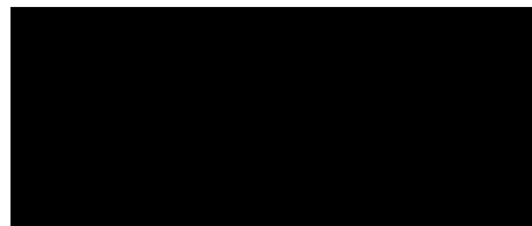
IN THE FAIR WORK COMMISSION (FWC) Matter No: AM2021/65
Application to vary the Social, Community, Home Care and Disability Services Industry Award

SUPPLEMENTARY STATEMENT OF GABRIELLE ANNE MEAGHER

I, Dr Gabrielle Anne Meagher, Professor Emerita at Macquarie University in the State of New South Wales, state as follows:

1. I have prepared a supplementary report dated 27 October 2021 which I prepared at the request of the Applicant for the purposes of these proceedings (**Supplementary Report**).
2. A copy of the Supplementary Report is annexed to this statement and marked **GM-5**.
3. The Supplementary Report expands on a report I previously provided in relation to Matter No: AM2020/99 (application by the HSU and others to vary the Aged Care Award 2010), which report was annexed to my statement in those proceedings dated 31 March 2021.
4. A copy of the letter of instruction issued to me by the Applicant in relation to the Supplementary Report is annexed to this statement and marked **GM-6**.
5. A copy of my Curriculum Vitae is annexed to this statement and marked **GM-7**. My Curriculum Vitae contains a summary of my training, qualifications and experience which provide me with the specialised knowledge to prepare the Supplementary Report annexed to this statement.
6. The opinions I have expressed in the Supplementary Report are based wholly or substantially on specialised knowledge arising from my training, study and experience.
7. I have made all the enquiries that I believe are desirable and appropriate and no matters of significance which I regard as relevant have, to the best of my knowledge and belief, been withheld from the Fair Work Commission.
8. I have been provided with a copy of the Federal Court of Australia Expert Evidence Practice Note dated 25 October 2016, and I have read and understood the Practice Note, agree to be bound by it, and have complied with it in preparing the Supplementary Report.
9. I have read the Expert Witness Code of Conduct and Agree to be bound by its terms.



Dr Gabrielle Meagher

Date: 27 October 2021

Faculty of
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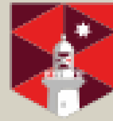

MACQUARIE
University

Research Report

Supplementary report on workforce and work value issues in Australian home care for older people

Prepared by
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Introduction

This supplementary report presents the findings of research on the nature and valuation of care work in home care and home support in Australia, in the context of change in the structure of the sector and in community expectations about aged care. The focus is the care work carried out by employees under the Social, Community, Home Care and Disability Services [SCHADS] Industry Award (2010), who provide personal care, maintenance, domestic assistance and support services to older people living in the community.

These employees work in organisations that are funded under two main Australian Government programs: the Commonwealth Home Support Programme (CHSP) and the Home Care Packages program (HCPs). The CHSP is described by the government as providing 'entry level support',[1] while HCPs 'are designed for those with more complex care needs that go beyond what the Commonwealth Home Support Programme can provide'.[2] Unless any findings relate specifically to one of these programs, they are referred to together as 'home care and support' throughout this report. The non-professional workforce who deliver these services are referred to as 'community care workers'.

To understand the changing nature of care work in home care requires knowledge about change in 1) the group of people who receive home care services, 2) the role and operation of the home care and support system, and 3) the structure and characteristics of the workforce employed to provide care and support, and 4) models of care and support. The report analyses these aspects of the Australian home care and support system and discusses the implications of the trends identified for home care and support work. The research is based on analysis of a wide range of official data, public policy documents related to aged care, and other national and international peer-reviewed studies about home care and support.

The findings should be considered in the context of international peer-reviewed research on the nature and valuation of care work, specifically on factors that lead to the historical and contemporary undervaluation of work in occupations such as community care worker in home care. This research on undervaluation of care work is presented in an earlier report, *Changing aged care, changing aged care work: workforce and work value issues in Australian residential aged care* (Meagher, 2021).

[1] https://www.myagedcare.gov.au/help-at-home/commonwealth-home-support-programme.
[2] https://www.myagedcare.gov.au/help-at-home/home-care-packages

1. Who receives home care and support and how is this group changing?

Around a million older people receive care and support in their own homes through an Australian Government funded program. On 31 March, 2021, more than 167,000 older people were receiving a home care package, while during the year to 30 June 2020, around 830,000 older people received some form of care, assistance and support through the Commonwealth Home Support Program.[3]

In recent years, the proportion of people aged 65 years and older who use home care services has increased and the proportion using residential care has decreased,[4] in line with government policies of ageing-in-place and older people's preferences to remain in their own homes for as long as possible (for more detail, see Section 2 below). **Overall, the home care and support system is growing and the profile of older people using services is becoming more diverse and complex.**

While people aged 65 and over (and Aboriginal and Torres Strait Islander people aged 50 and over)[5] are eligible for aged care services, the majority of people receiving home care and support are 80 years or over. Among recipients of home care packages, 64% were aged 80 and over in 2020, while around two-fifths were aged 85 and over (41%). Among recipients of support under the CHSP, 53% were aged 80 and over in 2020, while 30% were aged 85 and older.[6]

Older people who use home care and support are often frail and many suffer from multiple health conditions. Starting to receive home care and support is often precipitated by a health event, such as hospitalisation for a heart attack, stroke or heart failure.[7] Around two fifths (41%) of people entering home care and support have a major cardiovascular disease, compared to less than one fifth (16%) of older people who do not receive aged care services.[8] Older people who receive home care are twice as likely to fall, compared to those who do not receive home care,[9] with falls being the main injury-related reason older people present to emergency or are admitted to hospital.[10] Injuries sustained during falls increase

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[3] See 'Client summary' table in the *2020 Aged Care Data Snapshot*, published by the Department of Health. Retrieved from https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Data-Snapshot/Aged-Care-Data-Snapshot-2020-Release-3-1.xlsx.

