UNITED WORKERS UNION

SUBMISSION TO THE ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

DECEMBER 2019

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WORKERS UNION

“I’ve been in the industry for a really long time, this is my 46th year as an aged care worker. I’ve always loved doing what I do and I look forward to coming to work pretty much every day. The joy you can put on someone’s face, just by being yourself. Aged care is disrespected by so many, but it’s nice to be surrounded by good people. If you’re having a bad day, they’ll lift you up. Things are so difficult at the moment with all the bad stuff that’s come out of the Royal Commission, and that’s set us back on our backsides for a little while. It’s upsetting. But it’s no good just blaming the people we work for – I work for a not-for-profit residential company – it’s no good blaming them, because they can only do what they can with the funding they get. My biggest bugbear is that we are so disrespected, and as care workers we get a lot of disrespect from media and people who should know better. The good thing is though, that by having this Royal Commission, people out in the community are actually listening to us now. Maybe now we will see some real changes. We’ve never really had a voice, so I’m just looking forward to the future.”

INTRODUCTION

United Workers Union welcomes the opportunity to make a submission on behalf of our members to the Royal Commission into Aged Care Quality and Safety.

United Workers Union is a powerful new union built from two proud unions coming together: United Voice and the National Union of Workers. Our union is 150,000 workers across the country from more than 45 industries and all walks of life, standing together to make a difference.

Our work reaches millions of people every single day of their lives – we feed you, educate you, provide care for you, keep your communities safe and get you the goods you need. Without us, everything stops. We are the working people of Australia, coming together to take action and win secure jobs and a better future.

In 2019, in collaboration with the Health Services Union and Australian Community Research, United Workers Union (then United Voice) undertook a survey of over 5,000 aged care workers across Australia about issues affecting their work and the quality of care delivered to residents **(2019 UWU/HSU Survey)**. The questionnaire included both mandatory choice questions where overall figures could be obtained and open-ended questions where staff could voice their concerns in their own words. This submission is largely informed by the results of that survey. Copies of both survey reports are attached for your reference.

As the people working in aged care on a daily basis, many of whom also have loved ones who receive support in the aged care sector, our members appreciate the opportunity to have their opinions, concerns and experiences considered as part of this inquiry.

For more information regarding this submission please contact Carolyn Smith

Carolyn Smith
National Director Aged Care
WA State Secretary

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EXECUTIVE SUMMARY

"The Liberal Government needs to act now – because no matter how many reports are written, the only thing that will fix the issues in aged care is immediate action."

United Workers Union **(UWU)** members working in aged care understand the importance of this Royal Commission for the future of aged care in Australia.

Our members are the people who every day provide care and support to older Australians. They by and large love their work, but are acutely aware that a constrained funding environment and poor working conditions continue to impact adversely on their ability to provide the quality care that every older Australian deserves.

Membership coverage in the aged care sector differs across the national union on a state basis. In Queensland, South Australia, Western Australia, the Australian Capital Territory and the Northern Territory, we have coverage of direct care staff and support staff (catering, cleaning, gardening, maintenance) in residential aged care. We also have coverage of direct care staff in home care in the above states and in New South Wales. In Western Australia, UWU also has coverage of Enrolled Nurses **(EN)** in residential and homecare. As titles for occupational groups differ on a state basis, unless otherwise stated we have used the term 'aged care worker' to refer to our members collectively throughout this submission.

As our population ages and the demand for aged care services increases, so too will the workforce need to increase to meet demand. UWU believes the immediate challenge facing the aged care sector is to build and retain a workforce large enough, and with the necessary skills, to meet increased demand, while providing quality care within the constraints of funding models.

The aged care sector is characterised by an ageing workforce, attraction and retention issues and jobs with low pay, insecure hours and limited career opportunities. This combination of factors hinders the ability to ensure a sustainable workforce with the necessary capacity to provide quality aged care into the future.

All workforce issues are underpinned by chronic underfunding of the sector. Unless funding issues are addressed on a systematic basis, older Australians will never receive the quality care they deserve. To ensure the required workforce growth is met and a sustainable workforce continues into the future, the Federal Government must act now to deliver an improved funding model that covers the true cost of delivering quality care, is targeted to the workforce and accountable to the community.

The alternative is a further devaluing of the work in this sector, which ultimately will impact on the quality of care provided to older Australians.

We need to be informed by our past experience in this sector instead of maintaining the same unsatisfactory approach and feigning confusion as to why the sector is at breaking point. The answer is clear – the sector desperately needs more funding to address workforce issues and it needs this funding now.

SUMMARY OF RECOMMENDATIONS

RECOMMENDATION 1: the Federal Government must be the leader in the delivery of quality aged care services and support best practice by immediately address the funding issues that have put the financial sustainability of the sector at risk.

RECOMMENDATION 2: the Federal Government must introduce targeted funding for the aged care workforce with sufficient transparency and accountability mechanisms to ensure funding goes directly to improving the wages and working conditions of aged care workers.

RECOMMENDATION 3: the Federal Government must undertake a cost of care study as a matter of priority to determine the true cost of providing quality care, specifically including workforce costs.

RECOMMENDATION 4: the Federal Government must respond to concerns with the AN-ACC model and individualised funding in home care and commit to new funding models that reflect the true costs of delivering quality care.

RECOMMENDATION 5: in addition to targeted workforce funding, the Federal Government must ensure appropriate accountability mechanisms linked to indicators of decent working conditions, including appropriate wages, job security, minimum hours and training.

RECOMMENDATION 6: that industry bargaining is introduced to rectify the limitations of a conventional enterprise bargaining system in the aged care sector.

RECOMMENDATION 7: that the prevalence of insecure work is addressed by regulation to reduce the use of minimal hour contracts.

RECOMMENDATION 8: that the Aged Care Award 2010 is revised to implement classifications that recognise workers' qualifications, skills and experience and better reflect current practice.

RECOMMENDATION 9: that the Federal Government, in conjunction with the union movement, develop extensive safeguards for an award review process to ensure it is not unduly costly or time consuming and to all conditions are upheld or improved and are not reduced.

RECOMMENDATION 10: that a minimum qualification at the Certificate III level be introduced for the aged care workforce.

RECOMMENDATION 11: that the State, Territory and Federal Government come together to implement a Certificate III in Care Support as per the Skills IQ Review.

RECOMMENDATION 12: Aged Care providers are required to demonstrate the provision of ongoing training, through federal funds allocated, in order to continue operating and receiving funding.

RECOMMENDATION 13: while TAFE is the provider of choice, oversight measures for Registered Training Organisations should be reviewed and strengthened to ensure the quality and consistency for those seeking training to enter the aged care sector.

RECOMMENDATION 14: that in consultation with the sector, the Federal Government develop a mandated minimum staffing model for aged care that meets the total care needs of all residents, including physical, social and emotional needs, provided by a workforce skilled to deliver such care.

RECOMMENDATION 15: the Government develop a pre-employment screening and registration scheme for the non-clinical aged care workforce through a regulatory body that is not AHPRA, appropriate to the skills, roles and professional expectations of these workers and will not create excessive, inappropriate or false barriers to entry.

RECOMMENDATION 16: the Government extend whistle blower legislation to all sector employers to support and encourage workers to speak up without fear of being persecuted or targeted where a report is made in good faith.

SECTION ONE - ROLE OF GOVERNMENT IN AGED CARE

> *"Older Australians built this country to be the Australia it is today and they deserve to be cared for and respected. This should be a no brainer for the Government."*

Governments are elected to serve the community and this service should be accountable, transparent, and democratic. As the regulator and primary source of funding, the Federal Government is responsible for ensuring the financial viability, stability, and sustainability of the aged care sector. The Government is responsible for setting the policy agenda and regulating the delivery of services predominately through the private sector. In conjunction with state governments, it also supports the industry through funding and regulating higher education and the vocational education and training systems.

All Australians have a right to expect consistent access to quality and appropriately funded aged care services. An aged care sector that is focused on community needs provides universal access to quality services, delivered by a quality workforce, appropriately funded by Government and are responsive and flexible to the changing needs of the community. Sufficient and appropriate funding is vital for the delivery of quality care and maintaining a sustainable skilled workforce now and into the future. This cannot be achieved in the current economic environment.

An irresponsible and unaccountable approach to funding by successive Liberal Federal Governments has resulted in a chronically underfunded aged care sector. The Government should be promoting and supporting best practice for the aged care sector. Sufficient funding that is directed to the workforce with appropriate accountability measures is the fundamental first step that needs to occur before we can see any real positive change for the sector. If we get funding right, the rest will follow. Anything other than immediate action by Government is a serious disservice to all Australians.

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RECOMMENDATION 3: the Federal Government must undertake a cost of care study as a matter of priority to determine the true cost of providing quality care, specifically including workforce costs.

