FAIR WORK COMMISSION
MATTER NUMBERS AM2020/99; AM2021/63; AM2021/65

WORK VALUE CASE – AGED CARE INDUSTRY

SUBMISSIONS OF THE COMMONWEALTH

A. INTRODUCTION AND SUMMARY

1. This submission is made on behalf of the Commonwealth of Australia in accordance with the Directions of the Full Bench of the Fair Work Commission (**Commission**) on 6 June 2022.

2. These submissions are structured as follows:

   2.1. **Part B** of these submissions sets out the Commonwealth's response to the request by the Commission in its statement of 20 June 2022 ([2022] FWC 102) for information regarding the aged care sector.

   2.2. **Part C** of these submissions sets out the Commonwealth's response to the provisional views of the Commission, as identified in its statement on 9 June 2022 ([2022] FWCFB 94).

   2.3. **Part D** of these submissions provides the Commonwealth's response to Questions 2, 4 and 5 posed by the Commission in *Background Document 1 — The Applications* and in the Statement of 9 June 2022 ([2022] FWCFB 94).

   2.4. **Part E** of these submissions sets out the Commonwealth's submissions on the modern awards objective.

   2.5. **Part F** of these submissions provides the Commonwealth's response to the issue of modern award classification structures.

The Commonwealth's position

3. The Final Report[1] of the Royal Commission into Aged Care Quality and Safety (**Aged Care Royal Commission**), published on 1 March 2021, made 148 recommendations to improve the aged care sector. Recommendation 84 specifically recommended that the Commonwealth collaborate with employers and employee organisations to seek to vary

[1] Digital Hearing Book (**HB**), tabs 355–362.

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the modern award minimum wages in the *Aged Care Award 2010* (**Aged Care Award**), the *Social, Community, Home Care and Disability Services Industry Award 2010* (**SCHADS Award**), and *Nurses Award 2020* (**Nurses Award**) to reflect the work value of aged care employees.[2] The Commonwealth recognises the importance of this recommendation, and makes this submission as part of its commitment to implement aged care reforms. It is the work of the employees affected by these Applications which will be critical to implementing the reforms recommended by the Aged Care Royal Commission. The Commonwealth supports a minimum wage increase for aged care workers. The Commonwealth submits that the work value of aged care workers is significantly higher than the modern awards currently reflect.

4. The Commonwealth also wishes to acknowledge the ongoing commitment and dedication of the aged care workforce and the additional effort and burden placed on these workers during the COVID-19 pandemic in supporting the safety and care of older Australians.

5. The Commonwealth is the principal funder in the aged care sector.[3] The Commonwealth will provide funding to support any increases to award wages made by the Commission in this matter and that will help deliver a higher standard of care for older Australians. The Commonwealth would also welcome an opportunity to work with the Commission and the parties regarding the timing of implementation of any increases, taking into account the different funding mechanisms that support the payment of aged care workers' wages.

6. The Commonwealth supports the Applicants' argument that strengthened regulatory demands in the sector have increased the expectations of the workforce to have the skills and attributes to deliver a higher standard of quality and safe care while also placing additional administrative requirements on many workers. This is particularly the case for the roles of personal care workers (**PCWs**), enrolled nurses (**ENs**) and registered nurses (**RNs**) in residential aged care and in-home aged care settings. It is also relevant to categories of ancillary workers including cooks, cleaners and administrative workers. For the reasons addressed in Part B of these submissions, the Commonwealth submits that these strengthened regulatory demands contribute to the work value of aged care workers being significantly higher than the modern awards currently reflect.

7. The Commonwealth further submits that a range of skills and other factors relating to the work value of aged care workers have not previously been recognised when setting the modern award minimum wages for the overwhelmingly female employees in the aged care sector. As set out in more detail in Part D of these submissions, the Commonwealth agrees with the Applicants that the undervaluation of caring work in the aged care sector has, in part, been driven by gender-based assumptions about the work value of that work. The Commonwealth submits that this contributes to the work value of aged care workers being significantly higher than the modern awards currently reflect.

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2 HB, tab 355, page 20090.

3 HB Tab 116, page 815-817 (Commonwealth response to ANMF request for information and Data).

8. The Commonwealth also agrees with the Applicants that the average care requirements for aged care recipients in both residential and in-home care have increased in acuity and complexity over time, and that this further contributes to the work value of aged care workers being significantly higher than the modern awards currently reflect.

9. The Commonwealth also recognises the need to ensure that the wages and conditions of the aged care sector support the attraction and retention of sufficient workers to meet the expected growth in demand for aged care services over the next 30 years.

B. THE AGED CARE SECTOR

10. As requested by the Commission in its statement on 20 June 2022 ([2022] FWC 102), these submissions address the nature of the aged care sector, including:

    10.1. data on the composition of the aged care workforce, which is set out in Annexure A to these submissions;

    10.2. a profile of the employees employed in the aged care sector (by classification and qualification, where available), which is set out in Annexure B to these submissions;

    10.3. the Commonwealth's regulation of the aged care sector; and

    10.4. the current funding model (the Aged Care Funding Instrument (**ACFI**)) and the transition to the new funding model (the Australian National Aged Care Classification (**AN-ACC**)).

Data relied on

11. The majority of the Commonwealth's data on the aged care workforce originates from the Aged Care Workforce Censuses (**ACWC**), completed in 2003, 2007, 2012, 2016 and 2020. These provide a point-in-time snapshot of the size of the workforce, the numbers of each type of worker, additional qualifications of workers, and some key demographic features.

12. While ACWC data has limitations, including response rates, the exclusion of aged care workers not working for a provider, and duplication of workers across different types of aged care, the ACWC provides the best quantitative descriptions of the aged care workforce over time.

13. Readily available data held by the Australian Bureau of Statistics (**ABS**), such as the ABS Characteristics of Employment publication, captures aged care workers in residential care but is unable to capture in-home care aged care workers without including a variety of other non-aged care related workers such as disability support workers.

14. In 2021 and 2022, the Department of Health and Aged Care (**DoHAC**) commissioned modelling to estimate the cost impacts and flow on effects of a wage increase within the aged care sector. This work drew upon several data sources, including the ACWC, ABS

data, DoHAC's internal aged care workforce supply and demand modelling, and the Commission's register of enterprise bargaining agreements (**EBAs**).

Profile of aged care employees

15. Australia has approximately 365,000 aged care workers, across residential and in-home care. Australia's ageing population is both growing and living longer. This means there are more older Australians, often living much longer with complex and chronic health care needs. Despite this increased complexity, PCWs are now more likely than nurses to be delivering care to residential aged care recipients.

16. PCWs account for approximately 58 per cent of the aged care workforce and RNs (including nurse practitioners (**NPs**)) account for approximately 9 per cent. Most direct care workers, across residential and in-home care, are employed on a permanent part-time basis (approximately 65 per cent).

17. The proportion of PCWs with a Certificate IV in Aged Care roughly tripled in residential care (to 22.9 per cent) between 2003 and 2016, and almost doubled in in-home care (to 12.2 per cent), between 2007 and 2016.[4] Around two-thirds of PCWs hold a relevant Certificate III (2020).[5]

18. The aged care workforce is highly feminised, diverse and increasingly made up of a younger demographic. The vast majority of direct care workers in residential and in-home aged care services (over 83 per cent) and indirect care workers in residential aged care (around two thirds) identify as women.[6] Over one-third of the direct care workers in the residential aged care workforce identifies as culturally and linguistically diverse (**CALD**), with PCWs (36 per cent) and nurses (35 per cent) most likely to identify as CALD.[7] Providers with more care recipients who identify as CALD are more likely to have direct care workers who identify as CALD. The residential aged care workforce became younger from 2016 to 2020, with higher proportions of workers in the 20-29 and 30-39 age groups, and lower proportions in the 40-49 and 50-59 age groups.[8]

19. First Nations people make up a smaller proportion of the aged care workforce, making up 1.9 per cent of direct care workers in residential aged care and 2 per cent of direct care workers in in-home aged care, despite comprising of 3.2 per cent of the national population. As with the CALD workforce, aged care providers with more care recipients who identify as First Nations people are more likely to have direct care workers who identify as First Nations people.

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4 See Table B12 in Annexure B to these submissions.

5 See Table B12 in Annexure B to these submissions.

6 See Tables A3 and A4 and paragraph [14] in Annexure A to these submissions.

7 Table A9 of Annexure A to these submissions.

8 Table A8 of Annexure A to these submissions. However, consistent with [216] and [301] of the HSU's Closing Submissions, significant portions of the workforce are still in the 40-49 (19 per cent), 50-59 (18 per cent) and 60+ (10 per cent) cohorts.

20. Modelling from DoHAC indicates the majority of the aged care workforce (76 per cent of those covered by the Aged Care Award, 86 per cent for the Nurses Award, and 32 per cent for the SCHADS Award) are currently covered by EBAs.[9]

21. However, the vast majority of these EBAs have passed their nominal expiry dates. Most of these workers are paid the award wage, by default, as annual increases to the award rapidly surpassed the EBA rate.[10] Aged care workers covered by the Aged Care Award and SCHADS Award, who have active EBAs in place, are only marginally better off than aged care workers who are award reliant. These workers are typically only paid a few per cent above award wages.[11]

22. Conversely, nurses on EBAs are broadly paid 15 per cent above award rates. There is a high proportion of nominally-expired EBAs which currently exist in the aged care sector which suggests that aged care workers' current bargaining power is low compared to previous years.

Regulation of the sector

23. The Commonwealth plays a key role in the regulation of the aged care sector, with DoHAC implementing the Commonwealth Government's policy settings for the sector and the Aged Care Quality and Safety Commission (**ACQS Commission**) acting as the regulator of the sector. The ACQS Commission grants approval for providers to deliver aged care services, subsidised by the Commonwealth, ensuring compliance with their regulatory obligations and performing an educative role for providers, families and aged care consumers. Approved providers may be subject to some regulation under state and territory legislation, for example, vaccination requirements for aged care workers in residential aged care facilities. However, the vast majority of regulatory obligations in the sector are imposed by the Commonwealth.

The Aged Care Quality Standards (the Standards)

24. The Standards are set out in Schedule 2 to the *Quality of Care Principles 2014* (**Quality of Care Principles**), a legislative instrument made under the *Aged Care Act 1997* (**Aged Care Act**). The Standards were registered in 2018 and commenced from 1 July 2019.[12]

25. All approved providers are required to comply with the Standards. Compliance with the Standards is a responsibility of approved providers under Chapter 4 of the Aged Care Act.

26. Providers delivering services under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program and services under the Commonwealth Home Support

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9 At paragraphs [18]–[24] of Annexure B to these submissions.

10 Noting the operation of s 206 of the *Fair Work Act 2009* (**FW Act**)

11 This is consistent with the submission of Baptist Care, who stated that their most common classification pays 4.2 per cent award the relevant Aged Care classification: HB, Tab 126, page 877 [21]. Uniting NSW.ACT state they pay a higher above award rate: HB Tab 131, page 3122. Evergreen Life Care quote rates of $25.93/hour for PCWs and $45.20/hour for RNS, but without sufficient information to allow the comparable award rates to be identified: HB Tab 132, page 3129.

12 *Quality of Care Amendment (Single Quality Framework) Principles 2018*, s 2.

Programme, are required to comply with the Standards in accordance with their respective funding agreements.

27. The Standards replaced the former Accreditation Standards, Home Care Standards and Flexible Care Standards (together, the **Former Standards**).

28. The care and services to be provided by an approved provider of residential care, home care, and flexible care in the form of short-term restorative care (**STRC**) if it is provided in a residential care setting, are set out in the Quality of Care Principles[13] and must be provided by the approved provider in a way that complies with the Standards.[14]

29. The Standards place the consumer at the centre of every decision, focus on the outcomes that each consumer experiences and give consumers greater control over their care. This is often referred to as 'consumer directed care'.

30. While there was a requirement under the Former Standards to have a 'care plan', which is referred to as a 'care and services plan' in the Standards, there is a greater emphasis on the individual needs of consumers under the Standards.[15]

31. In practice, the evidence before the Commission indicates that the care and service plans in residential aged care are generally signed off by RNs.[16] This has resulted in aged care workers, including RNs, spending more time with each resident to assess their needs and identify their goals and preferences.[17] With increasing changes in acuity and care needs of residents, the requirement has led to greater complexity in care planning and has led to an increase in workloads on RNs, ENs and PCWs to maintain care plans.[18]

32. As stated above, while the Standards place the consumer at the centre of every decision, the evidence demonstrates that there has been an increase in auditing and reporting required by approved providers to demonstrate compliance with the standards.[19] In addition, providers are subject to announced or unannounced visits by assessors from the ACQS Commission to ensure compliance with the Standards.

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13 Quality of Care Principles, Schedules 1, 3 and 5.

14 Quality of Care Principles, ss 7(3), 13(5), 15B(5).

15 See, for example, HB, Tab 289, Statement of Paul Sadler [25]; HB, Tab 290, Statement of Emma Brown [24]–[25].

16 Item 3.8 of Part 3 of Schedule 1 of the Quality of Care Principles require initial assessment and care planning to be carried out by a nurse practitioner or registered nurse, and ongoing management and evaluation carried out by a nurse practitioner, registered nurse or enrolled nurse acting within their scope of practice. See, for example, HB Tab 146, page 3365, XXN of Paul Jones PN1270–1273; HB Tab 146, pages 3395-6, XXN of Virginia Ellis PN1663–1666.

17 HB Tab 290, Statement of Emma Brown [26].

18 See the summation of this evidence in E.4.5 of the ANMF's closing submissions.

19 HB Tab 293 Statement of Johannes Brockhaus [26]–[29].

33. The evidence before the Commission has also demonstrated the practical impact of compliance with the Standards on the work conducted by aged care workers to ensure they are providing person-centred care.[20] For example:

    33.1. Emma Brown, Special Care Project Manager at Warrigal, explained with the changes to the Standards, PCWs need to ensure they are providing consumers with choices in their daily activities, such as deciding when they would like to be showered. This means that aged care workers need to have an understanding and knowledge of each of their consumers to ensure their choices and preferences are followed.[21]

    33.2. Johannes Brockhaus, CEO of Buckland Aged Care Services, noted in his evidence that the requirement of placing the person receiving care at the centre of every decision extends to the provision of food, cleaning and other services that the resident receives.[22]

    33.3. Craig Smith, Executive Leader Service Integrated Communities at Warrigal, noted that the main impact for PCWs and nurses was moving from a task based and regimented role, to the consumer having greater involvement. This has meant that there is a need for increased communication and to work flexibly, for example, a consumer may advise a worker that they would like to eat in their room instead of the dining room.[23] This impacts on the nature and complexity of the work performed by aged care workers, particularly those in direct care roles.

34. As with the Former Standards, non-compliance with the Standards may trigger a response from the ACQS Commission under Part 7B of the *Aged Care Quality and Safety Commission Act 2018* (**Commission Act**). The ACQS Commission may take administrative action or enforceable regulatory action to manage non-compliance (see part 8A of the Commission Act).

Requirements relating to the use of physical or chemical restraints

35. *The Aged Care and Other Legislation Amendment (Royal Commission Response No. 1) Act 2021* and the *Aged Care Legislation Amendment (Royal Commission Response No. 1) Principles 2021* introduced amendments to the Aged Care Act and the Quality of Care Principles which detail the responsibilities of approved providers of residential care and flexible care in the form of STRC provided in a residential care setting relating to restrictive practices. The amendments also limit the circumstances in which a restrictive practice can be used in relation to a care recipient in these settings.

