

# Health Services Union

Submission to the Senate Select Committee on Job Security

8 April 2021



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## About Us

The Health Services Union (HSU) is a growing member-based union with over 90,000 members nationally. Our members work across the breadth of health and social assistance industries, in the public, private and not-for-profit sectors. HSU members include aged care workers, disability support workers, pharmacists, mental health nurses, allied health professionals and assistants, paramedics, Aboriginal health practitioners, pathologists, administrative staff, kitchen staff, and cleaners. While this submission has been prepared by HSU National, it is made on behalf of our branches and members Australia-wide.<sup>1</sup>

HSU members are at the frontline of the ongoing COVID-19 pandemic. These workers are putting their lives on the line to protect those in their care, many of whom are the most vulnerable members of our communities. This essential work has been carried out in addition to immense workloads and pressures that pre-date the pandemic, including those associated with insecure work.<sup>2</sup> The fault lines of a system that promotes increasing job and wage insecurity have been brought to the fore during the pandemic, with tragic consequences for workers.

This submission will focus on insecure work in health and social assistance sectors, namely aged care and disability, as it has played out during the COVID-19 pandemic. The submission will primarily address Terms of Reference a, b, c and g however, the HSU notes that the myriad issues which arise from insecure work do not occur in isolation. As such, our responses may also cover additional Terms. The HSU urges the Committee to take a holistic and comprehensive view on the issues of insecure work and its intersection with deeper structural workforce, social and economic trends.

### ***a) the extent and nature of insecure or precarious employment in Australia***

#### ***The extent of precarious employment: aged care and disability***

HSU members across the health and social assistance industries will attest that insecure work is rife and rising. Their anecdotal evidence supports the formal data available. In the disability sector, approximately 80% of the sector is part-time employed and 40% is employed on a casual basis (and rising).<sup>3</sup> In aged care, 78% of the residential 'direct care workforce' is part-time and 10% is casual or contract. In home care, 'three-quarters of all... direct care workers are permanent part-time' and 14% are casual.<sup>4</sup> These numbers are significant as they are but do not capture the full scope of precarious employment arrangements.

#### ***Part-time employment and the myth of security***

Part-time employment is the most common arrangement in both aged and disability care, particularly in residential settings. Part-time employment is considered to provide a balance between certainty of

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<sup>1</sup> HSU National is the trading name for the Health Services Union, a trade union registered under the *Fair Work (Registered Organisations) Act 2009*. The HSU has registered branches for New South Wales/Queensland/Australian Capital Territory; Victoria (4); Tasmania; South Australia/Northern Territory; and Western Australia.

<sup>2</sup> Insecure work may also be referred to as job insecurity or precarious employment. All terms are used interchangeably and capture a range of working arrangements including casual employment, temporary and fixed-term contracts, labour hire, 'gig economy', zero and low hours contracts, and part-time underemployment.

<sup>3</sup> National Disability Services 2019, 'State of the Disability Sector', report, p. 55.

<sup>4</sup> Department of Health 2017, '2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce', report, pp. 10 and 67.

hours and wage, with an individual's external needs and responsibilities. Part-time employees rely on agreement at the commencement of employment with their employer as to the days they will work and the starting and finishing times on each of those days. With that agreement should come an ability to structure their lives accordingly. Part-time work arrangements are designed to allow workers an ability to meet other life responsibilities, such as caregiving for children and loved ones, or study commitments.

However, there is an increasing trend by employers to misappropriate part-time arrangements. The HSU has witnessed a marked increase in low and zero-hour part-time contracts. Low and zero-hour contracts place the balance of power into the hands of employers. It allows rosters to be filled entirely with "additional hours" at no extra pay. As there is no regular agreed pattern of work to alter, an employee's shifts may be assigned with little to no notice and without even the nominal written notice<sup>5</sup> currently required under the *Fair Work Act 2009 (Cth)*. Such "part-time" arrangements offer no security of hours and therefore no financial security or meaningful ability for workers to plan their lives outside of work. HSU members regularly report concerns relating to inconsistency of hours, despite being contracted with the supposed security of part-time work.

### ***Rising prevalence of non-direct employment***

For aged care, the data on modes of employment excludes non-pay as you go workers, which are agency/labour hire, brokered, externally contracted and the self-employed.<sup>6</sup> Non-pay as you go workers are a significant component of the health and social assistance workforce. It is increasingly common in home and community care, especially in disability, where over a quarter of providers in 2016 reported a preference for hiring people under these arrangements rather than by direct employment. Non-direct employment arrangements contribute to the problems associated with job insecurity. For example, these workers may experience diminished access to entitlements such as paid leave and may have reduced certainty of work hours and patterns. In turn, it is difficult for the individual to make medium and longer-term financial and social plans.

The experience of disability support workers in the National Disability Insurance Scheme (NDIS) in Australia is highly relevant when considering the nature of the employment relationship to the worker's wellbeing and livelihood, as well as to the wellbeing and outcomes for the care recipient. Care workers engaged via labour hire agencies, as independent contractors/sole traders or via digital platforms (gig and on-demand discussed further below under Term of Reference "C") often lack consistent access to collegiate and managerial support and supportive environments; safe work practices and safety training; access to ongoing and paid professional development opportunities; and access to fair and adequate industrial and legal representation. Modes of engagement that subvert the traditional employment relationship do so at a cost to building a stable, highly skilled, well-resourced and supported workforce. The ability for non-directly employed workers to provide high-quality care is compromised as a result of the system and arrangements they are operating within. (The relationship between job security and quality care discussed further below at Term of Reference "B").