RECOMMENDATION 4: the Federal Government must respond to concerns with the AN-ACC model and individualised funding in home care and commit to new funding models that reflect the true costs of delivering quality care.

Government as Funder

The aged care industry in Australia provides services to around 1.3 million Australians and generates annual revenues of approximately $22.6 billion. The industry makes a significant contribution to the Australian economy, representing 1 per cent of Gross Domestic Product **(GDP)**.[1] This is expected to double to around 1.7 per cent of GDP by 2055.

Australian Government expenditure on aged care in 2017 18 was $18.1 billion, up from $17.1 billion in 2016-17. This accounts for approximately 67% of total provider operational funding. This is projected to increase to $24 billion by 2021-22. While this is an increase on dollar value, in real terms this has resulted in less funding per resident.

The overall deterioration in the financial performance of providers has been clearly evidenced. Expenses are outstripping revenue with 45% of providers reported to be operating at a loss for year 2017-18.[2] This is mainly as a result of the government's decision to withhold funding through changes in ACFI scoring in 2016-17, no indexation of ACFI in 2017-18 and only a partial indexation of ACFI in 2017-18.

While indexation of ACFI has returned, providers have noted that the rate of indexation is well below the increase in their current costs.[3]

Funding and Quality Care

Inadequate government funding is at the core of all workforce issues across the aged care sector. Poor workforce outcomes can be directly linked to inadequate and outdated funding mechanisms. High workloads, no time to care, short shifts, inadequate hours, and high rates of part time or casual employment are all symptoms of a poorly funded system.

Our members have firsthand experience of how service quality has been compromised by fiscal constraints. In residential aged care our members have reported a noticeable difference in both staffing and resource levels. Less staff with fewer resources cannot maintain a high level of care delivery.

Members have reported using catheters for longer than the average five to six weeks, stretched out beyond eight weeks in some cases. We have heard reports of members being forced to dry people with paper towels because the actual towels were too expensive to launder off-site. Gloves are being withheld because providers have gone over budget. People are being asked to wash bandages from VRE and MRSA patients with their bare hands in warm water. Incontinence pads are being rationed. This is just a small sample of a whole range of disturbing working conditions our members have reported to union organisers.

Individualised funding in home care has also had an impact on care delivery. Since the introduction of individualised funding, members have reported a noticeable reduction in care hours, and a reduction or complete removal of paid team meetings and training. Team meetings are a vital opportunity for home care workers who otherwise work in isolation to come together to learn, share information and access peer support. In order to successfully manage individualised funding, providers have had to expand their focus so that the budget and financial transactions of a client are managed alongside their care provision.

"There is simply not enough funding in home care packages."

"Watching clients deteriorate is awful. Knowing that they may need further funding (through CHSP or package), but they may die before they receive it."

New Approach to Funding

It is clear that the aged care sector is chronically underfunded and this underfunding is the root of many of the workforce issues plaguing the sector. Despite this, less than 1% of the funding announcements in the last 12 months have been workforce purposed. This is an insult to every single worker and consumer of aged care services. The answer is simple – we need more funding for aged care and we need it now.

Concerns with the AN-ACC

In March 2019, UWU made a submission regarding the proposal for a new residential aged care funding model in which we outlined our concerns with the proposed AN-ACC model. A copy of the submission is attached.

While we are cautiously supportive of the proposed funding approach we have serious concerns that in its current form, the AN-ACC will not fix existing funding issues. Our main concern is that the funding model design is based on current practice within residential aged care facilities and does not necessarily reflect best practice. We are concerned that this will simply result in one flawed system being replaced by another.

Significant understaffing has meant that workers are rushing to complete tasks and do not have time to care for residents physical, social and emotional needs, which is discussed in more detail below at Section Two. As the foundational data for the AN-ACC does not adequately consider the true cost of care, it cannot possibly seek to solve the funding issues for the sector.

> *"We don't have the luxury of the time to have a conversation with residents, if we do, others will suffer! We assist them, although we still talk to them whilst we are helping the residents, it's not enough! We have to be as quick as possible to help other residents. It's frustrating and very stressful!"*

We are further concerned with the approach to pricing under the AN-ACC. An adequate pricing model reflecting the true cost of providing quality care is essential in ensuring a quality world class aged care system. The experience of the National Disability Insurance Scheme (NDIS) is that price has had a significant impact on the capacity of providers to provide quality disability supports. NDIS providers have struggled under inadequate pricing and some face closure as a result.[4]

Wages in aged care are currently at least 15% undervalued in aged care, as discussed further below.[5] A funding system that places further downward pressure on wages will only make this worse. There is a substantial risk with the AN-ACC that if prices are not adequately set and reviewed the model will create problems similar to those faced in the NDIS. We believe unless these concerns are addressed the AN-ACC will fail.

Transparent & Targeted Funding

A lack of transparency and accountability of Government funding compounds the failures of the current funding models. There are currently neither regulations nor mechanisms by which the Government can be assured that funding is being spent in a specific way. Governments, and recipients of Government funding, should be held to a high standards in terms of providing transparency to the public. Such transparency should ensure an adherence to principles, values and codes of conduct that bring about quality services that are sustainable and consistent with fair and decent work.

As there is no requirement for funding to flow automatically into wages, whilst the good intentions of some employers are acknowledged, previous injections of funds to the industry have not resulted in adequate and fair improvements to wages and working conditions. Failing to specifically target funds for aged care workforce initiatives such as wages invariably means they will not be used for that purpose.

Aged care consumers have a right to safe, secure, reliable and inclusive aged care services as well as choice and control over their care arrangements. Likewise aged care workers must have access to a quality, professional, safe and secure work environment and be paid a fair wage. Improved funding to aged care needs to consider the true cost of delivering care, examine where there may be efficiencies in the current system and ensure that funding allows older Australians a real choice in the delivery of their care.

Government and Bargaining

As the Federal Government determines the form and amount of funding the industry receives, individual providers are largely constrained by that funding in their capacity to improve wages and other workforce conditions. This is considered in further detail at Section Two.

Inadequate government funding is regularly cited by employers as being an impediment to paying fair wage rates. Many providers report that since the funding cuts of 2016-17, they cannot afford to maintain existing terms and conditions, let alone improve them. While we have limited means of testing such assertions, there is sufficient evidence and data which supports them.[6] The frequency with which UWU hears these assertions from numerous providers, and the available data on the deteriorating finacial performance of the sector, leads us to conclude that there is some truth in the assertions.

This environment has a significant impact on the Union's ability to bargain with providers. The current enterprise bargaining model was conceived for industries vastly different from the aged care industry. Those industries are not reliant on government funding to the extent that the aged care industry is. The aged care sector's reliance on government funding significantly limits the bargaining power of workers in the industry.

Government and Education

Regulation and funding for TAFE is a complex relationship between Federal and State governments. The universal provision of ongoing training for the aged care workforce is squarely within the role of the Federal Government to lead workforce development. Federal funding bodies need to ensure that training and education costs are borne by providers rather than workers. This means that workers must also be paid for time taken to do work-related training. In addition, federal funding bodies must develop mechanisms to ensure transparency and accountability in relation to providers' use of funding. There should be an obligation on providers to show that funding specifically allocated for training and continuing professional development purposes is actually used for those purposes. There is significant dissatisfaction with some current training delivery. A regulated system of training could ensure quality in this area. This is considered further in Section Three.

Government and Provider Best Practice

Reforming the aged care sector requires commitment from aged care providers. This in-turn depends on the Federal Government's appetite for structural reform. As such, the Federal Government must set the tone, firstly by implementing the recommendations of this Royal Commission.

In the statements before the Commission thus far, it is plain that aged care workers are often the first people to identify poor practices, and take their role as advocates, and sometimes as whistle-blowers, very seriously. However survey responses from the 2019 UWU/HSU Workforce Survey capture workers' experiences of disrespect and dismissal of concerns about the quality of care being provided to older Australians by their employers.

Aged care work is insecure, underpaid and unsupported by professional development. This works against the capacity of aged care workers to steer quality care through their firsthand knowledge of the sector. Addressing these issues, at a sector level with Federal Government commitment, will thus support workforce leadership.

"I get disheartened and frustrated – there's not enough staff or money for what we do. Management do not listen to us, notice what we do, or take notice of our complaints. This has to change".

SECTION TWO – WAGES & CONDITIONS

> *In the last three years my income has reduced each year and I expect this year to make four. I have no guarantee at all regarding how many hours I work. I cannot get out of this job soon enough and when I do would never consider working in this field again and would never recommend for anyone else to do so. It's a complete dead end.*

The current working conditions in aged care negatively impact on the capacity of the system to adequately meet the needs of care recipients. The aged care sector is characterised by a range of working conditions that are not conducive to quality jobs. These include (but are not limited to): low wages; inadequate or unpredictable hours and a reliance on contingent employment arrangements; excessive workloads and inadequate time to care; limited career opportunities; inadequate supervision; inadequate training and peer support and major institutional and funding pressures.