36. These amendments built on earlier amendments to the Quality of Care Principles and commenced on 1 July 2019.

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20 See also the evidence addressed in the HSU's closing submissions at [246]–[271].

21 HB Tab 290, Statement of Ms Emma Brown [25]–[26].

22 HB Tab 156, pages 4409–4410, XXN of Johannes Brockhaus, PN13814–13817.

23 HB Tab 291, Statement of Craig Smith, [31]-[33].

37. The reforms introduced strengthened requirements for the use of a restrictive practice in relation to care recipients in certain residential aged care settings and expanded on the types of restraints to be regulated to include environmental restraints, mechanical restraints, and seclusion.

38. Under the amendments, it is a responsibility of an approved provider under Chapter 4 of the Aged Care Act to ensure the use of restrictive practices in relation to care recipients is only used in the circumstances set out in the Quality of Care Principles. Approved providers could be subject to regulatory action by the Commissioner under Part 7B and Part 8A of the Commission Act if they fail to comply with their Chapter 4 responsibilities including sanctions. Inappropriate use of a restrictive practice in relation to a care recipient is also a reportable incident under the Serious Incident Response Scheme (**SIRS**) discussed below.

39. These amendments also introduced civil penalties for those approved providers who fail to comply with compliance notices given by the ACQS Commissioner in relation to a breach of restrictive practice responsibilities under the Aged Care Act.

40. The amendments implemented additional requirements, under s 15FC of the Quality of Care Principles, for an approved provider to use chemical restraints, including that a medical practitioner or NP must have:

    40.1. assessed the patient as posing a risk of harm to themselves or others;

    40.2. assessed that the chemical restraint is necessary; and

    40.3. prescribed the medication.

41. Division 3 of Part 4A of the Quality of Care Principles lists other additional requirements an approved provider must apply to use chemical restraints, including:

    41.1. documenting in the behaviour support plan for the care recipient a number of matters including the practitioner's decision to use the chemical restraint and the reasons the chemical restraint is necessary;

    41.2. ensuring informed consent has been given by the care recipient for the prescribing of the medication in an agreed way.

42. From 1 September 2021, approved providers of residential care and STRC in a residential care setting were also required to assess a care recipient to determine if a restrictive practice is needed and record in the care recipient's behaviour support plan whether this assessment has taken place and whether a restrictive practice is used.[24]

43. These amendments have introduced increased requirements for the use of restrictive practices in residential care settings, which aim to improve the health, safety and well-being of residents. There is evidence before the Commission that the increased

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[24] *Aged Care Legislation Amendment (Royal Commission Response No. 1) Principles 2021*, s 2.

regulation of the use of restrictive practices has led to a change in the roles performed by aged care workers in residential aged care facilities, and in particular RNs.

44. For example, according to Ms Brown, these amendments have led to increased documentation and assessments by RNs to undertake restrictive practices and supervision of care staff to assist in implementing alternative interventions before any restrictive practice is used.[25]

45. Annie Butler, Federal Secretary of the Australian Nursing and Midwifery Federation (**ANMF**) states that while these reforms are welcome steps, they have increased work complexity and required changes to the way work is performed.[26] For instance, the amendments included a requirement that a behaviour support plan must set out a number of matters, including alternative strategies for addressing behaviours of concern.[27] The intention of this requirement is to ensure that approved providers take a more preventative approach in relation to the use of restrictive practices by considering alternative strategies in the first instance, while examining and seeking to understand the cause of the behaviours.

The National Aged Care Mandatory Quality Indicator program (QI Program)

46. The QI Program has been in development since 2012 following a recommendation from the Productivity Commission's report, *Caring for Older Australians* (2011) and the Australian National Audit Office's report, *Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care Homes* (2011).

47. The QI Program was launched on a voluntary basis in January 2016 and became mandatory on 1 July 2019. At introduction of the mandatory QI Program, it required approved providers of residential care to report on three quality indicators (pressure injuries, physical restraint and unplanned weight loss) every three months.

48. As part of the 2019-20 Budget, expansions to the mandatory QI Program were announced to include two new quality indicators: falls and fractures, and medication management. These changes also included updates to the three existing quality indicators referred above.

49. As a result, from 1 July 2021, approved providers of residential care have been required, under s 26 of the *Accountability Principles 2014* (**Accountability Principles**), to collect and report information to the Secretary, in accordance with the QI Program Manual,[28] on five quality indicators for each care recipient every three months. Approved providers must submit quality indicator data no later than the 21st day of the month after the end of each quarter.

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25 HB Tab 290, Statement of Emma Brown, [17].

26 HB Tab 181, Statement of Annie Butler, [239].

27 *Quality of Care Principles 2014*, s 15HB.

28 https://www.health.gov.au/resources/collections/national-aged-care-mandatory-quality-indicator-program-manual

50. The information is collected and submitted at a service level, meaning each approved provider must submit data for each residential aged care service it operates.

51. The QI Program involves specific methods for collecting, recording, submitting, and interpreting information about the quality indicators. In accordance with the aged care legislation, residential care services must collect data consistently using the methods prescribed in the QI Program Manual. A data recording template is available for each quality indicator to automatically calculate and summarise the quality indicator data to enter and submit. Residential care providers record and submit their quality indicator data for each service into the My Aged Care provider portal.

52. The approved provider is responsible for ensuring that quality indicator data is submitted. This remains the responsibility of the approved provider despite any other organisation or mechanism, such as a commercial benchmarking service, being used in the submission of the data.

53. Under to s 26(a) of the Accountability Principles, approved providers must make measurements or other assessments that are relevant to indicating the quality of residential care, exactly as described in the QI Program Manual. Information from existing data sets (eg incident reporting systems) must not be used where information has been collected differently to what is described in the QI Program Manual.

54. For each quality indicator, an approved provider must keep records relating to measurements and assessments and information compiled for the purposes of ss 26(a), (b) and (c) of the Accountability Principles.[29]

55. The impact of the mandatory QI Program on aged care workers was raised in the evidence of a number of witnesses. For example:

    55.1. Alison Curry, an assistant in nursing (**AIN**) at Warrigal, stated that RNs are the most impacted by mandatory QI Program reporting, and this flows through to impact on ENs and AINs;[30]

    55.2. Ms Brown, also from Warrigal, gave evidence that managers of the residential aged care facility and RNs now spend more time gathering the required information for mandatory QI Program reporting, which means that the role of RNs has become more administrative.[31]

The SIRS

56. The SIRS commenced on 1 April 2021 and introduced new arrangements for approved providers of residential care and flexible care delivered in a residential setting to manage and take reasonable steps to prevent incidents.

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29 *Records Principles 2014* s 7(v).

30 HB Tab 205, Reply Statement of Alison Curry, [66]–[67].

31 HB Tab 290, Statement of Emma Brown, [31]–[32].

57. From 1 December 2022, compliance with the SIRS arrangements will also be extended to providers of in-home care and flexible care delivered in a home or community setting.[32] This commitment formed part of the 2021-22 Budget. The Commonwealth Government undertook public consultation on the proposed extension, and most stakeholders supported the introduction of SIRS for in-home care services. Most stakeholders also supported an approach that aligned the scheme as much as possible with the existing requirements for residential care providers.[33]

58. The SIRS currently requires providers of residential care to report all reportable incidents to the ACQS Commission via the My Aged Care provider portal and requires that reports are made in accordance with the requirements in the Quality of Care Principles. What is a reportable incident is set out in ss 54-3(2) of the Aged Care Act and further defined in s 15NA of the Quality of Care Principles, and includes unreasonable use of force, unlawful sexual contact or inappropriate sexual conduct, psychological or emotional abuse of the care recipient, unexpected death, unexplained absence, stealing and financial coercion, use of a restrictive practice other than in accordance with the Quality of Care Principles, and neglect.

59. The SIRS was implemented in a staged approach, with Priority 1 incidents being required to be reported to the ACQS Commission from 1 April 2021 and Priority 2 incidents required to be reported to the ACQS Commission from 1 October 2021.

60. A Priority 1 incident is a reportable incident that has caused or could reasonably have been expected to have caused a care recipient physical or psychological injury or discomfort requiring medical or psychological treatment; where there are reasonable grounds to report the incident to police; or is an unexpected death or unexplained absence. It is anticipated that from October 2022, all incidents of unlawful sexual contact or inappropriate sexual conduct will be a Priority 1 incident, with the obligation to report Priority 1 incidents for providers of in-home care and flexible care in a home or community setting commencing from 1 December 2022. Priority 1 incidents are required to be reported to the ACQS Commissioner within 24 hours of the provider becoming aware of the incident.

61. A Priority 2 incident is a reportable incident that has not been reported as a Priority 1 incident and must be reported to the ACQS Commissioner within 30 days of the provider becoming aware of the incident.

62. The SIRS replaced the previous responsibilities of approved providers of residential care in relation to reportable assaults and unexplained absences. The SIRS requires reporting of a wider range of incidents by a wider range of providers.

63. The SIRS also goes further than the previous reporting requirements as it includes both incident management and reportable incident responsibilities for providers, including

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[32] This measure forms part of the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022* (Schedule 4), which received Royal Assent on 5 August 2022.

[33] See *Serious Incident Response Scheme for Commonwealth funded in-home aged care services: Report on outcomes of consultation*, Department of Health, 24 August 2021 at: https://www.health.gov.au/sites/default/files/documents/2021/09/report-on-the-outcome-of-public-consultation-on-sirs-for-in-home-aged-care.pdf (accessed 15 July 2022).

through implementing and maintaining effective organisation-wide governance systems for the management and reporting of relevant incidents (see, for example, Division 3 of Part 4B of the Quality of Care Principles).

64. The SIRS also removed the exception for reporting assaults where the alleged perpetrator is a residential aged care recipient with a cognitive or mental impairment and the victim is another care recipient. This was in direct response to the findings of the Aged Care Royal Commission.

65. Compliance with the SIRS arrangements, as set out in the Quality of Care Principles, is a responsibility of approved providers under Chapter 4 of the Aged Care Act. As noted above, this responsibility currently only extends to approved providers of residential care and flexible care delivered in a residential setting but will extend to all approved providers by 1 December 2022.

66. As above, non-compliance with an approved provider's responsibilities may trigger the ACQS Commission's compliance functions under Part 7B (Sanctions) of the Commission Act and specified enforcement powers under Part 8A.

67. Wendy Pauline Knights, casual EN, gave evidence that the SIRS has added to the responsibilities of RNs, as they then have to assess whether an incident (referred to by the witness as "emergencies") is a reportable incident or not.[34] The role of RNs in reporting for SIRS is corroborated by the evidence of AIN Linda Hardman, who also states that her responsibilities have also changed as a result of SIRS and that her observation skills have needed to increase. [35]

68. Ms Brown gave evidence that the current SIRS arrangements primarily impacts the work performed by PCWs as they have to document the incidents and report to the RNs to investigate, and to the management team to report to the ACQS Commission.[36]

69. This view was reiterated by Virginia Ellis, a Homemaker at Uniting Aged Care Springwood, who gave evidence that a serious incident report would usually be made by a PCW before reporting it to the RN, and once the incident has been reported, PCWs have an important role to play in ensuring the resident is getting appropriate medical care.[37]

70. Allison Curry, AIN, also gave evidence that it is usually the AIN of the care service who makes the SIRS report as the RN on duty is usually busy completing documentation in an office.[38]

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34 HB Tab 153, Pages 4026-27, XXN of Wendy Knights PN9178-9183.

35 HB Tab 153, page 4076, XXN of Linda Hardman PN9821–9828.

36 HB Tab 290, Statement of Emma Brown, [35]–[39].

37 HB Tab 192, Reply Statement of Virginia Ellis, [55].

38 HB Tab 205, Reply Statement of Alison Curry [77]–[78].

Commonwealth funding in the Aged Care Sector

Current funding model — the Aged Care Funding Instrument (ACFI)

71. The basic subsidy for residential care is currently determined by the ACFI. The ACFI is completed by facility staff whenever a new resident enters a residential aged care facility. This initial assessment results in the resident being classified on each ACFI domain to one of four levels of need – nil, low, medium or high need. The ACFI domains are:

    71.1. Activities of Daily Living – covering nutrition, personal hygiene, mobility, toileting and continence;

    71.2. Behavioural Domain – covering cognitive skills, cognition, wandering, verbal and physical behaviour and depression; and

    71.3. Complex Health Care – covering medications and complex health care needs.

72. It is well recognised, including in the evidence before the Commission, that there are substantial issues with the ACFI funding model.[39] As such a new funding model, the AN-ACC model, is replacing the ACFI, as described below.

New funding model — Australian National Aged Care Classification (AN-ACC) Model

73. The AN-ACC funding model was developed by the Australian Health Services Research Institute within the University of Wollongong as part of work undertaken for the Australian Government. It was developed to address concerns in relation to ACFI and comprises:

    73.1. a new assessment tool and method for classifying and funding permanent residents;

    73.2. independent assessments to determine classification levels and care funding; and

    73.3. independent analysis each year to inform changes in funding.

74. The AN-ACC funding model intends to be more equitable, particularly in supporting care in rural and remote locations, and First Nations communities and in homeless specialist services. It aims to align care needs and cost drivers in residential aged care to better facilitate the provision of services and funds where they are needed. It is a streamlined model that is administratively simple. The Commonwealth expects that implementation of the AN-ACC funding model will address the issues with the ACFI, as noted in Dr Kathy Eagar's evidence,[40] and improve funding certainty for Government, approved providers and investors. In particular, under AN-ACC:

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[39] HB Tab 291, Statement of Craig Smith [74]; HB Tab 289 Statement of Paul Sadler [41]; HB Tab 153, XXN of Dr Kathy Eagar, pages 3990–3991, PN8763; Page 4007 PN8939.

[40] HB Tab 153, XXN of Dr Kathy Eagar, page 4007 PN8939.

74.1. Approved providers of residential care will no longer make their own assessments of residents for funding purposes. Instead, this will be undertaken by independent assessors,[41] which will deliver a more reliable and stable funding assessment. This will also take pressure off approved providers of residential care to conduct ACFI assessments for their residents and consequently reduce the associated administrative burden on their staff.

74.2. The existing methodology of indexing subsidies at a prescribed rate will be replaced by a methodology involving the work of the re-named Independent Health and Aged Care Pricing Authority (**Pricing Authority**) undertaking regular analysis of cost changes and drivers with these studies to inform the annual changes in subsidy rates from Government.

74.3. The ACFI assessment tool will be replaced with the AN-ACC Assessment Tool and separate funding for fixed and variable costs. The new tool will no longer encourage particular types of care delivery for funding purposes, supporting an improved focus on care needs and also a fairer allocation of funding between approved providers.

75. The AN-ACC funding model will replace ACFI and consolidate the existing basic subsidy for residential care, the amounts currently provided through various supplements (including the Basic Daily Fee supplement, the homeless supplement and the viability supplement) and the additional funding for care minutes from 1 October 2022. Other individual supplements such as the oxygen, enteral feeding, veterans and accommodation supplements will continue under the AN-ACC funding model, with some minor rationalisation of the overall structure of supplements.

76. Subsidy payments under the AN-ACC funding model will comprise three components:

76.1. Fixed — the characteristics of a residential aged care facility, such as location or specialisation, will determine a fixed amount of funding. For example, a facility catering to those at risk of homelessness or in a remote location. This recognises that some facilities, for example, those in rural and remote locations, may require additional funding than those in metropolitan areas.