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<sup>5</sup> Written notice can be as little as a text message sent to the employees immediately prior to a proposed shift.

<sup>6</sup> Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect*, p. 374.

## ***b) the risks of insecure or precarious work exposed or exacerbated by the COVID-19 crisis***

Nowhere was the pernicious impact of insecure work more pronounced than in the multiple outbreaks of COVID-19 in residential aged care facilities, particularly in Victoria during its second wave. However, the issues in care sectors, namely aged care and disability, pre-date the pandemic. These include low wages, low staffing levels, lack of skills mix, limited training and professional development, inadequate funding and financial transparency, non-direct employment, uncertainty and inconsistency in rostering. It is important to recognise that to continue effectively managing COVID-19, to adequately plan for any future major public health crises, and to ensure that on a day-to-day basis our frontline workers are respected and supported to provide the high-quality care our communities expect, we must comprehensively address the underlying systemic problems.

### ***Insecure work in the COVID-19 context***

In aged care, the dominance of insecure work, along with substandard wages, forces people to subsidise financial insecurity by working for multiple employers, across multiple job sites. In addition, insecure work severely restricts or entirely limits access to entitlements such as paid leave accruals. It also erodes the ability for workers to access comprehensive training and professional development, including any supplementary training in necessary areas such as infection control. It has been widely reported that access to Personal Protective Equipment (PPE) and training in the donning and doffing of PPE has been woefully inadequate throughout the pandemic. Examining two insecure work-related issues in the COVID-19 context – leave entitlements and secondary employment – provides a clear picture of the risks exposed and exacerbated by COVID-19.

### ***Leave entitlements***

In the context of a global pandemic and by the very nature of their work and workplaces, residential aged and disability care workers are at increased risk of exposure to COVID-19 and other illnesses and present an increased risk of transmitting the virus and other illnesses to those in their care. This is increased during cold and flu season, and in the context of COVID-19, requires additional vigilance and precautionary measures, such as higher infection control measures. As such, these workers were (and are) being required to use leave at higher-than-normal rates.<sup>7</sup>

The prevalence of precarious employment in these sectors means workers are often not entitled to accrual of paid leave or do not have large accruals, especially not enough to cover test and isolate orders or a 14-day isolation, which is likely to occur on more than one occasion (at very instance a worker presents with cold and flu i.e., COVID-19 symptoms). Precarious employment, intersecting with the markedly low wages and limitation of paid leave, placed/places care workers in a very difficult position. In some cases, it prevented workers from self-isolating with cold and flu symptoms because doing so and losing work would make them unable to meet personal financial commitments and needs.

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<sup>7</sup> Gilbert, L & Lilly, A, 'Independent Review of COVID-19 outbreaks at: St Basil's & Epping Gardens', 30 November 2020, pp. 18-19.

From early in the pandemic, the HSU and other unions advocated for additional government-funded leave<sup>8</sup> and industrial variations to provide aged care workers (and other health workers) with sufficient paid leave during the COVID-19 pandemic. While there were some small wins in this area, such as the Fair Work Commission (FWC) decision to award paid pandemic leave to aged care workers, these were slow to come and did not go far enough. The FWC decision was not made until August 2020, after the FWC initially rejected the application, and it excluded casual workers with irregular hours from accessing the paid leave. This exclusion undermined the very intent of the claim and overlooked the exact workers who were at highest likelihood of working multiple jobs to subsidise wage and job insecurity.

### ***Secondary employment***

It is common for aged care workers to hold secondary employment to subsidise the sector's low wages and overreliance on precarious employment arrangements. Secondary employment may be between residential facilities or across multiple home care service providers, or a combination of both. Secondary or multiple job sites are common for work arranged via job agencies or the self-employed – especially for allied health professionals, registered nurses and general practitioners. Secondary employment is often a necessary means for the individual to ensure financial stability and/or adequate hours of work. It also arises in the form of providers operating multiple facilities and directing employees to work across various locations.

From early on, directly employed workers in aged care received directives from employers to cease secondary employment due to COVID-19. Often, there was no underpinning policy or citation of industrial grounds provided for the decision. No financial compensation or remedy was offered by providers or the Government. The plethora of guidance material<sup>9</sup> on infection material, visitation, PPE and other pertinent matters to working across employers/worksites, and a lack of consistent training and workforce support and resourcing measures, left workers confused and stressed as to what was required of them, how they could safely maintain necessary secondary employment, and what their rights are when directed to cease additional jobs or have hours cut at a secondary job or worksite.

