrong. Providing in-home care for the elderly, they’re reported to now be refocusing to rely on tie-ups with hospitals for aftercare of patients, rather than families to engage them. In any case, they appear to employ mostly nurses at higher skill and pay levels.

A more Indian perspective on health throughout aging was proposed by some, rather than western trends for specialist allied health or greater intervention. This involves preventative health measures and complements the burgeoning wellness industry. It was also remarked that Australia’s reputation as an active, outdoor, sport loving country fitted better with this, rather than trying to claim world class expertise in aged care and its skill development.

A number of Indian stakeholders interviewed were unconvinced there was an Australian value-add for skilling for in-India roles in aged care. Much better prospects were seen in health care where higher quality was more valued. This was especially considered the case if for offshore employment where delivery of Australian AQF qualifications might be valued as a benchmark of quality.

Suitable business or partnership models for Australian RTOs depend on the business opportunity. Some existing Australia/India partnerships may benefit in marketing terms from the association, but the degree of ‘Australian’ input is not always clear. A consortia of providers with a very Australian identity and Australian standard quality metrics could appeal to offshore employers.

### KEY MESSAGES about business issues

15. **Business opportunities warranting further exploration include skill development for offshore employment in health care, possibly via a consortium of Australian RTOs.**

16. **Australian RTOs are more likely to benefit from targeting health related skilling, and addressing aged care within that broader context, while closely monitoring the development of aged care as an industry in India.**

### Policy

A number of those consulted in India for this project expressed disappointment that limited progress has been made by Australian RTOs in India. Despite many visits over many years, they felt the same conversations were occurring, with little advancement. They were very clear that action oriented pilot projects, rather than more studies, were needed so that the focus was now on doing, not more talking.

While positive and supportive of Australia’s efforts to enter the market in a more meaningful way, those consulted indicated that India’s confidence in meeting their own skill market needs is growing. This could make Australia’s value proposition more difficult to prove over time.

Better fundamentals for TNE success seem to have been put in place long ago by competitor nations like Germany and UK, apparently through greater and more strategic government investment. This challenge is often met by calls for the VET sector to work in partnership with our governments, Commonwealth and State, to implement more innovative approaches.

On the consultants’ previous visits to India, government agencies (Central and State) have repeatedly requested more Australian providers to choose from in their tender processes. The Australian VET approach to quality and methodology in VET is valued by government, but having so few players in the market brings an overreliance on them with possible unintended consequences.
One skills provider commented that the Indian skills sector is currently driven more by government than employers or broader industry as the ultimate beneficiaries. This might be taken into account in relationship building, by combining Australia’s business and policy efforts in India more closely. Support for and active participation in this integration by the many government agencies involved in policy and trade development would be invaluable.

Australia’s National Strategy for International Education calls for ‘transformational partnerships’. Austrade’s AIE2025 Roadmap encourages RTOs to utilise consortia arrangements for TNE. This also appears well supported by key stakeholders in India.

A structured program approach of capability building for RTOs and government collectively of the type proposed by Trade and Investment Queensland (TIQ) in their TNE Action Plan for India may be useful. Partnerships between providers and government, of the sort proposed in this work, are more likely to result in the integrated effort needed for providers’ success.

The inevitable topic of skilling for migration to Australia needs a more sophisticated and consistent response throughout our TNE India agenda. This could greatly assist branding and associated quality, reputational and relationship issues.

**KEY MESSAGE about policy**

17. Integrated and active program responses by business and policy agencies, in partnership with Australian providers, would help build the foundations necessary for TNE success in India.

7. **Conclusions**

Indications arising from consultations are that the viability of aged care TNE business opportunities for RTOs within India is limited to specific circumstances. Generally, a joined-up, collective response, or investment beyond that of individual education providers does not seem warranted.

As one Australian consultee experienced in the India skills market noted -

*“Theoretically aged care skills training should be possible. But low wages, low respect, and low take-up of skill development means it’s not yet well enough valued by employers in India”.*

Australian RTOs are more likely to benefit from targeting health related skilling, and addressing aged care within that broader context, while closely monitoring the development of aged care as an industry within India.

Most Australian providers of aged care training also have health, community services and related qualifications on scope, so are likely to have the expertise and experience needed for this suggested broader view.

Within that context, business opportunities warranting further exploration include skill development for offshore employment in health care job roles, possibly via a consortium of Australian RTOs.