76.2. Variable — each aged care resident is assessed by an independent assessment workforce as discussed in Dr Eagar's evidence.[42] The resident's care needs are aligned with one of the AN-ACC case mix classifications, or classes of care. The AN-ACC classification defines the amount of funding allocated for the aged care resident. In contrast to ACFI, the AN-ACC funding model will also cover care recipients who receive respite care in residential aged care facilities, with different classes of care according to need.

76.3. A one-off entry payment — each time an aged care resident enters a residential aged care facility, a one-off payment is made. The payment aims to cover one-off

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41 Ibid PN8943.

42 Ibid PN8943.

costs related to transitioning into a new care environment. As discussed in Dr Eagar's evidence, this payment recognises that there are additional care needs when someone first enters care.[43]

77. The legislative amendments to the Aged Care Act which support the introduction of the AN-ACC funding model are included in the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022*, which received Royal Assent on 5 August 2022. As such, the AN-ACC will commence from 1 October 2022.

C. WORK VALUE REASONS

78. In its statement on 9 June 2022 ([2022] FWCFB 94), the Commission identified the following provisional views:

    1. Based on the submissions of the Unions and the Joint Employers, the relevant wage rates in the Aged Care Award, the Nurses Award and the SCHADS Award have not been properly fixed.
    2. It is not necessary for us to form a view about why the rates have not been properly fixed.
    3. Our task is to determine whether a variation of the relevant modern award rates of pay is justified by 'work value reasons' (and is necessary to achieve the modern awards objective), being reasons related to any of s.157(2A)(a)-(c) the nature of the employees' work, the level of skill or responsibility involved in doing the work and the conditions under which the work is done.

79. The Commonwealth does not make submissions contrary to the provisional views. It further notes that:

    79.1. In respect of provisional view 1, the Commonwealth notes that it appears to be common ground between Unions and the Joint Employers that the minimum rates of pay in the Awards have not been properly fixed in accordance with the method stated in the *ACT Child Care Case.*[44] The Commonwealth takes no issue with the Commission proceeding on the basis that this issue is not in dispute.

    79.2. In respect of provisional view 2, the Commonwealth agrees. Contrary to the submissions of the Joint Employers,[45] the Commonwealth also submits that the 'proper fixation' of minimum rates according to the approach in the *ACT Child Care Case* should not be considered a necessary precursor or a 'gateway' to the Commission's exercise of its powers under s 157 of the *Fair Work Act 2009* (**FW Act**).

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43 Ibid PN8869.

44 *Australian Liquor, Hospitality and Miscellaneous Workers Union re: Child Care Industry (Australian Capital Territory) Award 1998 and Children's Services (Victoria) Award 1998 — re: Wage rates* [2005] AIRC 28 (**ACT Childcare Case**); also in *Independent Education Union of Australia* [2021] FWCFB 2051 [560]-[562] and *Re 4 yearly review of modern awards* (2018) 284 IR 121 [159] (**Pharmacy Decision**).

45 *Submission of Aged & Community Services Australia, Leading Age Services Australia and Australian Business Industrial*, dated 4 March 2022 at 13.1.

79.3. The approach taken to the fixation of rates in the *ACT Childcare Case*[46] was relevant to the Australian Industrial Relations Commission's (**AIRC**) exercise of its powers and functions under the *Workplace Relations Act 1996* (Cth), as it stood at the time, and the principles applied by the AIRC in discharging its functions and powers under that legislation. The AIRC enunciated a set of Wage Fixing Principles.[47] Further to this, the AIRC adopted a method of setting award wages, which it described in cases such as the *ACT Child Care Case* as the 'proper approach'. These principles and this approach were adopted by the AIRC as a matter of discretion, within the scope of its legislative powers.

79.4. While consideration of whether the rates in the relevant awards were set in accordance with historical approaches to work value assessments can be a relevant consideration in determining whether a variation of the relevant modern award rates of pay is justified by 'work value reasons', it is not necessarily the first step in doing so.[48]

79.5. In respect of provisional view 3, the Commonwealth agrees with the identification of this task, save to say that — assuming the Commission is satisfied that any variation is justified — the Commission will then need to go on to consider *what* variation is justified. The balance of these submissions seek to assist the Commission with this task, taking into account the particular circumstances of these applications, given the conclusions reached in provisional views 1 and 2.

D. APPROACHES TO ASSESSING WORK VALUE

80. The Commonwealth makes the following submissions in answer to Questions 2, 4 and 5 posed in *Background Document 1*.

Response to Question 2

81. *Background Document 1* refers, at [57], to the ANMF's submission to the effect that s 157(2A) of the FW Act 'exhaustively defines work value reasons as being reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to:

> (a) the nature of the work;
>
> (b) the level of skill or responsibility involved in doing the work; and
>
> (c) the conditions under which the work is done.'[49]

82. Question 2 seeks the parties' response to the ANMF submission.

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46 *ACT Childcare Case* [2005] AIRC 28.

47 The relevant legislation was the *Workplace Relations Act 1996* (Cth) and the *Industrial Relations Act 1988* (Cth).

48 *Pharmacy Decision* [168], also set out as proposition 5 in *Background Document 1*.

49 ANMF submission dated 29 October 2021 [23].

83. The Commonwealth agrees with the ANMF that s 157(2A) exhaustively defines work value reasons in the sense that there are no other express provisions which inform the meaning of s 157(2A).

84. The Commonwealth also agrees with the observation made by the Full Bench in the *Pharmacy Decision* that the three limbs of s 157(2A) are sufficiently broad so as to import the fundamental criteria used to assess work value changes under the wage fixing principles which operated from 1975 to 1981 and 1983 to 2006.[50] There is nothing to indicate that the legislature, in enacting the FW Act, intended to change the meaning of 'work value' as a core concept.

85. Since the earliest days of the federal industrial relations system it has been accepted that an intrinsic part of a work value assessment is that the rates of pay for particular work should be understood and assessed relative to other rates of pay for comparable work.[51]

86. The Commonwealth submits that the Commission should continue to have regard to relativities in wage rates within and between awards (internal and external wage relativities), but that such considerations should not be determinative.

87. Ultimately, the Commission has discretion as to whether it should vary modern award minimum wages where the criteria in s 157(2) are met.

Response to Question 4

88. *Background Document 1* refers, at [58], to the Health Services Union (**HSU**) having submitted that the specific items in s 157(2A) should be interpreted as follows:

> 1. 'The "nature of the work" includes the nature of the job and task requirements imposed on workers, the social context of the work and the status of the work.
> 2. Assessing "skills and responsibilities" involved in the work includes:
>
> (i) Consideration of initial and ongoing required qualifications, professional development and accreditation obligations, surrounding legislative requirements and the complexity of techniques required of workers;
>
> (ii) The level of skill required, including with reference to the complexity of the work and mental and physical tasks required to be undertaken; and
>
> (iii) The amount of responsibility placed on the employees to undertake tasks.
>
> 3. The "conditions under which work is performed" refers to "the environment in which work is done."

89. Question 4 seeks the parties' response to the HSU submission.

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50 *Pharmacy Decision* [166].

51 See Preston, A *The Structure and Determinants of Wage Relativities Evidence from Australia (2019),* p.54 citing *The Sunshine Harvester Case* (1907) 2 CAR 1, 11-12

90. The Commonwealth broadly agrees with the submission of the HSU set out at [58] of Background Document 1 as to how paragraphs 157(2A)(a)–(c) should be interpreted.

91. The Commonwealth further notes the submission at [41] of the HSU's closing submissions, in response to *Background Document 1*, Question 3. The Commonwealth agrees that if the Commission has regard to the social value of the work, it would be alert to ensuring that its assessments are not affected by the perceived prestige of the work. The Commonwealth notes the community recognition of the importance of frontline workers, such as aged care workers, arising from the COVID-19 pandemic.

Response to Question 5

92. The Background Document, at [59]–[68], sets out propositions drawn from the *Pharmacy Decision*. Question 5 asks the parties whether any of the propositions from the *Pharmacy Decision* are contested.

93. The Commonwealth does not seek to contest the principles identified in the *Pharmacy Decision*, as set out in [66] of *Background Document 1*.

94. As principle 5 identifies, it is open to the Commission to have regard, in the exercise of its discretion, to considerations which have been taken into account in previous work value cases under differing past statutory regimes.

95. The Commonwealth agrees with the HSU that 'the FW Act leaves it to the Commission to exercise a broad and relatively unconstrained judgment as to what may constitute work value reasons justifying an adjustment to minimum rates of pay'.[52]

96. The limits on what the Commission may take into account are identified in principle 3 from the *Pharmacy Decision*:

> The definition of 'work value reasons' in s.156(4) requires only that the reasons justifying the amount to be paid for a particular kind of work be 'related to any of the following' matters set out in paragraphs (a)-(c). The expression 'related to' is one of broad import that requires a sufficient connection or association between 2 subject matters. The degree of the connection required is a matter for judgment depending on the facts of the case, but the connection must be relevant and not remote or accidental. The subject matters between which there must be a sufficient connection are, on the one hand, the reasons for the pay rate and, on the other hand, any of the 3 matters identified in paragraphs (a)-(c) — that is, any one or more of the 3 matters.[53]

97. In the *Pharmacy Decision*, the Full Bench compared the *Pharmacy Industry Award 2010* (**Pharmacy Award**) wages and qualifications with the *Manufacturing and Associated Industries and Occupations Award 2020* (**Manufacturing Award**) and found that wage relativities did not align for equivalent qualifications.[54] The Full Bench stated that this appeared to be inconsistent with the approach taken in the *ACT Child Care Decision* of setting award rates relative to appropriate key classifications in awards, with the

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52 HB Tab 137, HSU submissions in reply dated 21 April 2022 [13].

53 *Pharmacy Decision* [165].

54 *Pharmacy Decision* [195].

Engineering Tradesperson Level 1 (the C10 level) in the *Metal Industry Award 1984* as a starting point, noting that the *ACT Child Care Decision* was made under a different statutory regime and pursuant to wage-fixing principles which no longer exist.[55] The Full Bench stated that the inconsistent treatment of equivalent qualification levels 'may potentially constitute a work value consideration'.[56]

98. The approach referred to in the *ACT Child Care Decision* has its origins in the *National Wage Case February 1989 Review*, in which AIRC stated that minimum rates awards would be reviewed to ensure that classification rates and supplementary payments in an award bear a proper relationship to classification rates and supplementary payments in other minimum rates awards.[57]

99. In the *August 1989 National Wage Case Decision,* the AIRC set rates for a metal industry tradesperson and a building industry tradesperson and stated: [58]

> Minimum classification rates and supplementary payments for other classifications throughout awards should be set in individual cases in relation to these rates on the basis of relative skill, responsibility and the conditions under which the particular work is normally performed.

100. In the *Paid Rates Review* the AIRC stated: [59]

> We have decided that in principle all awards which provide for rates of pay which are not operating, or not intended to operate, as minimum rates and which do not bear a proper work value relationship to award rates which are properly fixed minima, should be subject to a conversion process so that they do contain properly fixed minimum rates of pay.

101. The *ACT Child Care Case* included the following statement: [60]

> The key classification in the relevant award is to be fixed by reference to appropriate key classifications in awards which have been adjusted in accordance with the MRA process with particular reference to the current rates for the relevant classifications in the Metal Industry Award. In this regard the relationship between the key classification and the Engineering Tradesperson Level 1 (the C10 level) is the starting point.

102. These decisions variously refer to wages being set 'relative' to, by 'reference' to and having a 'relationship' to the key classification in the *Metal Industry Award*.

103. This approach **did not** mandate that wages for employees with qualifications equivalent to C10 must be set so as to be equal to the C10 wage rate.

104. The approach also did not require that qualifications be the only means for considering appropriate relativities. In the *ACT Child Care Case*, the AIRC stated that a comparison

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55 *Pharmacy Decision* [197].

56 *Pharmacy Decision* at [198].

57 (1989) 27 IR 196, 201.

58 (1989) 30 IR 81, 94.

59 (1998) 123 IR 240, 253.

60 *ACT Child Care Case* [2005] AIRC 28 [155].

of the qualifications required at particular classification levels 'is one method for establishing properly fixed minimum rates'.[61] It stated:

> Prima facie, employees classified at the same AQF levels should receive the same minimum award rate of pay **unless the conditions under which the work is performed warrant a different outcome**. (emphasis added)

105. The International Labour Organisation's Committee of Experts on the Application of Conventions and Recommendations has repeatedly emphasised the need for jobs to be evaluated using an objective method that includes criteria such as skills, effort, the responsibilities and working conditions.[62] This recommendation arose from recognition of gender-based segregation in different sectors.[63]

106. There was never a barrier to setting wages for particular employees higher than those of metal industry employees with equivalent qualifications. The Commission's predecessors were open to considering whether there were factors such as the conditions under which the work is performed that would justify such an outcome. This broad approach to assessing work value is reflected in the work value factors in s 157(2A).

The Commission's approach to work value should rectify undervaluation of work for gender-related reasons

107. As referred to at [70] of *Background Document 1*, in the *Equal Remuneration Decision* [2015] FWCFB 8200, the Full Bench stated (at [292]) that:

> We see no reason in principle why a claim that the minimum rates of pay in a modern award undervalue the work to which they apply for gender-related reasons could not be advanced for consideration under s.156(3) or s.157(2). Those provisions allow the variation of such minimum rates for 'work value reasons', which expression is defined broadly enough in s.156(4) to allow a wide-ranging consideration of any contention that, for historical reasons and/or on the application of an indicia approach, undervaluation has occurred because of gender inequity.[64]

108. The link between work value assessments and gender undervaluation is consistent with the Full Bench's conclusions in the *Equal Remuneration Case* [2011] FWAFB 2700 that:

    108.1. the characterisation of work as caring work can disguise the level of skill and experience required and contribute, in a general sense, to a devaluing of the work

    108.2. because caring work in this context has a female characterisation, to the extent that work in the industry is undervalued because it is caring work, the undervaluation is gender-based.[65]

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61 *ACT Child Care Case* [2005] AIRC 28 [172].

62 2014 General Survey of Wage Fixing Instruments, [167]: https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_235287.pdf

63 Ibid.

64 *Equal Remuneration Decision* [2015] FWCFB 8200 [292].

65 at [253].

109. The 'indicia approach' to identifying gender-based undervaluation was developed by the New South Wales Industrial Relations Commission in its Pay Equity Inquiry,[66] and reflected in the New South Wales and Queensland Equal Remuneration Principles.[67] This approach identifies a number of elements which, prima facie, could indicate the possibility, or even probability, of undervaluation of work based on gender.[68] It has been observed, however, that the 'indicia approach' was never intended to be a prescriptive formula to identifying gender undervaluation.[69] The aged care workers covered by the applications, particularly PCWs, home care workers and nurses are overwhelmingly female.[70] Further, the majority of aged care workers are considered 'low paid'.[71]

110. While the reasons for the low pay of aged care workers are complex, the evidence before the Commission is broadly consistent with the indicia of undervaluation identified in pay equity inquiries.

111. A recurrent theme of the expert evidence is that aged care workers, particularly PCWs, AINs and ENs, exercise skills that have not been properly recognised in work value assessments.