Measures to mitigate the risks of secondary or multiple employment have been introduced, namely the single site employment guide from Victoria during the second wave outbreak.<sup>10</sup> Unions including the HSUs Victorian branches were consulted in the development of this guidance material. This was encouraging as genuine, coordinated, and tripartite sector consultation had been distinctly lacking until this point. Disappointingly however, and despite union recommendations otherwise, the guiding principles were not mandated by the Federal Government and there was no compliance obligation to ensure providers adhered to them. HSU members began reporting as early as August the first week of August that providers were unfairly dismissing employees who do not elect them as their primary employer. Such action was well out of step with the Principles and industrial protections that should have been afforded to workers during this crisis point, and outside of the pandemic.

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<sup>8</sup> Submission of the Health Services Union to the Attorney-General's Department Inquiry 'Monitoring the impacts of coronavirus on the Australian workforce', 25 March 2020.

<sup>9</sup> At July 2020, the HSU was aware of the following, often conflicting, sets of guidance material for the aged care sector: Residential Aged Care Visitor Access Code, the Communicable Diseases Network Australia guidelines, released 13 March 2020; the Australian Health Protection Principal Committee guidelines, released 22 April 2020; and the Aged Care Quality and Safety Commission and Department of Health, released 23 April 2020.

<sup>10</sup> Department of Health, 'Guiding principles for residential aged care – keeping Victorian residents and workers safe', 27 July 2020.

## Case Studies

**Attached** are three pertinent case studies which highlight the culmination of these insecure work and other structural workforce and regulatory issues as they played out from early in the pandemic. These case studies are on the outbreaks that occurred in the Tasmanian North West Region, at Newmarch House in New South Wales, and at St Basil's in Victoria. The case studies reflect the tragedy of the pandemic and varying responses around the country.

***c) workplace and consumer trends and the associated impact on employment arrangements in sectors of the economy including the 'gig' and 'on-demand' economy; and***

***g) the interaction of government agencies and procurement policies with insecure work and the 'on-demand' economy***

As the economic impacts of COVID-19 continue to be felt for the foreseeable future, the growing health and social care sectors will prove a vital piece in Australia's recovery. The on-demand and "gig-economy", commonly known for its online digital platforms in the transport and food delivery industries, has disrupted the employment and industrial relations system for hundreds of thousands Australian workers. An examination of the wages and conditions under which individuals work for these platforms paints a picture of underpaid and insecurely employed workers with few rights.<sup>11</sup>

## Models of On-Demand Work in the Disability Sector

Emerging on-demand platforms in the disability sector have generally marketed their offering to NDIS participants who either plan-manage or self-manage their funding as these participants can use unregistered service providers. We have identified two competing on-demand models that have emerged in the disability sector following the introduction of the NDIS. The table below identifies the differing features of the two models by comparing the practices of the most used providers under each model.

	Direct Employment (Casual) Hireup <a href="https://hireup.com.au/">https://hireup.com.au/</a>	Independent Contracting Mable <a href="https://mable.com.au/">https://mable.com.au/</a>
<b>Engagement model</b>	Workers are directly employed by Hireup as casual employees. Hireup provides an online matching service between support-recipients and support workers through its website.	Independent contractor model. Mable provides a matching service through its website, whilst support workers operate as independent contractors, negotiating a rate with the support-recipient.
<b>NDIS Registration</b>	Registered NDIS provider in NSW, VIC, QLD, TAS and ACT	Not a registered NDIS provider in any jurisdiction. Individual workers may be registered.

<sup>11</sup> Victorian Council of Social Service, 'A fair-go in Victoria's on-demand economy', Submission to the Inquiry into the Victorian on-demand workforce, February 2019.

	<b>Direct Employment (Casual)</b> Hireup <a href="https://hireup.com.au/">https://hireup.com.au/</a>	<b>Independent Contracting</b> Mable <a href="https://mable.com.au/">https://mable.com.au/</a>
<b>Platform costs (users)</b>	Users pay a set price to Hireup depending on when support is provided. For a weekday shift performed between 6am and 8pm, Hireup charges \$49.20 to the service recipient. Rates vary depending on whether the support is delivered on a weekday (day/evening/night), weekend, public holiday.	Users pay a flat 5% on top of the hourly rate they have negotiated with the support worker.
<b>Platform fees (workers)</b>	Nil.	Workers pay a 10% service fee deducted from their negotiated hourly rate.
<b>Wage regulation</b>	As the direct employer, Hireup is bound by the minimum terms and conditions prescribed in the relevant Modern Award – <i>Social, Community, Home Care and Disability Services Industry Award 2010</i> (SCHADS)	Mable's policy dictates that workers cannot enter into an hourly rate of less than \$25. Mable suggests personal care rates of between \$28 and \$40. <sup>12</sup>
<b>Superannuation</b>	As the direct employer, Hireup pays the 9.5% superannuation guarantee to its employees provided they earn more than \$450 per month with Hireup.	Mable does not pay superannuation to support workers, instead workers are encouraged to negotiate a price that would cover the 9.5% superannuation guarantee
<b>Insurance</b>	Hireup states that it provides its employees with workers compensation insurance and professional indemnity insurance.	Mable states that it provides professional indemnity, public liability and personal accident insurance (including journey insurance) to all workers who deliver support through its platform.