The recently released ‘India Economic Strategy to 2035’ report by Peter Varghese cites education as the flagship sector of our bilateral relationship. Our VET sector is acknowledged as being highly regarded. Health is identified within six promising sectors for engagement.

The capability of RTOs and Australia’s policy and business development agencies in India to work together to realise TNE business opportunities would be enhanced by a structured program of work, worthy of further investment. If this were supported, pilot projects that were action oriented, rather than more studies, would be key to laying firmer foundations for future TNE success in health and other industry sectors.

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*Note: the project consultant previously worked with TIQ to develop this plan.*
## KEY MESSAGES about products

1. ‘Product’ should be considered more broadly than course delivery, with many possibilities for innovative solutions to business opportunities for Australian RTOs in India.

2. Indian stakeholders consistently ask for Australian RTOs to be more client-focused and flexible in their product offering and design.

## KEY MESSAGES about demand for students/skilled labour

3. Despite an apparent growing demand for care workers to assist the elderly within India, demand for skills development in aged care, does not seem to correspond.

4. Demand from employers appears more common for -
   - Firstly - mid to high level health care skills, for institution related care.
   - Secondly - low level generic care skills and some domestic abilities, for in-home care.

## KEY MESSAGES about supply of students

5. Student recruitment is difficult for aged care courses, with insufficient numbers to meet demand willing to consider these job roles.

6. Working in the health industry rather than ‘care’ industry is more aspirational because of higher status and career progression.

7. A promising market for exploration is mid to high level courses designed for overseas employment in broader healthcare job roles, with some but fewer possibilities for aged care. Possible links with India International Skills Centres should be explored.

8. Students seeking overseas employment require complex supports to avoid exploitation.

## KEY MESSAGES about scalability

9. E-learning techniques offer possibilities to assist scalability in the healthcare industry in India.

10. Developing the capabilities of RTOs to work in consortia arrangements may also assist.

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## KEY MESSAGE about social issues

14. Aged care is an emerging industry in India, but take-up faces challenges based on deeply held social values and family obligations to care for the elderly.
### KEY MESSAGES about business issues

15. Business opportunities warranting further exploration include skill development for offshore employment in health care, possibly via a consortium of Australian RTOs.

16. Australian RTOs are more likely to benefit from targeting health related skilling, and addressing aged care within that broader context, while closely monitoring the development of aged care as an industry in India.

### KEY MESSAGE about policy

17. Integrated and active program responses by business and policy agencies, in partnership with Australian providers, would help build the foundations necessary for TNE success in India.
Appendix 2 - Project plan

Project Plan
TNE Aged Care Skills Development Viability in India

Project purpose
The project will examine the viability of Australian vocational education and training (VET) providers delivering skills development products and services for the aged care industry in India.

Within the specific context of this industry, factors likely to influence the viability of transnational education (TNE) business for Australian Registered Training Organisations (RTOs) within India will be considered.

Issues for exploration relate to –

- Market - supply and demand, products, scalability, costs, price
- Business – relationships, opportunity identification, processes

As well as -

- Social – cultural and community issues for aged care in India
- Policy – government and key stakeholder settings

By focusing on one industry – aged care – as a test case for deeper examination, actual practicalities of viability questions can be more accurately considered. However some findings are likely to be made that have broader application to other industries for TNE engagement in India.

Project objectives
The project aims to -

- Understand characteristics of the Indian aged care industry relevant to skill development
- Understand relevant issues for Australian RTOs interested in transacting TNE business in India in the aged care industry
- Identify types of skilling products/services and business models that are best suited to be used to deliver aged-care training products and services in India
- Suggest viable options (scenarios) for Australian VET providers to extend their delivery of aged care training products and services in India.

Outputs and outcomes
Expected direct outcomes of the project are –

- Valuable guidance for Australian RTOs delivering aged care products/services who are considering TNE opportunities within India
- Increased likelihood of these RTOs transacting successful business successfully in India

Within time, broader outcomes may include –

- Increased number of RTOs capable of realising TNE opportunities in India
- Deeper understanding of TNE opportunities for VET in India

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Delivery of education within another country for students who remain offshore.
The key output from the project is a report to the Department of Education and Training (DET) as project funders. This will include description of current environment, stakeholder views, analysis of options likely to be most viable for RTOs to explore further, with supportive findings and recommendations.

**Background**

Opportunities for Australian VET providers and businesses seeking to engage with India’s skills development market are highest in niche industry sectors where India’s existing system capacity is low, or only emerging (Freeman, 2017).