The workforce issues outlined below are not new concepts to the sector. Numerous reports and inquiries have determined that it is the nature and conditions of the work in aged care that continue to impact attraction and retention issues in the sector.[7]

RECOMMENDATION 5: in addition to targeted workforce funding, the Federal Government must ensure appropriate accountability mechanisms linked to indicators of decent working conditions, including appropriate wages, job security, minimum hours and training.

RECOMMENDATION 6: that industry bargaining is introduced to rectify the limitations of a conventional enterprise bargaining system in the aged care sector.

RECOMMENDATION 7: that the prevalence of insecure work is addressed by regulation to reduce the use of minimal hour contracts.

RECOMMENDATION 8: that the Aged Care Award 2010 is revised to implement classifications that recognise workers' qualifications, skills and experience and better reflect current practice.

RECOMMENDATION 9: that the Federal Government, in conjunction with the union movement, develop extensive safeguards for an award review process to ensure it is not unduly costly or time consuming and to all conditions are upheld or improved and are not reduced.

Low Remuneration

Aged care workers are some of the lowest paid workers in Australia. This is a significant problem for the industry and is recognised by providers and workers as an obstacle to genuine reform. The ramifications of low pay ripple throughout the industry and are closely connected with other issues raised by this submission. 75% of both residential and home care workers cite pay as being insufficient to meet their needs and a significant factor in deciding whether to stay in the industry.

It is well established that the aged care workforce is undervalued and resultantly underpaid.[8] Concurrently, reports have consistently emphasised the pressing need to grow and upskill the aged care workforce in response to an aging population and increase in complex health conditions such as dementia. The 2018 A Matter of Care Report found that direct care staff were paid significantly below the market median and undervalued by at least 15%.[9] Despite this, there have been no significant attempts to address wages in aged care by the Federal Government.

The low remuneration of aged care workers is amplified when compared with their counterparts in the health and disability sectors. In comparing wages in aged care and disability services the common comparator is the certificate III and IV wage rates between the Aged Care, Nurses and SCHADS awards. On this basis aged care aged care workers' base wage rates are 18-31% lower than the comparable disability support workers' base wage rates. These are workers who are similarly qualified and undertake similar tasks. The only conclusion to draw from this is that the aged care sector has been ascribed less social value when compared to other health caring sectors.

"Poor pay and unpredictable income and generally being treated as though I am somehow less important than everybody else. This is an industry of exploitation. Every day I am treated poorly by my employer."

Low remuneration is further exacerbated by structural issues such as funding arrangements and bargaining as well as other undesirable workforce conditions such as high turnover, underemployment, insecurity of rostered hours, wage classification and superannuation. These are explored in more detail below.

Funding and Wages

As noted above in section one, as the system funder, the onus is unavoidably on the Federal Government to deliver funding sufficient to fairly remunerate the aged care workforce. The Government sets the funding model and is accountable for its successful delivery. As previously outlined, current and proposed funding models do not adequately address the true cost of care and are not structured to directly address wage rates.

History has shown that workers have borne the brunt of a systemic shift away from targeted funding to a more generalised pool of funding. The historical CAM/SAM funding arrangements were instituted in 1987 as a way to improve the accountability of residential aged care providers. As a supplement based on a resident's required level of care, the CAM portion of funding directly linked funding to the care to be provided. For workers, these funding arrangements provided greater certainty in terms of working conditions and wage rates than the current system.

The abolition of the CAM/SAM system in the mid-nineties marked a departure from an input-regulated to an outcomes-assessed quality system in aged care. This new approach was "to be driven by care needs of residents, rather than arbitrarily devised inputs".[10] This left providers free to determine how they spent their funding. As noted above, failing to specifically target funds for aged care workforce initiatives such as wages has resulting in funding not being used for that purpose.

Structural change to aged care funding resulted in providers opting for the most economically 'efficient' means of meeting quality outcomes. In an industry where a substantial proportion of costs are from labour, the net result of change to funding agreements has been increasing pressure on the workforce, without any direct labour regulations to compensate.

Further, as noted above, aged care funding is not being indexed with increases to award rates of pay and the rate of indexation is well below the increase in their current costs.[11] Direct care workers are low paid and award reliant. As 94% of direct care costs are employee expenses the annual indexation of ADFI should be no less that the minimum wage increases awarded by the Fair Work Commission otherwise providers will always be in a situation where increases in expenses exceed increases in revenue received.

The funding arrangements in aged care can be sharply contrasted to the price controlled model of the NDIS. The NDIS is to link care funding to skill level of the worker and corresponding award rate of pay. The National Disability Insurance Agency is working towards a single national price guide by 2021 to allow providers time to move to the SCHADS Award. Price controls in disability support will therefore represent award based remuneration, in line with the SCHADS Award.

We are not suggesting that the NDIS model is without its flaws. There are clearly evidenced shortcomings in limiting workers' rates of pay to award rates under the NDIS. However, the cost controlled model is at least premised on the recognition of labour costs as a given within the cost of care – rather than an efficiency to be found within a lump sum.

As recommended in Section One, it is imperative that the Federal Government fulfils its responsibility for adequate pay and conditions in aged care through federal funding arrangements in aged care that are targeted and include accountability mechanisms for providers linked to decent working conditions.

Conventional Bargaining

Conventional enterprise bargaining has failed to deliver fair pay and conditions for aged care workers. UWU submits that it is extremely difficult to rectify the low remuneration and poor working conditions endemic in the aged care sector through the current enterprise bargaining system. The landscape of the industry, desegregation of home care, underfunding, minimal requirements of the better off overall test (BOOT), and implementation gap in enterprise agreements undermine the effectiveness of enterprise bargaining.

In the last few years we have seen wage growth stagnate in aged care agreements. Annual wage increases across the providers with which we currently bargain are around 1-1.5%. This is significantly lower than the Fair Work Commission's recent minimum wage increase. Such increases are also insufficient to keep up with rising costs of living. Though there are mechanisms in the Fair Work Act 2009 (Cth) (Fair Work Act) which prevent base rates in enterprise agreements from falling below award rates, these mechanisms do not apply to penalty rates. Therefore, where an agreement provides for a loading of only 80% on a Sunday rather than the 100% entitlement under the relevant award, there is the potential for workers to earn significantly less than they would under the award.

As noted, indexation of Federal Government funding is not keeping up with annual increases to award rates of pay. This limits providers' capacity to pay wages which are higher than award rates. For this reason, some providers will only agree to terms and condition which just satisfy the BOOT assessment for enterprise agreements, yet allow the providers to water down award conditions such as giving workers certainty to ongoing rostered working hours.

Number and Attitudes of Providers

Enterprise bargaining does not account for the growing number of providers in the aged care sector. Bargaining is inherently resource intensive and time consuming. The inefficiency of bargaining across a proliferation of providers is aggravated by the reluctance or refusal of a number of providers to engage with unions.

While there are mechanisms under the Fair Work Act to pressure employers to engage in bargaining, not all such processes are appropriate to the aged care sector. At a national level, UWU has accessed Equal Remuneration Orders, Low Paid Authorisations, Majority Support Determinations, Protected Action Ballots and the Modern Awards Review with limited success. The aged care workforce consists of low paid workers, many of whom are in insecure work arrangements. They are in many respects vulnerable workers. Some of these mechanisms have the potential to make workers' situations more insecure rather than win improvement.

Desegregated Home Care Industry

UWU has experienced the most difficulty improving conditions for home care workers. Home care workers are inherently 'isolated' at work. They work alone, and do not have fixed, regular places of work. As a result, home care workers lack many of the supports and networks available to residential care workers. It is resultantly difficulty for home care workers to form networks, and for the union to connect with home care workers in their workplace. Further, the home care industry itself is largely desegregated. Unlike residential care in which large private providers with a significant number of facilities constitute a large proportion of the sector, home care is characterised by a proliferation of smaller, localised care providers. These two factors severely undermine the efficacy of enterprise bargaining in home care.

Implementation Gap

In enterprise bargaining, UWU has been able to improve classification structures in some enterprise agreements so that workers are able to progress through, or be promoted to, various classification and pay levels in accordance with their skills, qualifications and experience. However suchclassification structures provide only limited benefit where providers do not employ or appoint workers across all levels of the structure. As such, the effectiveness of more nuanced classifications in enterprise agreements is limited by the implementation of providers.

Industry Bargaining Reform

The ineptitude of enterprise bargaining to raise the remuneration and conditions in the aged care sector is well-documented and well understood by workers and the union who confront these obstacles daily. Enterprise bargaining in aged care is flawed by design, rather than ineffective through lack of effort or expertise. Institutional reform is clearly necessary as pay and conditions are foundational to the quality and sustainability of the aged care sector. UWU advocates for industry bargaining across the aged care sector.

