Submission of the Health Services Union to the Senate Community Affairs Legislation Committee on the *Aged Care Legislation Amendment (Financial Transparency) Bill 2020*

31 July 2020

About the HSU

The Health Services Union (**HSU**)[1] is a growing member-based union with nearly 90,000 members nationwide, representing workers in every state and territory. Our members are working at the frontline of health and social care, in diverse roles across every level of health and community services infrastructure. Our members are employed in not-for-profit, privately owned and public organisations.

HSU members in residential aged care facilities (**RACFs**) work in roles including, but not limited to, personal care worker (**PCW**),[2] physiotherapist, occupational therapist, therapy assistant, lifestyle assistant, assistant in nursing, enrolled nurse, administration assistant, food services/caterer, laundry attendant, and cleaner. In addition to those directly employed in the sector, the HSU has members in occupations at the health interface with aged care, requiring them to interact on a regular basis with older Australians transitioning to or living in residential care. These occupations include, but are not limited to, paramedics, mental health clinicians (e.g. psychologists and social workers), hospital orderlies, disability support workers, radiographers, and technicians.

The HSU is a driving force to make Australia a better place. We work to ensure that the rights of not just our members, but all working Australians, are protected. Our work and advocacy centre on the inextricable link between accessible, quality and safe care, and meaningful social and economic participation. Valued health and social care workforces are central to delivery of these outcomes.

The tens of thousands of HSU members working in aged care are deeply committed to ensuring the holistic wellbeing of older Australians, their loved ones, and communities. Via the lived experiences and insights of our members, we are expertly placed to make a submission to the Senate Community Affairs Legislation Committee's (**the Committee**) inquiry into the *Aged Care Legislation Amendment (Financial Transparency) Bill 2020* (**the Bill**).

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[1] HSU National is the trading name for the Health Services Union, a trade union registered under the *Fair Work (Registered Organisations) Act 2009*.

[2] Personal Care Worker can also be referred to as Personal Care Assistant or Extended Care Assistant. For this submission, Personal Care Worker will be used to capture each and any of the relevant job titles.

Executive Summary

The Australian aged care system has been subject to myriad inquiries commenting on its effectiveness. Central in these reviews has been the issue of funding and its quantum, regulation, and expenditure accountability. Throughout the various inquiries, the most recent being the ongoing Royal Commission into Aged Care Quality and Safety (**the Royal Commission**), it has been clearly established that inadequate funding levels and financial regulation is adversely impacting on the system's capacity to assure the delivery of safe, quality, person-centred care to older Australians.

Despite an extensive and complex regulatory framework,[3] Australia's aged care system is marked by systemic failings. Ambiguity persists as to what an ideal workforce-care relationship looks like and how this should be delivered by providers. Commonwealth subsidised providers must adhere to criteria set out in the Act to retain funding.[4] However, neither the criteria nor legislative instruments require any disclosure as to staff numbers and skills mix per care recipient and care needs profile; staff qualifications and training, including any provided by the employer; or amounts spent on direct and indirect care requirements, including but not limited to wages, training, medication and food.

This vacuum in the regulatory environment results in care provision incongruent with assessments of quality, and a failure to meet community expectations. The Federal Government provides a significant amount of taxpayer subsidies to the sector[5] and should have a vested interest in knowing how these monies are spent. Compelling providers under legislation to be transparent about how they allocate public funds should be a priority for Government; as it is for older Australians, aged care workers and the wider community.

The Bill seeks to amend the Act to require providers to furnish the Aged Care Quality and Safety Commissioner with an annual financial report, and for the Commissioner to make the reports public. It also seeks to amend the *Corporations Act 2001* (**Corporations Act**) to ensure the reports are detailed. While the Royal Commission has cautioned reforms that pre-empt its final report, the sooner expenditure practices (priorities) of providers is known, the better-informed future reforms will be.

The HSU recommends the Committee support the Bill and recommend its passage in the Senate, with attention to clarifications sought in this submission. Additionally, this submission recommends:

- that detail is provided on the appropriate categories of 'other staff members.'
- that a clear definition of direct and indirect care be included.
- attention be paid to the scope and fluidity of various aged care occupations.
- that external consultants be extended to include agencies.
- that the Bill require training expenditure by category, and a link be established between training expenditure and compliance penalties.
- salary and wage reporting include additional detailed wage funding information.
- that all providers meet Tier 1 reporting requirements, at least in the first period.