[4] Khadka, Lang, Ratcliffe, Corlis, Wesserlingh, et al. (2019).

[5] Eligibility for aged care services is defined this way in Australian policy. Planning for aged care services uses the ratio of service provision to the share of the population aged 70 and over. Various data are reported using these two different definitions of the relevant population, which is why usage varies in this report.

[6] Aged care data snapshot 2020–third release. Retrieved from https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Data-Snapshot/Aged-Care-Data-Snapshot-2020-Release-3-1.xlsx.

[7] For example, a study by Hsu, Korda, Lindley et al. (2021) found that older people in New South Wales who had been hospitalised for a heart attack, stroke or heart failure were significantly more likely to start to use 'community care' (encompassing HCP, CHSP and smaller programs such as Transitional Care) during the year following discharge, with the probability increasing over that year (Table 2).

[8] Hsu, Korda, Naganathan, Lewis, Ooi et al. (2021).

[9] Burton, Lewin, O'Connell, & Hill (2018).

[10] Lee, McNamara, English, & Meusemann (2020).

older peoples' immediate need for care and support if they are able to return home, and may also lead to long term increases in care and support needs.

Further, there is evidence that the population of older people entering the home care and support system is becoming more frail and less healthy over time. A study published in 2021 examined the health status and health care usage trends of older people using aged care in Australia between 2006 and 2015.[11] The study included **home care package recipients** and found that:[12]

- In 2015, 61% of HCP clients had at least five health conditions, up from 53% in 2006, while one in 14 had ten or more health conditions, up from one in 17 in 2006.
- In 2015, more than one fifth of HCP clients had dementia (22%). Overall, older people with dementia are significantly more likely to use a home care package than older people without dementia.[13]
- Half (51%) had a high frailty score in 2015, up from 15% in 2006.
- More than a third were assessed as having depression in 2015 (36%), up from 32% in 2006, and a third had pain (34%) in 2015, up from a quarter (24%) in 2006.
- The median number of medications prescribed for HCP clients within one year of entering home care was nine; identical to that of older people entering residential care. This 'polypharmacy' (usually defined as use of five or more medications) opens the risk of adverse medication interactions and use of unnecessary and inappropriate medicines.[14]
- A fifth (20%) had an urgent attendance after hours at a health care service during the first year of services in 2015, up from 15% in 2006.
- Around one in twenty recipients died within three months of entering home care services and more than a third (35%) died within three years. Further, the rate of death among home care package recipients was four times higher than the rate of death in the Australian population as a whole, adjusted for age and sex.[15]

More than two fifths of older people receiving a home care package lives alone (43%).[16] The remainder mostly live with their partner or other family members.

In 2019-2020, the median length of time a person held a HCP was 16 months, while the average length of stay was 27 months.[17] This suggests that there are large minorities of both

[11] Inacio, Lang, Bray, Visvanathan, Whitehead, et al. (2021). Studies that provide robust measures of the health status of older people using aged care services require the linking of records across multiple data systems. Establishing databases takes a considerable length of time, hence the delay in reporting on older people currently using the system.
[12] Inacio, Lang, Bray, Visvanathan, Whitehead, et al. (2021), Table 1. All findings reported in this list are taken from this study, unless otherwise noted. This study included older people who received residential care or a home care package only, because it relied on ACAT assessments for health data. CHSP clients are assessed under a different process.
[13] Welberry, Jorm, Barbieri, Hsu & Brodaty (2021), p. 1159.
[14] Bony, Lloyd, Hotham, Corre, Corlis et al. (2020).
[15] Inacio, Lang, Khadka, Watt, Crotty et al (2020), page e540.
[16] Department of Health (2020b), page 26.
[17] Aged Care Financing Authority (2021), page 21.

short-term HCP clients (since half stay less than 16 months) and long-term HCP clients (since the average is much higher than the median). There also appears to be considerable turnover among HCP clients.[18] While the majority of people who exited a HCP in 2019-20 moved into residential care (55%) in 2019-20, a third (34%) exited because they died.[19]

Table 1 shows the entry and turnover of older people into the HCP system in the context of system expansion. Column A shows the number of people holding a home care package at 31 March for each of the last three years. As discussed in more detail in Section 2 below, the data in Column A show that the HCP program has been expanding rapidly in recent years. Column B shows the number of people who entered a HCP for the first time in the year to 31 March, for each of the last three years. In a growing system, we need to separate people entering because there are now more places from people entering a vacancy created by another person's exit. Accordingly, Column C captures *system growth*, showing the increase in the number of people in a HCP package over each of the last three years. (For example, on 31 March 2021, there were 30,125 more people in a home care package than there were on the same date in 2020.). Column D captures *turnover* in the HCP system, showing the number of new entrants over the preceding year that cannot be accounted for by system growth. These data suggest that there has been 20% turnover in home care package clients over the last two years.

Table 1: New entrants, system growth and turnover in the HCP program, 2018-2021[20]

	A In a HCP at 31 March	B Entered a HCP for first time in year to 31 March	C Growth in no. of HCP holders since previous year (system growth)	D Net new entrants (Total entrants less system growth)	E Net new entrants as a share of all HCP holders at year's end
2021	167,124	63,192	30,215	32,977	20%
2020	136,909	65,638	37,799	27,839	20%
2019	99,110	41,451	14,139	27,312	28%
2018	84,971	-	-	-	-

There is less recent research about older people receiving services from the Commonwealth Home Support Scheme. **CHSP recipients** are slightly younger, on average, than home care package recipients.[21] A small minority of CHSP clients lives with a carer; only 16% did so in 2018.[22]

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[18] Welberry, Jorm et al. (2021) looked at use of aged care by all members of a longitudinal ageing study (the 45 Up Study) who died between 1 July 2011 and 30 June 2014. Among users of lower level home care packages, median length of stay was 9 months for people with dementia and 12 for people without dementia. Among users of higher level packages, median length of stay was 9 years, regardless of dementia status (Table 1).
[19] See https://www.gen-agedcaredata.gov.au/Topics/People-leaving-aged-care.
[20] Author's analysis of data provided in quarterly Home Care Packages Program Data Reports. Retrieved from https://gen-agedcaredata.gov.au/Resources/Reports-and-publications/2020/September/Home-care-packages-report.
[21] Author's analysis of data provided at https://www.gen-agedcaredata.gov.au/Topics/People-using-aged-care#Aged%20care%20use%20by%20age%20and%20sex%20over%20time.
[22] Department of Health (2020a), page 16.