High Workforce Turnover

Low remuneration undercuts a sustainable, skilled aged care workforce. The A Matter of Care Report found that poor pay "directly impacts on workforce attraction and retention".[12] Low pay is a 'push' factor for workers leaving the industry and disincentive to those looking to enter the aged care workforce.[13] The 2016 National Aged Care Workforce Census and Survey (the 2016 Workforce Census) reported that "negative perceptions of aged care work as an occupation of low pay and status remain".[14] Low pay is seen as reinforcing low social priority of aged care.[15]

The 2016 Workforce Census reported that "providers in Australia commonly express concerns regarding difficulties recruiting and retaining skilled staff".[16] Low pay exacerbates poor conditions and workforce instability, as turnover worsens high workloads, unpredictable hours and the use of agency staff.[17] Research into the experience of aged care has found that both staff and clients identify continuity as a key indicator of quality care.[18] By precipitating workforce turnover, low pay inhibits the experience of quality aged care.

The 2019 UWU/HSU Survey found that 40% of all survey respondents said that they would likely not be working in the aged care sector in five years' time. Aged care workers express feeling unappreciated as a result of their poor remuneration. This is in stark contrast to the physical and psychological demands of the work and additional care that many workers provide. Aged care members have explained that care and compassion motivates them to stay in the industry, despite their low pay.

"I do the job because of how much I care not for the money because it's terrible pay for the amount of physical, mental and emotional strain on us...I'm sure more people would do it if the pay was better"

"Paper work, documentation are necessary but our residents come first, carers are working back in their own time to finish workload"

"I work extra hours in my own time"

The turnover rate in aged care is estimated at 25% per annum and is roughly the same as in the disability support industry.[19] While the remuneration of disability support workers is considerably better, as will be discussed below, this workforce is highly casualised. As such, turnover in disability support can be attributed to the NDIS funding model with uncertainty of funding, inadequacy within the funding model and the insecurity associated with on-demand support arrangements.

Underemployment

The impacts of low wages on the workforce are exacerbated by the high rates of part time and casual work in aged care. The care sector is dominated by a part-time and casual workforce and full-time employment is relatively uncommon for direct care workers.

The 2016 Workforce Census found that 30% of residential aged care workers and 39.8% of home care workers wanted more hours of work.[20] Furthermore the 2016 Workforce Census found that 9% of residential aged care worker and 16% of home care workers held mo re than one job. The figure at the same time across the entire workforce was 5.3%.[21] The desire for increased hours of work and the high rates of multiple job holding highlights the need for improved wages and more reliable hours of work.

Underemployment is among the top reasons why people leave the aged care industry. For those intending to find new jobs within aged care, 30% cited not getting enough hours as the major reason.[22] The large proportion of part-time and casual employment translates directly to workers' total take home pay and makes the sector relatively unattractive for potential workers looking for full-time employment.

No Security of Hours

Unpredictable and inadequate hours are a significant feature of current aged care work that can negatively impact on job quality and thus the quality of care provided to residents.

Security of hours is undermined in the residential care setting through changes to roster arrangements which typically result in a reduction of rostered hours for many part-time employees. Where employees are on minimal-hour contracts, or where their contracts of employment don't adequately reflect the number of hours they actually work, they may have no legal recourse to address a sudden and significant reduction of hours.

In the home care setting, where work is more immediately driven by client demand, security of hours is a significant problem. Home care workers are typically engaged on minimal-hour contracts by which the provider commits only to provide additional work within the employee's stated availability as it becomes available and based on client need. Many workers will indicate a wide span of availability, so as to maximise their hours of work, yet there is no obligation on the employer to provide any more than minimum contracted hours.

Further, workers can be effectively rostered on for an entire day but only be paid for a small number of hours when they are with a client. The pervasiveness of these split or broken shift arrangements means it can be hard for people to gain additional work and takes them away from family and other responsibilities for lengthy periods of time for which they are not being financially compensated. Such workers are essentially 'on call' without pay. If the worker reduces their availability with the provider (for example, in order to gain work elsewhere), the provider may reduce the worker's minimum contracted hours to the extent of the reduction in availability.

This variability of earnings means workers have no certainty over meeting bills and planning for the future and throws into doubt an individual's eligibility to claim various forms of social benefits. While weekly income can frequently be inadequate, the need to be available for work when required by the employer hinders the ability of workers to take up other employment. The need to respond to calls

to attend work, frequently at short notice, disrupts life outside work and places particular strain on families and arranging care for children. This is particularly problematic given that the majority of the aged care workforce is women. Women are still more likely than their male colleagues to have caring responsibilities which are not compatible with irregular hours and 'on call' working arrangements.

"The lack of payment for travel time in my area - semi rural. Often I can be driving all day yet I am only paid for the clients I see and no travel time. This means I can work all day and only get paid a few hours. Sometimes my shifts get cancelled on short notice and I don't get paid. This job is very hard financially".

"Many broken shifts. Happy to work an 8 hour day but this is a rarity. It's common to start work at 7am and finish at 5pm we may only have 5 hours during that time."

The insecurity of minimal-hour contracts is pervasive in home care despite the requirements of the Social, Community Home Care and Disability Award 2010 (SCHADS Award). The SCHADS Award provides that before commencing employment, employers are to agree in writing with part-time employees:

(i) a regular pattern of work including the number of hours to be worked each week; and
(ii) the days of the week the employee will work and the starting and finishing times each day.[23]

It is our experience that this is rarely observed. Instead this clause motivates employers to negotiate enterprise agreements that do not contain such rostering requirements. However it is difficult to determine the monetary value of a regular working pattern for part-time employees when assessing whether such agreements satisfying the BOOT assessment. A small wage increase may be taken to offset award provisions relating to security of hours. The end result is that employers gain the significant advantage of an effectively 'on call' workforce without compensation.

Wage Classifications

Wages in the aged care sector do not correspond to qualifications, skills and experience. While a significant proportion of the aged care workforce holds formal qualifications and undertakes further training, there is limited recognition of this through wage or classification level.

The classification structure within the Aged Care Award 2010 (Aged Care Award) and agreements is generally very flat. As an example the difference between the lowest and highest rates of pay in the Aged Care Award per week is $169 for a full time worker. As an hourly rate this is just over $4 per hour.[24] This amount in no way reflects the increase in skills, experience and even qualifications gained by aged care workers over time.

UWU is party to more than 180 current and expired agreements in the aged care sector across Australia. Under our agreements the classification approximated with Aged Care Worker Level 1 under the award starts at $20.90 to $24.53 and Level 5 between $23.59 to $27.89. The majority of agreement-reliant Level 1 workers sit between $21.09 and $22.49 per hour, with the $24.53 rate anomalous. The majority of agreement-reliant Level 5 workers sit between $23.59 to $24.92 per hour, with the rate of $27.89 being anomalous.

Home care providers often pay workers on the basis of the nature of the work performed, which is variable and driven by client-need. For example, a provider may employ a carer on the basis that they have a Certificate IV qualification in aged care. By employing this worker, the provider is able to offer care to a broader range of clients, from low-to-high needs. Under the SCHADS Award, the worker would be entitled to a Level 4 wage of five possible levels. The provider may, however, roster the worker to care for a client who requires only low level care, or basic domestic assistance in the home. Where this occurs, some such providers will pay the worker the entry-level, unqualified carer rate for all work performed for that client, on the basis that the worker is performing tasks that do not require the skills of a Certificate IV qualified worker. Under this model, pay rates can vary significantly from week to week and without a worker's control, depending on the needs of individual clients, which may change quite unpredictably.

It is also common practice that workers are paid a fixed rate based on the category into which the majority of their work falls. This means that, although a carer may perform work for a variety of clients, some of whom are 'high needs' and require specialised care of the nature that only a qualified carer is able to give, if the majority of the carer's work falls into the category of 'basic domestic assistance', they will receive only the basic-level rate for all of the work that they perform, including the work with 'high-needs' clients. Thus aged care workers are not always paid commensurately with their skills, qualifications and experience.

Superannuation

Members are increasingly reporting having to work for more than one provider to earn sufficient income. They may not meet the threshold minimum amount above which a provider is obliged to pay superannuation with one or more of their employers, and therefore earn little or no superannuation.

Commitments in enterprise agreements go some way towards addressing the problem, in the absence of changes to the superannuation legislation. Through bargaining, UWU has been successful in obtaining commitments from some providers to pay superannuation to workers who earn less than the threshold minimum amount imposed by the superannuation legislation.

However, given that most women in Australia retire with significantly less superannuation than men, and that women comprise a significant portion of the aged care workforce, it is particularly important that this loophole be addressed across the whole workforce.