Table 1: Comparison of On-Demand Models in the Disability Sector

### ***Institutionalising Wage Theft, Low Wages and Insecure Work***

The HSU submits that on-demand platforms which apply the independent contracting model (such as Mable) institutionalise wage theft. The chart below shows a comparison of the minimum rate allowed by Mable (\$25.00 less 10% service fee) and the low range of the average weekday rate advised by Mable (\$38 less 10% service fee) against minimum wage, minimum Award wage and minimum Award wage for Certificate IV qualified disability support worker.

<sup>12</sup> See: [https://blog.mable.com.au/blog/care-workers/setting-indicative-rates-mable/?\\_ga=2.43545958.27907279.1550612363-2132846583.1548050034](https://blog.mable.com.au/blog/care-workers/setting-indicative-rates-mable/?_ga=2.43545958.27907279.1550612363-2132846583.1548050034)



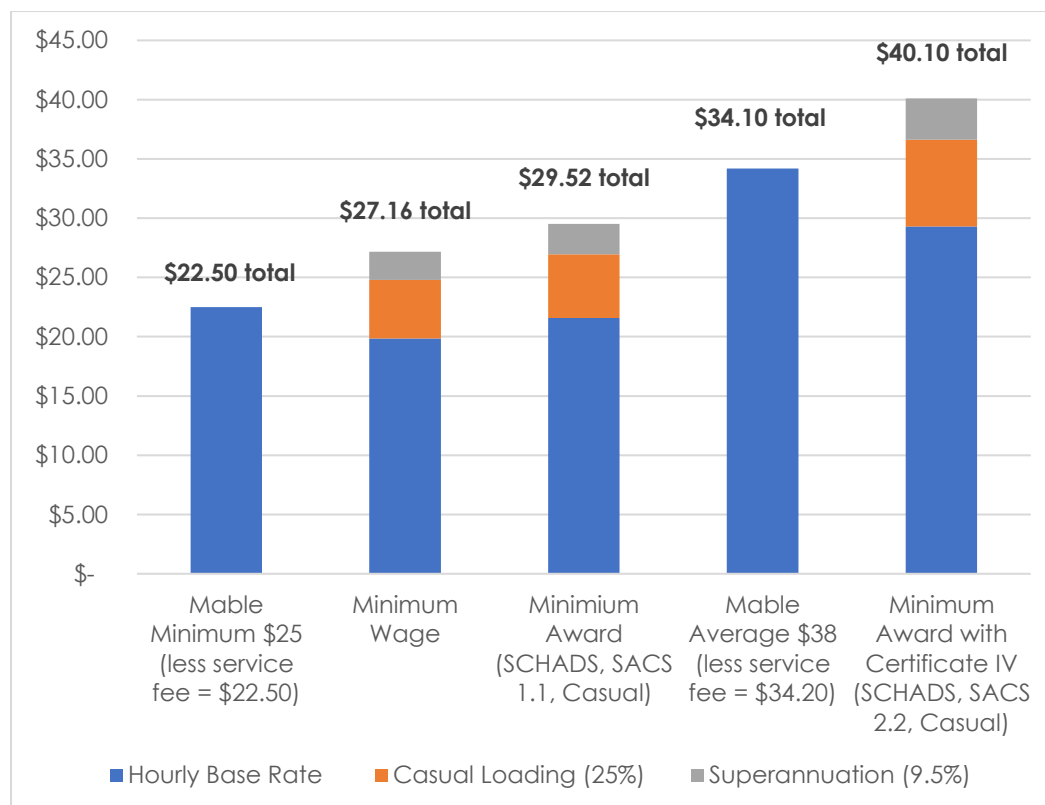


Figure 1: Comparison of total hourly remuneration for weekday, daytime support

As the table shows, the minimum rate allowed by Mable on its platform (less the 10% service fee) undercuts the legal minimum wage for a casual employee receiving the 9.5% superannuation guarantee by \$4.66 per hour or 1/5<sup>th</sup> of the legal minimum wage. Whilst on-demand platforms such as Mable would argue it is the responsibility of individual workers to negotiate a rate with a service user that reflects their own perceived value, HACSU would submit Mable exerts a significant degree of control over support workers using its platform and that they ought to be classified as employees rather than independent contractors.<sup>13</sup> Mable's own advice to prospective workers ignores the reality that in Australia there is a set of legally binding employment instruments which dictate minimum rates of pay and conditions:

*"Remember – What eventually determines a rate is the marketplace. You could have all the qualifications in the world, but if there are care workers operating in your area with equal qualifications at a cheaper rate, then the users of your services have the power to 'shop around' for better value."*<sup>14</sup>

By misclassifying workers as "independent" contractors these types of on-demand platforms are able to circumvent industrial laws and regulations, enabling exploitative labour practices that provide these operators with a competitive advantage over more "traditional" service providers.