Like HCP clients, CHSP clients are relatively frail compared to the rest of the community-dwelling population, and their use of services is higher the more health and social concerns they face. A longitudinal study of older women found that those who had chronic health conditions, and those who reported lower health, social and physical functioning were significantly more likely to use home support services than those without chronic conditions and with higher levels of functioning.[23] And once a person accesses home support, there is evidence that people with more functional limitations and specific health conditions, such as dementia or stroke, use more services.[24]

There is considerable turnover in the group of older people receiving services under the CHSP. A recent study for the Department of Health found that the average length of service from entry to exit was around two years (102 weeks). In 2017-18, around half clients received services for the whole year, one fifth began services and continued, and around a third either exited (17%) or started and exited within a year (15%).[25] Some clients exit to other aged care services (a home care package or residential care) because they require additional assistance, while others pass away. A small minority exit services because they no longer need assistance.[26]

Older people receiving home care and support come from a diverse range of backgrounds and 'special needs groups', as identified under the Aged Care Act. Identified special needs groups include people who are: Aboriginal and Torres Strait Islander; from culturally and linguistically diverse (CALD) backgrounds; living in rural or remote areas; financially or socially disadvantaged; veterans; experiencing homelessness or at risk of becoming homeless; care leavers; parents separated from their children by forced adoption or removal; [and] lesbian, gay, bisexual, transgender and intersex.[27]

While the CHSP and HCP program are funded separately and have ostensibly different target populations, they serve at least partly overlapping target groups, and to some extent, the same clients. A 2020 study of the CHSP for the Department of Health found that nearly a quarter (24%) of older people receiving a home care package *also* received services from the CHSP. Clients using both programs tended to be older and were more likely to come from special needs groups, including Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse (CALD) backgrounds and people with a disability.[28] And while half all CHSP clients (50%) accessed only one service type during 2019-20, more than two fifths (43%) accessed between two and four service types. The remaining 7% accessed five or more service types.[29] This is approximately 58,000 people – the same as the number of Level 2 HCPs in 2020.

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[23] Rahman, Efird, Kendig & Byles (2019).
[24] Department of Health (2020a), page 7.
[25] Department of Health (2020a), author's calculations based on data presented in Chart 1.8, page 18.
[26] Department of Health (2020a), page 18.
[27] https://www.health.gov.au/health-topics/aged-care/providing-aged-care-services/working-in-aged-care/working-with-diverse-groups-in-aged-care
[28] Department of Health (2021), page 32.
[29] Aged Care Financing Authority (2021), page 35. Number of people receiving five or more service types calculated as 7% of the total number of CHSP recipients.

2. How does the home care and support sector operate and how is this changing?

Change in the nature of work in home care and support has been partly driven by change in the design, funding and operation of the home care and support system.

Home care and support have an increasing role relative to residential care in Australia's aged care system, as successive Australian governments have used funding and planning levers to shift the distribution of aged care funding and operations towards home care and support and away from residential care. These changes help explain the increasing level of need among home care and support clients.

Governments have also changed models of home care and support through concepts such as 'consumer directed care' and 'wellness and reablement', and in recognition of the diversity of the ageing population and the special needs of particular groups, such as older people with dementia. Social expectations around the quality and availability of care have also changed, bringing new demands on care systems and care workers. These issues are discussed in more detail in Section 2.4 below.

Meanwhile some problems persist, notably unmet and under-met need for care and support, which also make strong demands on care systems and care workers.

2.1 The growing and changing role of home care and support in the aged care system

As noted above, there are two main programs for home care and support. **The Commonwealth Home Support Programme (CHSP) is framed as an 'entry level' service.** According to the Department of Health, the CHSP's program goals are to 'help people live as independently as possible', to 'focus on working with them, rather than doing things for them', and to 'give a small amount of help to a large number of people'.[30] The CHSP is a block-funded program, whereby providers receive grants to deliver services including allied health care, domestic assistance, specialised equipment and assistive technology, home maintenance, home modifications, meals, nursing, personal care, social support, transport and respite for carers. Unlike Home Care Packages, as discussed below, funding and provision under the CHSP 'have never been formally linked to the size of the population base through a device such as the planning ratio'.[31]

The Home Care Packages program 'supports older people with complex care needs' through a 'a coordinated mix of services' offered in a tiered system 'from level 1 for basic care needs to level 4 for high care needs'.[32] The list of services that can be provided within an HCP is much the same as the services offered under the CHSP (see Section 2.2

[30] https://www.health.gov.au/initiatives-and-programs/commonwealth-home-support-programme-chsp/about-the-commonwealth-home-support-programme-chsp.
[31] Gibson (2020), page e520.
[32] https://www.health.gov.au/initiatives-and-programs/home-care-packages-program/about-the-home-care-packages-program.

below), although the amount and mix of services differs especially at higher levels of HCP, and care management is also included.

Unlike the CHSP, the HCP program is integrated into the population-based 'aged care provision target ratios'. Successive governments since the mid 1980s used these ratios in an effort to distribute residential care, and later community care packages, between 'aged care planning regions' according to local need, including the share of older people in the population. Together, home care packages and residential care places are 'aged care places', offered in a ratio per 1,000 people aged 70 and over.[33] **Over time, the share of residential and home care packages has shifted in favour of home care packages.** In 1992, the planned ratio was 10 home care[34] and 100 residential care places[35] per 1,000 people aged 70 and over. In 2013, the planning ratio was set at 27 home care and 86 residential care places under a total of 113 places.[36] The *Living Longer, Living Better* policy of 2012 adjusted the target ratios to progressively increase total places per 1,000 people 70 and over from 113 to 125 by 2021-22. Within this overall total, the target for home care packages was increased from 27 to 45, with a corresponding fall in the number of residential care places from 86 to 78.[37] In fact, more packages have been released than planned for in the LLLB package. At 30 June 2020, there were 53.6 mainstream packages available per 1,000 people aged 70 and over.[38]