SECTION THREE - SKILLS & COMPETENCIES

> ***"The wealth of knowledge that exists with the more senior staff of the home care workforce is priceless. With the right mentor training, they [employer] could harness this knowledge and encourage youngerpeople to choose home care as a career, we could teach them how to find the passion that is required, how to love your job and deliver the best care for the clients."***

Quality aged care requires a stable workforce of trained, qualified and dedicated workers who are fully supported to provide services that are respectful of, and facilitate an individual's needs and goals.

Increasing complexity of care, higher expectations from people who use services and growth in community based and in-home care delivery means that workers are often placed in demanding situations without immediate support. Appropriate qualifications and access to quality ongoing training and education is essential to ensure that all workers across the sector have the required knowledge and skills to carry out their role to a high standard.

Without access to appropriate training, workers are unfairly put into situations in which they are unprepared to deal with the needs of all clients. This is particularly the case in relation to care of people with dementia and complex needs.

RECOMMENDATION 10: that a minimum qualification at the Certificate III level be introduced for the aged care workforce.

RECOMMENDATION 11: that the State, Territory and Federal Government come together to implement a Certificate III in Care Support as per the Skills IQ Review.

RECOMMENDATION 12: Aged Care providers are required to demonstrate the provision of ongoing training, through federal funds allocated, in order to continue operating and receiving funding.

RECOMMENDATION 13: while TAFE is the provider of choice, oversight measures for Registered Training Organisations should be reviewed and strengthened to ensure the quality and consistency for those seeking training to enter the aged care sector.

Mandated Minimum Qualification

There are currently no mandated minimum qualifications for aged care workers. However, there are high levels of relevant formal qualifications within the workforce. The 2016 Workforce Census shows that a Certificate III in Aged Care is the most prevalent foundational qualification. A Certificate III in Aged Care is held by 54.6% and 44.4% of the direct care workforce in residential and home care respectively.

Completion of Certificate III qualifications by Residential Direct Care workforce, by occupation[25]

Occupation	RN	EN	PCA	AH	All DCW
Certificate III in Aged Care	13%	32.5%	67.4%	35.8%	54.6%
Certificate III in Home and Community Care	1.3%	4.2%	12.0%	8.2%	9.5%
Certificate III in Disability	0.6%	1.4%	5.2%	2.%	4.0%

Completion of Certificate III qualifications by Home Care Direct Care workforce, by occupation[26]

Occupation	RN	EN	CCW	AH	All DCW
Certificate III in Aged Care	4.4%	28.0%	50.90%	12.5%	44.4%
Certificate III in Home and Community Care	0.4%	3.1%	26.6%	6.9%	22.8%
Certificate III in Disability	0.2%	4.0%	8.6%	3.5%	7.5%

We believe that a requirement for a minimum qualification at the Certificate III level should be introduced. While workers have further qualifications relevant to the requirements of their occupation, mandating a minimum qualification assures that workers enter the sector with a level of knowledge and skill upon which to build and that may be transferred and recognised across the industry. This in turn will foster confidence in the sector amongst workers, clients and their families.

The requirement for a mandatory qualification to enter the workforce will not become a barrier to entry where appropriate mechanisms are place to address issues such as cost, accessibility and to provide genuine exemptions for hardship.

Providing Vocational Education and Training

Aged care providers and UWU members have raised concerns about the quality of vocational training, and resultant value that should be placed on Certificate III qualifications. Concerns about training quality do not undermine mandating a minimum qualification. Instead, these concerns highlight the need for government to fulfil its role as the system steward of aged care and leader in workforce planning and development.

In the union's experience, the delivery of training by some Registered Training Organisations is particularly questionable.

"What we need is more experienced carers. Not new carers that do not know what they are doing. It is not fair on residents and carers. We are dealing with the elderlies' lives."

"People should not be allowed to do a 6 month course and then be qualified to work in aged care. They have no idea what they are doing and it's not fair on the elderly that end up getting these care staff."

"It took me 9 months to get qualified through TAFE. Stop doing six week courses to qualify to be a carer."

A mandated minimum qualification must be deliverable through TAFE as the provider of choice. TAFE is the only vocational education and training provider that operates nationally, including in regional Australia, is motivated by the nation's educational needs rather than profit, and is directly accountable to government for its efficacy in this role.

While the Federal Government is the only one capable of mandating and regulating a minimum national qualification, TAFE is also governed and funded on a State and Territory level. Currently, course costs, available subsidies and modes of teaching in Certificate III in Individual Support vary across TAFEs nationally. For example, the Certificate III in Individual Support is a priority course that is tuition free in Victoria, while course costs will be halved in 2020-21 in Western Australia.[27] State, Territory, and Federal Governments must come together to develop a Certificate III qualification for aged care that is contemporary, consistent and accessible.

UWU has been part of the Skills IQ Review of Certificates III. We endorse the introduction of Certificate III in Care Support with specialisations in Ageing, Disability, and Home and Community.

As the public, government-funded vocational education and training provider, TAFE must be prioritised in education funding by governments. Funding to TAFE will need to be increased to meet demand for a mandated minimum qualification for current and prospective students.

While there is space for Registered Training Organisations, oversight measures for organisations should first be reviewed and strengthened. All non-TAFE organisations holding out vocational qualifications should be registered to ensure that those seeking training to enter the aged care sector are not short-changed.

Role of Government

Providing ongoing training for the aged care workforce is firmly within the remit of the Federal Government to lead workforce development. As discussed in Section Two, enterprise bargaining delivers variable outcomes in differing agreements across aged care providers. Further, in our experience it has been difficult to improve enterprise agreement terms and conditions in relation to education and training.

For these reasons, it is imperative that federal funding bodies ensure that training costs sit with providers or government, not workers. As will be explained in Section Three, workers are increasingly expected to complete training online and in their own unpaid time. Workers must be compensated for the time taken to do work-related training.

As discussed at Section Two, there are currently means to monitor providers' use of funding, including in relation to education and training. Providers should be required to demonstrate the provision of training and professional development with federal funding.

Ongoing Training and Professional Development

While a mandated minimum Certificate III qualification ensures workers are equipped to enter the sector, ongoing training and professional development must support workers to continue developing skills, knowledge and expertise to provide high quality, individual-centric care.

The 2019 UWU/HSU Survey showed that the content and calibre of training provided to aged care workers in the course of their employment varied widely.

"Quality of care decreases as many new staff aren't adequately trained or have little experience."

Further, UWU members report that providers are cutting back on the amount of training provided to workers. The range of training provided to workers has decreased, as well as the frequency of training. Further, much of the training provided is online rather than face-to-face and must be completed outside of work hours.

Aside from issues of work-life balance, online training can be problematic for workers who have language or literacy difficulties, and for workers who do not have adequate and affordable access to computer and internet facilities outside the workplace.

While there is a place for online training, it should not displace face-to-face learning. Simply providing access to training, without having regard to its quality or appropriateness, will not result in quality support services. What is required is access to ongoing professional training that provides an appropriate balance between theory and hands-on experience. Issues with training by providers also reinforce need for a mandated minimum Certificate III qualification to provide foundational, practical training for the aged care workforce.

Specialised Training

UWU believes there should be the opportunity for workers to obtain additional qualifications in specific areas, such as the care of persons with dementia, palliative care and mental health. This training will deliver better care and when linked to wages will develop career pathways for workers which is crucial to offering practical policy solutions to retention issues.

"I believe we can always improve quality of care by undertaking extra training especially in dementia and palliative care."

Workforce Mentoring

UWU members are eager for more opportunity for ongoing workplace learning through workforce mentoring. For example, buddy shift arrangements would provide less experienced workers opportunity to work alongside more experienced colleagues. Peer support is of particular utility to home care workers due to the highly desegregated nature of work outlined in Section Two.

SECTION FOUR - STAFFING MODELS

> *"I am tired of hearing the media reports saying carers no longer have empathy – we do! We just don't have the time."*

The immediate challenge facing the aged care sector is to build and retain a workforce large enough, and with the necessary skills, to meet increased demand and complexity of care while maintaining quality care. As our population ages and the demand for aged care services increases, the workforce will need to increase to meet this demand. People using aged care services today, on average, have more complex needs, and require supports beyond basic physical care including social and emotional care. Despite this, staffing levels have not evolved to meet increased demands and current. Further, proposed funding models devalue the importance of the psychosocial dimensions of care that we know to be consistent with quality.

RECOMMENDATION 14: that in consultation with the sector, the Federal Government develop a mandated minimum staffing model for aged care that meets the total care needs of all residents, including physical, social and emotional needs, provided by a workforce skilled to deliver such care.

Understaffing

There is a clear link between staffing numbers and the quality of care people can expect to receive in aged care.[28] Quality of care is highly dependent upon adequate direct care staffing levels. If staffing levels fall below minimum staffing levels then quality of care is compromised, causing increased morbidity, reduced life expectancy, loss of mobility and increased mental and physical frailty of residents.

