1. Introduction

Purpose at Work is a consulting firm which assists disability and mental health providers in making work more satisfying, purposeful and efficient for workers, participants and providers themselves.

We are acutely aware of the tough constraints the NDIS places on our clients and all NDIS providers. Consequently, our submission will focus on the Term of Reference (c):

- 'the role of Commonwealth Government policy in influencing the remuneration, conditions, working environment (including Workplace Health and Safety), career mobility and training needs of the NDIS workforce'

We note however that the same difficulties the NDIS creates for providers in managing their workforce also make it difficult for them to attract and retain workers, which in turn exacerbates sector-wide workforce shortages. This makes our submission also relevant to Term of Reference (b).

The importance of a quality workforce in social care services is an easy case to make. The disability and home care sectors have relatively low capital intensity, few supervisors per worker and, typically, dispersed workforces. This means that the quality of work necessarily depends on the capability of individual workers more, for example, than in large centralised corporations, or an industry like manufacturing, where the amount and quality of capital investment decisions, and management oversight, are key influences. As Cortis et al wrote in 2013, '[Workers] are the main determinant of the quality of care and the major cost of service delivery.'[1]

Inquiry reports from the social care sector (aged and disability care) consistently point to the importance of client and patient staffing ratios, staff consistency, skills, engagement and training in providing safe, high quality services. For example, the 2017 Australian Law Reform Commission report on elder abuse observed:

> a safe, qualified aged care workforce in sufficient numbers is an essential safeguard against elder abuse in aged care.[2]

In its landmark 2011 disability report, the Productivity Commission made a strong argument that *job quality* as well as *workforce quality* would improve under the new personalised scheme it was proposing. It claimed wages and working conditions for disability workers would improve, and that this in turn would allow Australia to expand the sector as the country needed to do.[3]

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[1] Cortis, Natasha et al (2013) Building an Industry of Choice: Service Quality, Workforce Capacity and Consumer-Centred Funding in Disability Care. Report for United Voice, Australian Services Union, and Health and Community Services Union. Social Policy Research Centre, University of NSW. p. 6.
[2] Australian Law Reform Commission (2017) Elder Abuse—A National Legal Response, Report 131, p. 126. www.alrc.gov.au/publications/elder-abuse-report
[3] Productivity Commission (2011) Disability Care and Support, Inquiry Report no. 54 Overview.

However, as this submission will argue, there is no evidence this has occurred, and mounting evidence to the contrary.

Meanwhile, workforce-related government action and regulatory initiatives have to date focused mainly on the skills, qualities and volume of the workforce, leaving the issues of wages and working conditions, or the broader work context out of the equation. Governments have devised codes of conduct, practice standards, capability frameworks and screening processes intended to regulate the disability and mental health workforce and have placed new requirements on those who work in and manage them. Examples are the NDIS Quality and Safeguarding Framework and the NDS Quality and Safeguards Commission's current project, the Workforce Capability Framework. However, the impact of the NDIS itself on job design, labour supply, working time and workplace health and safety are ignored.

This submission argues that 'workforce quality' has many important dimensions, including:

- The capability of individual workers (their skills, orientation and overall capability)
- The nature of the jobs that social care workers undertake (employment conditions, how the constraints of the job affects their autonomy and ability to reform, the degree of stress, resources and support, the impact on people's physical and mental health)
- The structure of the organisation itself, including when the worker is a sole operator.

All of these affect the quality of work produced by the workforce – that is, care and support work of people with disability.

Another way to think about this is to use a broader conception of capability than is usually adopted in debates about disability workforce. Capability frameworks in disability typically focus on individual worker and management competencies. However, in other contexts, capability is conceived more broadly as a product of a system. In disaster management, for example the national framework[4] states:

> Capability is the collective ability and power to deliver and sustain an effect within a specific context and timeframe. The level of capability is determined by the combination of ability and capacity across the following core elements of which people are but one:
> - People
> - Resources
> - Governance
> - Systems
> - Processes.

[4] Department of Home Affairs (2018) Australian Disaster Preparedness Framework for the Australia-New Zealand Emergency Management Committee, p 8.

This submission describes the relational characteristics of disability work that make it so vulnerable to the impact broader operating environment, or system capabilities.

2. The context

Ungerson and Yeandle[5] have documented how in the wealthiest and most economically developed countries, 'cash-for-care' or 'consumer-directed' arrangements have become widely adopted as a response to the demographic trends. Another distinctive feature is the importance of human rights movements in their emergence. As well as responding to ballooning needs and costs, governments introduced the new approaches in Australia because of consumer advocacy for personal, non-institutional systems that afford more dignity to the individual. In disability, the Every Australian Counts social campaign of people with disability, their families, carers, and support organisations, emerged in 2011 to fight for 'a national system with enough funding to provide tailored, individual support'.

A further design influence is the fact that the new approaches to social care were introduced in a period when two other traditions of government policy in OECD countries had become dominant. These are:

i. Neo-liberal economic management – a set of policy ideas that includes economic liberalisation policies such as privatisation, austerity, deregulation, free trade and reductions in government spending in order to increase the role of the private sector in the economy.
ii. New Public Management – the idea that the state should have a distanced approach to state-community relationships, acting as contract manager (rather than direct service provider) and offering usually short-term funding on the basis of precisely specified outputs, measurement and reporting.