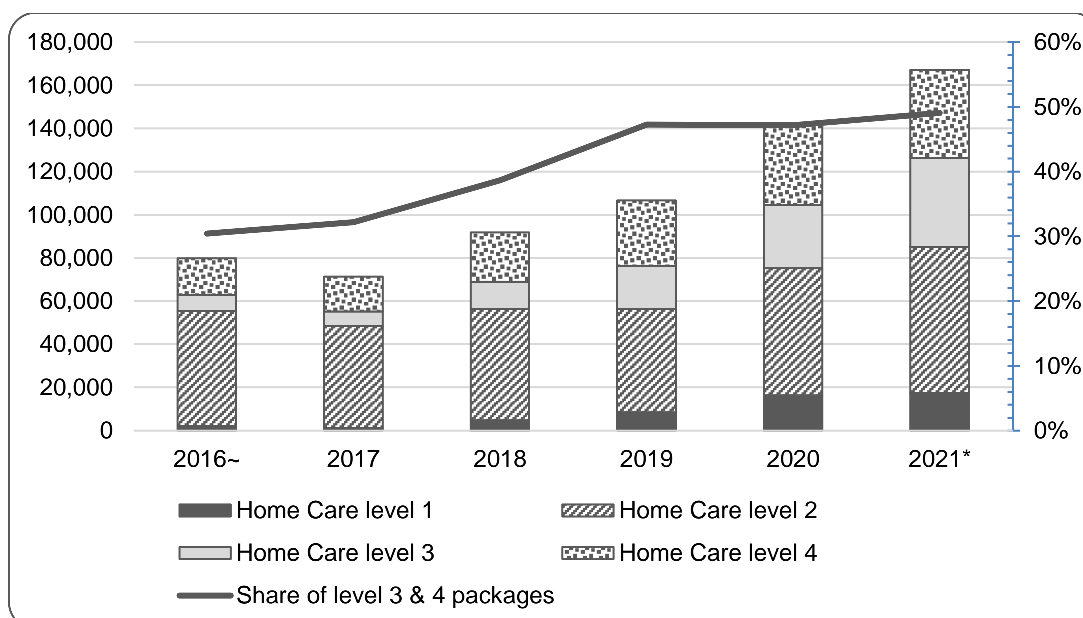
The trend towards home support is clear: **the share of people aged 65 and over who lived permanently in residential care during the year fell from 65 per 1,000 in 2011-12 to 56 per 1,000 in 2019-20, while the share receiving a home care package increased from 23 per 1,000 to 41 per 1,000 across the same period.**[39] Over time, then, the **Home Care Packages Program has 'increasingly developed as a viable alternative to residential care**, allowing older people to age in their own homes'.[40] This is especially the case with rapid growth in the number and share of higher level packages over recent years, as the share of older people receiving services from the CHSP and its precursors has declined slightly over the last decade. As *Figure 1* shows, between 2016 and 2021, the number of packages has more than doubled from around 80,000 to nearly 170,000, while the share of level 3 and 4 packages increased from less than a third (30%) to almost half (49%).

There is also some evidence that CHSP services are a partial substitute for residential aged care, especially in remote and regional areas. A recent study reported that greater use of home support in remote/regional areas reflected limited access to residential aged care and

[33] The annual Aged Care Approval Rounds through which 'operational places' in residential and home care were 'released' for provider tender are
[34] Australian Institute of Health and Welfare (2000), Section 2.1. At this time, packages were called 'Community Aged Care Packages'.
[35] Australian Institute of Health and Welfare (1993), page 208.
[36] Aged Care Financing Authority (2013).
[37] The two remaining places were allocated to the Short Term Restorative Care Programme. Aged Care Financing Authority (2021), page vi.
[38] ACFA *Annual Report on the Funding and Financing of the Aged Care Sector – 2021*, page vi
[39] *Report on Government Services 2013* for 2011-12 and *Report on Government Services 2021* for 2019-20.
[40] Gibson (2020), page e520.

the relative costs to older people of the two services (higher in residential care; lower in home support).[41]

Figure 1: Number of home care packages at 30 June 2016-2020, and at 31 March 2021 (left axis), and share of level 3 and 4 packages 2016-2020 (right axis)



Notes: ~ In 2016, the reported numbers are operational HCP places. Following the introduction of 'consumer-directed care' in 2017, reported numbers are people in packages as at 30 June.
* Data are available only to 31 March for 2021.

2.2 What services are offered in home care and support?

To understand work in home care and support, it is useful to know more in detail about the amount and kinds of services offered under these programs. Analysis shows that the majority of services are provided by community care workers, as would be expected on the basis of the workforce data (see Section 3 below).

As noted above, both the CHSP and HCP programs offer similar services. *Table 2* shows the services offered under the CHSP in 2019-20, the latest year for which data are available. Services can be divided into those offered to older people, mostly in their own homes and those offered in group settings or centres. Community care workers and home maintenance staff under the SCHADS Award deliver the vast majority (80%) of hours of service to individuals, and more than half (54%) of the total hours of all CHSP services.

As noted above, 50% of CHSP clients use two or more services. Some common combinations of services suggest that it is possible for the same worker to deliver more than one service type to the same client. For example, Among the 329,700 people who received domestic assistance in 2018-19, 13% also used personal care, 18% also used individual social support, and 4% also used flexible respite. Among the 79,900 who used personal care, 60% also used

[41] Rahman, Efird, Kendig & Byles (2019), page 300. See also Royal Commission into Aged Care Quality and Safety (2021), page 72.

domestic assistance, 24% also used individual social support and 13% also used flexible respite.[42]

Table 2. CHSP services received per 1,000 people aged 65 years or over and Aboriginal and Torres Strait Islander people aged 50–64 years, 2019-20[43]

	Hours	Share of hours services received by individuals at home	Share of total CHSP hours received
Care and support services to individuals at home			
Domestic assistance*	2,156	40%	30%
Personal care	606	11%	8%
Individual social support and flexible respite	1,131	21%	16%
Home maintenance	358	7%	13%
Nursing and allied health	973	18%	2%
Specialised support for people who are homeless	111	2%	5%
Total, hours of care services to individuals at home	***5,335***	***100%***	
Care services in group settings or at centres			
Centre-based and cottage respite	429		6%
Group social support	1,473		20%
Grand total	***7,237***		***100%***

* Includes 'Other food services', a very small service separate from meals provided at home or in a centre.