It is important to acknowledge that most modernised healthcare systems have a staffing model for aged care.[29] However, there are no comprehensive, uniform regulations regarding specified minimum staffing levels in aged care in Australia.[30] The current Australian system of accreditation does not prescribe specific staffing levels beyond a requirement for a "sufficient skilled and qualified workforce" and does not, as a matter of course, provide specific information about staffing levels in the publicly available reports it produces on residential facilities.[31]

There is a lack of access to timely and comprehensive workforce data. The Australian Government does not routinely capture workforce data beyond the four yearly National Aged Care Workforce Census and Survey **(Workforce Census)**.

The most recent available workforce data from the 2016 Workforce Census indicates that there has been no increase, but a slight decrease, in the ratio of full time residential aged care workers to operational places between 2003 and 2016.[32] This is in conflict with the increased need of aged people in residential care.[33]

"Our residents are more complex, requiring more staff but no staffing changes in 15 years - it has been the same [despite] more complex work and time required. Staff just have to deal with the load and manage due to staff budgets."

"Funding does not reflect cognitive decline and the increased care needs of someone who may be mobile, but has poor insight and cannot remember from one second to the next what needs to be done. Funding does not also reflect the increased need for structured activities and managing difficult behaviours. I work in a facility that probably has 80% with cognitive decline…I love my work, but would like to see greater staffing levels for these residents also."

"Over the past 15 years in nursing I've observed older people in all settings with more complex care needs."

"The more complex one person's needs are, the less time you get to spend on another resident. When you are short staffed this becomes a nightmare."

"As we have more duties, the time required to complete care increases. Stress levels increase as no new staff are appointed despite management being aware of increased needs of each resident. We cannot operate continually on existing staff numbers. Increased workload surely means more staff needed."

"The ratio of staff to consumer has not increased with the increased consumer needs and complexities leading to staff burn out."

This pattern of understaffing in aged care is consistent with the workforce experience reported to the union. Aged care staff report that the care needs of residents have increased because residents are entering residential care more unwell and less mobile than previously, but that there has not been a corresponding increase in the number of staff on shifts. The 2019 UWU/HSU Survey found that 75% of union members have noticed a reduction in staffing numbers over the last two years. 74% of workers reported having to hurry up or rush residents to get through their work and 81% of residential workers stated that they always or often do not have enough time to undertake necessary tasks. Further, 93% of residential aged care staff said that they have seen an increase in residents having complex care needs while they have been working in aged care.

The most consistent workplace issue raised by union members is the lack of time they have to provide quality care that is adequate, appropriate and respectful to the people in their care. This is not simply referring to time pressures and deadlines that are reflective of many modern workplaces. This is the inability of the aged care workforce to provide basic and fundamental support to people in their care in the time they have available to provide such care.

UWU members report being forced to rush through basic tasks such as showering, feeding and dressing in residential aged care and are limited to, in some cases, 15 minute visits in home care.

Members often tell us about working unpaid overtime in order to do their job to their satisfaction, to complete tasks or just to be able to spend time with those they care for.

"When there isn't enough staff people are left in their own poo and urine soaked clothes. We are not able to shower them properly."

"I work in an aged care facility and there only two carers to 42 residents on a shift. This means that the concept of personal care no longer exists – we just don't have the time to provide the individual care residents deserve."

"We are always understaffed and the workload is terrible. You have got 12 residents. You have got to do the medication, plus do your showers, do the breakfast. You might have to bring them up tea – a thousand jobs you have to do: get the clothes from the laundry, plus having to be cutting nails, heat packs. It goes on and on. It's like a conveyer belt. I am sorry, but that's what it is, because you do not have time to sit with this resident for 25 minutes. You just do not have the time. It is just terrible."

"I'm often too scared to call in sick when I need to because they will be short and upset with me because of it. Staffing ratios [are important] because sometimes I need help with a two person lifter and no one can help, so I have to wait longer than I should until someone can. We are running around and getting everyone later than ideal because it's hard. I'm feeling sore, run down and stressed to go to work and to get the job done."

Safety

Where there is not enough time to care, the quality of care someone receives will suffer and there will inevitably be an increase in clinical errors. Care workers and other staff report that having to rush through their tasks and hurry up residents leads to stress for both staff and residents and increases the likelihood that accidents or injuries to either staff or residents may occur. 67.5% of residential aged care staff reported that they often or always have to do things by themselves when more staff are needed.

"It means we are always rushing and things get skipped. It's very stressful and it compromises resident care."

"Lack of staffing causes poor care and dangerous situations, particularly in the case of dementia."

"Working understaffed mean that small problems get overlooked leading to them becoming bigger problems."

"Staff are often having to choose between a safe practice and an efficient practice. Not having time to fill out forms, handover information to staff."

A 2017 research survey on missed care in Australian residential facilities found that all care activities surveyed were missed at least some of the time.[34] This included tasks relating to complex heath care needs such as intravenous or central line care as well as those relating to comfort and dignity such as feeding residents while food is warm and assisting with toileting within five minutes. The research report concluded that one of the primary reasons for missed care was staffing shortages.[35]

Staffing shortages are a health and safety risk to workers, as well as residents and care recipients. Workers are increasingly placed in demanding and dangerous situations due to insufficient staffing and support. Workers face physical injuries and the emotional toll of care work is compounded by high workloads. The negative effects of staffing shortages are exacerbated by increasing complexity of care. Personal care work inherently entails a level of risk that must be mitigated through practice grounded in occupational health and safety. As the experience of behavioural and mental health conditions such as dementia increases, increased risk of harm to staff has gone unchecked by the existing staffing model.

"We feel like they expect for us to make miracles and safety is not considered. It is really hard working [short-staffed] in high care as a lot of people are two-assist, which means they have to use two staff for part of their care needs. In particular you need two people to lift them in or out of the bed or a chair."

"The extremely heavy workload every single shift. It's not fair having to work so hard and fast every single shift. It's physically and mentally very draining."

"The abuse from residents is only going to get worse. I have had broken wrists from residents grabbing on, saying, 'No, I don't want to be moved. I don't want to shower. I'm not going to eat,' so they grab your wrists. Your wrists get pretty tender after a while, so I have had both wrists broken quite a few times. I have had my arm pulled out of its socket and ribs taken off the front and the back by that injury. That took me two years to come back from. I have been stabbed with scissors. I have been stabbed with forks. I have been pushed, punched, kicked, had hair pulled out from people who do not know what they are doing. That is the risk that we take every day when we are out on the floor".

Case Study

I have been working in aged care for over 20 years. The stress and burnout in aged care are huge! The job is physically, mentally and emotionally exhausting. I can feel the repetitive strain injuries I have developed in my back, feet and shoulders. It is wear and tear on joints and soft tissue from the physical nature of the job. Because it is a repetitive strain, you can't really do anything about it. Mentally it is stressful with the high workloads and constant changes to the sector. We also manage challenging behaviours with increasing dementia and complex mental health needs. All of this has a negative impact on the future of the workforce. A lot of my co-workers tell me they anticipate leaving the sector within the next few years because of these issues. They're workers who are experienced and highly skilled carers, so it is very disheartening.

Reablement

The sense of urgency and pressure to finish tasks in a context of chronic understaffing means there often isn't time for workers to respectfully deliver true person-centred care. This isn't limited to the emotional and social aspects of care as will be further discussed below, but having the time to promote a person's independence.

In the 2019 UWU/HSU Survey, 74% of workers reported having to hurry up or rush residents to complete their workload. For example, residential aged care workers report transporting residents the dining room in wheelchairs to save time, although the resident is physical abled. This is in direct conflict with person-centred care. The current staffing model does not support workers to promote independence.

Case Study

The hardest part of my day is the early morning as it has become so difficult to get residents ready for the day. The morning starts off very busy, with residents already knowing they will not get a chance to relax. It is difficult to get Mrs Haye out of bed in the morning because of her sore knee and back, but it is even more heartbreaking to operate within such a short time frame for toileting, showering and getting her ready for breakfast. I don't have a lot of time to shower, toilet and dress residents, so I need to act quickly. I want to give my residents a sense of independence, but by not having enough time to do personal care tasks with them, you end up taking that independence away. It makes me feel so sad that I have to do this – they are human beings with emotions. This is where [I] see the biggest impacts of the funding cuts in not having enough time for personal care activities for residents.

Social and Emotional Support

The lack of time to care for physical needs is compounded by the complete lack of time to care for emotional needs. Members consistently report that they do not have time to support older Australians at a suitable or emotionally sensitive and dignified pace. They do not have time to provide what they see as essential care, for example, cut a resident's nails or sit with a person for an extra few minutes while they are dying. Members are concerned that they do not have time to spend quality time with older Australians when they are sad, lonely or just need some company. Ironically it is these things that residents report most valuing; the time to make connections with their carer.