112. Associate Professor Meg Smith and Dr Michael Lyons observe:

> In summary it is our opinion that barriers and limitations to the proper assessment of work value in female dominated industries and occupations include:
>
> - changes in the regulatory framework for equal pay and equal remuneration applications and the interpretation of that framework
> - procedural requirements such as the direction in wage-fixing principles that assessment of work value focus on changes in work value and tribunal interpretation of this requirement.
> - conceptual including the subjective notion of skill and the "invisibility" of skills when assessing work value in female-dominated industries and occupations.[72]

113. In identifying causes for the low pay of aged care workforce Dr Sara Charlesworth points to:

    113.1. the failure of collective bargaining to provide an effective option for addressing low remuneration and poor working conditions in aged care;[73]

    113.2. options to address low remuneration in aged care, both in awards and collective bargaining, being "entirely dependent on federal government commitment and action";[74]

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66 New South Wales Industrial Relations Commission, *Pay Equity Inquiry (Report to the Minister, 14 December 1998),* Vol 1, 46-7; Vol 2 267.
67 *Re Equal Remuneration Principle* (2000) 97 IR 177; *Re Equal Remuneration Principles* (2002) 114 IR 305.
68 *Equal Remuneration Decision* [2015] FWCFB 8200, [33].
69 *Equal Remuneration Decision* [2015] FWCFB 8200, [139].
70 See Tabs A3 and A4 of Annexure A to these submissions.
71 HB Tab 166, Expert Report of Associate Professor Meg Smith and Dr Michael Lyons at [118].
72 HB Tab 166, Expert Report of Associate Professor Meg Smith and Dr Michael Lyons [93].
73 HB Tab 160, Expert Report of Dr Sara Charlesworth [34].
74 Ibid [39].

113.3. historical as well as an ongoing undervaluation of work performed by PCWs in residential aged care.[75]

114. Dr Charlesworth states that the problems with collective bargaining with residential care are amplified in in-home care. Dr Charlesworth refers to the isolation of aged care workers in the location of their work in private homes.[76]

115. Through her application of the 'Spotlight Tool', Honorary Associate Professor Anne Junor also opines that the work and skill of ENs and AINs/PCWs located in aged care facilities in metropolitan and regional/rural locations are under-recognised on the basis of gender. [77]

116. The Spotlight Tool is described by Honorary Associate Professor Junor as:

> …an aid in identifying, naming and classifying invisible skills used in undertaking service work processes. It is designed to reduce the unwitting gender bias that can occur in describing and analysing jobs, and hence in assigning value to them, if these skills are overlooked.[78]

117. For the reasons set out below, the Commonwealth submits that there is cogent evidence before the Commission to support the proposition that the application of 'invisible' skills, broadly describable as social and emotional and interpersonal skills, that have not been fully assessed in previous work value exercises, justifies the conclusion that the work value of aged care workers is significantly higher than the modern awards currently reflect, particularly for those employed in personal care (including in in-home age care), AIN and EN roles.

118. Firstly, the Commonwealth agrees with the conclusions reached in Honorary Associate Professor Junor's report that ENs and AINs/PCWs are exercising skills which have not previously been taken into account when assessing the work value of their roles, and that the reasons for the under-recognition of these skills are fundamentally gender-based.

119. Secondly, as summarised in the Report to the Commission on the lay witness evidence, aged care employees frequently exercise 'invisible' skills arising from:

119.1. changes to staffing levels and skills mix;

119.2. regular interactions with residents' and community care clients' families;

119.3. observation and assessment to identify potential underlying health issues, manage behaviour and provide care;

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75 Ibid [42]-[46].

76 Ibid [48] and [58].

77 HB Tab 167, Expert Report of Honorary Associate Professor Anne Junor.

78 Ibid, [7] (HB page 4957).

119.4. the application of a high-level of interpersonal skills, such as empathy, communication, positive mental attitude, time management and the ability to handle criticism;

119.5. the physically, mentally and emotionally taxing and stressful work;

119.6. the need to deal with behaviours and aggression in residents, including strategies such as distraction and de-escalation.[79]

120. The Commonwealth submits that the Commission should find, based on the evidence before it, that the current award rates significantly undervalue the work performed by aged care workers, for reasons related to gender.

121. The Commonwealth does not agree with the submission at [4.36] of the Joint Employers' closing submissions (expanded on in Annexure J) that this evidence is of 'limited utility'. Amongst other matters, this submission does not recognise the award dependence of the sector, or the consideration by Dr Charlesworth of the failures of collective bargaining in the sector.

The proper approach to work value should be consistent with the objects of the FW Act

122. Section 15AA of the *Acts Interpretation Act 1901* requires that the construction that would promote the purpose or object of the FW Act is to be preferred to one that would not promote that purpose or object. The Commission is also specifically required to take into account the objects of the FW Act when performing functions or exercising powers under the FW Act.[80] This necessarily includes assessing whether variations to modern awards are justified by work value reasons.[81]

123. In *Mondelez Australia Pty Ltd v Australian Manufacturing Workers Union*,[82] a majority of the High Court found that:

> the stated objects show that the Act is intended to provide fairness, flexibility, certainty and stability for employers and their employees. 'Fairness' necessarily has a number of aspects: fairness to employees, fairness between employees, fairness to employers, fairness between employers, and fairness between employees and employers.

124. The legislative objects of the FW Act have also been considered by Expert Panels during the Annual Wage Reviews.

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79 Annexure 1 to the ANMF's closing submission provides the Full Bench with a detailed analysis of the interaction between the lay witness evidence and Professor Junor's report.

80 FW Act s 578.

81 FW Act s 157(2).

82 *Mondelez Australia Pty Ltd v Automotive, Food, Metals, Engineering, Printing and Kindred Industries Union; Minister for Jobs and Industrial Relations v Automotive, Food, Metals, Engineering, Printing and Kindred Industries Union* (2020) 94 ALJR 818 [14].

124.1. In this context, it has been noted that there is a degree of overlap between the matters specified in the modern awards objective, minimum wages objective, and objects of the FW Act.[83]

124.2. The Expert Panel has also commented that the range of considerations required to be taken into account calls for the exercise of broad judgment, rather than a mechanistic approach to minimum wage fixation.[84]

124.3. In the *Annual Wage Review 2016-17 decision*, the Expert Panel noted that the object of the FW Act speaks to multiple legislative purposes, and plainly seeks to strike a balance between competing interests.[85]

125. Assessing work value in a manner which continues, as a starting point, to align rates of pay in one modern award with classifications in other modern awards with similar qualification requirements would support a system of fairness, certainty and stability in assessing the relative value of work between awards. However, a strict alignment of award relativities based on qualifications, without proper consideration of the true work value of the cohort of employees in question, would result in award minimum rates of pay which could not be said to be fair or relevant.

Relevance and Application of the Australian Qualifications Framework

126. While the Commonwealth does not consider that qualifications should be the only determinant of appropriate award relativities, qualifications provide a useful indicator of the level of skill involved in particular work for the purposes of s 157(2A)(b).

127. The Australian Qualifications Framework (**AQF**) has the benefit of providing a relatively objective point of comparison that can be drawn upon across industries and occupations.

128. In 2018 it was found that there were, at that time, 88 industrial awards which refer to the AQF.[86]

129. The approach of applying the AQF in assessing work value may have particular value for employees working in occupations with a clear hierarchy of skills and formal qualifications. This is clearly the case for nursing. However, the AQF cannot be relied on as the sole indicator of skills in the workforce, as the AQF is limited to recognition of formal qualifications, and does not take into account skills which may be developed outside of formal education.

130. The Commonwealth submits that the Commission should have regard to the recent review of the AQF (**AQF Review**), resulting in the report published on 24 October 2019,

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83 *Annual Wage Review 2011-12* [2012] FWAFB 5000, [359].
84 *Annual Wage Review 2011-12* [2012] FWAFB 5000, [359].
85 *Annual Wage Review 2016-17* [2017] FWCFB 3500.
86 Attorney General's Department, Communication, 10 July 2019, as referred to in *Review of the Australian Qualifications Framework 2019* (Final Report, 24 October 2019) 92.

Review of the Australian Qualification Framework Final Report 2019 (**AQF Report**),[87] when considering the relevance of the AQF to assessing work value in this matter.

The Purpose of the AQF

131. The AQF was introduced in 1995, establishing the structure of the Australian education and training system and underpinning Australian qualification standards. Australia was amongst one of the first countries to develop a national qualifications framework.

132. The Commonwealth, State and Territory Skills and Education Ministers collectively own and are responsible for the AQF, including any updates.

133. One of the key objectives of the Australian Qualifications Framework is to facilitate pathways to, and through, formal qualifications.[88]

Recent AQF Review

134. In 2019 an expert panel reviewed the AQF structure to ensure that it was still able to correctly reflect the knowledge, skills and capabilities required by the current and future work force.[89]

135. The AQF Review found that since the AQF was established, workplaces have changed considerably.[90] More skills and expertise are required by employers, meaning that employees are upskilling and training for specific roles, with some roles requiring constant and regular training and progression.

136. Further, workers are transitioning to different roles at a far faster pace than in previous generations. Employees are managing multiple career pivots and changes throughout their working lives, achieved through continuous learning and development.[91] People are choosing short, more purpose driven and flexible courses to achieve their qualifications and upskill (both within and outside traditional education).[92]

137. The AQF Report notes that the AQF has encountered criticism from stakeholders over the years, including that the framework as a whole fails its key objective to '*clarify for the general public the options from which they may choose to achieve their learning and employment goals*'.[93] The structure is also criticised for being unnecessarily complex, without providing any meaningful guidance on the skills and knowledge which attained at each 'level'[94] and providing '*poor differentiation between some qualification types, and*

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87 *Review of the Australian Qualifications Framework 2019* (Final Report, 24 October 2019).
88 AQF website: https://www.aqf.edu.au/about/what-aqf.
89 *Review of the Australian Qualification Framework Final Report 2019,* 17, Appendix 1 (Terms of Reference).
90 *Review of the Australian Qualifications Framework* (Final Report, 24 October 2019) 7.
91 *Review of the Australian Qualifications Framework* (Final Report, 24 October 2019) 7.
92 *Review of the Australian Qualification Framework (*Final Report, 24 October 2019) 7, 8.
93 *Contextual Research for the Australian Qualifications Framework Review* (5 June 2018) as referred to in *Review of the Australian Qualification Framework Report 2019* (Final Report, 24 October 2019) 23. This report was commissioned by the Department of Education in 2018.
94 Australian Qualifications Framework Council, *Strengthening the AQF: An Architecture of Australia's Qualification*s (Consultation Paper, 2009) 7, as referred to in *Review of the Australian Qualifications Framework 2019* (Final Report, 24 October 2019) *8, 73.*

descriptions of skills and knowledge that do not reflect existing practice, let alone meet future requirements'.[95]

138. The AQF Report found that the AQF is too rigid and overly hierarchical,[96] as it places too much weight on its ten-level structure, which was referred to as an 'artificial and arbitrary' distinction between the levels. The AQF Report recommended reducing the number of levels from ten to eight for knowledge and to six for skills. The AQF Report recommend renaming the levels as 'bands', enabling the bands to be flexibly applied across qualification types. The AQF Report also recommended revising the descriptors for knowledge, skills and skills applicable so that they were not necessarily locked in at a single AQF level for each qualification type.

139. The AQF Report recognises that the current approach to describing graduate outcomes as part of qualification types (rather that the individual qualification) is problematic, as it assumes that all qualifications with a qualification type are equally likely to lead to employment at a certain hierarchical level.

140. Finally, the AQF Report notes that classifications do not currently match across qualifications[97] with the same work value and the AQF needs to be significantly reformed,[98] to address and correct this disparity.

Application of the AQF in this matter

141. The AQF can be a useful means of assessing the skill involved in work and differentiating between the work at different levels when designing award classification structures. The Commonwealth endorses the HSU's submission (at [71] of its outline of closing submissions) that the AQF is a 'useful starting point'.

142. There are likely to be aspects of the skill involved in performing work that are not captured by the AQF. Therefore, the Commonwealth submits that the Commission should not rely on the AQF as the only means to assess these matters.

Whether there is an anomaly in the rates for degree qualified nurses

143. In *Pharmacy Decision*, the Full Bench identified that some classifications in the Pharmacy Award which require a degree qualification have rates that are less than the rates for trade qualified classifications in the Manufacturing Award.[99] The Full Bench stated that this may be inconsistent with the relationship between wage rates and qualifications recognised in previous decisions and invited submissions from interested parties.[100]

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95 *Review of the Australian Qualifications Framework 2019* (Final Report, 24 October 2019) 8.

96 *Review of the Australian Qualifications Framework 2019* (Final Report, 24 October 2019) 8.

97 *Review of the Australian Qualifications Framework 2019* (Final Report, 24 October 2019) 12.

98 *Review of the Australian Qualifications Framework 2019* (Final Report, 24 October 2019) 8.

99 *Pharmacy Decision* [195]-[196].

100 *Pharmacy* Decision at [197].

144. The Full Bench subsequently decided to refer the issue to the President of the Commission for consideration of the appropriate procedural course.[101] This was on the basis that a broader review of the issue across a number of awards may be called for.

145. On 27 August 2019, President Ross issued a statement in which he identified 29 awards to be referred to a separate Full Bench for review.[102] The four modern awards identified to be given priority in the review (based on levels of award reliance) were:

    - *Children's Services Award 2010*;
    - SCHADS Award;
    - *Health Professionals and Support Services Award 2020*; and
    - Nurses Award.

146. The President decided to defer the Commission's consideration of the issue until after a decision in the Independent Education Union of Australia's (**IEU**) application to vary the *Educational Services (Teachers) Award 2020* (**EST Award**) to allow the outcome of the work value application to be taken into account.

147. On 19 April 2021, the Full Bench issued a decision on the IEU's application (**the IEU Decision**).[103] The Full Bench accepted that the EST Award rates had not properly been set, found that there had been significant increases in the work value and proposed a new classification scale that would reflect the work value. The new classification scale was anchored on the Australian Professional Standards for Teachers.[104.]

148. In the *IEU Decision*, the Full Bench stated that the 'key classification', around which award minimum wages for other classifications in the EST Award would be set, was a Proficient Teacher who has a degree and has obtained registration. The Full Bench aligned Proficient Teacher with Level C1(a) in the Metals Industry classification structure. The Full Bench decided to align the rate for a Graduate Teacher with Level C2(b) in the Metal Industry classification structure.

149. The ANMF submits that if the Commission considers it necessary to start by fixing a 'key classification' to the comparable classification in the Manufacturing Award, the key classification is Registered Nurse Level 1 Grade 1.[105] The ANMF submits that, while this is not the case it is advancing, the alignment of RN Level 1 Grade 1 with C1(a) would result in a 35 per cent wage increase across all levels of the Nurses Award.[106]

150. The Joint Employers observed that the minimum rates in the Nurses Award do not correspond to the minimum qualifications of the positions when compared against the AQF and note that the Nurses Award was one of the awards identified by the President

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101 *Pharmacy Decision.*

102 *Section 157 proceeding* [2019] FWC 5934.

103 *Independent Education Union of Australia* [2021] FWCFB 2051.

104 *Independent Education Union of Australia* [2021] FWCFB 2051 [653].

105 HB Tab 136, ANMF Submissions in Reply, 21 April 2022, [58].

106 HB Tab 136, ANMF Submissions in Reply, 21 April 2022, [59].

for review.[107] They also submitted that the classification of Registered Nurse should align with C1.[108]

151. Consistent with the above, the Commonwealth submits that a comparison to rates in the Metal Industry classification structure with equivalent qualification levels may be of some assistance when the Commission is dealing an application under s 157 of the FW Act to vary modern award minimum wages on work value grounds but is not a complete answer. In addition to the level of skill involved in doing the work, s 157 requires the Commission consider whether there are work value reasons related to the nature of the work, the level of responsibility involved in doing the work and the conditions under which the work is done.