Table 3 shows the shows the services offered HCP program in 2018-19, the only year for which such data are available.[44] As can be seen in the table, although some service titles differ, the services offered are much the same as under the CHSP.[45] Further, just as for services delivered to individual CHSP clients, the majority of hours of service in home care packages (74% across all package levels) are delivered by community care workers under the SCHADS Award.

[42] Department of Health (2020a), page 29, Table 2.3.
[43] Author's calculations based on data in the *Report on Government Services*, 2021, Table 14A.23.
[44] As noted in Department of Health (2020b), page 1, 'the Department of Health … has limited data on the volume or cost to the consumer of specific services delivered under a Home Care Package, as this information is documented and agreed between the provider and the consumer. To rectify this limited data resource, a survey of home care providers has been conducted'. The survey collected data for the year 2018-19.
[45] There are some differences in reporting because of the different program structures. All services under a HCP are delivered to individual older people, so there are no group services in the service categories as in the CHSP. Further, care management is not reported as a client service under the CHSP, while it is reported for HCPs. Transport is reported as the number of one-way trips in CHSP data (see Report on Government Services 2021, Table 14A.23), not as hours of services, as for HCPs. The slightly lower proportion of 'SCHADS hours' in level 1 packages is because care management is a higher proportion of hours at level 1 than at higher package levels.

Table 3. Average hours of service per package per fortnight, by service type and package level, 2018-19*

	All Average	Level 1	Level 2	Level 3	Level 4
Care management	1.23	0.65	0.82	1.43	2.01
Nursing (registered and other licensed)	0.14	0.03	0.04	0.17	0.34
Allied health care	0.13	0.03	0.07	0.14	0.25
Cleaning and household tasks	2.04	0.98	1.67	2.13	2.92
Personal care	2.58	0.50	1.10	2.64	5.82
Social support, shopping services, community access	1.65	0.45	1.05	1.87	2.89
In-home respite	0.52	0.07	0.14	0.49	1.35
Light gardening	0.18	0.12	0.15	0.22	0.24
Transport services	0.45	0.16	0.3	0.54	0.73
Other services provided to home care recipient	0.53	0.12	0.33	0.58	0.97
Total Hours of Service Provision	**9.45**	**3.11**	**5.67**	**10.21**	**17.52**
Total hours of core activities of SCHADS workers	**6.97**	**2.12**	**4.11**	**7.35**	**13.22**
Share of work carried out by SCHADs workers in HCPs	***74%***	***68%***	***72%***	***72%***	***75%***

* Source: Department of Health (2020b), Table 27; categories given in original; author's calculations in final two rows. Core activities of SCHADS workers shown in shaded rows. Hours are expressed in decimal terms, not with minutes; for example, 9.45 hrs is equivalent to 9 hours and 27 minutes.

Community care workers also meet the vast majority, if not all, HCP clients. A survey of clients undertaken for the Royal Commission into Aged Care Quality and Safety found that 90% used domestic assistance, 46% used personal care, 49% used home maintenance, 35% used social support and 10% used respite care.[46] Many, of course, use multiple services in various combinations.

2.3 Unmet need for home care and support

Around one third of older Australians living at home have needs for assistance that remain unmet.[47] Some of these older Australians may be receiving some, but not enough, care and support from either the CHSP or HCP; some may be waiting for assistance, and some may not be accessing care and support at all.

There is documented unmet need across both the CHSP and HCP program. Need can be unmet when older people cannot access a service or when they cannot access enough services. Both these forms of unmet need have implications for the skills and judgement demanded of care workers, as discussed below, in Section 4.

In the CHSP, providers reported that they could not meet demand for assistance from across the full range of services included in the program. The following proportions of providers could not meet need for domestic assistance (21%), home maintenance (17%) personal care (13%), individual social support (13%), allied health and therapy services (14%), and nursing (8%), among other services.[48]

For home care packages, rationing through the target ratio planning system, proposed for continuation until 2024,[49] has been a cause of unmet need. The process of intermittent release of packages and the number of packages released has resulted in long waiting times. In May 2021, the wait time between approval and receiving a HCP for a person with a medium priority approval entering the National Priority System was 3-6 months for a level 1 package and 9-12 months for levels 2, 3 and 4.[50] Further, as shown above, the share of higher level packages has grown only very recently. Indeed, one reason for the strong growth in HCPs in recent years has been the government's response to ongoing community concern about lengthy waiting times for people assessed as eligible for a package but who are unable to access one because there is not a package available.

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[46] Batchelor, Savvas, Peck, Dang, Wade et al. (2020), page 31, Table 10.

[47] Australian Bureau of Statistics Survey of Disability, Ageing and Carers, as collated in the Report on Government Services 2021, Table 14.A31.

[48] Department of Health (2020a), page 59. Providers are counted at the level of aged care planning regions for this measure; the aim is to understand (relatively) local availability of services.

[49] Australian Government response to the Final Report of the Royal Commission into Aged Care Quality and Safety, page 21.

[50] Department of Health (2021b), page 14. This is an improvement; less than two years before, in August 2019, equivalent times were 3-6 months for a level 1 package and more than 12 months for levels 2, 3 and 4; see Department of Health (2019a), page 13.

Despite the increase in the number of HCPs released in recent years (see *Figure 1*), there is still considerable unmet and under-met need for home care and support. As of 31 March 2021, there were:[51]

- 87,162 people waiting for a HCP at their approved level. This is equivalent to slightly over half the number of people who were actually in a HCP on that date (167,124). Of the people waiting for a package at their approved level:
    - 55,483 (64%) had not yet been offered a package. Of these:
        - 6,380 (11%) were waiting for a level 4 package.
    - 31,679 (36%) had already been offered a lower level HCP. Of these:
        - 21,011 (66%) had chosen to take the lower level package.
    - 86,094 (99%) had also been assessed as eligible for CHSP services; there is no data about how many actually receive them.
    - 53,036 (60.8%) had also been assessed as eligible for permanent residential care, providing further evidence that home care and residential care are positioned as alternatives in the aged care system.