In Australia's current social care systems we see the consequences of all of these policy currents inter-twined.[6] As a consequence, and despite enthusiasm about the introduction of consumer-directed care, there has been concern and some evidence that the quality of care is being compromised, rather than improved as a result of consumer-directed care. People With Disabilities Australia, the peak body of people with disability and families, states:

> The NDIS came from people with disability. It was created to give people choice and control over what supports they needed, who would deliver them, how and when they would be delivered. However, those implementing the NDIS are not handing over choice and control to us, and we have seen a return to the practices it was supposed to solve, such as difficulty

[5] Ungerson, Claire and Yeandle, Sue (eds) (2007) Cash for Care in Developed Welfare States, Palgrave Macmillan.
[6] See Cunningham, Ian (2016) 'Non-profits and the 'hollowed out' state: the transformation of working conditions through personalizing social care services during an era of austerity', Work, Employment and Society, Vol. 30 (4) pp 649–668.

accessing the scheme, inadequate funding of supports, deficit based assumptions about people, and huge delays in reviews and access requests.[7]

The 2019 Joint Parliamentary Committee on the NDIS report expressed concern that the loss of skilled and experience workers was undermining the quality of care and not consistent with the insurance principles governing the scheme.[8]

In home care, consumers appear are not fully expending the funds available to them and average staff hours, and profitability of providers are decreasing.[9] The company responsible for home care market surveys noted in March 2019: 'The trend…clearly shows the continuing decline in operating results since the introduction of Consumer Directed Care'. Another recent study found that rather than increasing efficiencies, just 50% of home care packages were being used for direct care or equipment, while administration and care co-ordination accounted for nearly 40% of the total expenditure.[10]

In short: although in the new systems people needing care theoretically have more power, it is not clear that to date they have been able to exercise it constructively or for beneficial outcomes. This is often interpreted as an implementation failure and/or, a problem associated with the transition to something new. Undoubtedly, there are transition issues. Stakeholders report that individuals learn to be more demanding and discerning consumers over time. However, researchers and practitioners are increasingly arguing that the problems which threaten to undermine quality and affect the sector's sustainability also arise from inherent problems in design. These arise directly from the way consumer-directed care schemes can undermine the very conditions of work which promote quality care.

3. The distinctive nature of social care work

The distinctive features of the care workforce is much discussed in academic literature, and include:

- caring work is a special type of emotional labour
- the work is 'coproduced' by people needing support and workers
- the workforce is made up mainly of women[11]

[7] See pwd.org.au/our-work/policy-areas/ndis/
[8] Joint Standing Committee on the NDIS (2019) Progress Report 2019. General issues around the implementation and performance of the NDIS. Chapter 3. See www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme
[9] StewartBrown (2019) Aged Care Financial Performance Survey Sector Report, (nine months ended March 2019) p. 21 and 23.
[10] Bulamu, Norma et al (2019) 'An early investigation of individual budget expenditures in the era of consumer-directed care' in the Australasian Journal on Ageing, first published 9 August 2019.
[11] In Australia Eastman reports that the most recent 2016 Census found around 80% of 'aged and disabled carers' and 85% of 'personal care assistants' were female. Eastman, Christine (2018) Carers in Australia, 2016, unpublished.

Like many types of customer-service work, work in aged care, disability and similar sectors involves a high degree of 'emotional labour.'[12] This is labour that operates directly on people's feelings and emotions, and where workers must themselves display certain types of emotions. Typically such work involves management of the worker's own emotions in order to create a desired effect in others. Making and taking calls in call centres is one example of such work, where workers are usually expected to follow tight scripts but also display empathy and a 'positive, service-driven attitude'.[13]

Rather than 'coming naturally' researchers have documented its skilled and intensive nature. They argue that it is usually not fairly compensated because the workforce is mainly female and emotional labour is simply expected of women or worse, is just not noticed.[14] The social and inter-personal skills used are derived from the domestic sphere but exploited in the paid work setting.

However, in discussing the distinctive nature of *social care work* researchers observe that workers often report that their job is somewhat or highly rewarding. In the most recent large-scale survey of Australian disability support workers Martin and Healy found that workers expressed considerable satisfaction with their work, except on the matter of pay. On most job features their attitude scores were similar to those of the Australian female workforce as a whole, with the exception of markedly lower results on 'satisfaction with total pay' and higher results on 'satisfaction with the work itself'.[15]

A recent Victorian Government disability worker survey[16] found similar results, commenting:

> Many participants talked about how fulfilling it can be when they feel they have made a real difference in the lives of people with a disability and their families, even if it is just a 'small thing'. The relationships developed with clients and families, sometimes over a very long period, was also critical.

Similar results were found in aged care by Martin and Healy. Workers gave high scores for job satisfaction, again rating especially highly 'the work itself'. Those performing direct personal support in homes and the community reported slightly higher rates of job satisfaction than those working in residential facilities.[17]

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[12] Steinberg, Ronnie J and Figart, Deborah M (1999) 'Emotional labor since *The Managed Heart'* in the Annals of the American Academy of Political and Social Sciences, Vol 561 pp. 8-26.
[13] Korczynski, Marek et al (2000) p 675.
[14] As a group aged and disabled carers have lower incomes than the rest of the workforce, with a median gross income of $26,000-$33,800 annually in 2016, short and often insufficient working hours and high casual employment. Social care workers' job conditions are discussed in more detail below at section 4.
[15] Martin, Bill and Healy, Josh (2009) Who Works in Community Services? A Profile of Australian Workforces in Child Protection, Juvenile Justice, Disability Services and General Community Services. The Australian Government and the National Institute of Labour Studies, p. 136.
[16] Ipsos Public Affairs (2018) Understanding the Workforce Experience of the NDIS: 2018, Longitudinal Workforce Study Report, p. 12. Available at www.vic.gov.au/supporting-disability-workers-NDIS
[17] Mavromaras, Kosta et al (2017) National Aged Care Workforce Census and Survey - The Aged Care Workforce, 2016. p. 96. The Australian Government and the National Institute of Labour Studies. Available at www.gen-agedcaredata.gov.au/www_aihwgen/media/Workforce/The-Aged-Care-Workforce-2016.pdf

Himmelweit argues that this is because social care involves a special type of emotional labour which has two separate aspects: 'caring for' and 'caring about.'[18] The worker needs to perform certain services *for* the person, but also be motivated to care *about* them. Or, as Himmelwait explains, 'caring, whether unpaid or paid, can and does consist of both labor and love.'[19] Others have referred to social care as 'relationship-centred' or 'relational care' for this same reason.

In part this is because social care work (usually) involves longer and more established relationships than other types of emotional labour where customer contacts are often transitory (for example, hotel front desk staff, flight attendants or the call centre operators mentioned earlier). Armstrong and Lowndes observe of aged care workers in residential facilities: 'relational care takes time every day, as well as over months and years.'[20] As the care is provided, a relationship forms.