152. It would be open to Commission to align modern award wages rates for employees with equivalent AQF qualification levels in the absence of any countervailing work value reasons. However, there may be reasons justifying different wage rates for employees, despite their having attained equivalent AQF qualifications. For example, employees may have different levels of responsibility, perform work of a different nature or under different conditions. There may also be factors other than qualification that have a bearing on the level of skill involved in doing the work.

E. SUBMISSIONS ON THE MODERN AWARDS OBJECTIVE

153. The Commonwealth submits that the Commission can be satisfied that increases to the minimum wages in the Aged Care Award, and the minimum wages for aged care employees in the SCHADS Award and Nurses Award are necessary to achieve the modern awards objective. The Commonwealth addresses particular aspects of the modern awards objective below.

154. In the *Pharmacy Decision*, the Full Bench set out a number of key principles governing the construction of s 134.[109] The requirement to take the matters listed in s 134 into account means that, each consideration, insofar as they are relevant, must be treated as a matter of significance in the decision-making process.[110] However, no particular primacy is attached to any of the s 134 considerations and not all of the matters identified will necessarily be relevant in the context of a particular proposal to vary a modern award.[111]

155. It is not necessary for the Commission to make a finding that the award fails to satisfy one or more of the s 134 considerations as a prerequisite to the variation of a modern award.[112] In giving effect to the modern awards objective, the Commission's task is to perform an evaluative function, taking into account the matters in ss 134(1)(a)–(h) and

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107 HB Tab 130, ACSA, LASA and ABI Submissions, 4 March 2022, at [24.10] and [22.16].

108 HB Tab 130, ACSA, LASA and ABI Submissions, 4 May 2022, 196.

109 *Pharmacy Decision* [2018] FWCFB 7621 [126].

110 *National Retail Association v Fair Work Commission* [2014] FCAFC 118 [56].

111 *Shop, Distributive and Allied Employees Association v The Australian Industry Group* [2017] FCAFC 161 [33].

112 *National Retail Association v Fair Work Commission* [2014] FCAFC 118 [105]-[106].

assessing the qualities of the safety net by reference to the statutory criteria of fairness and relevance.[113]

156. In *4 yearly review of modern awards - Real Estate Industry Award 2010*, the Full Bench found that where the wage rates in a modern award have not previously been the subject of a proper work value consideration, there can be no implicit assumption that at the time the award was made its wage rates were consistent with the modern awards objective.[114]

134(1) - 'A fair and relevant minimum safety net of terms and conditions'

157. The Commonwealth submits that increases to the minimum wages in the Aged Care Award, and the minimum wages for aged care employees in the SCHADS Award and Nurses Award are necessary to ensure that modern awards, together with the National Employment Standards, provide a 'fair and relevant minimum safety net of terms and conditions' in the aged care sector. The Commonwealth does not contest the principles identified in the *Penalty Rates Review* and the *Penalty Rate Decision*, as set out in [79], [84]–[85] and [87]–[88] of *Background Document 1*, relating to the interpretation of the modern awards objective.

158. The Commonwealth broadly supports the HSU submission, as set out in [80] of *Background Document 1*, that in the context of minimum wages the phrase 'fair and relevant':

> should be interpreted as referring to rates which properly remunerate workers for the value of their work, taking into account all surrounding factors, and are not so low compared to general market standards as to have no relevance to the industry, for example in the context of bargaining.[115]

159. The Commonwealth submits that what is 'fair and relevant' must be viewed in the contemporary context of the aged care sector as a Government-funded sector. This follows from the Full Court's observations that '*Contemporary circumstances are called up for consideration in both respects* [of fairness and relevance]'[116] and the Full Bench's observation that 'relevant' is to be considered by its dictionary meaning and '*is intended to convey that a modern award should be suited to contemporary circumstances*'.[117]

160. Fairness is to be considered from the perspectives of both employees and employers.[118] The Commonwealth supports the Applicants' submissions that current award rates significantly undervalue the work performed by aged care workers, employees covered by the application are low paid and experience relative living standards aligned to low

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113 *Alpine Resorts Award 2010* [2018] FWCFB 4984 [52].

114 *4 yearly review of modern awards – Real Estate Industry Award 2010* [2017] FWCFB 3543 [80].

115 HB Tab 137, HSU submissions in reply dated 21 April 2022 [65].

116 *Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) FCR 368 [49], [65].

117 *4 Yearly Review of Modern Awards – Penalty Rates* [2017] FWCFB 1001 [120].

118 *Shop, Distributive and Allied Employees Association v The Australian Industry Group* (2017) 253 FCR 368 [53].

remuneration, and that the increase of modern award minimum wages would improve the living standards of the low paid.[119]

161. As noted above, aged care employees covered by the Aged Care Award and SCHADS Award whose pay is set by collective agreement are not paid significantly more than those employees covered by the application whose pay is set by an award. Increases to modern award minimum wages in the aged care sector would therefore improve pay rates and provide a fair and relevant safety net for employees in the sector, not just for employees paid at award rates, but also those whose pay is set by an enterprise agreement.

162. In evidence before the Commission, Dr Charlesworth makes the point that while collective bargaining is to be encouraged, modern awards should not be left 'hollowed out' in the process.[120] The Commonwealth agrees modern awards must remain relevant and that the avenues for wage increases for award dependent employees in the aged care sector should not be limited to Annual Wage Review increases.

163. The Commission has observed that addressing the gender pay gap is an element of fairness for the purposes of s 134(1).[121] This aspect is discussed further below. There is expert evidence before the Commission to the effect that gender has influenced the treatment of the sector at industrial and societal levels. Dr Charlesworth observes:

    163.1. frontline residential aged care work has historically been viewed as quintessentially 'women's work' and therefore of little economic value; and

    163.2. an assumed link between unpaid care work in the family and paid care work has influenced how it has been valued by society.[122]

164. The Commission should ensure that gendered assumptions do not influence the assessment of fair wages and conditions in the aged care sector.

165. With regard to fairness for employers, the Commonwealth submits that the particular contemporary context of Government funding for the aged care sector means employers are unlikely to experience significant detrimental impacts as a result of increases to modern award minimum wages in the sector. Such wage increases could therefore not be considered to be unfair to aged care employers.

134(1)(a) – Relative living standards and the needs of the low paid

166. The Commonwealth submits that relative living standards and the needs of the low paid weigh in favour of increasing the modern award minimum wages for aged care workers. Many of the award rates of pay sit below the low paid threshold of two-thirds of median full-time wages. There is evidence before the Commission which

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119 UWU outline of submissions dated 1 April 2022 [36]; ANMF submission dated 1 April 2021 [12]; HSU outline of submissions dated 1 April 2022 [64], [67].

120 HB Tab 160, Expert Report of Dr Sara Charlesworth [41]; HB Tab 161, Supplementary Report [58].

121 *Re Annual Wage Review 2017*-18 (2018) 279 IR 215 [36].

122 HB Tab 160, Expert Report of Dr Sara Charlesworth at [43].

demonstrates the challenges many workers face in meeting financial obligations and saving for the future due to the low rates of pay and the often insecure nature of work in the aged care sector.[123]

134(1)(b) - The need to encourage collective bargaining

167. The Commonwealth submits that it is very difficult to anticipate what effect increases to modern award minimum wages in the aged care sector would have on collective bargaining. At best, the Commonwealth anticipates that, if granted, the increases sought would have a neutral effect on bargaining in the sector.

168. The Commonwealth notes that, in the recent *Annual Wage Review 2021-22* decision, the Expert Panel was not satisfied that increases to the National Minimum Wage (**NMW**) and modern award minimum wages would *encourage* collective bargaining.[124] While the Expert Panel accepted there has been a decline in current enterprise agreements, it observed that '*a range of factors impact on the propensity to engage in collective bargaining, many of which are unrelated to increases in the NMW and modern award minimum wages*.'[125]

169. The consideration of the need to encourage collective bargaining in respect of this current case should be distinguished from the Expert Panel's reasoning in the *Annual Wage Review 2021-22*, because that decision related to minimum wage increases across the entire workforce as opposed to a single sector.

170. Importantly, collective bargaining in the aged care sector is already widespread, leaving only those workplaces least likely to bargain as potential additional sites for bargaining. Modelling from DoHAC indicates the majority of the aged care workforce are currently covered by EBAs, albeit with a low bargaining premium (the extent to which enterprise agreements exceeded the award base rate of pay) in most cases.[126] There are specific reasons for unsatisfactory wages results through collective bargaining across the aged care sector, as noted in the Applicants' submissions and expert and witness evidence.[127]

171. Dr Charlesworth observes that options to address low remuneration in aged care, both in awards and collective bargaining, are entirely dependent on Commonwealth Government commitment and action.[128]

172. The Commonwealth notes the evidence of the United Workers Union (**UWU**), stating increases to modern award minimum wages in the sector would create incentives for

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123 See the evidence addressed in HSU Closing Submissions, [392] – [400].

124 Re Annual Wage Review 2021-22 [2022] FWCFB 3500 [85].

125 Ibid [84].

126 See paragraphs [18]–[24] of Annexure B to these submissions.

127 UWU submission p 12; HB Tab 272, Statement of Wendy Knight p 15; HB Tab 168, Report of Dr Susan Kurrle p 19.

128 HB Tab 166, Expert Report of Dr Sara Charlesworth at Charlesworth, [39]; HB Tab 161, Supplementary Report of Dr Sara Charlesworth [55].

employers to engage in collective bargaining and provide industrial parties with a realistic basis from which to engage in collective bargaining.[129]

173. These submissions argue for increases to modern award minimum wages for aged care workers and for further encouragement for the sector to engage in collective bargaining.

174. Collective bargaining will continue to be an important driver of flexibility and productivity in the aged care sector. EBAs can provide a means of improving operational efficiency and including additional employee incentives in a way that is tailored to the needs of the business and assist with employee retention. However, increasing the rate of collective bargaining in the aged care sector, by itself, will not necessarily improve wages as the bargaining premium for the sector is unusually low. The bargaining premium in the aged care sector has been quite low for at least the last few years.

134(1)(c) - The need to promote social inclusion through increased workforce participation

175. The Commonwealth submits that increasing wages in the aged care sector could significantly improve workforce participation and social inclusion. Raising wages increases workforce participation by encouraging those currently unemployed, underemployed or not in the labour force to join the workforce. Higher wages make jobs more attractive, particularly when compared with the alternative of unemployment.

176. Areas of high unemployment are often areas of social exclusion. Drawing employees from this pool will promote social inclusion — improving participation, increasing their income and enhancing their opportunities, in meaningful aged care work.

177. In June 2022, there were 493,900 unemployed, 857,000 underemployed, and a further 3.2 million (aged 15-64) who were not in the labour force.[130] Many of these people may be unable to find work — or sufficient work — due to inadequate training, caring responsibilities or a lack of job availability close to home.

178. At the same time, the aged care sector is facing a projected shortfall in workers. DoHAC modelling estimates that the aged care workforce will have to expand by an average of 6.6 per cent each year over the next five years to support quality of care and growing demand.[131] In 2020, for example, the ACWC estimated that there were 22,000 vacancies in direct care roles across the aged care sector.

179. Many positions available in the aged care sector require only entry level or relatively low skill levels (Certificate II or III), making these jobs more accessible to those who are unemployed or not in the labour force for other reasons (for example, unpaid carers). Around 51.5 per cent of residential care services industry workers have a skill level commensurate with a Certificate II or III qualification; a further 9.5 per cent of workers

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129 UWU submission p 12.

130 Australian Bureau of Statistics, *Labour Force, Australia, June 2022* (Catalogue No 6202.0, 14 July 2022).

131 See Tables B2, B4, B8 and B11 of Annexure B to these submissions.

(possibly entry-level positions) have a skill level commensurate with having completed secondary education.[132]

180. Many aged care jobs also offer significant flexibility, with nearly 80 per cent of aged care workers working part time, presenting opportunities for those with caring responsibilities. In February 2022, there were 294,500 people who were not employed and who said that caring for an ill or elderly person affected their participation in the workforce.[133]

181. Encouraging the unemployed to take up higher paid aged care jobs may also help to address the disparity in capital city and regional unemployment rates — and improve social inclusion in regional and rural areas. The demand for aged care services is widely distributed across the country, but regional unemployment rates tend to be higher than those in capital cities. For example, in May 2022, the unemployment rate in state capital city areas averaged 3.7 per cent, whereas the unemployment rate across the rest of the states averaged 4.1 per cent.[134]

182. The aged care sector is dominated by female workers. In 2020, 86 per cent of the direct care workforce in residential aged care were female.[135]

183. Given the female dominance amongst workers in the aged care sector, lifting wages will likely attract more women into the workforce, leading to an improvement in the female overall workforce participation rate, and reducing the gender workforce participation gap. At June 2022, the female participation rate was 62.5 per cent, compared to 71.2 per cent for men.[136]

184. Evidence submitted by the HSU provides the Commission with a basis to conclude that increasing wages in the aged care sector could improve workforce participation and therefore social inclusion. Given an overwhelming majority of employees in the aged care sector are women, creating an incentive for employees to remain in the sector (through increased rates of pay and an enhanced classification structure) could increase the workforce participation of women. Further, given women still perform the majority of unpaid caring responsibilities for the elderly outside of paid employment, increased confidence in the aged care sector may allow those women providing unpaid care to their elderly relatives, the opportunity to return to the workforce. However, the Commonwealth acknowledges that there are other significant barriers to women's workforce participation, such as the unpaid care of children and other family members, and workplace discrimination.

185. Evidence given by Dr Charlesworth argues that both poor job quality and quality of life have been associated with intention to quit and difficulties with attraction and retention of workers in the aged care sector. In the *IEU Decision*, the Commission found that the

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132 Australian Bureau of Statistics, *Characteristics of Employment,* Australia, August 2021.

133 Australian Bureau of Statistics, Participation, Job Search and Mobility, Australia (Catalogue No 6226.0, 25 June 2022).

134 Australian Bureau of Statistics, *Labour Force, Australia, Detailed May 2022* (Catalogue No 6291.0., 23 June 2022).

135 2020 Aged Care Workforce Census.

136 Australian Bureau of Statistics, *Labour Force, Australia, June 2022* (Catalogue No 6202.0, 14 July 2022).

strong possibility of higher wage rates in the early childhood sector attracting greater workforce participation from teachers weighed significantly in favour of granting the application.[137] This supports the Commonwealth's view that increasing wages in the sector will improve attraction and retention in the sector and overall workforce participation in the Australian economy.

186. Research from the University of Adelaide found that there are issues in the sector that may discourage men from entering the sector, or lead to poorer retention of existing male workers. These include perceptions of caring as being 'women's work', client preferences for female carers, trouble adapting to employment in workplaces with typically high proportions of female employees, poor working conditions and lack of career opportunities.[138] Increasing wages could encourage more men to work in the sector, which would in turn increase workforce participation across the economy.

134(1)(e) – the principle of equal remuneration for work of equal or comparable value

187. The Commonwealth recognises that the aged care sector has one of the highest proportions of women compared with other workforces and industries in Australia. Further information about this has been provided above in Part B. In light of this, the Commonwealth submits that this principle is of particular relevance in this matter.

188. As noted above, there is no reason why a claim that the minimum rates of pay in a modern award undervalue the work to which they apply for gender-related reasons could not be advanced for consideration under s 157.[139]

Male comparator

189. The Commonwealth submits that, in dealing with an application under s 157, the Commission does not need to identify a male comparator.

190. The Commonwealth submits that the Commission should find, based on the evidence before it, that the current award rates significantly undervalue the work performed by aged care workers, for reasons related to gender. Accordingly, the principle of equal remuneration for work of equal or comparable value should weigh in favour of increasing the award rates for aged care workers.