[3] Namely, the *Aged Care Act 1997* (Cth) (**the Act**), the *Aged Care Quality and Safety Commission Act 2018*, the *Quality of Care Principles 2014*, legislative instruments including the *Aged Care Quality Standards* (**the Standards**), overseen by various government and regulatory authorities including Department of Health (**DoH**) and Aged Care Quality and Safety Commission (**ACQSC**).
[4] *Aged Care Act 1997* (Cth), ss. 53-68
[5] Explanatory Memorandum, p. i.

Amendments

The HSU supports the Bill however, it is important to place the amendments in context. Following, we request provision of detail on the items specified below. Further amendments to the Bill may need to be considered as a result.

Categories of staff member: *defining the aged care workforce, direct and indirect care*

As the aged care sector dominates an ever-growing share of the Australian social and economic infrastructure, and to ensure reform measures such as the Bill are most effective, it is critical to understand key workforce characteristics and pressures.

In 2016, the Aged Care Workforce Census found there were approximately 366,000 paid workers (up from 240,000 in 2012) and 239,000 were employed in 'direct care' roles. The vast majority (87 per cent) of these workers are women and older than the average for other professions (median age 46 years). In the next 30 years, an estimated 640,000 additional workers across the full spectrum of roles will be needed to meet the demands of an ageing population, exacerbated at the intersection with an ageing workforce.

It is important to note here that there is not consensus on what defines 'direct care' or a 'direct care' employee. The COVID-19 pandemic has bought this issue into stark focus. There is a fluidity between roles that is expected by providers and which enriches the relationship between the worker and care recipient. Food services, cleaners, laundry attendants, therapy assistants, lifestyle coordinators, and administrative staff are fundamental to the quality and continuity of care of older Australians in residential facilities. Yet, these groups of workers were excluded from the Aged Care Retention Bonus (the bonus), announced as a measure to ensure workforce continuity in the sector during the COVID-19 pandemic. The Minister for Aged Care and Senior Australians cited the reason for these roles being excluded from the bonus scheme as they are not involved in the provision of direct care and/or do not have substantial contact with residents. This is a false and misguided conclusion to draw. These workers are equally important in protecting older Australians during crises or otherwise, and these multi-faceted roles must be duly recognised.

Related to the above is the correlated link between a sustained reduction in staffing levels at RACFs across roles (namely Registered and Enrolled Nurses, PCWs, food services, cleaners, laundry attendants, therapy assistants, and lifestyle coordinators), the demand for these groups of workers to increase their scope of practice (leading to high rates of stress burnout and injury to worker and care recipient), and a decline in quality of care. At increasing rates and expectation, cleaners are having to attend to the social and emotional needs of care recipients, cooks are assisting with feeding, and PCWs are carrying out cleaning duties.

Policy makers and government officials have placed aged care services adjacent to other health and care settings such as hospitals, despite sharing many characteristics. Each is primarily government funded with taxpayer money; is regulated by government authorities; is responsible for the care of vulnerable members of society; and has a mandate to deliver care in line with community expectations. Yet, unlike hospitals or other care settings such as childcare centres, RACFs 'can employ as few staff as

they like',[6] reducing overheads through reduction of labour costs, where less people are employed, on increasingly precarious employment arrangements. Holistic, person-centred care requires adequate staff, appropriate skills mix and job security.[7]

In this context, it is necessary that additional detail is provided on the appropriate categories of 'other staff members.'[8] The HSU **recommends** that these categories stipulate the inclusion of food services staff, cleaners, laundry attendants, therapy assistants, and lifestyle coordinators.