This relational dimension means that care relationships can vary almost infinitely:

> The care a carer provides is basically inseparable from the relationship that is being developed with the person she is caring for…Other people may be able to care for that person, too, but in doing so they will be developing their own, different relationship.[21]

This is why, in discussions of what makes a quality worker, people needing care and their families often give priority to factors such as having a good match between themselves and the worker, and the fact the worker likes and understands the person being supported or cared for. For example, in a report on high rise living in a Sydney disability organisation the 'valued workforce qualities' that people with disability identified were listening, friendliness, kindness, happiness and familiarity – 'people I know'.[22] Tamara Daly writes that quality services are likely to promote authentic experiences that 'meet people where they are at' and activate care users. She calls for ways to track intangible aspects of quality, such as 'residents' and care workers' joy'.[23]

A recent Victorian study of young people with physical or intellectual disabilities found that people conceptualised care in both activity-based and relationship-based ways. However the authors noted:

> Many people…placed a priority on having someone to talk with when they were feeling sad or upset, and they valued the emotional care that was provided in these relationships….[24]

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[18] Himmelweit, Susan (1999) 'Caring Labor' in the Annals of the American Academy of Political and Social Sciences, V 561 January 1999 p. 27-38.
[19] Himmelweit (1999) p. 32.
[20] Armstrong, Pat and Lowndes, Ruth eds (2018) Negotiating Tensions in Long-Term Residential Care: Ideas Worth Sharing. The Canadian Centre for Policy Alternatives. p. 29.
[21] Himmelweit (1999) p. 29.
[22] Carnemolla, Phillippa (2018) Beyond the Group Home, a project funded through the Innovative Workforce Fund, Achieve and UTS. Available at workforce.nds.org.au/media/projects/media/Achieve_final_report_Hc55g30.pdf
[23] Daly, Tamara (2018) 'The quality conundrum', in Armstrong, Pat and Lowndes, Ruth eds (2018).
[24] Robinson et al (2019), p. 50.

> Participants in this study were strongly in favour of relationship-focused support.[25]

Family members involved in caring may also want to form a positive relationship with the care worker, adding another ingredient to the mix. In a 2018 on-line discussion of 'what makes a quality disability worker' one person wrote: 'For me it is a total understanding of my issues [as a mother of the person with a disability], caring and kindness'.

A second distinctive feature of social care work is the fact that it is (to different degrees) co-produced. Social care work shares with other types of service work the characteristic that the person who 'consumes' the work performed by the worker also *contributes* to it.

The contemporary concept of 'mutuality' is used in Australia to address this aspect of social care work, referring to the process of how support workers and people with support needs mutually create work together. In government policy the concepts of person-centred and consumer-directed care recognise the same idea, and have been applauded as an important advancement. Fisher et al found from scanning a range of disability policy documents that:

> People…are positioned in the national policies in ways that propose they should be actively engaged in decision making. The policies foster their choice and control not only with respect to decision making, services, personal goal setting and planning (individual outcomes), but also in areas of service improvement and service management.[26]

However, Robinson et al note that the role of people with disability in actively building safe and respectful relationships with the people supporting them is still underestimated.

> To prevent harm, people with disability report across multiple studies that they do more than avoid abuse. *They work to actively build safer lives*. To do this, people prioritise relationship building in support, building trust, using known supporters, seeking out workers who listen, and using support that enables them to maximise control in their lives wherever possible.[27]

The considerations above explain why pinning down the meaning of the concept 'quality workforce' can be complicated. In the high-rise living project mentioned earlier the researcher found little alignment in the qualities identified as most important by parties to the relationship, as shown below.[28]

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[25] Robinson et al (2019), p. xx.
[26] Fisher, Karen R. et al (2019) 'Disability and support relationships: what role does policy play?' in the Australian Journal of Public Administration, Vol 78 pp 37–55.p. 46.
[27] Robinson et al (2019), p.28
[28] Carnemolla, Phillippa (2018).

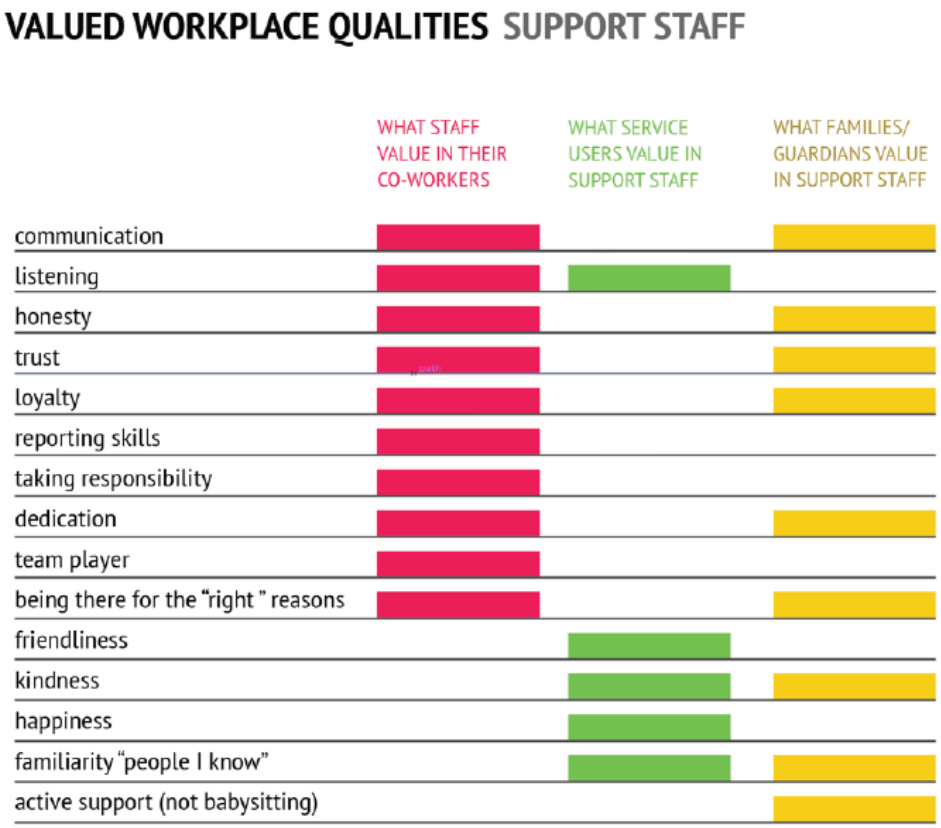

Figure 1: Table analysing valued qualities of staff by stakeholders

Researchers have however uncovered recurring types of relationship; or at least recurring patterns in the way people refer to their relationships. A recent English study of people with a disability and their personal assistants found that some 'metaphors to work by' recurred as both workers and people receiving personal assistance spoke about their care relationships.[29] The most common were:

i. Extension of self ('my arms and legs'; 'it's just, it's a physical, mechanical thing, you know')
ii. Staff (employees or even servants, who need to be 'managed')
iii. Colleague (seen as more mutual and empowering than 'staff')
iv. Professional (a distanced relationship with clear boundaries)
v. Paid friend (often qualified as 'friend-like' in recognition of the difference between 'true friends')
vi. Family (a relationship with a strong emotional content)

It is easy to see that what counts as doing a 'good job' and being a 'quality worker' would differ in each of the relationship types listed above. Desired qualities might range from being able to quickly learn what's needed, to being well-trained and experienced, to having sensitive listening skills and a range of other personal attributes and inter-personal skills.

[29] Shakespeare, Tom, Stöckel, Andrea and Porter, Tom (2018) 'Metaphors to work by: the meaning of personal assistance in England', in the International Journal of Care and Caring, Vol 2, no 2, pp 165–79. p. 171.

Shakespeare et al noted that people used more than one metaphor to describe a relationship, and that relationships transformed over time (eg from staff to paid friend). They also observed that people used different metaphors in speaking about the different workers who supported them, and that age, sex and cultural differences influenced this. Workers and care-givers were alive to the complexities of relationships as the following quote shows:

> She is part of the household, really, because my daughters all love her…I would say it is almost like a family friend – not quite a personal friend…It's like a forced relationship through what you need…it is a very unusual relationship, it is not a mother-child, it's not a parenting, but it has got all those elements [older person needing care speaking about their worker]

Interviews conducted by peak disability body in Australia, NDS, revealed many instances of family-led teams emerging under the NDIS where disability providers formally employed staff but family members recruited, trained and managed them on a day-to-day basis. In one such case, the 'team leader' whose brother was very vulnerable, with complex support needs, observed:

> We are a high performing team. I expect very high professionalism and performance. [My provider] can and should learn from this….
> But I'm learning from the staff as well. I used to be a dictator; now I've learned to step back. The main thing is that everyone has a voice.

Such research and examples suggest that in the best of possible worlds, people needing support, their families, and well-matched workers might find each other and navigate appropriate relationships where each had similar expectations. Indeed, this may be occurring naturally and aided by market-based systems of care. Chenoweth, Ward and Hughes argue that a process of 'self-selection' is underway:

> Good (sic) support workers gravitate to employment with service-users who can envision and plan a good life…they have had opportunities to foster their imagination, to build informal networks of support, and develop resilience and independence.[30]

In disability, evaluations of limited self-directed support trials in the early 2010s did indeed find that families especially appreciated the direct employment of support workers 'which enabled them to hire workers with suitable personalities and skill sets that were directly relevant to the needs of the client'.[31] One care-giver was quoted as saying:

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[30] Chenoweth, Lesley, Ward, Margaret and Hughes, Jacqui (2015) I'm Here to Help. The Role of the Support Worker in the NDIS. p. 49.

[31] Fisher, Karen and Purcal, Christiane (2010) Effectiveness of Individualised Funding approaches for Disability Support, Social Policy Research Centre, University of NSW. Occasional Paper 29. p. 42. Available at www.sprc.unsw.edu.au

> What we can offer our son he could never get from an agency. The support people he has, we have picked them because of some part of their character that our son is going to relate to and feel at ease with. So those sorts of things I don't think an agency can pick up and manage the same.

The next sections of the submission deal with the implications of current policy and environmental settings for sustainable social care and support services and quality jobs for workers.

They relate to:

- Pay and other working conditions
- Job security
- Work intensification and stress

Pay and other working conditions

The vast majority of aged care, home care and disability support workers are employed on the basis of minimum award wages. The award rates remain comparatively low, despite Equal Remuneration Adjustments in recent years. Additionally, there is evidence that certain types of under-payment are becoming more common as consumer-directed care rolls out. Forms this takes are:

- **Underpayment:** Employers and agencies under-paying or not paying workers for certain tasks such as travel and administrative work (also known as wage theft). One small diary-based study of disability workers found that wage theft occurred for a significant amount of the hours they worked, including travel time and administrative work.[32] Some NDIS workers were not being paid for between 12% and 21% of total work time.

- **Contracting:** Care workers are more frequently being directly engaged as contractors by people with disability or carers, often after meeting up on web-based or digital platforms which manage ongoing payments and other aspects of the care relationship for a fee. A large study commissioned by the Victorian Government found that around 7% of digital platform workers were care workers. Forty per cent of all digital workers did not know how much they earned per hour and many mistakenly believed they were employees.[33] Care workers in the study frequently indicated their income category as $20.00-$29.99 per hour, which is likely be less than award rates once other award entitlements are considered.[34]

[32] Macdonald, Fiona, Bentham, Eleanor and Malone, Jenny (2018) 'Wage theft, underpayment and unpaid work in marketised social care', The Economic and Labour Relations Review, Vol. 29(1) pp 80–96.
[33] McDonald, Paula et al (2019) Digital Platform Work in Australia, Preliminary findings from a national survey, Victorian Department of Premier and Cabinet.
[34] McDonald et al p.19. Note that workers often do not consider award entitlements such as travel time, casual loadings, penalty rates, cancellations, allowances, minimum start periods and leave when they negotiate their hourly rates.