Closing the gender pay gap

191. The Commonwealth submits that this principle therefore enables the Commission to take into account gender-related issues and whether or not a variation would contribute to closing the gender pay gap. The gender pay gap was 13.8 per cent in November 2021.[140]

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137 At [661].

138 Linda Isherwood, Kostas Mavromaras, Megan Moskos and Shang Wei, 'Attraction, Retention and Utilisation of the Aged Care Workforce' (Working paper prepared for the Aged Care Workforce Strategy Taskforce, The University of Adelaide, 19 April 2018).

139 *Equal Remuneration Decision 2015* (2015) 256 IR 362 [292], cited in *Pharmacy Case* [165].

140 Workplace Gender Equality Agency, *Australia's new national GPG of 13.8% released; employers urged to take action as IWD approaches* (24 February 2022) available at:

192. The Commonwealth notes a decision to increase minimum award wages in care classifications in the Awards would deliver significant benefits to the women working within this highly feminised and undervalued sector, and, by increasing the relative earnings of a female dominated sector, would contribute to narrowing the gender pay gap.

Assessing undervalued gendered skills

193. The Commonwealth also notes that the *Gender-inclusive job evaluation and grading* Australian Standards (the **Australian Standards**)[141] were agreed in 2012, by a committee[142] with members including: the Australian Chamber of Commerce and Industry; the Australian Council of Trade Unions; the Australian Industry Group; the Australian Public Service Commission; the Employer of Choice for Women; and the Equal Opportunity for Women in Workplace Agency.

194. The Commonwealth submits that the Australian Standards provide an objective standard for the Commission to consider, and would assist the Commission with assessing the relevant skills in this matter. The Commonwealth notes that the Australian Standards set out (at Appendix C of the Australian Standards) a number of frequently overlooked job characteristics in jobs predominantly done by women, including:

    194.1. Demands and working conditions, such as: dealing with upset, hostile and irrational clients; providing caring and emotional support to individuals (both to care recipients and families); managing one's own response to disgusting situations; the physical nature of regular moving and lifting of clients; and dealing with the trauma of death of care recipients (on both the care worker and the family).[143]

    194.2. Knowledge and skills such as: interpersonal skills of being able to engage with elderly clients, many with declining health or mental capabilities and from many cultural backgrounds; non-verbal communication; dispensing medication to patients; manual dexterity in giving injections or typing; and awareness of complex requirements when dispensing medication to patients.[144]

    194.3. Skills for which there are no name such as tact, discretion, or work behind the scenes.[145]

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https://www.wgea.gov.au/newsroom/Australias-new-national-GPG-of-13.8-percent-released, citing ABS Average Weekly Earnings seasonally adjusted November 2021 data. See also *Annual Wage Review* [2022] FWCFB 3500, [86].

141 Standards Australia, *Gender-inclusive job evaluation and grading* (Standard, AS 5376-2012, 15 May 2012).

142 Committee MB-020, Gender-inclusive Job Evaluation and Grading.

143 Standards Australia, *Gender-inclusive job evaluation and grading* (Standard, AS 5376-2012, 15 May 2012) 37.

144 Standards Australia, *Gender-inclusive job evaluation and grading* (Standard, AS 5376-2012, 15 May 2012) 36.

145 Standards Australia, *Gender-inclusive job evaluation and grading* (Standard, AS 5376-2012, 15 May 2012) 38.

195. The Commonwealth submits that there is evidence to support that the skills set out above are characteristics of the caring classifications under the Awards and are likely not to have been taken into account in assessing the work value of those classifications.

196. The Commonwealth submits that the above supports a conclusion that there is gender-based undervaluation in respect of the applicant groups.

Broader Gender Pay Equity

197. The Commonwealth notes that, in *Annual Wage Review 2017-18,* the Expert Panel noted that that the broader issue of gender pay equity, and in particular the gender pay gap, is relevant to establish a safety net that is '*fair*.[146] The Panel concluded that:

> Women are disproportionately represented among the low paid and, hence, an increase in minimum wages is likely to promote gender pay equity. Increases in minimum wages, particularly adjustments that might exceed increases evident through bargaining, are likely to have a beneficial impact. This is so because of the dispersion of women within award classification structures and the greater propensity for women to be paid award rates.[147]

198. The Commonwealth submits that increasing aged care minimum wages is a critical and necessary step to address the gender undervaluation within Australia, going some way towards appropriately recognising the highly skilled and technical work which workers in the aged care sector perform.

199. While the Commonwealth is of the view that paragraph 137(1)(e) of the Modern Awards Objective already enables the Commission to take into account gender when making a determination to vary an award, the Commonwealth also notes that the Government intends to introduce amendments to the FW Act to explicitly add gender pay equity as an object of the FW Act to strengthen the Commission's powers to order pay rises for workers in low paid industries dominated by women.[148]

134(1)(f) - Impact on business

200. The cost to business of increasing aged care sector wages would likely be substantial, depending on the quantum and phasing of wage increases.

201. However, as the primary funder of aged care services, the Government has committed to ensuring that the outcome of the aged care work value case is funded. The Commonwealth submits that the Commission can therefore proceed on the basis that the impact on business of significant increases to award minimum rates in the case will not be material. The Commonwealth considers the impact on business overall will be positive, in particular, by facilitating a strengthened ability to recruit staff and meet regulatory requirements.

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146 *Annual Wage Review 2017-18* (2018) 279 IR 215 [36].
147 *Annual Wage Review 2017-18* (2018) 279 IR 215 [436].
148 Commonwealth, *Australian Women Labor's Plan for a Better Future* 2022, 6-9.

134(1)(g) – Simple, easy to understand, stable and sustainable modern award system

202. The Commonwealth notes the Joint Employer submission that the C10 framework plays a central role in the maintaining a stable and sustainable modern award system for the purposes of s134 (1)(g).

203. As the Commonwealth has observed above when discussing the objects of the FW Act, assessing work value in a manner which continues, as a starting point, to align rates of pay in one modern award with classifications in other modern awards with similar qualification requirements is one means of achieving the broad objective of stability. However, a strict alignment of award relativities based on qualifications, without proper consideration of the true work value of the cohort of employees in question cannot be expected to result in outcomes that are fair or relevant.

204. The Commonwealth submits that stability can be achieved by the Commission adopting an approach that involves a rigorous work value assessment in each case before it, having regard to all relevant factors.

134(1)(h) - Impact on employment growth, inflation and the sustainability, performance and competitiveness of the national economy

205. The Commonwealth submits that these factors do not militate against award minimum wage rises in this matter.

206. The aged care sector makes up around 2.4 per cent of total workers. To support quality of care and growing demand, DoHAC modelling estimates that the aged care workforce would have to expand by an average of 6.6 per cent each year over the next five years. Beyond the limited supply of additional hours from the existing aged care workforce, this additional labour supply would mostly draw on workers in other sectors of the economy, as well as new entrant workers and migrants.

207. Treasury finds that a 25 per cent increase to aged care worker wages, as sought by the Applicants, could potentially increase labour supply in the aged care sector by up to five to 10 per cent after five years over what would otherwise occur without the policy change.[149] However, this analysis assumes workers are indifferent between sectors and there is no impediment to the functioning of the labour market.

208. The impact on aggregate demand of a 25 per cent nominal wage increase confined to aged care workers alone would not be material, due to the relatively small size of the aged care sector relative to the economy as a whole. Treasury estimates that a 25 per cent wage subsidy contained to aged care workers would increase economy-wide wages by less than one per cent. However, in the current economic environment of above-target inflation and persistent global price shocks, there would be risks to inflation expectations if similar wage rises are demanded in associated industries.

209. Treasury finds the effect on Gross Domestic Product and productivity of an increase in aged care worker wages to be ambiguous. This result reflects the fact that aged care

[149] Based on modelling undertaken by Treasury.

services (including wages in the sector) are predominantly government funded, and the sector is subject to significant intervention, making it difficult to determine the economic impacts. As above, however, given the relatively small size of the aged care sector, Treasury would expect the effect on GDP (regardless of direction) to be modest.

F. AMENDMENTS TO CLASSIFICATION STRUCTURE

210. The Final Report of the Aged Care Royal Commission (the **Final Report**) emphasises the need to professionalise the personal care workforce and in this regard, made various observations that may be relevant when considering modern award classification structures. [150]

211. For example, the Final Report cites witness evidence, including from the UWU, that the structure within the Aged Care Award for the personal care workforce is very flat with limited career progression opportunities.[151] The Final Report refers to the 2018 recommendations of the Aged Care Workforce Strategy Taskforce (**Taskforce**). The Final Report states the Taskforce saw redefining existing roles and introducing new roles as a way to enable career progression opportunities.[152]

212. The Final Report states that now is the right time to review and modernise occupational and job structures to lay the foundation for reforms to pay classifications so that the pay classifications reflect their competency and qualifications and complexity of the work.

213. Similar issues are revealed in the expert evidence before the Commission. For example, Dr Charlesworth expresses concern that skills classifications in the Aged Care Award and SCHADS Award are rudimentary and compressed. She argues that increasing wage rates needs to be accompanied by a comprehensive skill and classification structure tied to training. [153] In both her report addressing the Aged Care Award and her supplementary report addressing the SCHADS Award, Dr Charlesworth concluded:

> It is the lack of recognition of the skills and competencies required and used by home care workers in award skill classifications, the inadequate provision of additional on-the job training opportunities and the lack of any meaningful wage increases in progression up the limited skill classification in the … Award that work to reinforce a view of home care workers as 'under skilled'.*[154]*

214. Professor Smith and Dr Lyons also provided expert opinion that the Aged Care Award classification structures lack relevant description and information, with the result that the work undertaken is not properly described and recognised in value.[155]

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150 HB Tab 357, Royal Commission into Aged Care Quality and Safety (Final Report, 1 March 2021), Volume 3A Chapter 12.3.

151 Ibid [12.3.1].

152 Ibid [12.3.1].

153 HB Tab 166, Expert Report of Dr Sara Charlesworth at Charlesworth, [13]; HB Tab 161, Supplementary Report of Dr Sara Charlesworth [16], [62].

154 HB Tab 166, Expert Report of Dr Sara Charlesworth at Charlesworth, [56]; HB Tab 161, Supplementary Report of Dr Sara Charlesworth [72]-[73].

155 HB Tab 166, Expert Report of Associate Professor Meg Smith and Dr Michael Lyons [91].

Aged Care Workforce Industry Council and its work

215. The Aged Care Workforce Industry Council (**ACWIC**) was established in May 2019. It is an industry-led council responsible for coordinating, monitoring and reporting on the 14 strategic actions set out in Australia's aged care workforce strategy, A Matter of Care. While ACWIC receives funding from the Commonwealth Government, it operates as a not-for-profit organisation, independent of Government. Consistent with the recommendations of the Taskforce and Commissioner Briggs,[156] ACWIC is currently working on a project to design the future structure of the aged care workforce.

216. While the Commonwealth notes that this work is ongoing, it also observes that the Commission's task is to determine the applications based on the evidence that it is before it.

Classification changes sought by the HSU

217. The classification changes to the Aged Care Award sought by the HSU would go some way towards improving career advancement for PCWs. Primarily these would:

- limit the application of Level 2 of the classification structure to PCWs with up to 6 months experience;
- describe PCWs at Level 4 as 'Senior Personal Care Workers' and specify that they may be required to assist residents with medication and hold the relevant unit of competency;
- recognise Specialist Care Workers, within level 6.

218. Currently, the Aged Care Award does not contemplate PCWs being employed at Level 6. According to the Classification Definitions in Schedule B, employees at this level exercise greater autonomy and responsibility, amongst other things, compared to employees at Level 5. The wage rate for employees at Level 6 is approximately 5.4 per cent higher than the Level 5 rate.[157]

219. The HSU's application would vary the Classification Definitions to include 'Specialist Personal Care Workers' and 'Senior Recreational/Lifestyle activities officers' within the Level 6 definition. The definition would state that Specialist PCWs provide specialised care and may have undertaken additional training in specific areas of care (eg Dementia Care, Palliative Care, Household Model of Care).

220. This would result in PCWs having access to an additional level in the Aged Care Award classification structure and allow access to the associated career progression and higher rates of pay. The Commonwealth supports these proposed variations and notes that as the clinical care needs of aged care recipients increases in complexity, more specialised personal care roles will be required in the sector. For example, the number of Australians living with dementia is projected to double, from around 400,000 in 2021 to nearly

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156 Ibid Recommendation 76.

157 $1,025.20 per week compared to $972.80 per week.

850,000 by 2058.[158] Over half of care recipients in residential aged care live with dementia, and two-thirds of those living with dementia live in the community. As such, the projected increase in prevalence of dementia over the next 40 years will affect the delivery of both residential and in-home aged care services. Establishing a 'Specialist Personal Care Worker' role would recognise the increased need for direct care workers in aged care with specialised skills to manage the complexities of these care needs and remunerate them accordingly.

221. The Commonwealth would support classifications set in a way that aligns with the AQF and the additional skills and training that workers may undertake over time. Both Certificate III and Certificate IV should be recognised and also that workers may undertake additional training in specific areas (eg units of competency).

Further variations open to the Commission

222. Having regard to the findings of the Aged Care Royal Commission and other evidence before the Commission, it would open to the Commission to vary the classification structure of the Aged Care Award beyond what is sought by the HSU, to provide further opportunities for career progression of aged care workers. This could include adding additional classification levels or making additional pay points available within a classification level.

223. The Classification Definitions in the Aged Care Award provide a particular wage level for employees with a Certificate III qualification. The definition of a Level 4 employee relevantly includes:

> …in the case of a personal care worker, holds a relevant Certificate 3 qualification (or possesses equivalent knowledge and skills) and uses the skills and knowledges gained from that qualification in the performance of their work.

224. The definition of a Level 5 employee relevantly includes:

> may require formal qualifications at trade or certificate level and/or relevant skills training or experience.

225. The classification definition for a Level 6 aged care employee under the Aged Care Award states that it '*…may require formal qualifications at post-trade or Advanced Certificate or Associate Diploma level and/or relevant skills training or experience*'. The HSU's application would vary this definition to replace 'Advanced Certificate' with 'Certificate IV' and replace 'Associate Diploma' with 'Diploma'.

226. In contrast, the ANMF's application to vary the Aged Care Award would include reference to Certificate IV within Level 5.

227. At present, rates of pay for home care workers in the aged care sector and residential aged care workers are set by very different classification structures, despite doing similar

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[158] *Dementia in Australia Report 2021*, 20 September 2021 available at: https://www.aihw.gov.au/getmedia/4afad8ba-08b5-4092-ab40-049a3cdb94eb/Dementia-in-Australia.pdf.aspx?inline=true

work. The Commission may wish to consider variations to the classification structure for home care workers in the aged care sector.

228. The Commission could also consider other variations to the classification structures of the Awards if it were satisfied that these are justified on work value grounds and necessary to achieve the modern awards and minimum wages objectives.[159]

229. Qualifications would not be the only available reference point. The Commission's predecessor tribunal has stated that the range of work functions performed, and the skills required should determine the appropriate number of levels in a classification structure.[160] The Commission ultimately has broad discretion in this regard.

Date: 8 August 2022

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Paul Vermeesch
AGS lawyer
for and on behalf of the Australian Government Solicitor
Solicitor for the Commonwealth of Australia

These submissions were settled by Yaseen Shariff SC and Vanja Bulut, counsel for the Commonwealth of Australia.