Australia has an established aged care industry, and this sector has experience in training the aged care workforce. As Australia’s demand for an aged care workforce has increased, Australian VET providers have developed recognised capacity in aged care training (KPMG, 2016). This includes experience in delivering aged care training and skills development internationally, particularly in China (Liu, 2016).

India’s elderly population is projected to increase, in line with global trends. Despite this, India has inadequate healthcare infrastructure and training capacity in geriatric care. There is high demand for training in the healthcare sectors, particularly in aged care (e.g., home care, dementia care, palliative care). As such, there may be opportunities for Australian VET providers and businesses to engage with India’s aged care sector.

**Project Scope**

The project scope is limited to the vocational education or skill development sector. Higher education or schools are not considered.

The project will not include:

- Identification or development of preferred or standard products or services, (acknowledging that design and selection of appropriate products is dependent on each specific business opportunity)
- Identification or pursuit of actual business opportunities for aged care products or services
- Detailed market research or analysis

**Project management structure**

The project will be managed by the Australia India Institute (AII), University of Melbourne via a funding contract with Department of Education and Training (DET) as part of the 2015-18 Grant Agreement.

It will utilise the following governance arrangements -

<table>
<thead>
<tr>
<th>Role</th>
<th>Fulfilled by</th>
</tr>
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<tbody>
<tr>
<td>Consultative Group</td>
<td>(to be formed by AII)</td>
</tr>
<tr>
<td>Project Sponsor</td>
<td>Haripriya Rangan, AII</td>
</tr>
<tr>
<td>Project Manager</td>
<td>Karen Barker, AII</td>
</tr>
<tr>
<td>Project Consultant</td>
<td>Paula Johnston, Skills Think Consulting</td>
</tr>
<tr>
<td>Project Researcher</td>
<td>Surjeet Dogra Dhanji, AII</td>
</tr>
</tbody>
</table>

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8 Freeman, B. (2017). A report on Australian engagement with India’s skills agenda.
9 KPMG (2016). The global demand for skills. KPMG.
## Project methodology/ approach

A variety of approaches will be used in each project stage as outlined below -

<table>
<thead>
<tr>
<th>Stage</th>
<th>Methodology/ Approach</th>
<th>Deliverables</th>
<th>Leader (assisted by)</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 1. Preparation | N/A                   | • Project plan  
• Consultant contract  
• Start-up workshop            | Paula (Karen)             | Report to include available data, overview of aged care sector in India, and skills development systems in both contexts. |
| 2. Research  | Environmental scan –  
• Literature review,  
  including known product  
  issues e.g. scalability etc.  
• India – characteristics of  
  aged care sector, skills  
  development providers,  
  products/services  
• Australia – RTOs, products/services,  
  industry differences | Environment report –  
10-15 pages max        | Surjeet (Paula)             | Including government, skills development providers, employers, other stakeholders. |
| 3. Consultation and analysis – (Australia and India) | • Structured interviews - face to face, phone, online questionnaire (not survey)  
• Identification of most viable product options/scenarios | Consultation report and findings – 10-15 pages max | Paula (Surjeet) | Including government, skills development providers, employers, other stakeholders. |
| 4. Testing   | • Costing by RTOs  
• RTO Workshop to ‘test’ options | Documentation of findings – 5-10 pages max | To be confirmed | To include private and public RTOs |
| 5. Findings  | Workshop – project team collaboration | Compile final report | Surjeet (Priya) | Final report will include all reports from previous stages |
| 6. Review    | Team input, feedback from DET | Sharing of review feedback with all | Karen (Priya) | To be done post project |

### Stakeholders

#### Australia
- DET, including the Education Counsellor and First Secretary, Delhi
- Austrade and a sample of State and Territory trade agencies in Australia (and India offices)
- Peak bodies - TAFE Directors Australia (TDA), Australian Council for Private Education and Training (ACPET)
- Sample of training providers, public and private

#### India
- Ministry of Skills Development and Entrepreneurship (MSDE)
- National Skills Development Corporation (NSDC)
- Healthcare Sector Skills Council (geriatric care) and Domestic Workers Sector Skills Council
- Industry associations (e.g., CII, FICCI, Indian aged care associations)
- Sample of Indian training providers working in aged care sector - public and private.
- Indian companies operating in aged care sector
- Research institutes involved in community services relevant to aged care
Planning assumptions

The project assumes that –

- a market exists for aged care skill development in India
- suitable employment opportunities exist for aged care workers in India
- high quality RTOs working in aged care training services exist
- RTOs capable of realising TNE opportunities in India exist, who are, or can readily be, export ready.
- the aged care industry in Australia and India have enough aligning or common factors, (acknowledging that differences will be evident), to support Australian RTOs working in India.