2.4 Current principles of aged care quality and associated regulation

As noted in the main report,[52] regulatory requirements and community standards, which are underpinned by principles of care quality, should guide the practice of the aged care workers, so understanding these principles, how they are embodied in regulation, and how they are changing, sheds light on the expectations and roles of aged care workers.

Community expectations now encompass high quality support to enable older people with significant health concerns and frailty to live at home. Just as in residential care, prevailing ideals relate to autonomy for the older person and person-centredness in care, with individually-adapted and flexible supports grounded in caring relationships. Further, regulatory oversight and increasing quality expectations combine to increase documentation requirements in home care and support services.

The same principles of aged care quality apply in both residential and home care and support; the only exception is that principle 5, which relates to 'the organisation's service environment' does not apply in home care.[53] Accordingly, please refer to the main report for further discussion of the expectations that the quality standards establish for care workers. While the discussion in that report relates specifically to residential aged care, the principles are the same. As in residential aged care, there is a large body of research internationally that

[51] All data in this list are taken from Department of Health (2021c), page 3.
[52] Meagher (2021).
[53] There are also some specific reporting and regulatory requirements in residential aged care only, including the Serious Incident Response Scheme (see https://www.agedcarequality.gov.au/sirs), and regulations to minimise restrictive practices (see https://www.agedcarequality.gov.au/minimising-restrictive-practices).

establishes the organisational requirements, including employment and working conditions, that allow the underlying ideals of high quality home care and support to be realised.[54]

2.5 Changing models of home care and support

The nature of home care and support is changing under the influence of multiple drivers. This section discusses those most important for affecting the skills, responsibility and judgement required to work in a transforming sector. How the skills, responsibility and judgement are affected is discussed below in Section 4 below.

The expectation that older people can be maintained longer at home, delaying or avoiding admission to residential care despite significant ill-health and frailty is one major driver of change in home care and support. The impact of these changes on the service profile of aged care and on the needs profile of older people who use home care and support has been discussed above. However, one issue not yet touched on is end-of-life care. Older people are increasingly remaining at home, and a significant minority currently die while receiving home care and support. This means that possibility that they will die at home may also have increased. This, in turn, raises the need for quality end-of-life care, including palliative care, for older people receiving care at home.

Other drivers include new service goals and new modes of service organisation and funding. In recent years, **concepts of consumer choice and control have become very important in organising and funding aged care services,** building in various ways on longer-standing ideas in disability support. Since 2015, when the CHSP was established, one of this program's key principles has been 'consumer choice'. Older people have options to choose a provider, following a new, more centralised assessment process that should focus on their needs and goals. Since 2017, all home care packages have been required to be delivered on a 'consumer directed care' (CDC) basis. The aim of CDC is to give older people more choice about the kinds of services they receive and how and when the services are delivered. Previously, funding for packages was allocated to providers, who controlled service provision and delivery.[55] Choice of provider and increased control over the use of funds are central features of CDC, and funds are now 'individualised', that is, allocated to eligible individuals.[56] Under these models, home care and support providers negotiate the types of services older people prefer and community care workers negotiate the day-to-day implementation of clients' service preferences at work.

New service goals of 'wellness and reablement' have been introduced in home care and support programs as these have been reformed over the last half decade or so. The Department of Health defines these concepts as follows:

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[54] For example, see Barken, Denton, Sayin, et al. (2018); Charlesworth & Malone (2017); Franzosa, Tsui & Baron, S. (2019); Hart, Bowman & Mallett (2021); King, Parsons, Robinson & Jörgensen (2012); Leverton, Burton, Beresford-Dent, et al. (2021); Macdonald & Charlesworth (2021); Wise (2020); Yeh, Samsi, Vandrevala & Manthorpe (2019).
[55] Gill, McCaffrey, Cameron, Ratcliffe, Kaambwa et al. (2017).
[56] Department of Health (2019b).

Wellness is an approach that involves the assessment, planning and delivery of supports that build on an individual's strengths, capacity and goals. This includes encouraging actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home.

Wellness as a philosophy is based on the premise that, even with frailty, chronic illness or disability, people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing to live autonomously and as independently as possible.

Reablement involves short-term or time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Like wellness, reablement aims to assist people to reach their goals and maximise their independence and autonomy.[57]

These very wide-ranging principles embody the idea that home care and support services should enable older people live a good life, including having high levels of social and emotional well-being, regardless of their level of health and their need for assistance. Home care and support practice is changing as a result, as new approaches are being explored to embed these ideas in daily work, including that of community care workers. These approaches include having community care workers:

a) use diverse strategies to engage with home care and support clients so they are optimally engaged in activities[58]
b) offer exercise interventions to prevent falls at home[59]
c) participate in health literacy training of their clients[60]
d) incorporate social support and recreational activities as part of home care[61]
e) participate in and improve oral health care for older people living at home[62]
f) collaborate in designing assistive technologies for preventing malnutrition in older people with dementia[63]
g) be integrated into interdisciplinary palliative care teams to support clients at the end of life[64]

Particular attention has been given to working with the reablement approach and non-pharmacological interventions with people living with dementia at home. Both the Royal Commission into Aged Care Quality and Safety, and the Aged Care Quality Standards point to the inappropriateness of the use of anti-psychotic medications to manage the behavioural and psychological symptoms of these older people. Instead, non-pharmacological interventions are a focus, such that interactions and practices in care provision are adapted to the needs of people with dementia.

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[57] Department of Health (2021c), page 14.
[58] Baker, Harrison & Low (2016).
[59] Burton, Boyle, O'Connell, Lewin, Petrich et al. (2021).
[60] Palesy & Jakimowicz (2020).
[61] Low, Baker, Harrison, Jeon, Haertsch et al. (2015).
[62] Lewis, Harvey, Hogan & Kitson (2019).
[63] Jayatilaka, Ranasinghe, Falkner, Visvanathan & Wilson (2020).
[64] Poulos, Harkin, Poulos, Cole, & MacLeod (2018).