159 FW Act s 157(1).

160 *National Wage Case February 1989 Review Decision* (1989) 27 IR 196.

Annexure A: Composition of the Aged Care Workforce

Sources of data and limitations

1. Data presented in this paper is based on the National Aged Care Workforce Census (ACWC) of 2003, 2007, 2012, 2016 and 2020, unless stated otherwise. Sources for the original materials are provided.[1]

2. The aged care system changed substantially between the 2003 and 2020 ACWCs. Commonwealth-funded in-home aged care services have changed in format, and nature, over time. For 2020 data, "in-home aged care" refers to the Home Care Packages (HCP) program, and Commonwealth Home Support Program (CHSP). Typically, this data is provided separately for each program type. Due to overlap in workers between these programs, headcounts of HCP and CHSP cannot be added to obtain a total "home" workforce size. For 2016 data, "in-home aged care" refers to the "home care" and "home support" workforces. Statistics are combined within the report. In 2012 and 2007, "in-home aged care" refers to the "community aged care workforce", who operate "community based care". This included programs under a variety of funding arrangements, between the Commonwealth, and states and territories.

3. 2020 ACWC data is not de-duplicated. For example, a worker who works part-time at two separate residential aged care facilities will be counted as two residential aged care workers, or a worker who works across the HCP and CHSP programs will be counted once in each worker total.

4. Changes to ACWCs over time limit their direct comparison to earlier data sets:

    4.1. In 2020 the ACWC was asked only of providers, with no survey component requested of workers. This may limit the accuracy of some responses, such as the proportion of personal care workers with specific qualifications.

    4.2. The category Personal Care Worker (trainee) was not included in ACWCs prior to 2020. In this paper, Personal Care Workers and Personal Care Workers (trainee) have been combined in 2020 data.

    4.3. In 2020 the worker age brackets are different to those of 2003-2016.

    4.4. Questions asked in two subsequent ACWCs are not always identical. Where possible, questions that will provide similar outcomes have been combined, and in these cases the wording of all questions is provided.

    4.5. Nurse practitioners were first separated from the broader "registered nurse" category in 2012. Similarly, allied health professionals and allied health

[1] Sources are the four most recent ACWC reports:
2020: https://www.health.gov.au/resources/publications/2020-aged-care-workforce-census
2016: https://gen-agedcaredata.gov.au/www_aihwgen/media/Workforce/The-Aged-Care-Workforce-2016.pdf
2012: http://www.agedcarecrisis.com/images/pdf/The_Aged_Care_Workforce_Report.pdf
2007:
http://web.archive.org/web/20091129023625/http://www.health.gov.au/internet/main/publishing.nsf/Content/AAB95DEA18120153CA257512000423CB/$File/who%20cares.pdf
Data from 2003 are presented where they are reproduced in the 2007 report.

assistants were first separated in 2012, and were presented as a combined allied health workforce in 2007 and 2003.

5. Unless otherwise specified, n/a means “not available” – meaning the specific data point was not available in that ACWC report. Additionally, unless otherwise stated, “whole direct care workforce” data includes that of allied health professionals and allied health assistants, who are out of scope of the FWC work value case.

Size of the workforce

6. Data showing the size of the residential aged care workforce is presented in Table A1. Data showing the side of the in-home aged care workforce is presented in Table A2.

7. The residential workforce has grown by 77 per cent between 2003 and 2020. The total workforce size in in-home care has similarly grown, but the total FTE of care provided have remained similar.

8. In residential care, the total number and Full-time Equivalent (FTE) of enrolled nurses remained near constant over 2003-2020, and the total number and FTE of registered nurses remained near constant from 2003-2016. However, between 2016 and 2020, FTE of registered nurses grew by 38 per cent and headcount by 45 per cent.

9. In in-home care, the total number and FTE of enrolled nurses has stayed fairly constant over 2007-2020. The total FTE of registered nurses has reduced from 2012 to 2016, and from 2016 to 2020.

10. Much of the residential care workforce growth between 2003 and 2020, but particularly between 2003 and 2016, is in the personal care workforce. The total personal care workforce in residential care increased by 118 per cent between 2003 and 2020.

11. In residential care, the ratio of FTE of personal care workers to nurses has increased, from 1.58:1 in 2003 to 3.08:1 in 2020. In in-home care, the ratio of FTE of personal care workers to all nurses has increased, from 4.93:1 in 2007 to 8.03:1 in 2020 (considering a sum of HCP and CHSP FTE in 2020). This indicates a shift in the make-up of the workforce over the past 20 years, with a higher proportion of care provided by personal carers rather than nurses.

Table A1: Size of the Residential aged care workforce, by headcount and by FTE

Classification	Total workforce (headcount)				
	2020 ACWC	2016 ACWC	2012 ACWC	2007 ACWC	2003 ACWC
Whole PAYG workforce	277,261	235,764	202,344	174,866	156,823
Whole direct care workforce	208,903	153,854	147,086	133,314	115,660
Nurse Practitioner	203	386	294	22,399	24,019
Registered nurse	32,726	22,455	21,916		
Enrolled Nurse	16,000	15,697	16,915	16,293	15,604
Personal Care Worker	146,378	108,126	100,312	84,746	67,143
Allied health professional	10,604	2,210	2,648	9,875	8,895
Allied health assistant	2,992	4,979	5,001		

Classification	Total workforce (FTE)				
	2020 ACWC	2016 ACWC	2012 ACWC	2007 ACWC	2003 ACWC
Whole direct care workforce	129,151	97,920	94,823	78,849	76,006
Nurse Practitioner	163	293	190	13,247	16,265
Registered nurse	20,154	14,564	13,939		
Enrolled Nurse	9,919	9,126	10,999	9,856	10,945
Personal Care Worker	93,115	69,983	64,669	50,542	42,943
Allied health professional	4,081	1,092	1,612	5,204	5,776
Allied health assistant	1,720	2,862	3,414		
FTE ratio PCW:nurses	*3.08*	*2.92*	*2.57*	*2.19*	*1.58*

Table A2: Size of the In-home aged care workforce, by headcount and by FTE

Classification	Total workforce (headcount)				
	2020 ACWC		2016 ACWC	2012 ACWC	2007 ACWC
	HCP	CHSP			
Whole PAYG workforce	80,340	76,096	130,263	149,801	87,478
Whole direct care workforce	64,019	59,029	86,463	93,359	74,067
Nurse Practitioner	60	184	53	201	n/a
Registered nurse	3,022	5,008	6,969	7,631	7,555
Enrolled Nurse	887	1,699	1,888	3,641	2,000
Personal Care Worker	56,242	47,861	72,495	76,046	60,587
Allied health professional	3,376	4,306	4,062	3,921	3,925
Allied health assistant	432	705	995	1,919	

Classification	Total workforce (FTE)				
	2020 ACWC		2016 ACWC	2012 ACWC	2007 ACWC
	HCP	CHSP			
Whole direct care workforce	25,308	21,141	44,087	54,537	46,056
Nurse Practitioner	28	131	41	55	n/a
Registered nurse	1,241	2,298	4,651	6,544	6,079
Enrolled Nurse	357	813	1,143	2,345	1,197
Personal Care Worker	23,251	15,818	34,712	41,394	35,832

Allied health professional	766	1,834	2,785	2,618	2,948
Allied health assistant	147	249	755	1,581	
FTE ratio PCW:nurses	*14.3*	*4.88*	*5.95*	*4.63*	*4.92*
	8.03				

Gender split of the workforce

12. Data showing the proportion of the residential aged care workforce who identify as female is presented in Table A3. Similar data for the in-home aged care workforce is presented in Table A4.

13. In both residential and in-home aged care services, the vast majority of direct care workers (over 83 per cent) identify as female. This is the case for all direct care roles where this data is provided in 2016. 2016 data suggests the proportion of males is highest (over 10 per cent) in the personal care workforce and allied health workforce. The proportion of female workers in the residential care direct care workforce has decreased slightly from 2007 (93 per cent) to 2020 (86 per cent).

14. Approximately two thirds of indirect care workers in residential aged care who are in scope of this work value case – such as cooks, cleaners, and administrative staff – identify as female.[2]

Table A3: Proportion of direct care residential aged care workers who identify as female

Classification	**Percentage identifying as female**			
	2020 ACWC[3]	**2016 ACWC**	**2012 ACWC**	**2007 ACWC**
Whole direct care workforce	86	87.0	89	93
Nurse Practitioner	n/a	87.6	n/a	n/a
Registered nurse				
Enrolled Nurse		91.4		
Personal Care Worker		86.2		

Table A4: Proportion of direct care In-home aged care workers who identify as female

Classification	**Percentage identifying as female**			
	2020 ACWC[4]	**2016 ACWC**	**2012 ACWC**	**2007 ACWC**
Whole direct care workforce	n/a	89.1	90	91
Nurse Practitioner	n/a	93.7	n/a	n/a
Registered nurse	93			
Enrolled Nurse	n/a	94.3		
Personal Care Worker	89	88.8		

[2] Australian Bureau of Statistics, Characteristics of Employment, August 2021

[3] Noting that in 2016 gender distributions excluded agency/subcontractor roles, while 2020 responses did not differentiate these roles.

[4] Noting that in 2016 gender distributions excluded agency/subcontractor roles, while 2020 responses did not differentiate these roles.

Part-time and casual employment

15. The proportion of direct care workers in residential care and in-home care employed as permanent part time, casuals, or agency/contractors are shown in Tables A5 and A6 respectively.

16. Most direct care workers, across residential and in-home care, are employed on a permanent part-time basis. There is no consistent trend in these proportions over 2007-2020.

17. Across residential and in-home care, nurse practitioners are the most likely to be employed through agency or subcontractor arrangements. However there are only small number of nurse practitioners working in aged care (Tables A1-A2).

Table A5: proportion of Residential aged care direct care workers employed as permanent part time, casual/contractor, and agency/contractor

Classification	% permanent part time			
	2020 ACWC	2016 ACWC	2012 ACWC	2007 ACWC
Nurse Practitioner	29	67.7	61.3	59.9
Registered nurse	65			
Enrolled Nurse	76	78.9	74.7	72.9
Personal Care Worker	75	80.3	73.6	69.8

Classification	% casual/contractor			
	2020 ACWC	2016 ACWC	2012 ACWC	2007 ACWC
Nurse Practitioner	2	9.8	19.4	23.6
Registered nurse	22			
Enrolled Nurse	18	7.8	14.8	16.6
Personal Care Worker	20	10.8	19.5	23.4

Classification	% agency/contractor 2020 ACWC
Nurse Practitioner	17
Registered nurse	1
Enrolled Nurse	1
Personal Care Worker	1

Table A6: proportion of In-home aged care direct care workers employed as permanent part time, casual/contractor, and agency/contractor

Classification	% part time				
	2020 ACWC		2016 ACWC	2012 ACWC	2007 ACWC
	HCP	CHSP			
Whole direct care workforce	50	68	75.3	61.2	n.a.
Nurse Practitioner	16	44	59.4	53.3	52.9

Registered nurse	51	65			
Enrolled Nurse	55	69	71.5	67.2	52.9
Personal Care Worker	51	71	79.0	62.9	60.6

Classification	**% casual/contractor**				
	2020 ACWC		**2016 ACWC**	**2012 ACWC**	**2007 ACWC**
	HCP	**CHSP**			
Whole direct care workforce	41	23	13.5	27.3	
Nurse Practitioner	4	0	5.7	14.2	13.6
Registered nurse	29	17			
Enrolled Nurse	26	19	4.7	15.8	23.0
Personal Care Worker	44	25	15.3	30.4	31.9

Classification	**2020 ACWC: % agency/subcontractor**	
	HCP	**CHSP**
Nurse Practitioner	35	7
Registered nurse	3	1
Enrolled Nurse	2	2
Personal Care Worker	1	2

Workforce by age group

18. The age groups of direct care workers are shown in Table A7, for residential care workers, and Table A8, for in-home care workers. The age group brackets used in 2003-2016 ACWCs do not align with those in 2020, making it difficult to determine trends in this space.

19. However it is clear the residential care workforce became younger from 2016 to 2020, with higher proportions in the 20-29 and 30-39 age groups, and lower proportions in the 40-49 and 50-59 age groups.

Table A7: Age profile of the Residential aged care direct care workforce

Classification	**% of total direct care workers per age group**				
	2020 ACWC	**2016 ACWC**	**2012 ACWC**	**2007 ACWC**	**2003 ACWC**
16-24	n/a	6.4	7.1	6.1	6.0
< 20	1	1*	n/a	n/a	n/a
25-34	n/a	18.8	12.3	11.4	12.4
20-29	23	15	n/a	n/a	n/a
35-44	n/a	19.5	20.7	22.3	25.5
30-39	28	19	n/a	n/a	n/a
45-54	n/a	28.0	32.7	37.6	39.2
40-49	19	24	n/a	n/a	n/a
55-64	n/a	24.3	24.5	20.8	16.1
50-59	18	29	n/a	n/a	n/a
65+	n/a	2.9	2.7	1.7	0.8
60+	10	13	n/a	n/a	n/a

*In the 2020 ACWC report, 2016 age brackets were regrouped to 2020 age brackets by distributing workers across ages in line with 2016 ABS census residential aged care direct care worker ages. 2016 age totals excluded agency/subcontractor roles, while 2020 responses did not differentiate these roles

Table A8: Age profile of the In-home care aged care direct care workforce

Classification	% of total direct care workers per age group				
	2020 ACWC		2016 ACWC	2012 ACWC	2007 ACWC
	HCP	CHSP			
16-24	n/a	n/a	2.4	2.7	2.0
< 20	1	1	n/a	n/a	n/a
25-34	n/a	n/a	9.1	8.0	7.7
20-29	13	10	n/a	n/a	n/a
35-44	n/a	n/a	16.3	19.3	20.4
30-39	18	17	n/a	n/a	n/a
45-54	n/a	n/a	33.4	37.2	40.7
40-49	23	23	n/a	n/a	n/a
55-64	n/a	n/a	32.9	29.7	26.7
50-59	29	31	n/a	n/a	n/a
65+	n/a	n/a	5.9	3.1	2.5
60+	16	17	n/a	n/a	n/a

Culturally and Linguistically Diverse (CALD) status of workers

20. The proportion of aged care direct care workers self-identifying as CALD (in 2020) or born overseas (for 2007-2016, as a proxy for CALD status) are shown in Table A9, for residential care workers, and Table A10, for in-home care workers. Data suggests the proportion of CALD workers is highest for personal care workers and nurses.

21. The 2021 ABS Census determined 27.6 per cent of Australia's population were born overseas. The participation of overseas-born workers in the residential aged care workforce is higher than a proportional amount based on the Australian population. However this difference is not clear in the home care sector. In 2016 and 2020 the proportion of overseas-born/CALD-identifying workers has dropped below the Australian population average.

Table A9: CALD status (or proxy) of Residential aged care direct care workers

Classification	% of direct care workers self-identifying as CALD (2020) % of direct care workers born overseas (2016, 2012, 2007)			
	2020 ACWC	2016 ACWC	2012 ACWC	2007 ACWC
Nurses	35	28.7	34.6	32.5
PCWs	36			
Allied health	20			

Table A10: CALD status (or proxy) of In-home aged care direct care workers

Classification	% of direct care workers self-identifying as CALD (2020) % of direct care workers born overseas (2016, 2012, 2007)				
	2020 ACWC		2016 ACWC	2012 ACWC	2007 ACWC
	HCP	CHSP			

Nurses	17	8	22.9	26.7	27.7
PCWs	22	18			
Allied health	13	8			

Annexure B: Profile of the employees in the aged care sector (by classification and qualification)

Workers by award classification

1. The *proportion* of workers allocated to each award classification, by job title, has been estimated in Department of Health and Aged Care (DHAC) modelling.