It is **recommended** that a clear definition of direct and indirect care be drafted and included at a relevant section(s) of the Act, with amendments made correspondingly to relevant legislative instruments. This supports categorising staff and improving transparency around staffing and care outcomes, but also to improving understanding (and transparency) as to what constitutes direct and indirect care expenditure.[9]

In submissions to the recent 'Aged Care Worker Regulation Scheme - Consultation Paper', released by the DoH, the HSU **recommended** attention be paid to the National Disability Insurance Scheme's (**NDIS**) definition of roles requiring more than incidental contact in the course of normal duties. The NDIS provides the following:

'The normal duties of a role are likely to require more than incidental contact with a person with a disability if those duties include:

- *Physically touching a person with disability; or*
- *Building a rapport with a person with disability as an integral and ordinary part of the performance of those duties; or*
- *Having contact with multiple people with disability –*
    - *As part of the direct delivery of a specialist disability support or service, or*
    - *In a specialist disability accommodation setting.'*[10]

The roles specified in this submission for aged care are highly likely to meet the above definition. This further demonstrates the fluidity of roles, their involvement in care provision, and supports the case for clear definition and inclusion in regulatory mechanisms such as the Bill.

Categories of external services

The HSU supports an examination of expenditure by providers on external industrial relations, human resource, and accounting consultants. The definition of an approved provider staff member, as having the same meaning as exists in the Act,[11] speaks to the prevalence of the use of agency, labour-hire and external contract staff and services across the sector. In particular, it is common practice for registered nurses, enrolled nurses, allied health professionals[12] to be hired under these arrangements.

[6] Explanatory Memorandum, p. ii
[7] Baines, D & Armstrong, P 2019, *Promising Practices in Long-term Care: Ideas Worth Sharing*, RR Donnelley, pp. 73.74.
[8] Schedule 1, Item 1, s 9-2A(3)(h) (p. 4, lines 16-18).
[9] Schedule 1, Item 1, s 9-2A(2)(e) (p. 3, lines 21-25)
[10] NDIS Quality and Safeguards Commission, 2020, https://www.ndiscommission.gov.au/providers/worker-screening#01. The HSU notes that different Rules will apply to different registration groups and that these have not yet been determined.
[11] s63-1AA
[12] Schedule 1, Item 1, s 9-2A(a)(b)(d) (p. 4, lines 16-18).

Additionally, and going to the need to define other categories of staff, it is also common for cleaning and catering services to be outsourced. The use of these employment methods comes at a cost to providers, care recipients and workers, both financially and in the adverse impact on continuity of care and care outcomes.

It is **recommended** that external consultants[13] be extended to include 'and agencies.' Alternatively, a definition and appropriate breakdown of categories of external consultants should be provided and include agencies.

Categories of training: improving the status quo

The absence of formalised minimum training and qualification standards undermines the quality of care available in Australia's aged care system. The current training and qualification environment for aged care is marked by inconsistencies in quality and job readiness.[14] PCWs, as an example, do not have professional training or workforce entry qualification requirements of the kind that underpins nursing or allied health. As such, the wages and opportunities for career development are much lower for this group of workers. Aged care workers report a dearth in continued professional development (**CPD**), namely specialised training for specific care areas (e.g. dementia, wound management, fall prevention).[15] There is a sectoral culture of placing the onus of responsibility on individual workers to upskill, meaning that where a form of CPD is offered, it is often unaffordable for workers to access.

Furthermore, the training and qualification standards of staff does not have any relationship to the regulation and accreditation of providers. Just as there is no standard as to what training must be provided by employers, there are no reporting requirements as to whether training is offered, what training is offered or what percentage of funding is allocated to training. Given the role employer supported CPD can play in elevating job satisfaction and wages, thereby reducing staff turnover and vastly improving care outcomes, it is practical and necessary to link training provision, expenditure and reporting with ongoing approved provider status.

The HSU **recommends** that the Bill require the reporting of expenditure on staff training by training category.[16] This should be accompanied by appropriate amendments to the Act and/or any relevant legislation to mandate qualification and training requirements, and link provider failure to meet these with compliance penalties.

Funding and wages: a transparent and accountable system

Funding

There is considerable evidence that funding of the aged care sector is not substantial enough to meet growing demands,[17] is allocated based on overly individualised, clinically focused calculations, and expenditure of funds lacks transparency measures that satisfy principles of good governance. The Commonwealth model for funding and operating aged care was designed in a care environment that is vastly different to that which exists today. People are entering the aged care system at a later stage,

[13] Schedule 1, Item 1, s 9-2A(3)(g) (p. 4, line 15)
[14] Royal Commission into Aged Care Quality and Safety 2019, *Interim Report: Neglect*, pp. 222-227.
[15] Ibid, pp. 205-206.
[16] Schedule 1, Item 1, s 9-2A(2)(h) (p. 3, insertion at line 29).
[17] Royal Commission into Aged Care Quality and Safety 2019, *Consultation Paper 2: Financing Aged Care,* June 2020, pp. 6-7.

often with more complex medical needs, while at the same time, expectations for care have expanded (rightly so) to include social and emotional dimensions.