In addition to calling on home care and support providers to promote independence, reduce risks, assist clients to meet their goals, and maintain and make gains in their physical, social, and emotional well-being, **aged care policies now formally recognise the special needs of specific groups,** as noted above. **Meeting the needs of these groups requires service providers to recognise and respond to what causes people of particular groups to be more likely to have special needs.** For example, meeting the needs of Aboriginal and Torres Strait Islander older people requires recognising historical legacies of discrimination and exclusion, as well as sensitive engagement to focus on people's strengths.[65] Another special needs group is care leavers, which includes the 'Forgotten Australians', who are child migrants and non-Indigenous Australian-born children raised in institutions.[66] Research with Forgotten Australians has found that they 'suffer lifelong health and well-being impacts, have lower educational attainment, lower paid employment, are less likely to own their home, and have difficulty forming relationships' and that members of this group 'are unlikely to access care when needed due to high levels of mistrust and fear of reliance on others and authorities'.[67] Other groups are not formally recognised in policy also have special needs related to trauma, such as Holocaust survivors.[68]

Another driver of change in home care and support is the take-up of digital technologies, which are being promoted as a means of enabling 'new models of care and support where consumers can connect more easily to programs and to care professionals'.[69] Some new technologies are based with the older person at home and allow forms of monitoring and communication; others are based with providers, including community care workers, and used to work with client records, care plans, staffing and so on. Because of home care and support clients are both dispersed in the community and living in private homes, and because community care workers are 'out and about' rather than stationed in a workplace (such as a residential aged care home), some aspects and challenges of the digital transformation of care are distinctive to home care. For example, it may be more demanding to maintain client privacy.

3. Who cares for older Australians using home care and support and how is this workforce changing?

Home care and support services employ more than 156,000 people in Australia.[70] The majority of these, around 123,000, are the direct care workers (including community care

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[65] Gibson, Crockett, Dudgeon, Bernoth, & Lincoln (2020).
[66] Dow & Phillips (2009).
[67] Browne-Yung, O'Neil, Walker, Smyth & Putsey et al. (2021), page 174.
[68] Teshuva, Borowski & Wells (2021).
[69] Barnett, Livingstone, Margelis, Tomlins, Gould et al. (2020), page 13. This document has been produced by the Aged Care Industry Information Technology Council, which is a project of the two main aged care industry peak bodies, Leading Aged Care Services and Aged and Community Services Australia, and which has received support from the Australian Government. See: https://www.aciitc.com.au/about-us/.
[70] Department of Health (2021a); author's calculations based on data presented on pages 27 and 39 for the HCP and CHSP workforces respectively. The 2020 Aged Care Workforce study was affected by the COVID-19 pandemic; e.g., there was no workforce survey or worker interviews, so the report relies on manager reports of

workers, nurses and allied health workers) who assist older people to maintain their lives at home and with some of their health needs. A further 6,100 employees offer other forms of support, including cooking, cleaning and gardening. The work of these two groups: community care workers and (to the extent that data is available) other support workers is the main focus of this report. Another 27,000 employees in home care and support are care managers/coordinators, managers or administrators, while a further 100 or so provide spiritual or pastoral support.[71]

As noted above, the home care packages program and the CHSP are funded separately, and have ostensibly different target groups. Yet there is clear evidence of complex overlaps both in client groups (nearly a quarter of HCP clients also receive services under the CHSP), and in target groups (around 58,000 CHSP clients receive five or more CHSP services in a year).

There is also an overlap in providers sharing staff across both HCP and CHSP services. Not all providers offer both kinds of service. Nevertheless, HCP providers responding to the Aged Care Workforce survey in 2020 reported that 27% of their community care workers also worked in their CHSP operations, while CHSP provider respondents reported that 36% of their community care workers also worked in their HCP operations.[72] Further, **more than half all HCP providers (52%) and CHSP providers (54%) also offer services under the National Disability Insurance Scheme**.[73]

3.1 Gender in the home care and support workforce

The direct care workforce in home care and support is overwhelmingly female.

Among community care workers, 89% identified as female in 2020, the same proportion as in 2016 and 2012.[74] Other direct care workers, including nurses and allied health workers are also predominantly female.

The National Aged Care Workforce Census does not collect demographic information about workers other than those directly delivering care. Home and community care services for older people are not classified separately as an 'industry' in the Australian and New Zealand Standard Industrial Classification which is used to classify labour force and other data by the Australian Bureau of Statistics, whereas residential care for older people is. Therefore, it is unfortunately not possible to use other sources of data, such as the Census of Population and Housing, to understand the demographic profile of people who work in non-direct care roles in the home care and support sector.

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staff demographics. Data on employees in non-direct care roles were reported in less detail than in previous reports.

[71] Author's calculations, based on data presented in Tables 5.1 and 5.4 and on page 27 of Mavromaras, et al. (2017), and Tables 3.1 and 4.1 and pages 27 (HCPs) and 39 (CHSP) in Department of Health (2021a). Numbers are weighted, estimated headcounts of people employed in different occupations and rounded to the nearest 100 for ease of reading.

[72] Data provided by the Australian Government Solicitor to the Fair Work Commission. 'Response to Question 1(3) Part 2: Proportion of providers sharing staff across their other service care types'; letter dated 31 Aug 2021.

[73] Department of Health (2021a), pages 36 and 54 for the HCP and CHSP respectively.

[74] Department of Health (2021a), pages 29, 41. In both the HCP and CHSP workforces are 89% of community care workers female.

3.2 The changing occupational structure of the home care and assistance workforce

The occupational structure of the residential care workforce has changed in recent years, in two ways.[75]

***First*, the share of community care workers in the direct care workforce increased from 78% to 83% between 2007 and 2020**, measured as full-time equivalent employees, while the share of nurses fell and the (small) share of allied health workers fluctuated (see *Table 4* and *Figure 2*). There was also a large absolute decline in the number of registered nurses on this measure. Almost all the growth in the FTE direct care workforce was among community care workers (99%).