Isolation is a real problem for many older Australians and our members are often their main regular social contact. As many as 40% of aged care residents report receiving no visitors.[36] The 2019 UWU/HSU Survey found 93% of residential aged care staff report that there are residents in their care who don't have family or friends visiting regularly. Further, 96.7% say that residents want them to stop and talk to them, and 90.7% of residential aged care staff say that there are times when residents need them to spend more time with them and they have to say no because they have too much other work to do.

"Staff numbers mean that the quality of care is cut short so that basic daily needs are met. Residents are left without being supported emotionally, palliative care is not being tended to properly and morale within the work place for both staff and residents is low."

"When a resident wants to talk to you because they're feeling sad and just need to talk to you. It's difficult because we don't have enough time as we have so many other residents to get up, and that you get so stressed out but also feel for the resident that really wants to talk to you."

"We need more time to sit and have a cuppa and just listen to them instead of rushing them. Taking them out make them feel like they are still part of a community and are valued."

"Spend time with them as people not just when providing aid. A simple task like a jigsaw, knitting, cooking, a coffee and chat, a walk in the gardens, doing gardening ect improves their happiness which in turn improves their physical and emotional health."

"The lack of time able to spend with residents to not only complete their basic daily needs but also attend to their social needs, it might only mean spending another five to 10 with each to impart that social chatter needed whilst attending to basic needs."

A 2019 UNSW, Macquarie University and RMIT report analysed a range of consumer experience studies and concluded:

"Older people's assessments of residential care quality emphasise the social and emotional dimensions of life and care, including good relationships with care staff, staff having time to care, feeling at home and feeling valued. Family members also highly value these dimensions."[37]

This same report found that direct care staff also view quality care as that which allows for care and support that goes beyond the physical and that allows relationships to develop between staff and residents.[38] This can only happen when care workers have the time to provide quality care.

Case Study

I've worked as a carer in aged care for 46 years across multiple organisations. I started when I was only 15 years old. Nowadays, it would be very rare to see a 15 year old working in aged care as times have changed. The job of a carer has also changed dramatically in my time. Now the increasing complexity of care needs is a real issue for carers. So many people are coming into aged care as residents further along in their life. At the beginning of my career, people came into aged care as residents at a low care level and would enjoy 10-15 years at the facility. Now, people coming into aged care tend to be at the end of their life and we only really have them for 2 years before they pass away. This significant change has increased not just the physical demands of the job, but also the mental and emotional demands, as carers constantly have to say goodbye and deal with grief more regularly. The workload has increased so significantly over my 40 year career. So now, our time on the floor is very limited. We simply don't have time for providing emotional support to residents like we used to. Yet, at the same time, the residents in need of emotional support is greater than ever before. Over the years, carers have seen the burden of paperwork increase and therefore the hours spent with residents has decreased. Now it is all about getting things done as fast as possible and then doing paper work - yet all we want to do as carers is to be on the floor and care for residents. We need more time with residents, not at a computer justifying every dollar. In essence, we need more funding for quality care.

Skill Mix

Addressing the chronic understaffing in aged care needs to be considered within the context of employing the right mix of a qualified and experienced workforce vital for the delivery of safe and quality aged care services. It is important to acknowledge that while there has been a significant amount of academic research regarding staffing models in aged care, the vast majority has been in the context of the nursing workforce. Despite the fact that they comprise 70% of the workforce, there is a lack of academic research prioritising the role of personal care workers in the wider aged care team.

There is clear evidence which links an appropriate skill mix with positive patient outcomes in a health services context.[39] There are significant risks to patients of understaffing and providing an inadequate skill-mix; including compromised safety and diminished quality of care; increasing morbidity and mortality and an increased occurrence of adverse events.

Concerns have been raised that the skill mix in the aged care workforce has not adjusted with a corresponding level of increased care. According to the 2016 Workforce Census, the aged care workforce is comprised of 70% personal care workers, 15% registered nurses and 10% enrolled nurses. The proportion of personal care workers has continued to increase from 58% in 2003. Personal care workers comprise the largest cohort of workers in the aged care team and are integral to the provision of safe, efficient and high-quality aged care.

UWU believes that an appropriate skill mix for the aged care sector is one that optimises the skills and capacity of each layer of the aged care team and enables all workers to work to their maximum scope of practice or capacity. Employing the right mix of a qualified and experienced regulated workforce is vital and cost savings should never be at the expense of providing quality care. However, an appropriate skill mix must be one that operates within the reality of funding constraints.

Nursers play a vital role in providing safe and quality aged care services. There is a definite need for a nursing presence on every shift in residential aged care and nursing support available on every shift in home care. However, as supporting the activities of daily living comprise the bulk of daily care, we are cautious about an approach to workforce planning which would significantly reduce the number of personal care workers in the aged care team and replace them with a professional workforce such as nurses and allied health.

There is a body of research that indicates scope to change the skill mix in the nursing workforce in the broader health sector whilst maintaining safe, quality patient care.[40] Drivers for such change include freeing up of the regulated nursing workforce resources to be employed in more complex practice activities, cost savings delivered by a changed skill mix, as well as increased job satisfaction for highly-trained professionals performing the role they were trained for, with likely consequent effects on workforce retention.[41] These outcomes will have positive flow on effects for patient care.

This can be similarly applied to the aged care sector. The activities of daily living and social and emotional supports that are predominantly understaffed fall within the scope of practice of personal care workers. Increasing the number of nurses within the workforce will not necessarily solve this issue, unless nurses are employed to undertake these tasks that fall outside of what they are qualified to do.

An approach to workforce planning that optimises the skill set of each member of the aged care team, and addresses weakness in skill capacity (for example providing upskilling for personal care workers in specific care issues such as dementia) will likely result in more efficient use of the workforce and may address some attraction and retention issues by enabling workers to provide the levels of care they are trained to do.

Further, there is a strong economic and pragmatic case for maintaining the proportion of personal care workers in the workforce. Personal care workers can be trained and deployed into the workforce at a faster and cheaper rate than nurses or allied health professionals. With a budget under significant pressures, and a massive increase in workforce demand, this will ensure available funding is utilised in a manner that both optimises patient outcomes and is fiscally responsible.

Minimum Staffing Model

UWU believes a mandated staffing level and skill mix model in residential aged care is essential to address workload and care deficits. A model should be developed that establishes, based on residents' physical, social and emotional needs, what a minimum number and mix of staff should look like.

UWU agrees with the position that static models or set staffing ratios will not assist in meeting these expectations or necessarily result in better quality of care outcomes. UWU proposes a model that can average across residents and encompasses all of the aspects of care rather than a strict numerical ratio of staff to residents. For example, the Nursing Hours per Patient Day model for nurses in Western Australia's public hospitals is not simply a flat staffing ratio, but is flexible enough to take into account patient acuity.

One option is a staffing model based on care hours per resident, encompassing all aspects of care including physical, social and emotional. The model would prescribe a minimum staffing level allowing providers of aged care to exceed this minimum where they wish to.

UWU believes the underlying principle of any staffing model should be that residential aged care is a person's home, where all their social, physical and emotional needs as well as medical needs should be met and supported. Any model should grant residents independence and provide the right kind of staff to support them to have the best possible quality of life. A model whereby emotional and social supports are considered a bonus if a worker has a few spare minutes, or are provided only to those residents who are able to pay a top level of fees, is unacceptable.

Staffing models or systems should be developed for in-home care to ensure minimum visit times are adequate and workers have time to spend with recipients of care as necessary. In-home care models should also recognise the unique difficulties of working in isolation in people's homes and should include the capacity for workers to come together regularly in paid time for training and peer support. The model should allow for adequate supervision and support via buddy shifts where workers are new or where there are particular safety concerns.

University of Wollongong Report

Given the importance that is placed on social and emotional aspects of care by both workers and residents, UWU has some concerns that the University of Wollongong report (UoW Report) focuses too heavily only on providing clinical and physical care only. While these are obviously very important aspects of care, they are not the totality of care and support that makes for quality care.

As noted above, UWU provided a response to the Proposal for a new residential aged care funding model consultation paper, which emphasised our concerns that the proposed new funding model does not adequately address this aspect of care (see attached).

UWU favours an approach to staffing that addresses care hours and meeting the physical, social and emotional needs of care recipients. On this basis the model recommended by the UoW Report, the USA Centers for Medicare and Medicaid Services (CMS) Nursing Home Compare, does seem to be a possible model that could be adapted to the Australian context. However, we would not support this model without further detail and consideration of how it might work in an Australian context.

Some issues for consideration include;

Ability to fall below minimums standards

While minimum staffing levels should be mandated, providers must not be able to fall below these minimums. Therefore in the example of the recommended model where ratings 1 and 2 represent unacceptable levels there should be no levels 1 or 2. The minimum should start at acceptable and go up from there.

Given the report found currently 57.6% of resident are in residential facilities that have an equivalent 1 or 2 rating, this would require an average increase of 37.3% in staffing to meet the 3 star rating. This is a significant gap in current care delivery. An increase in staffing that would meet these benchmarks would require significant additional funding.