2. In this paper we use the DHAC's workforce modelling to estimate the *number* of workers on each award classification in 2022–23. DHAC's modelling does not contain the following job titles: nurse practitioners, personal care worker (trainee). As such, estimated proportions for these workers are presented, but numbers of workers are not.

Proportion and number of workers, by job title, allocated to each award classification

Aged Care Award 2010

3. The percentage of each job title allocated to each Aged Care Award classification (in this case, Employee Levels 1-7) are shown in Table B1. Note that some totals in columns do not add to 100 per cent, as some job titles may be classified across multiple awards (for example, health and welfare service managers without nursing qualifications are classified on the Aged Care Award, but those with nursing qualifications are classified on the Nurses Award).

Table B1: Percentage of workers on each classification within the Aged Care Award

Aged Care Award Employee level	Percentage of workers on each classification										
	Health and welfare service manager	Personal care worker	Personal care worker (trainee)	Diversional therapist	Other direct care*	Chef	Cook	Cleaner	Laundry hand	Kitchen hand	Other indirect care**
1							5	10	10	10	20
2		10	100				25	90	90	35	20
3		24		40			35			45	10
4		40		40	20	20	20			10	10
5		20			20	30	15				10
6					20	40					10
7	5	6		20	20	10					10

*where other direct care is Welfare, Recreation and Community Arts Workers and Welfare Support Workers

**where other indirect care is Administration, Pastoral and Spiritual Care, and Unknown/other ancillary (which may include, e.g. gardeners, interpreters, drivers)

Using the proportions in Table B1, and DHAC's aged care demand modelling to determine the number of workers under each job title, the estimated number of workers on each of these award classifications in 2022-23 is shown in Table B2.

Table B2: Estimated number of workers on each classification within the Aged Care Award, 2022-23

Aged Care Award Employee level	Number of workers on each classification													Total
	Health and welfare service manager	Personal care worker	Personal care worker (trainee)	Diversional therapist	Other direct care	Chef	Cook	Cleaner	Laundry hand	Kitchen hand	Administration*	Pastoral and spiritual care*	Unknown/ other indirect care*	
1	-	-	-	-	-	-	203	658	239	1422	1372	170	169	4233
2	-	7510	-	-	-	-	1013	5919	2148	4975	1372	170	169	23276
3	-	18024	-	2002	-	-	1418	-	-	6397	686	85	84	28696
4	-	30040	-	2002	1288	557	810	-	-	1422	686	85	84	36974
5	-	15020	-	-	1288	835	608	-	-	-	686	85	84	18606
6	-	-	-	-	1288	1114	-	-	-	-	686	85	84	3257
7	402	4506	-	1001	1288	278	-	-	-	-	686	85	84	8330
Total	402	75100	-	5005	5152	2784	4052	6577	2387	14216	6860	848	843	124226

*proportions from Table B1 for “other indirect care” are applied to these occupations

Nurses Award 2020

4. Within the Nurses Award are four separate sets of classifications, for four different sets of workers:

    4.1. Assistants in nursing

    4.2. Enrolled nurses

    4.3. Registered nurses

    4.4. Nurse practitioners

5. We consider each relevant classification separately here.

Assistants in Nursing

6. Deloitte's modelling determined that effectively no Assistants in Nursing are classified on the Nurses Award, rather they are classified as personal care workers on either the Aged Care Award or the Social, Community, Home Care and Disability Services Industry (SCHADS) Award, depending on their workplace.

Enrolled Nurses

7. The percentage of enrolled nurses allocated to each relevant enrolled nurse classification (in this case, Pay Points 1-5) are shown in Table B3.

Table B3: Percentage of aged care enrolled nurses on each classification within the Nurses Award

Nurses' Award Enrolled Nurse Classification	Percentage of workers on each classification	
	Residential care	In-home care
Pay point 1	14	14
Pay point 2	18	18
Pay point 3	20	20
Pay point 4	24	24
Pay point 5	24	24

8. Based on DoHAC's aged care demand modelling, the estimated number of workers on each of the enrolled nurse award classifications in 2022–23 is shown in Table B4.

Table B4: Estimated number of aged care enrolled nurses on each classification within the Nurses Award, 2022-23

Nurses' Award Enrolled Nurse Classification	Percentage of workers on each classification		Totals
	Residential care	In-home care	
Pay point 1	1782	68	1850
Pay point 2	2291	87	2378
Pay point 3	2545	97	2642
Pay point 4	3054	116	3170
Pay point 5	3054	116	3170
Totals	12726	484	13210

Registered Nurses

9. Several job titles within aged care are classified to registered nurse levels within the Nurses Award: registered nurse, nurse manager, and health and welfare service manager.

10. The percentage of workers considered as *registered nurses* allocated to each relevant registered nurse classification (in this case, Levels 1-5, with various pay points within each level) are shown in Table B5.

Table B5: Percentage of aged care registered nurses on each classification within the Nurses Award

Nurses' Award Registered Nurse Classification		Percentage of workers on each classification	
Level	**Pay point**	**Residential care**	**In-home care**
1	1	3	7
1	2	3	7
1	3	3	8
1	4	3	8
1	5	4	9
1	6	4	9
1	7	5	9
1	8 and thereafter	5	10
2	1	6	4
2	2	6	4
2	3	10	6
2	4 and thereafter	10	6
3	1	2	1
3	2	2	1
3	3	3	1
3	4 and thereafter	4	1
4	1	2	1
4	2	3	1
4	3	4	1
5	1	2	1
5	2	2	1

5	3	3	1
5	4	3	1
5	5	4	1
5	6	4	1

Nurse managers are senior registered nurses, and are classified from Level 3 and above within the registered nurse levels on the Nurses Award. The percentage of *nurse managers* allocated to each relevant registered nurse classification are shown in Table B6.

Table B6: Percentage of aged care nurse managers on each registered nurse classification within the Nurses Award

Nurses' Award Registered Nurse Classification		Percentage of workers on each classification	
Level	**Pay point**	**Residential care**	**In-home care**
3	1	5	3
3	2	5	3
3	3	10	5
3	4 and thereafter	10	5
4	1	5	3
4	2	5	4
4	3	10	5
5	1	5	10
5	2	5	10
5	3	8	12
5	4	8	12
5	5	12	14
5	6	12	14

Health and welfare service managers with nursing qualifications are classified at the highest registered nurse level within the Nurses Award, Level 5. The percentage of *health and welfare service managers* allocated to each relevant registered nurse classification are shown in Table B7.

Table B7: Percentage of nursing-qualified aged care health and welfare service managers on each registered nurse classification within the Nurses Award

Nurses' Award Registered Nurse Classification		Percentage of workers on each classification	
Level	**Pay point**	**Residential care**	**In-home care**
5	1	5	0

5	2	5	5
5	3	5	5
5	4	10	10
5	5	10	10
5	6	10	10

11. Based on DHAC's aged care demand modelling, the estimated number of workers on each of these registered nurse award classifications in 2022–23 is shown in Table B8.

Table B8: Estimated number of aged care workers on each registered nurse classification within the Nurses Award, 2022-23

Nurses' Award Registered Nurse Classification		Number of workers on each classification		Totals
Level	Pay point	Residential care	In-home care	
1	1	1634	237	1871
1	2	1634	237	1871
1	3	1634	271	1905
1	4	1634	271	1905
1	5	2179	305	2484
1	6	2179	305	2484
1	7	2723	305	3028
1	8 and thereafter	2723	339	3062
2	1	3268	136	3404
2	2	3268	136	3404
2	3	5447	204	5651
2	4 and thereafter	5447	204	5651
3	1	1239	41	1280
3	2	1239	41	1280
3	3	1934	46	1980
3	4 and thereafter	2479	46	2525
4	1	1239	41	1280
4	2	1784	44	1828
4	3	2479	46	2525
5	1	1641	58	1699
5	2	1641	351	1992
5	3	2276	356	2632

5	4	2678	648	3326
5	5	3343	653	3996
5	6	3343	653	3996
Totals		61085	5974	67059

Nurse Practitioners

12. The percentage of workers allocated to each relevant nurse practitioner classification are shown in Table B9.

Table B9: Percentage of aged care nurse practitioners on each classification within the Nurses Award

Nurses' Award Nurse Practitioner Classification	Percentage of workers on each classification	
	Residential care	In-home care
1st year	20	20
2nd year	80	80

13. DHAC's modelling does not separate nurse practitioners from registered nurses. As such, no worker totals per classification are presented here.

SCHADS Award 2010

14. The percentage of each job title allocated to each SCHADS Award classification (in this case, Employee Levels 1-5, with one or two pay points per level) are shown in Table B10. Note: some totals in columns do not add to 100 per cent, as some job titles may be classified across multiple awards (for example, health and welfare service managers without nursing qualifications are classified on the SCHADS Award, but those with nursing qualifications are classified on the Nurses Award).

Table B10: Percentage of workers on each classification within the SCHADS Award

Classification		**Percentage of workers on each classification**										
Level	**Pay point**	**Health and welfare service manager**	**Personal care worker**	**Personal care worker (trainee)**	**Diversional therapist**	**Other direct care***	**Chef**	**Cook**	**Cleaner**	**Laundry hand**	**Kitchen hand**	**Other indirect care****
1	1		10	70		10			15	15	15	16
2	1		10	30		5			20	20	20	5
2	2		17			14			50	50	50	20
3	1		5			5	5	15	5	5	5	5
3	2		16			15	20	60	10	10	10	20
4	1		5		5	5	15	5				5
4	2		16		15	15	45	20				12
5	1	5	5		35	5	5					5
5	2	5	16		45	14	10					12

*where other direct care is Welfare, Recreation and Community Arts Workers and Welfare Support Workers

**where other indirect care is Administration, Pastoral and Spiritual Care, and Unknown/other ancillary (which may include, e.g. gardeners, interpreters, drivers)

15. Using the proportions in Table B10, and DHAC's aged care demand modelling to determine the number of workers under each job title, the estimated number of workers on each of these award classifications in 2022-23 is shown in Table B11.

Table B11: Estimated number of workers on each classification within the SCHADS Award, 2022-23

Classification		Percentage of workers on each classification													Totals
Level	Pay point	Health and welfare service manager	Personal care worker	Personal care worker (trainee)	Diversional therapist	Other direct care	Chef	Cook	Cleaner	Laundry hand	Kitchen hand	Administration *	Pastoral and spiritual care*	Other/ unknown indirect care*	
1	1	-	5783	-	-	2193	-	-	87	29	68	2278	19	1334	11791
2	1	-	5783	-	-	1096	-	-	116	39	91	712	6	417	8260
2	2	-	9831	-	-	3070	-	-	291	96	228	2848	24	1667	18055
3	1	-	2891	-	-	1096	11	42	29	10	23	712	6	417	5237
3	2	-	9252	-	-	3289	44	170	58	19	46	2848	24	1667	17417
4	1	-	2891	-	17	1096	33	14	-	-	-	712	6	417	5186
4	2	-	9252	-	52	3289	99	57	-	-	-	1709	14	1000	15472
5	1	293	2891	-	122	1096	11	-	-	-	-	712	6	417	5548
5	2	293	9252	-	157	3070	22	-	-	-	-	1709	14	1000	15517
Totals		5851	57828	-	348	21928	220	283	582	193	457	14240	119	8335	110384

*proportions from Table B10 for “other indirect care” are applied to these occupations

Additional qualifications of workers

Personal care workers

16. The 2020 Aged Care Workforce Census (ACWC) reported: 66 per cent of personal care workers in residential care, 60 per cent of HCP workers, and 70 per cent of CHSP workers held a Certificate III level qualification or higher in a relevant direct care field.

Table B12: Additional qualifications of personal care workers in 2003-2020 ACWC

Worker Classification	Minimum required qualification	Percentage with additional qualifications, reported in ACWC					
		Additional qualification description	2020	2016	2012	2007	2003
Residential care Personal Care Worker	**None**	Any post-high school qualification	n/a	87.4	84.1	76.3	83.6
		A relevant Certificate III	66	n/a	n/a	n/a	n/a
		Certificate III in aged care	54.9	67.4	65.7	65	65
		Certificate IV in aged care	11.1	22.9	20.0	13	8
		Currently studying a relevant qualification	2	17.1	24.9	n/a	n/a
In-home care Personal Care Worker	**None**	Any post-high school qualification	n/a	85.8	83.7	76.1	n/a
		A relevant Certificate	HCP: 63 CHSP: 71	n/a	n/a	n/a	n/a
		Certificate III in aged care	n/a	50.9	48.1	48.3	n/a
		Certificate IV in aged care	n/a	12.2	13.3	6.2	n/a
		Currently studying a relevant qualification	HCP: 4 CHSP: 2	10.6	21.4	n/a	n/a

Nurses

17. The 2020 ACWC did not contain any information about additional qualifications of aged care nurses. However, some data is available from the 2016 and 2012 Aged Care Workforce Censuses, presented in Table B13. Less than 30 per cent of registered nurses, and less

than 20 per cent of enrolled nurses, held an additional specialised qualification in ageing or aged care in 2012 and 2016, on top of their minimum required qualification.

Table B13: Additional qualifications of nurses in 2012 and 2016 ACWC

Worker Classification	Minimum required qualification	Additional qualification description	Percentage with additional qualifications			
			Residential care		In-home aged care	
			2016	2012	2016	2012
Registered nurse	**Bachelor's Degree**	Specialised qualifications in ageing or aged care	29.0	31.0	23.0	22.1
Enrolled Nurse	**Diploma**	Specialised qualifications in ageing or aged care	17.5	19.8	19.7	6.3

Enterprise Bargaining Agreement (EBA) coverage

18. The EBA coverage on each in-scope award has been estimated as part of DHAC's modelling. This coverage is split into additional sub-categories: nominally-expired EBAs, where wages have dropped back to award levels; and active or nominally-expired EBAs where wages are a low, medium, or high percentage above award levels. These low, medium and high percentages were determined using a sampling of active EBAs and are different for each award.

Aged Care Award 2010

19. 24.20% of in-scope employees on the Aged Care Award 2010 are estimated to be on award, with 75.80% on EBAs.

20. This 75.80% on EBAs was broken down further:

    20.1. 46.59% were on nominally expired EBAs, where wages have dropped back to award levels.

    20.2. 8.65% were on EBAs with wages <3% higher than award

    20.3. 12.99% were on EBAs with wages 3%-6% higher than award

    20.4. 7.57% were on EBAs with wages over 6% higher than award

Nurses Award 2020

21. 14.30% of in-scope employees on the Nurses Award 2020 are estimated to be on award, with 85.70% on EBAs.

22. This 85.70% on EBAs was broken down further:

    22.1. 45.77% were on nominally expired EBAs, where wages have dropped back to award levels.

    22.2. 16.50% were on EBAs with wages <15% higher than award

    22.3. 9.84% were on EBAs with wages 15%-25% higher than award

22.4. 13.59% were on EBAs with wages over 25% higher than award

SCHADS Award 2010

23. 68.00% of in-scope employees on the SCHADS Award 2010 are estimated to be on award, with 32.00% on EBAs.

24. This 32.00% on EBAs was broken down further:

24.1. 20.42% were on nominally expired EBAs, where wages have dropped back to award levels.

24.2. 10.25% were on EBAs with wages <5% higher than award

24.3. 1.33% were on EBAs with wages over 15% higher than award