From a project management perspective, it is assumed that these pre-requisites are in place -

- Financial resources - have been allocated and will be managed to cover all reasonable and appropriate expenses.
- Human resources - Suitably skilled staff/contractors are in place or can be sourced.

Communications

The project team will provide fortnightly written updates to the Project Manager who will compile written progress reports and forward to DET fortnightly from July to November.

The Project Sponsor will lead fortnightly project meetings with DET from August to November, and will provide available drafts of stage reports to the department for consideration in advance of meetings. The project team will meet separately every other fortnight.

Feedback will be sought from the consultative group at key points during the project, including via the circulation of end-of-stage reports.

Risk management

<table>
<thead>
<tr>
<th>Risk</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Mitigation strategy</th>
<th>Residual Impact</th>
</tr>
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<tbody>
<tr>
<td>Insufficient skills and knowledge will be available to the project team</td>
<td>medium</td>
<td>high</td>
<td>Appoint sub-contractor with appropriate skills and knowledge</td>
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<td></td>
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<td>Establish consultative committee</td>
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<td></td>
<td>Consult regularly with DET</td>
<td></td>
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<tr>
<td>Timelines won’t be met</td>
<td>medium</td>
<td>high</td>
<td>Timelines monitored by Project Manager Weekly reporting to DET</td>
<td>low</td>
</tr>
<tr>
<td>Quality expectations won’t be met</td>
<td>medium</td>
<td>high</td>
<td>Appoint qualified and skilled researcher and contractors</td>
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<td></td>
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<td>Advice from consultative committee</td>
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<td></td>
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<td></td>
<td>Academic oversight incorporated into project</td>
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</tr>
<tr>
<td>Insufficient information sources will be available to consultations</td>
<td>medium</td>
<td>high</td>
<td>Identify alternative sources of information</td>
<td>low</td>
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<tr>
<td></td>
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<td>Use Aii and Consultant networks to ensure availability of information sources</td>
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</tbody>
</table>
### Schedule of activities

<table>
<thead>
<tr>
<th>Project activity</th>
<th>Leader</th>
<th>Date start</th>
<th>Date finish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preliminary</td>
<td>Paula</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start Up workshop</td>
<td></td>
<td>6/6/18</td>
<td></td>
</tr>
<tr>
<td>Preparation</td>
<td>Karen</td>
<td></td>
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</tr>
<tr>
<td>Finalise funding source/contracts</td>
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<tr>
<td>Finalise project plan</td>
<td></td>
<td>29/6/18</td>
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<tr>
<td>Finalise project governance (consultative group)</td>
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<tr>
<td>Research</td>
<td>Surjeet</td>
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<tr>
<td>Environmental scan and literature review draft</td>
<td></td>
<td>16/7/18</td>
<td></td>
</tr>
<tr>
<td>Circulate to consultative group</td>
<td></td>
<td>27/8/18</td>
<td></td>
</tr>
<tr>
<td>Convene consultative group</td>
<td></td>
<td>31/8/18</td>
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<tr>
<td>Consultations</td>
<td>Paula</td>
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<tr>
<td>Australian targets identified and approached</td>
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<td>29/6/18</td>
<td>15/7/18</td>
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<tr>
<td>Australia questionnaire and/or interviews conducted</td>
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<td>29/6/18</td>
<td>22/7/18</td>
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<tr>
<td>India targets identified and approached</td>
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<td>6/7/18</td>
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<td>India itinerary planned</td>
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<td>29/6/18</td>
<td>16/7/18</td>
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<tr>
<td>India meetings and interviews conducted</td>
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<td>23/7/18</td>
<td>3/8/18</td>
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<td>Analysis</td>
<td>Paula</td>
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<tr>
<td>Identification of most viable options</td>
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<td>6/8/18</td>
<td>24/8/18</td>
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<tr>
<td>Circulate report to consultative group</td>
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<tr>
<td>Convene consultative group</td>
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<td>31/8/18</td>
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<tr>
<td>Testing</td>
<td>TBA</td>
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<tr>
<td>Costing of options</td>
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<td>3/9/18</td>
<td>10/9/18</td>
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<tr>
<td>Circulate report to consultative group</td>
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<td>12/9/18</td>
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<tr>
<td>Workshop with consultative group / RTOs</td>
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<td>14/9/18</td>
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<tr>
<td>Documentation of results</td>
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<td>17/9/18</td>
<td>21/9/18</td>
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<tr>
<td>Findings</td>
<td>Surjeet/Priya</td>
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<tr>
<td>Workshop with team to finalise findings</td>
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<td>28/9/18</td>
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<tr>
<td>Finalise draft</td>
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<td>1/10/18</td>
<td>5/10/18</td>
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<tr>
<td>Circulate final draft to consultative group / feedback due:</td>
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<td>8/10/18</td>
<td>12/10/18</td>
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<tr>
<td>Review</td>
<td>Karen</td>
<td></td>
<td>Dec 2018</td>
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<tr>
<td>Post project</td>
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</tbody>
</table>