Case mix staffing

We are concerned of the practicalities of matching staffing to a case mix funding model. It is neither feasible nor desirable to have a staffing model that needed to constantly change to meet a changing mix of residents. This could have the perverse incentive of leading to greater casualisation of the workforce and less stable and secure jobs. Any staffing model must ensure permanent stable jobs or it will not be sustainable.

Funding

As noted above, the increase in staffing to meet the benchmarks of the recommended model would require significant additional funding. In addition to the funding required for a numerical increase there is also the issue of the current undervaluation of the workforce and the impact this has on attraction and retention. UWU agrees with the UoW report that there should be accountability mechanisms in place to ensure funding goes to staffing and improved outcomes for residents.

Quality care

UWU is supportive of a mandated minimum staffing model that meets the total care needs of all residents. We believe the question of whether the American CMS system is the right system for Australia requires further consideration. Any mandated staffing model has to be in conjunction with a funding system that is transparent and accountable and adequately funds the increased staffing needed. It must also be considered within the broader scope of increasing the base qualifications for personal care workers and expanding professional and career developments.

SECTION FIVE - REGISTRATION

> ***There are many vulnerable people in the community and they need to feel confident in, and develop trust, with workers to know that they will receive a high standard of care in a friendly, professional manner.***

UWU members are concerned by the numerous accounts of misconduct and poor quality services that have been uncovered in the Royal Commission proceedings.[42] It is important to recognise that most aged care support services are delivered in a way that does not put people at risk. However, we know that abuse, neglect and exploitation in service environments do occur and these accounts being voiced in the Commission, while concerning, unfortunately are not surprising.

UWU supports the introduction of a pre-employment screening and registration scheme for the non-clinical aged care workforce through a regulatory body that is appropriate to the skills, roles and professional expectations of this cohort of workers. Registration should be predominantly concerned with the issue of safeguarding elderly Australians and enhancing the quality of the aged care workforce. Registration for aged care workers must be separate from existing clinical registration for health professionals.

Successfully safeguarding an individual requires a myriad of safeguards that will operate differently for each individual. We recognise that age itself does not necessarily make a person vulnerable to mistreatment. However, some people may be more vulnerable due to their specific circumstances including; isolation, incidence of morbidity, mobility constraints, dependence, lack of community relationships and language or communication barriers.

Appropriate pre-employment screening is one key safeguard, however it cannot be the sole safeguard at the expense of other protective measures. Simply because someone may hold a professional registration, it does not automatically follow that they will not pose a risk. Evidence and allegations of misconduct in the sector are not isolated to the unregistered workforce. While registration for the aged care sector is an important safeguarding strategy, it should not be intended as the sole means of safeguarding those who access services.

RECOMMENDATION 15: the Government develop a pre-employment screening and registration scheme for the non-clinical aged care workforce through a regulatory body that is not AHPRA, appropriate to the skills, roles and professional expectations of these workers and will not create excessive, inappropriate or false barriers to entry.

RECOMMENDATION 16: the Government extend whistle blower legislation to all sector employers to support and encourage workers to speak up without fear of being persecuted or targeted where a report is made in good faith.

AHPRA

It has been suggested by some stakeholders that the Australian Health Practitioner Regulation Agency (AHPRA) is the appropriate body to regulate registration for non-clinical aged care workers. UWU strongly disagrees with this position. Non-clinical aged care workers should not be required to apply for registration through a clinical registration body such as AHPRA.

AHPRA regulates health professionals, typically occupations that require university qualification, such as doctors, nurses, dentists, psychologists and physiotherapists. AHPRA is primarily concerned with the clinical skills of these workers and how they perform in relation to those clinical skills.

It is incorrect to suggest that aged care workers do similar work to nurses so therefore they should be held to the same regulatory standards. Aged care workers comprise the majority of the workforce and are essential in the delivery of safe and quality aged care services. However they are not nurses. They hold very different positions and are trained in a very different way. Direct care work is not embedded in the provision of nursing care, it is not simply a subset of nursing. While nurses are predominantly focused on the clinical aspects of care, aged care workers cover a wide range of tasks including physical and emotional needs such as daily activities of living including cleaning, cooking, feeding and showering.

It is wholly inappropriate to hold aged care workers to the same clinical and professional standards as health professionals who have legislated standards and scope of practice, and enjoy commensurate remuneration and working conditions.

The cost of registration needs to be considered. The current registration fees for the Nurses and Midwifery Board are $475 for the first year and an ongoing annual payment of $175. This fee structure is wholly inappropriate for personal care workers. The cost itself would be prohibitive and would leave low paid workers unfairly subsidising the system.

We also have concerns about a formal complaints mechanism that would apply through a regulatory body such as AHPRA, particularly in the context of a culturally diverse workforce. Overseas born workers comprise a significant proportion of the aged care workforce. In 2016, 32% of residential workers and 23% of home care workers were recorded as being born overseas.[43]

Aged care residents are a microcosm of our diverse society. It is an uncomfortable truth that racism exists across our community and is an issue affecting both the culturally and linguistically diverse people entering into aged care and the workforce. It is important to acknowledge that many of our members have direct experience of racially motived abuse from residents in their care. Such instances will likely be worsened in the context of increasing numbers of residents who suffer from dementia and other mental illness going into aged care services. In the absence of sufficient safeguards, an external complaints mechanism that is linked to an individual's registration will unfairly impact on workers from culturally and linguistically diverse backgrounds.

"Most of the African workers have been in trouble and get sacked. The same resident calls African workers her slaves. Our FM, Clinical nurse manager sees the abuse we experience from the resident yet management does nothing. The resident verbally abuses us and uses racial slurs towards us. I wrote the incidents of racial abuses in the progress notes and I was told by the FM to remove it. I did not remove it. People should know what we are experiencing."

Further, AHPRA's specific guidelines about English language requirements may be challenging for a large proportion of the workforce that are culturally and linguistically diverse.

The 2019 UWU/HSU Survey supports the understanding that the aged care population is also increasingly culturally and linguistically diverse. As such, culturally and linguistically diverse workers possess a valuable ability to speak to older people in language and bring firsthand cultural understanding to care. Also CALD workers often bring a cultural respect for Elders which is reflected in their care. A culturally and linguistically diverse workforce should be celebrated and supported in their provision of social and emotional care.

"Non-English speaking residents becomes isolated and time consuming for staff as we try to understand their needs, especially when there is no or limited family/friends support"

As has been highlighted in this and many other submissions, this is a low-paid, low-hour workforce and creating excessive, inappropriate or false barriers to entry would not be sustainable in a sector that desperately needs more staff.

Model for Registration

In general, a registration model for the aged care workforce should provide for;
pre-employment screening, a national positive registry of workers, provision for a mandated minimum entry qualification at a Certificate III level, and a requirement for ongoing training and professional development. It should be low cost and be able to cross-cover disability workers in the long term. Any registration model must also have a clear no-cost appeals process.

This is a low-paid, low-hour workforce that urgently needs more staff. Any model for registration must respect this reality and appropriately safeguard against creating any inappropriate or excessive barriers for entry. For example, it must be low cost, have a speedy and clear process for registration, and must be worker friendly and respect worker rights.

The registration model could be akin to the model being rolled out as part of the NDIS Quality and Safeguarding Framework. Worker screening under the NDIS is a way to check that the people who are working, or wish to work, with NDIS participants don't present an unacceptable risk to people with disability. It provides registered NDIS providers with an important tool for their recruitment, selection and screening processes, and assists in the ongoing review of the suitability of workers.

While registration for the aged care sector is an important safeguarding strategy, it should not be exclusively relied on to protect aged care consumers. Where registration models exist, they have not been shown to eliminate all undesirable behaviour. Government investment to address adequate staffing numbers, working conditions and to support training and professional development for aged care workers will have a more significant and lasting impact on the quality of the workforce and therefore the quality of care that elderly Australians can expect to receive.

Whistle Blower Legislation

The requirement for some sector employers to have a whistle blower policy in place by 1 January 2020 is a welcome intuitive for the sector. However, UWU believes that whistle blower legislation should be mandatory for all sector employers to support and encourage workers to speak up without fear of being persecuted or targeted by their employers where a report is made in good faith.

Merely having established complaints procedures will not be a sufficient safeguard in a workplace culture where workers are disinclined or are not supported to make a complaint or raise a concern. Further, as the workforce is characterised by casual and low hour workers who are subject to changing rosters, this may affect the likelihood of whistle blowing due to fear of consequences.

A workplace culture where people are supported and encouraged to speak up requires an accessible, transparent and robust complaints system that workers have received appropriate education and training, and a national whistle blower policy that allows workers to raise concerns without fear of persecution. Protecting potential whistle blowers at law will improve workplace cultures and attitudes to raising concerns.

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