Position downgrading: Dismissal and re-employment at a lower award classification, sometimes in a new subsidiary has been occurring. Instances have received media attention, especially in community-managed mental health services. In one case the union official observed:

> …20 mental health workers with the organisation were now being made redundant and had been offered new positions with its subsidiary's NDIS-funded programs, but at a lower level and only on fixed-term contracts…if they want to keep their job, they've got to lose up to $150 a week.[35]

There are several reasons why consumer-directed care is facilitating or encouraging these forms of underpayment, although other social and economic factors are also relevant. In disability, self-management is explicitly promoted by the NDIA and has been rising steadily. By mid-2019 nearly one-third (29%) of new NDIS plans approved were partially or fully self-managed.[36] The growth of sophisticated systems for online commerce has also made directly self-managing the funds more available to people by making it far easier than in the past. Such systems automate and simplify functions (paying and insuring people, undertaking criminal and qualification checks etc) which were previously more onerous.

Another factor is the prices set in consumer-directed care. Workers' wages are not prescribed under the NDIS. But government (the NDIA) does set the maximum prices that providers can charge, and many argue these are too low to properly compensate workers and still survive financially.[37]

The inadequate pricing of support and services in aged care and disability also means that enterprise bargaining is unproductive and therefore less likely, since employers have little to bargain with. The broader general context is that in Australia today many work conditions are not covered by industrial awards, in the expectation that they will be negotiated workplace by workplace. The Social, Community Homecare and Disability Services award for example only partially specifies travel time, work-related training, overnight care for a person living at home and minimum shift hours. In the past some of these important aspects of work were set through agreements and government funding contracts (now replaced by CDC), while others were the subject of workplace agreements. In male-dominated industries there has been more scope for bargaining and a longer history of it due also to higher rates of unionisation. Further, in disability work, unlike many other industries, part-time workers can be 'flexed' up and down without being eligible for penalty rates.

As social care work becomes further fragmented, and workers dispersed, alternatives to enterprise bargaining are needed to address basic workforce rights. Moreover, the NDIA, when developing NDIS packages should take into consideration how the hours of care agreed translate into a decent job, or part thereof. This is not simply the provider's responsibility since it is very difficult to create

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[35] ABC (2019) 'Move to NDIS resulting in mental health worker job insecurity, Tasmanian peak body says' ABC News website, first posted 23 July 2019.
[36] NDIA (2019) COAG Disability Reform Council Quarterly Report 30 June 2019 p. 23. The 29% figure is for plans approved between March and June 2019.
[37] Cortis, Natasha et al (2018) 'Underpricing care: a case study of Australia's National Disability Insurance Scheme', International Journal of Care and Caring, Vol 2 (4): 587–93.

decent, reasonable-hours work when a participant is awarded, for example, 30 minute parcels of care

Job security

There is a general perception in advanced industrial societies such as Australia that work is becoming more insecure, jobs more precarious. Job security is usually defined either by how secure workers *believe* their job to be or in terms of the *type of employment contract* (for example, whether a worker is working on a casual, permanent or contract basis).

No representative data on perceptions of job security is available for Australia, but just over half (51%) of those responding in Year 1 of the Victorian Government's longitudinal survey of disability workers agreed with the statement 'I worry about the future of my job' with just 18% disagreeing. A similar proportion (52%) said they felt positive about their work.[38]

When looking at the type of employment contract, the annual HILDA survey finds mixed evidence for rising 'non-standard' employment – that is, casual, agency and temporary employment.[39]

- **In disability**, the percentage of disability support workers casually employed has gradually risen, from an already high starting point. Employer data collected by peak body NDS showed that casual employment increased from 40% in 2015 to 46% in 2018 as a proportion of total employment. If fixed term employment is included, casual employment was over 50% of total workers.[40] A government-funded evaluation of the NDIS similarly found a growing trend towards disability workforce casualisation over the two waves of data collection (2013-15, and 2015-17).[41]

In a paper prepared for its 2018 secure work campaign the Australian Council of Trade Unions (ACTU) argued that 'employers have discovered many other ways to move workers from standard to non-standard insecure forms of employment,'[42] including using labour hire companies, multiple short-term contracts, and exploiting temporary visa-holders. Using this broader definition, the ACTU claimed that Australia is ranked fourth worst among OECD countries, with highly negative consequences for insecurely employed workers and the economy as a whole. This paper has already discussed the apparently growing use of contract care workers, but there is insufficient data to draw firm conclusions.

As with pay and work conditions, it is possible to pinpoint ways in which consumer-directed care contains inherent incentives to reduce job security. Some of these are deliberate, and from a consumer's perspective, desirable.

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[38] Ipsos Public Affairs (2018) p. 16.
[39] Melbourne Institute (2019) The Household, Income and Labour Dynamics in Australia Survey: Selected Findings from Waves 1 to 17, pp 74-76.
[40] NDS (2018) Australian Disability Workforce Report, 3rd edition, pp 5-6. Available at www.nds.org.au
[41] Mavromaris et al (2018) The Evaluation of the NDIS, Australian Government Department of Social Services and the National Institute of Labour Studies, Flinders University, consolidated report p. 62. Available at www.dss.gov.au/disability-and-carers
[42] ACTU (2018) Australia's Insecure Work Crisis: Fixing It for the Future, p. 2.

- Consumer preferences have more priority, so that people can and do more frequently cancel, postpone or alter care shifts that have been pre-arranged.
- Funding is often allocated for short shifts spread over the day and week, so that using casual or other non-standard workers becomes the most financially prudent way to utilise staff.
- Because social care is now available in a competitive market-place, workers who have frequent absences, or casual workers who are unavailable at short notice for family or other reasons may be no longer employed (since providers fear losing disgruntled consumers who can't access the worker they prefer).

However, as well as these inherent tendencies, other local, organisation and system factors influence outcomes. The state of the local labour market, which may make it hard for workers to seek work elsewhere, and the size, philosophy and resources of the organisation, influence the way organisations respond. In disability for example, NDS reported that the casualisation trend was found in small and medium organisations but not in large ones.[43] State and regional differences are also affect the level of casualisation in NDS's data collection. In aged care, significant differences exist between occupations (nurses, personal care assistants and allied health staff).