### Budget (internal to Aii)

The budget is managed by Aii from funds allocated under a grant from the Australian government Department of Education and Training 2015-18.
Australia India Institute (AII)
Aged Care TNE Viability Project

DRAFT
Summary of Indian consultations
11 August 2018

Project purpose

To examine the viability of Australian VET providers delivering products or services for the aged care industry in India.

Including consideration of issues around
  – Market
  – Business
  – Social
  – Policy
Considerations

India consultations were
• Focused on structured skills training
• NOT specific business opportunity identification
• NOT exhaustive market research, limited consultations only

Other challenges....
• Definition of viability? – worthy of broad effort
• Literature review not available
• Australian consultations not done beforehand

Consultations

20+ meetings

<table>
<thead>
<tr>
<th>WHO</th>
<th>WHERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector Skills Councils</td>
<td>Delhi</td>
</tr>
<tr>
<td>Indian Skills and Training</td>
<td>Hyderabad</td>
</tr>
<tr>
<td>providers</td>
<td>Bangalore</td>
</tr>
<tr>
<td>Government agencies - Indian and</td>
<td>Kochi</td>
</tr>
<tr>
<td>Australian</td>
<td>Trivandrum</td>
</tr>
<tr>
<td>Aged care providers</td>
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</tr>
</tbody>
</table>
Consultation headlines

- Mobilisation of students is difficult for aged care, particularly home based roles
  - UNLESS maybe for emerging market of specific offshore placement eg. Japan program

- Indian providers focus on allied health job roles
  - Broader than aged care eg. General duties assistant (GDA)

- Mobilisation easier for ‘institutional’ than home based

Consultation headlines

SO

- Viability for entry level aged care skilling may be limited to specific products designed for specific placements eg. offshore employment

- Skilling for para-medical and allied health job roles, (including aged care) at mid to high NQSF levels for domestic or offshore roles, holds greater possibility
Market

Demand for in-home elderly carers is evident
- BUT demand for skilled aged carers is currently low
- Many skills considered innate, or not worthy of training

Emerging market for institutional or agency home care
- BUT not aged care specific, GDA sufficient entry-level
- New ‘Geriatric aide’ higher role not yet tested
- Blended learning possible to assist scale
- Australian product value not clear – “content?”

Business

- Australian ‘value add’ not clear for in-India roles
- Australian ‘quality’ (or qualification?) is useful for offshore job roles
- BUT that is by agreement with employer and needs government assistance ideally
- Mobilisation and employment for these best done by local partners
- Business model depends on opportunity, consortia may be suitable
Social

- Employment as home carer for elderly not aspirational esp for young
- Domestic migrants in these roles are difficult to retain – ‘trained’ (not structured skilling) or not
- Deeply held family values desire family-like care
- Domestic workers take on many roles
- Growing middle-class may demand greater standards of at-home or institutional elderly health care as value of ‘skills’ grows in India

Policy

- Most viable option for aged care/health care is an offshore employment program
- Would benefit from government support (Indian and Australian) to help negotiate many complex issues
- Required ‘quality/qualification’ to be agreed with receiving employer and government
- Employees need considerable support to help prevent exploitation
- Indian International Skills Centres are an option for further consideration
Possible next steps

1. Finish project at this point as aged care not broadly ‘viable’. 
   Refer possibility of allied health care and offshore program/s to Austrade for further opportunity analysis.

OR

2. Test interest in a proposal for health carer offshore employment program with governments, and providers, and if viable then scope possible further examination