<sup>13</sup> Before allowing a worker to use its platform, Mable requires workers to submit a Police Check, performs personal and professional reference checks and requires uploaded copies of qualifications (including certificates and transcripts) for workers performing personal care. This type of screening is carried out by disability service providers who directly employ workers and appears to be quite comprehensive for a service that markets itself merely as a matching service between workers and service recipients. See: <https://help.mable.com.au/knowledge-base/how-does-the-registration-process-for-care-workers-work/>

<sup>14</sup> See: <https://help.mable.com.au/knowledge-base/how-much-should-i-charge/>

Whilst the prevalence of on-demand work in disability services is still limited at this stage<sup>15</sup> it is growing quickly.<sup>16</sup> The HSU is concerned that if these models continue unchecked, they will exert increasing downward pressure on wages and conditions for already low-paid workers. This concern is not unfounded, indeed the *Independent Pricing Review* performed by McKinsey & Company on behalf of the National Disability Insurance Agency (NDIA) to examine the adequacy of capped NDIS prices specially identified “tech-enabled providers” who “serve participants via online platforms, which allow participants to book and manage their own care schedule directly” were models that held “significant potential” for the future NDIS market.<sup>17</sup>

### ***Procuring On-Demand platforms during COVID-19***

In April 2020, while the Tasmanian North West and Newmarch House outbreaks escalated, the Commonwealth contracted Mable to provide surge workforce to the aged care sector for a four-week period. The Commonwealth notified providers it would pay the wage costs for any workers contracted via the Mable app for COVID-19 surge purposes. The contract with Mable was worth nearly \$5.8 million and was awarded in a limited tender process.

The scheme was available to Residential Aged Care, National Aboriginal and Torres Strait Islander Flexible Aged Care Program and Home Care Package providers. The take up of Mable by providers was low. In part this was due to the platform not having available workers in regional, rural and remote areas – reflecting the well-known issue of attraction and retention in these areas for the sector. The decision by the Federal Government to contract and promote at this time Mable directly contradicts their own public health advice to limit movements and interaction with more people than necessary. It demonstrates the lack of understanding and absence of appetite to provide a workforce that is stable, sufficient in size and adequately supported through decent wages and conditions.

### ***Conclusion***

Insecure work is an alarming and growing trend in Australia. For health and social assistance industries, the impact of precarious employment is to the detriment of care provision and outcomes. There are proven links between job quality – where the workforce is fairly remunerated, highly trained with ongoing professional development opportunities, and securely and stably employed – and care quality. As insecure work erodes these foundations of job quality, it in turn is undermining the level of care our essential frontline workers are able to provide. In a time of shared public health crises, as the COVID-19 pandemic has shown, the emphasis in our employment, industrial and regulatory systems must be on providing and promoting secure work.

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<sup>15</sup> As at September 2018, Mable reported it has a database of 50,000 workers and clients, see: <https://www.australianageingagenda.com.au/2018/09/12/online-care-marketplace-reborn-as-mable/>; Hireup reports that it has provided 1.2 million hours of support, but does not publicly report on the number of employees using its platform, see: <https://hireup.com.au/>

<sup>16</sup> Hireup reported that in the 3-years to December 2017, revenue had grown by 7,700%, see: <https://www.smartcompany.com.au/entrepreneurs/hireup-ditching-gig-economy/>

<sup>17</sup> McKinsey & Company (2018) *Independent Pricing Review* (commissioned by the National Disability Insurance Agency), p. 28.

## **Attachment – Case Studies**

### **CASE STUDY ONE: The Tasmanian North West Region Outbreak**

Tasmania had one of the swiftest state responses to COVID-19, declaring a public health emergency on 17 March 2020.<sup>18</sup> On the 17 April, after reporting of initial successes in the state government's containment strategy, it was announced that a health and aged care worker had tested positive to COVID-19.

The worker had completed shifts at the public North West Regional Hospital (**NWRH**) and North West Private Hospital in Burnie. They had also carried out shifts at three separate aged care facilities while infectious. These were Melaleuca Aged in Devonport; Eliza Purton Home in Ulverstone; and Coroneagh Park in Penguin.<sup>19</sup> COVID-19 presented in the Melaleuca residential aged care facilities. The Health and Community Services Union (HACSU)<sup>20</sup> attempted to raise concerns for aged care services with State public health officials shortly after news broke of this worker's positive test result. HACSU was advised that the aged care sector did not fall within their remit, beyond the broader responsibility of state officials to ensure that containment strategies were engaged at the specific workplace level.

As these conversations took place, news broke of a widespread COVID-19 infection amongst staff and patients at the NWRH. State public officials had diverted resources in attempt to contain and manage this growing outbreak. This left aged care facilities to manage outbreaks largely from their own direction and resourcing. Ultimately, the outbreak advanced to the point of complete closure of the NWRH, 500 workers and their families were sent into immediate 2- week isolation, and the North West Region of Tasmania was locked down.

It is important to consider the circumstances of the worker who was first announced as COVID-19 positive. They held two jobs across four worksites, moving between the public and private hospital health sector and aged care sector. These employment arrangements reflect the common need for aged care workers to hold multiple jobs to make an adequate living.

The regional and rural profile of the North West contributes to the commonality of workers either requiring secondary employment or being directed by their employer to provide services at multiple locations. The geographic movement of labour is an additional risk factor in the context of containment strategies.

The above issue became more complicated because General Practitioners work across multiple facilities (similar to allied health professionals, where employment is not direct through the provider/based out of the facility), and nursing and care staff, hired via job agencies, were relied upon to backfill rosters in aged care facilities. Aspen Medical<sup>21</sup> were put on standby by the Aged Care Minister to deploy emergency response teams to aged care facilities if required. The digital gig-economy workforce platform Mable<sup>22</sup> was also listed for use in surge workforce recruitment.