Organisations providing social care point to the inadequate funding and pricing associated with the new systems, which means there is constant pressure to maximise 'billable hours' as opposed to being able to fund downtime for administration, training and support which would create more stable and secure jobs. Cortis et al 2017 record many comments by workers and employers along the lines of the following:

> The pricing is not appropriate…The NDIS is squeezing organisations and promoting casualisation of the workforce and skills atrophy of staff. It is great in theory…but the implementation and understanding by government…is poor (CEO of large metropolitan organisation).[44]

Work intensification and job stress

International studies have documented how the combination of personalised systems, implemented in the context of governments seeking to reduce spending, can lead to job intensification and increased stress on workers.[45]

In Australia NSW research explored the specific effects of consumer-directed care on job stress. Evesson and Oxenbridge[46] found that the job stress risk factors experienced in their study of NSW

[43] NDS (2018) p. 6. Small is defined as less than 50 workers; medium is 50 to 199 workers; and large, 200 or more workers.
[44] Cortis et al (2017) p. 48.
[45] See Cunningham (2016).
[46] Evesson, Justine and Oxenbridge, Sarah (2017) The Psychosocial Health and Safety of Australian Home Care Workers: Risks and Solutions, Employment Research Australia. A complicating factor in measuring job stress is that workers are unlikely to make formal workplace health and safety or workers' compensation complaints, both because of fear of job loss and obligation to the people being supported. Surveys and workers

home care workers mirrored those reported internationally. In terms of magnitude, their research indicated that the most commonly experienced were:

- the emotional challenges of the work
- financial insecurity (earnings and hours)
- unsupportive and low trust work relationships
- compromised quality of care
- being undervalued.[47]

They observed that:

> Policy reform and its impacts were a source of stress for home care providers and workers… Employers expressed concerns that policies supporting consumer directed care would lead to financial instability and heightened insecurity for individual care workers, due to increased competition for clients and greater potential for clients to change providers if they were dissatisfied with any aspect of care provided.

Naturally different work-related stressors inter-relate. The quality of work organisation and management affect how people experience and process stress, also known as psycho-social hazards or risks. Hussein addresses the various ways *job demands* and *job control* (how much latitude people have in job decisions) are believed to interact.[48] She also showed that workers' ability to manage their own finances was another factor that had a significant relationship with job strain. Those finding their finances difficult or very difficult to manage displayed lower levels of job control.

For Hussein, this finding 'highlights the importance of "spillover" effects between personal and work lives, and the potential impact of low wages within the sector, particularly among women, who constitute the majority of [the long term aged care] workforce.'[49]

She found (or confirmed other research showing) three other significant relationships:

- social support (from co-workers and supervisors) mediated job stress, as noted earlier
- workers whose work involved mainly hands-on care had significantly lower job stress than those who also did administration
- trade union membership was related positively to job stress, which Hussein explains as due to the fact that trade unions tend to mobilise more people with grievances.

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compensation data may not capture people who have slowly 'burned out' and/or resolve unbearable situations by leaving their jobs.

[47] Evesson and Oxenbridge (2018) p. 6.

[48] Hussein, Shereen (2018) 'Job demand, control and unresolved stress within the emotional work of long-term care in England', International Journal of Care and Caring, 2(1) pp 89–108.

[49] Hussein (2018) p. 100.

Evesson and Oxenbridge[50] used multivariate analysis to untangle the most significant of the factors causing job stress to home care workers as they transitioned to consumer-directed care in NSW.

- constraints preventing the delivery of quality care (eg insufficient time; negligent co-workers)
- low pay – especially as working hours decreased
- inadequate risk assessment or information about clients, presenting safety risks
- inadequate organisational/management support
- working unpaid hours to meet client needs
- unpaid/insufficient travel time between clients
- poor rostering, rushing, and time constraints.

They also noted that many of these features can be mitigated by employer and organisational practices as will be discussed further below.

In another Australian study, Cortis et al looked at workers who transitioned to the NDIS in NSW. They identified many of the same factors as listed above as sources of increased job stress for workers. Understaffing and increased workload were especially important, especially for people who were coordinators. Their jobs contained (as in Hussein's study above) a mix of administrative and frontline work.[51]

As in Evesson and Oxenbridge's research on home-care workers, this study emphasised the stress caused by workers' concern for the people they supported whom, they felt, were receiving poorer quality services under the new personalised scheme than they had previously.[52] Many felt that in the new system they personally, or other workers, no longer had the time to maintain client safety and wellbeing, and to do the job required and expected of them. Scope to personalise services was being reduced with one front-line worker observing:

> …Less opportunities/funding for clients, being treated as a number without existence. Clients being rushed or misunderstood without a carer that understands [them]. e.g non-verbal clients…Client being rushed on one hour outings rather than being able to take their time… Less contact with staff whom the client know and have built rapport with. Strangers taking the clients for appointments. Client becoming house-bound, as they don't feel comfortable with unknown services/staff. Clients not getting heard! as the NDIS appointments are so rushed.[53]

Aged care workers providing home-based care have given evidence about funding-related constraints that cause or exacerbate job stress at the Royal Commission on Aged Care Quality and Safety. In March 2019 hearings, workers identified:

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[50] Evesson and Oxenbridge (2017), p. 74.
[51] Cortis, Natasha et al (2017), p.36.
[52] Cortis et al (2017) found that some 43% of workers in their employee survey disagreed with the statement that 'The NDIS is better than the previous system', compared to nearly 16% who agreed.
[53] Cortis et al (2017) p. 33.