The changing patterns of demand have not been matched with appropriate changes in funding models.[18] Inappropriate funding models have in turn driven inadequacies and incongruencies in the governing frameworks, and workforce development and staffing levels have borne the brunt of the pressures generated by these financial and regulatory blackspots. It is therefore structurally difficult for the aged care system to realise the principles of dignity, respect, and person-centredness which are enshrined in aged care policy and standards and expected by the community. The correlation between staffing levels, aged care funding, organisational accountability and government oversight in poor care outcomes is often overlooked in reform proposals.

The HSU takes this opportunity to call for funding to be increased to the sector, recognising that introducing transparency measures in conjunction with additional funding will improve system efficiencies, public trust and care outcomes.

Meaningful wages

The level of responsibility, skill and emotional labour inherent in aged care work is not reflected in remuneration levels. Under the *Aged Care Award 2010,* an entry level PCW is paid $20.73 per hour while an experienced PCW may receive up to just $25.18 per hour.[19] While there are arguments that Award rates of pay are an inaccurate indicator of the sector's wages as high numbers of Enterprise Bargaining Agreements (**EBAs**) have provided an avenue to raise wages, this is not accurate. Providers inform workers and their representatives engaged in bargaining that the quantum of funding allocated by government is based on Modern Award rates (irrespective of the number of employees covered by the Award). Employers make claim that because of this, they cannot bargain any higher.

However, there is no transparency around the relationship between funding and wages, including what classifications from the Award are applied and to which workers, how much funding is set aside for care provision, and whether the funding received is in fact spent on staff wages. There is also no mechanism for workers or their representatives to better understand these matters in bargaining as the funder (the Government) is not at the table. It must be noted here that the role of the Modern Award system under Australia's industrial relations system is to simply provide a minimum floor on wages and conditions. Instead, the aged care funding system has reappropriated the Modern Award as a ceiling on wages and conditions across an entire sector.

The HSU unequivocally **supports** the Bill in introducing transparency requirements for expenditure on salaries and wages for all staff by category.[20] However, it is important that staff categories are clearly defined as outlined above, and that additional salary and wage information is provided. Namely, the amount funding received that has been earmarked for expenditure on wages (if in fact this is the case), the proportion of earmarked funding spent on wages, and the allocation of funding by Award classification.

[18] Meagher, G, Cortis, N, Charlesworth, S & Taylor, W 2019, *Meeting the social and emotional support needs of older people using aged care services*, Macquarie University, University of New South Wales and RMIT University, p. 2
[19] Fair Work Ombudsman, *Pay Guide - Aged Care Award 2010 [MA000018]*, effective 1 July 2109, published 27 June 2019.
[20] Schedule 1, Item 1, s 9-2A(2)(g) (p. 3, line 27).

Corporations Act amendments

Some aged care providers, particularly smaller not-for-profits, specialised services or those in regional, rural and remote areas, are struggling to maintain financial viability.[21] Developing a detailed picture of the funding received and how it is allocated will assist in understanding the needs of such services and their residents. For the Bill to have its full and intended effect, it is critical that loopholes under the Corporations Act be closed to prevent simplified reporting. The HSU supports the Bill's measure to ensure this is achieved[22] however, we seek additional information as to how many approved providers currently receive less than $10 million funding from the Commonwealth in a financial year.

We **recommend** that in order to build a fully transparent picture of expenditure across the sector, the requirement for detailed reporting should, at least for the first reporting period after the Bill has come into effect, extend to all recipients of Commonwealth funding.

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[21] Royal Commission into Aged Care Quality and Safety 2019, *Interim Report: Neglect*, p. 172.
[22] Schedule 1, Item 4, After s 296(1B) (1C) (p. 5, lines 7-11)