Of the two aged care facilities in the region where positive cases were identified, one provided paid pandemic leave to staff, the other did not. In the latter, employees were forced to use other paid leave

<sup>18</sup> The State of Emergency was declared and given effect under s14 of the *Public Health Act 1997 (Tas)* and remains in place at time of writing.

<sup>19</sup> Eliza Purton Home and Coroneagh Park are both operated by Respect Care, a not for profit provider.

<sup>20</sup> HACSU is the state-registered branch of the Health Services Union in Tasmania.

<sup>21</sup> Aspen Medical are an Australian-owned private company 'providing health care solutions across a range of sectors' <https://www.aspenmedical.com/aspen-medical>. The Federal Government tendered their services during outbreaks across states.

<sup>22</sup> Mable is a digital workforce platform which operates similar to Uber for social care employees and providers.

entitlements (e.g., sick leave, annual leave) or take unpaid leave if their type of employment did not provide paid time off.

From the outset of the North West Region outbreak there was a lack of consistency in terms of crisis preparedness and mechanisms across sectors to deal with any outbreak. In aged care, some employers were on the front-foot and able to establish rigorous systems from the outset; others did not have the resources to do much beyond waiting to see what the government directed; and it became evident that some facilities had little to no emergency plans and policies in place. It was clear that arrangements for surge workforce, dedicated pandemic leave provisions, PPE stocks, and specialised training were not in place. There was absence of clear process within the facilities and more widely across the aged care sector. The lack of preparedness was exacerbated by the geographic profile.

Aged care workers reported a severe lack of consistent information and directives around their rights and responsibilities with respect to COVID-19. Workers were concerned for the livelihood as talk of restrictions on secondary/multiple employment circulated. Others, particularly older workers who make up much of the aged care workforce in the region, were fearful for their health and wellbeing, and that of their care recipients. The Federal Government's retention bonus for 'direct care workers' was met with dismay by many staff excluded from the scheme, or those set to receive less than their colleagues because they carried out more home care than residential cares shifts.

HACSU fielded hundreds of calls from members distressed by the circumstances and with questions about secondary employment rights, PPE access and training, retention bonus eligibility, and government support for any loss of income. HACSU's membership services were opened on weekends to assist with the influx of calls from members requiring assistance.

The aged care response was in complete contrast with the State public health response, where there appeared to be more, and more consistently, applied planning and policy, as well additional resources including funding and PPE. There is a continued absence of aged care crisis response planning, and workers from the North West Region have not been consulted on their experiences and insights. The Independent Review of the outbreak, established by the State Government, does not have the powers to afford workers who provide evidence with protections against employment ramifications. This will significantly (and understandably) reduce the willingness of workers to appear, further diminishing their voices in the dialogue on COVID-19. In Tasmania, the sector remains at just as much risk today as it did when the North West Region outbreak occurred.

### ***CASE STUDY TWO: Newmarch House, NSW***

Newmarch House (**Newmarch**) is a residential aged care facility in Penrith, Western Sydney, run by Anglicare.<sup>23</sup> On 13 April 2020, the NSW Public Health Unit (**NSW Health**) confirmed an aged care worker from Newmarch had tested positive for COVID-19.

The worker had carried out 5 shifts over 6 days at the facility while unknowingly infectious. They had also worked two shifts at Supported Independent Living accommodation run by Greystanes Disability Services (**Greystanes**) in Jamistown. Strict visitor restrictions were put in place for Newmarch. The public was reminded to stay home unless seeking medical attention, including testing.

The rate of worker and resident infections at Newmarch steadily increased over the following week and two residents died from COVID-19. Families were experiencing breakdowns in communication from Anglicare. They were advised by the provider and NSW Health that under public health orders, residents

<sup>23</sup> Anglicare is a denominational not-for-profit organisation providing aged care and community services.

were prevented from leaving or being moved out of the facility, even if they returned negative test results. Breaches of an order by a resident could lead to significant fines or imprisonment. A containment approach to the outbreak was being pursued. Part of this approach included 'Hospital in the Home', where residents would be provided additional care at the facility rather than being transferred to hospital.

By the two-week mark since the first infection was announced, 55 staff were self-isolating in their homes, and families had almost entirely stopped hearing from Anglicare. 6 deaths had occurred. The significant reduction in staff meant residents were missing out on basic care, such as showering. Families were told by their loved ones inside that food was of poor quality and there were not enough meals being provided. The social and emotional needs of the residents could not be cared for by staff or family.

Anglicare advised it was struggling to find replacement nurses, care staff and cleaners. The organisation stated it had reached out to job agencies, hospitals, and other aged care providers but could not source an adequate surge workforce. There were also difficulties with sourcing of Personal Protective Equipment (PPE), exacerbating infection control issues. Aspen Medical<sup>24</sup> were contracted by the federal government to provide surge staff to Newmarch to help contain the virus and provide resident care. Aspen Medical staff were also contracted to assist with the Ruby Princess cruise ship outbreak,<sup>25</sup> and some workers were working across the two outbreak sites.