- the challenges of working with unprepared staff due to inadequate induction, orientation and training, and training in dealing with older people with dementia
- the uncertainty and insecurity of attending people's homes, often in poorly lit locations at night
- a lack of guaranteed working hours and low levels of remuneration
- the stress of not being able to provide a quality service

In March 2019 Counsel Assisting commented on the evidence regarding workers' job conditions as follows:

> Regular hours personal care workers are receiving are often being cut, and there is evidence of employers moving away from offering full-time employment. Further, the time allocated to a particular care recipient can be a cause of strain and stress…Ms Jackson gave evidence that there are instances where she is allocated 15 minutes to see a client.[54]

4. Service quality and system effectiveness

The effect of personalised care systems on service quality, workforce and efficiency have been issues of concern in many countries in which such schemes have operated (usually for longer than in Australia).

As mentioned above, rationalisation and financial austerity have accompanied the implementation of the new social care systems, despite their origins in human rights movements and the way their purpose is often couched in terms of the empowerment of care users and the right of people needing care to have and make as many choices as others in the community.

Stone writes in the US context of the tension workers feel between forging strong relationships and completing the rigidly defined task list imposed on them to meet business goals. 'If a client asks a certified aide to just sit and talk, the aide cannot comply, because she is there to do bodily care.'[55] She argues that as well as bureaucratisation, in most countries personalisation has meant an (only) '*partial* entitlement to paid care', which leads inevitably to pressures to minimise costs and a care gap which workers feel a responsibility to fill through unpaid hours.

In Australia, Cortis argues that the relational aspects of care and support have been overlooked in the government setting of prices under consumer-based funding schemes, despite the importance of human nurturing and support in fostering users' capabilities, well-being and participation in order to promote independence and control.[56]

In short, evidence everywhere points to similar conclusions.

- Personalised social care systems offer promising opportunities for higher quality, relational care.

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[54] Counsel Assisting, Royal Commission on Aged Care Quality and Safety Transcript pp. 1113-4, 22 March, 2019.
[55] Stone, Deborah (1999) 'Care and trembling', The American Prospect; Mar/Apr 1999, Vol 43, pp 6 –69, p. 62.
[56] Cortis, Natasha et al (2017).

- They allow more scope for people needing support and their families and carers to connect with workers who have the skills and orientation that match with their own needs and expectations, and over time develop strong mutual relationships that are valued by all.

- Workers also value jobs which allow them to use their skills and judgement, and even when job demands are high, having the freedom to decide how to do the work can mitigate the stress.

- The evidence also suggests that this works best when such workers are trained and supported in their role by peers or supervisors who can also provide de-briefing and assist them to adjust or manage relationships where the emotional intensity is very great.

However, it is clear that the general roll-out of consumer-directed care has not created this happy result because of the operating constraints these systems place on providers and the workforce as they aim to minimise overall costs.

5. Promising strategies for change

There are changes that could ameliorate the issues confronting consumer-directed care in Australia. Safeguarding, effective complaints mechanisms and other governance and quality assurance processes will of course remain necessary. However, the focus could be on creating the conditions that *enable* workers to provide high quality care and by so doing, improve the attractiveness of the social care sector as a place to work, both for newcomers and existing workers. Simultaneous strategies to improve the pay, predictability and security of social care employment will reinforce this outcome.

Workforce development, broadly conceived, is needed to enable higher quality services

The areas where change is needed to improve quality services are listed below. Since workers are the main drivers of service quality, these changes entail enabling them to work differently and have more security and less stress in the work they do.

- the time available in the workplace to design and provide relational care
- personal and technical[57] support for workers who are undertaking emotionally skilled work, especially in isolated circumstances
- time for consumer needs and wishes to be understood and built into individual programs
- time for families' and carers' needs and wishes to be understood, negotiated and built into individual programs
- time to connect people needing support with others in the community who have the capacity and interest to build constructive relationships
- workers' financial anxiety arising from low pay, underemployment and job insecurity

[57] ie clinical and/or health-related

- workers' inter-personal skills and knowledge, and ongoing professional development.

To create change in these areas a 'systems' approach to 'workforce development' is needed.[58] This involves tackling a broad range of issues such as market strategies, work organisation, job design, workplace relations, patterns of innovation including ownership structures, corporate governance regimes, and wider investment patterns.

These are as important as individual worker capabilities and improved workforce planning because they create the context in which capabilities are needed, rewarded and used – as well as developed into the future. For example, workers can be trained at higher educational levels, such as Certificate 4, which was the norm in Victorian public disability services prior to the NDIS. However, if the training is not fit for purpose, if employers can't afford to pay people at a level commensurate with their qualification, if continuing on-the-job training is not provided, if the workforce turns over every year and if the services for which people are funded are too fragmented and siloed to encourage use of higher order skills then encouraging across-the-board training won't work as a driver of service quality. As Keep and Mayhew observe:

> More overt acknowledgment of the problems raised by the structure and incentives provided by current labour, product market and industrial relations regimes is required.[59]

Many elements of workforce development, broadly conceived, have been proposed by others and what follows incorporates their ideas.

6. Proposals for consideration by Senate Committee

(i) Acknowledgement of the value of front-line workers in pricing for social care packages and supports

What would this mean in Australia? Employment conditions are the province of employers and unions, and are set in industrial tribunals. However, funding bodies could and should attach greater value to front-line worker roles. Options could include increasing funding to accommodate higher level award classifications, and reducing expectations of how much time workers spend on client-facing time as opposed to other productive activities. Currently the 95% billable time expectation for disability workers is considered to be amongst the highest rate in the world.[60]

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[58] See for example, Keep, Ewart and Mayhew, Ken (2010) 'Moving beyond skills as a social and economic panacea' in Work, Employment and Society, Volume 24(3) pp 565–577.
[59] Keep and Mayhew (2010) p. 573.
[60] See Cortis, Natasha, Macdonald, Fiona, Davidson, Bob and Bentham, Eleanor (2018) 'Underpricing care: a case study of Australia's National Disability Insurance Scheme', International Journal of Care and Caring, 2(4), pp 587–93 where these arguments are well-summarised. 'Other productive activities' refers to activities such as rest breaks, required administrative tasks, peer support and professional development.

(ii) A structured, funded learning and development program for social care workers is needed on a large scale and urgently

Much of the scaffolding for improving front line worker skills and knowledge exists. As well as vocational education and training competencies and qualifications aligned to the Australian Qualifications Framework, a range of standards, capability frameworks and related products exist. Several currently operate in the Victorian community and social care sector.[61] Practice requirements for disability and aged care providers also specify that induction, and learning and development programs must be present in workplaces.

However, there is increasing evidence that time and cost constraints are leading providers to present training in the form of on-line modules, often with the expectation these are done alone in workers' own time or even before they are employed. While larger organisations are able to develop structured, progressive learning pathways over the first 12 months or more of employment small and medium providers often do not have this capability. It seems inefficient for each provider to develop their own version, although tailoring to different contexts is essential.

Just as the NDIS Quality and Safeguards Commission funded a short 'worker orientation' course for all disability workers, it should create additional standard earning modules suitable for blended learning and fund the time needed for workers to be actively trained in these.

(iii) Eliminate pricing incentives to fragmented work and casualisation

As noted above, community-based home care and supports under the NDIS should not contain specifications or pricing for short shifts (less than two hours), which clearly add to the travel and administrative burden on staff members and make it inherently more difficult for workers to spend time on *relationships* as opposed to *tasks*. Short shifts can also lead to an imbalance between administration and care. A recent study found that rather than increasing efficiencies, just 50% of home care packages were being used for direct care or equipment, while administration and care co-ordination accounted for nearly 40% of the total expenditure.[62]Two-hour minimum time-slots should be budgeted for in metropolitan areas and four hours in rural and remote ones where travel time is usually lengthy.

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[61] Capability frameworks are also common in the social care sector. Unlike standards, which spell out organisational responsibilities at a high level (such as 'an orientation and induction process is in place'), these zoom in on the skills, capabilities and personal attributes required to do jobs (such as 'Actively listens to colleagues and clients and passes on relevant information accurately and appropriately' from the Victorian Government Community Sector Capability Framework currently in operation. In addition, the Victorian Government is developing an allied health workforce capability framework and resources for allied health professionals who work with people with disability, a capability framework for NDIS frontline workers, and separately for mental health and drug and alcohol workers, while Mental Health Victoria is also developing a capability framework for community mental health workers.

[62] Bulamu, Norma et al (2019) 'An early investigation of individual budget expenditures in the era of consumer-directed care' in the Australasian Journal on Ageing, first published 9 August 2019.

(iv) Create consistent standards for contract workers

It is evident that partial or full self-management is popular among people with disability and/or their families, as well as the elderly. However the employment conditions of workers often engaged by this growing group of people are not clear. In at least some cases, direct employment via digital platforms is used to pay workers less and offer fewer entitlements than award workers receive. The government should (i) determine whether they are award-covered employees, or contractors as many assume and (ii) if they are contractors, set minimum standards for their engagement that equate to award standards.

As in the case of other issues, European countries are increasingly considering alternatives forms of employment contract, such as creating a class of dependent contractors, and these might be examined for applicability in the Australian environment. Alternatively, app-based solutions using artificial intelligence, such as an official pay and conditions 'ready reckoner' that allowed workers to easily check what their entitlement should be for a shift may help those seeking work through a digital platform service.

(v) Promote innovation and alternative models of care and work

In the wake of issues associated with consumer-directed care as implemented in Europe, North America and now Australia, innovation push-back has occurred. Organisations like the Dutch Buurtzorg explicitly reject the fragmented work, rushed service delivery, under-valued jobs and bureaucratic control that commonly accompany the service trends discussed above. Using the slogan 'Humanity above Bureaucracy,' Buurtzorg uses care funding to pay staff above-market wages, to invest in their professional development and to provide generous time for reflection, peer support, community networking and relationship building. Savings come from radically lean management and bureaucracy. 'Coffee before care' is the guiding principle for staff.

While Buurtzorg began in 2007, there are now many similar organisations operating in the UK, Europe, Asia and Australia. Organisations with alternative forms of governance, such as worker ownership, and carer control are also emerging. It is important to note that Buurtzorg benefitted from a protected space provided by the Ministry of Health in its first four years of operation, giving it time to demonstrate beneficial outcomes.[63] What the UK Care Quality Commission calls 'regulatory sandboxing'[64] occurred, including experiments such as allowing Buurtzorg staff to assess client needs, develop care plans and provide services - functions which, as in Australia, were previously separated.

[63] Paula Cristofalo, Odessa Dariel and Vanessa Durand (2019) 'How does social innovation cross borders? Exploring the diffusion process of an alternative homecare service in France.' Journal of Innovation Economics & Management, and pers. comm, Jos de Blok.

[64] See UK Care Quality Commission www.cqc.org.uk/news/stories/cqc-awarded-funding-support-encourage-innovation

An important role for the government could be to promote 'high road' innovation in business and workforce models and help organisations come together to share and learn from one another in a supportive environment. Government stakeholders need to become participants in workplace and service model innovation, so they can assert their interests and take away lessons that can be used to improve the functioning of the system as a whole. It is widely recognised in science and industry that research, testing and continuous improvement are lengthy processes needing ongoing support. FSSI's funding and the neutral space it occupies might give it the ability to run several experiments, and track results over time.

7. Conclusion

There is increasing worldwide recognition of the challenges being faced by consumers, workers and providers and consumers as consumer directed care is rolled out in disability and aged care.

For consumers such schemes are bringing care packages enveloped by bureaucratic rules and restrictions that can undercut the very increased choice and control the new systems promise. For workers the stress of unpredictable hours of work, and income, plus lack of access to support, and to structured training and professional development is detracting from the pleasure associated with the work itself. Sheer financial pressure is the reason workers cite as a factor in their intention to quit the sector, and providers meanwhile report great difficulty in attracting talented workers, especially in regional areas.

The positive aspect of the current situation is that all parties recognise the need for change. Despite the divergent interests of providers, consumers, workers and other stakeholders, everyone's common focus on high quality services creates a platform for negotiation. As argued above, addressing one aspect of the problem (such as training or award conditions) will be far less effective than understanding the dynamics of the social care ecosystem and adopting a multi-pronged strategy for change. A collaborative approach to projects such as those suggested in this submission would be a good place to start.