Complaints were being raised in the media, with Anglicare and to the regulator, the Aged Care Quality and Safety Commissioner (**the regulator**). At approximately 3-weeks since the first infection was reported, Anglicare advised it would separate negative and positive cases within the facility. Residents with COVID-19 were either moved to hospital at the insistence of family or made comfortable at Newmarch. By the end of May, 19 residents had lost their lives to COVID-19, 37 more were infected and 34 staff had tested positive for the virus. The facility was declared free of COVID-19 on 15 June.<sup>26</sup> The initial worker who attended Newmarch, and Greystanes, while infectious was employed on a part-time basis and held secondary employment with the disability service provider. The worker did not know she had COVID-19 and her symptoms were described as very mild.

The difficulties in finding surge staff, particularly as the outbreak grew, and the contracting out to Aspen Medical, meant training and supervision provided to workers new to the facility was minimal. Infection control and PPE breaches were reported (there is no suggestion these issues were the fault of the individuals). Measure to retain, upskill and support existing staff, such as provision of additional paid leave, training and adequate PPE from the outset, were not offered. The decisions by Anglicare not to transfer unwell residents to hospital or to separate those with the virus to a separate section of the facility, compounded the compromised infection control processes. The containment approach in a setting as high-risk and vulnerable as a residential aged care facility reflects a potential lack of crisis preparedness by providers and government officials.

The involvement of the regulator after the situation had escalated, and the decision by the regulator to appoint an independent adviser with no clinical experience and a minimal aged care background, reflected the haphazard approach to ensuring Anglicare's compliance with legal and best practice

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<sup>24</sup> Ibid 21.

<sup>25</sup> 'Aspen Medical reaps \$57m for Covid-19 work, including Newmarch House and Ruby Princess', The Guardian, 7 May 2020, <https://www.theguardian.com/australia-news/2020/may/07/government-to-pay-aspen-medical-57m-for-newmarch-house-and-ruby-princess-coronavirus-work>.

<sup>26</sup> Government of New South Wales, NSW Health, COVID-19 (Coronavirus) statistics, <https://www.health.nsw.gov.au/news>.

obligations. This is despite the Dorothy Henderson Lodge<sup>27</sup> cluster which started in early-March being managed much more swiftly and appropriately for residents and loved ones. Newmarch's response was reactive, as opposed to proactive.

### **CASE STUDY THREE: St BASIL'S HOMES and the VICTORIAN AGED CARE CRISIS**

Victoria responded swiftly to the presence of COVID-19, declaring a state of emergency on 16 March 2020.<sup>28</sup> Accompanying this, the Government established dedicated response teams within relevant Government departments and provided additional resources, including funding, to relevant health and social care services. Unlike some state counterparts, it appeared Victoria had successfully suppressed the virus.

Restrictions began lifting in mid-May, in line with the National Cabinet's roadmap.<sup>29</sup> However, in little over a month following the easing of restrictions, a spike in cases was recorded. Over the period following, Victoria's daily cases would continue to grow – from 1509 total cases at 12 May 2020 to 7125 total cases at 23 July 2020.<sup>30</sup>

Initially, these were linked to breaches in infection control in the hotel quarantine system. Disturbing reports emerged of privately contracted security officers receiving as little as three minutes training, if any at all, in the use of personal protective equipment (PPE), work health and safety inductions, COVID-19 specific inductions, and other infection control measures. Officers also reported not being provided with adequate PPE; an insufficient number of medical waste bins onsite; and an absence of managerial oversight from their employer, Wilson Security.<sup>31</sup> Wilson Security, despite contractual assurances otherwise, further subcontracted its hotel quarantine work. The employment arrangements meant contracted and subcontracted officers were predominantly working on a casual basis, across multiple hotel quarantine sites. There have been reports of recruitment via apps, such as WhatsApp messaging.<sup>32</sup>

The first announcement of security officers testing positive to COVID-19 after working with no or mild symptoms across hotels came in late-May. These officers, members of large families from culturally and linguistically diverse (CALD) backgrounds in Melbourne's north and north western suburbs, had also attended family gatherings while unknowingly sick with COVID-19. Around this time, reports emerge of a lack of CALD appropriate COVID-19 resources being provided to communities. The situation in Victoria escalated rapidly. Spread of the virus by community transmission was rising, and despite contact tracing efforts, many cases began to appear without known links.

In mid-July, news emerged of an outbreak at St Basil's Homes for the Aged (**St Basil's**)<sup>33</sup> in Fawkner, a suburb in Melbourne's north. A staff member had attended the facility while infected with COVID-19 but asymptomatic. The worker stopped attending work when symptoms appeared and notified St

<sup>27</sup> A residential aged care facility run by BaptistCare, a denominational not-for-profit aged and community care provider.

<sup>28</sup> The State of Emergency was declared and given effect under s198(1) of the *Public Health and Wellbeing Act 2008 (Vic)* and remains in place at time of writing.

<sup>29</sup> Australian Government, 'Roadmap to a COVIDSafe Australia: a three-step pathway for easing restrictions,' <https://www.australia.gov.au/>.

<sup>30</sup> Parliament of Victoria, Public Accounts and Estimates Committee 2020, 'Inquiry into the Government's response to the COVID-19 pandemic: Interim Report,' Minority Report, p. 196.

<sup>31</sup> Wilson Security is a private company providing security officers on a contract basis to security, healthcare, storage and parking sectors, <https://www.wilsonsecurity.com.au/about-us/>. The Victorian Government contracted Wilson Security, along with two other security firms (MSS and Unified), to provide personnel in the hotel quarantine system. Wilson Security was the primary employer with responsibilities and obligations to any contracted security officer, including on training and provision of PPE - as was MSS and Unified for their contractors.

<sup>32</sup> ABC news, 'Coronavirus quarantine guards in Melbourne hotels were recruited via WhatsApp, then 'told to bring their own masks', 21 July 2020, <https://www.abc.net.au/news/2020-07-21/coronavirus-quarantine-hotel-security-guards-recruited-whatsapp/12476574>.

<sup>33</sup> St Basil's is operated by the Greek Orthodox Archdiocese of Australia and is a not-for-profit provider.

Basil's when the positive test result was returned on 9 July. It took a further 6 days before all residents were tested and, in this time, unknowingly infected staff and residents mixed with those not infected.

Reports emerged from distressed St Basil's workers and resident's family members that there were not enough staff to provide basic care; PPE and training was being provided haphazardly; and loved ones were going without timely communication on the wellbeing of loved ones. The Aged Care Quality and Safety Commissioner and the Minister for Aged Care and Senior Australians announced interventions and investigations into the situation. Shortly after, workers were stood down by St Basil's and Aspen Medical<sup>34</sup> were brought in to staff the facility.

The same casualisation and income insecurity issues meant infected, but asymptomatic or mildly symptomatic workers were moving between St Basil's and other worksites. In conjunction with a lack of appropriate resources for CALD workers<sup>35</sup> and without appropriate economic and social supports for people moving in and out (most often for work, schooling or essential supply purposes) of the public housing towers in the north and north west,<sup>36</sup> community transmission was increasing rapidly.

The disturbing situation at St Basil's is being replicated across Victoria's aged care services. At the end of July, there were 13 residential aged care facilities across Melbourne and into the outer suburbs that had reported the presence of COVID-19 in staff and/or residents. Victoria currently accounts for 93 per cent of cases of COVID-19 in Commonwealth subsidised residential aged care facilities nationally.<sup>37</sup>

A heated political and public dialogue around differences between public and privately operated services has marked the Victorian COVID-19 aged care crisis. The Victorian Government is the largest public provider of residential aged care services in the country, attributable to its 180 public sector residential aged care services (PSRACS).<sup>38</sup> Of the nearly one thousand currently active cases in Victoria, only five are linked to one PSRACS.<sup>39</sup> The reasons for the higher rate of COVID-19 in private facilities/lower rate in state-run are myriad. Reasons cited include a lack of regulatory oversight from the Federal Government of private operators, the mandate of staffing ratios in state-run facilities, hinderances in the supply of PPE from Federal Government to aged care and other workers, and the geographic composition and market characteristics<sup>40</sup> - where the spread of COVID-19 to aged care in regional, rural and remote areas has to-date been limited, and private operators having a low market presence in these areas due to real or perceived viability issues.

The Victorian Government has worked to bring together relevant sector stakeholders, including Federal Government, industry, providers, and workforce representatives (unions) to develop responses and solutions to the crisis which continues to unfold. While many of the measures are supported in principle, and others are too much in infancy to understand worker take-up and effect, early reports from aged care workers suggest they do not go far enough. For example, the program to minimise workforce sharing across aged care sites<sup>41</sup> is not being implemented in good faith by employers, with workers reporting being unfairly dismissed by secondary employers when they advise they will be limiting (under the program) availability to one other employer.

<sup>34</sup> Ibid 21.

<sup>35</sup> Approximately 30 per cent of the aged care workforce is from a CALD background, with 70 per cent of this proportion working in personal care worker or similar roles. Department of Health 2017, '2016 National Aged Care Workforce Census and Survey – The Aged Care Workforce', report, p. 18.

<sup>36</sup> Royal Commission into Aged Care Quality and Safety, published submissions, document ID AWF.650.00053.0002, <https://agedcare.royalcommission.gov.au/media/27188>, pp. 3, 114-115.

<sup>37</sup> Australian Government, Department of Health, 'COVID-19 cases in aged care services – residential care.' Total cases including active, recovered and deaths. Current at time of submission.

<sup>38</sup> Ibid 36, p. 31.

<sup>39</sup> Ibid.

<sup>40</sup> Ibid.

<sup>41</sup> 'Guiding Principles for residential aged care – keeping Victorian residents and workers safe', 22 July 2020.



On 19 July 2020 the Government announced a range of new measures to minimise the spread of COVID-19 in the aged care sector. These included a program to minimise workforce sharing across aged care sites, infection control training for aged care workers, collaboration with the private sector to increase capacity, and improved surveillance, testing, and contact tracing. In addition, a one-off \$1,500 payment will be made to Victorian aged care workers who have been instructed to self-isolate or quarantine at home because they are either diagnosed with COVID-19 or are a close contact of a confirmed case but cannot rely on sick leave while missing work.