***Second*, the share of direct care workers in the total workforce increased from 62% of all employees to 78% between 2012 and 2020**, on a headcount measure.[76] Full-time equivalent data are not available for the following comparison, but the headcount measures available do provide some useful information. *Figure 3* shows that the number of direct care workers increased 32% while the number of non-direct care workers fell 41%. All this increase is in the occupation community care worker. *Figure 4* provides more detail on the non-direct care workforce, showing that the decline appears to be among managers and administrators. Unfortunately, unlike in the earlier aged care workforce studies,[77] there is no further breakdown of this group, so it is not possible to determine whether there were fewer of one, two or all categories of care managers/coordinators, managers and/or administrators.

Table 4: Full-time equivalent direct care employees in the home care and support workforce, by occupation: 2007, 2012, 2016 and 2020[78]

	2007	2012	2016	2020	*% change, 2007-2020*
Registered Nurses	6,079	6,599	4,692	3,698	-39.2
Enrolled Nurses	1,197	2,345	1,143	1,170	-2.3
Allied Health Workers	2,948	4,199	3,540	2,995	1.6
Community Care Workers	**35,832**	**41,394**	**34,712**	**39,069**	**9.0**
Community Care Workers (%)	*78%*	*76%*	*79%*	*83%*	
All direct care workers (FTE)	*46,056*	*54,537*	*44,087*	*46,932*	*29*

[75] As noted in my earlier report (Meagher, 2021) 'There are two ways of measuring change in distribution of workers between occupations: a 'headcount' and 'full-time equivalents'. A headcount captures the total number of people employed in each occupation, without considering the hours they work. (The workforce data presented above are based on headcounts.) A 'full-time equivalent' (FTE) measure captures the size of the workforce in terms of the available labour time. The two measures have different strengths and weaknesses. It is preferable to compare occupations and to measure change over time with FTEs, but this data is not always available.'
[76] Calculations based on data in Table 3.1 in Mavromaras et al. (2017), and data presented in Department of Health (2021a), pages 25 and 37.
[77] Mavromaras et al. (2017), page 54.
[78] Sources: Mavromaras et al. (2017), Table 3.3 and in Department of Health (2021a), Tables 3.1 and 4.1.

Figure 2: Occupational structure of the direct care workforce in home care and support 2012, 2016, per cent of total full-time equivalent workforce[79]

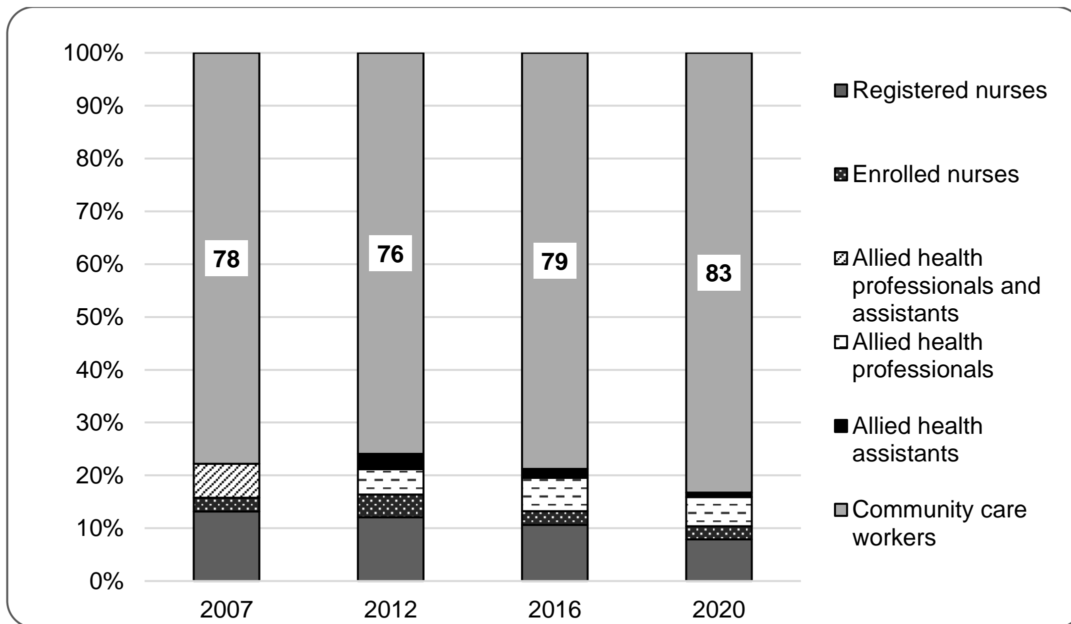
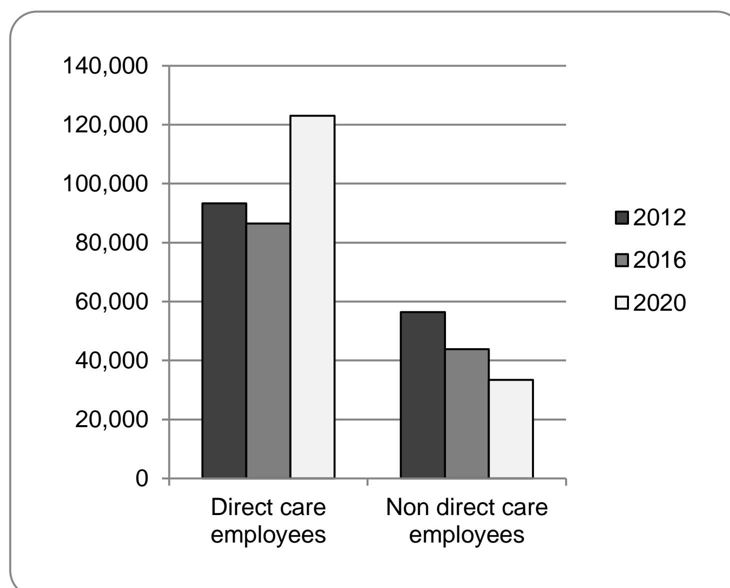


Figure 3: Number of direct care and non-direct care employees in home care and home support, 2012, 2016 and 2020, headcount measures



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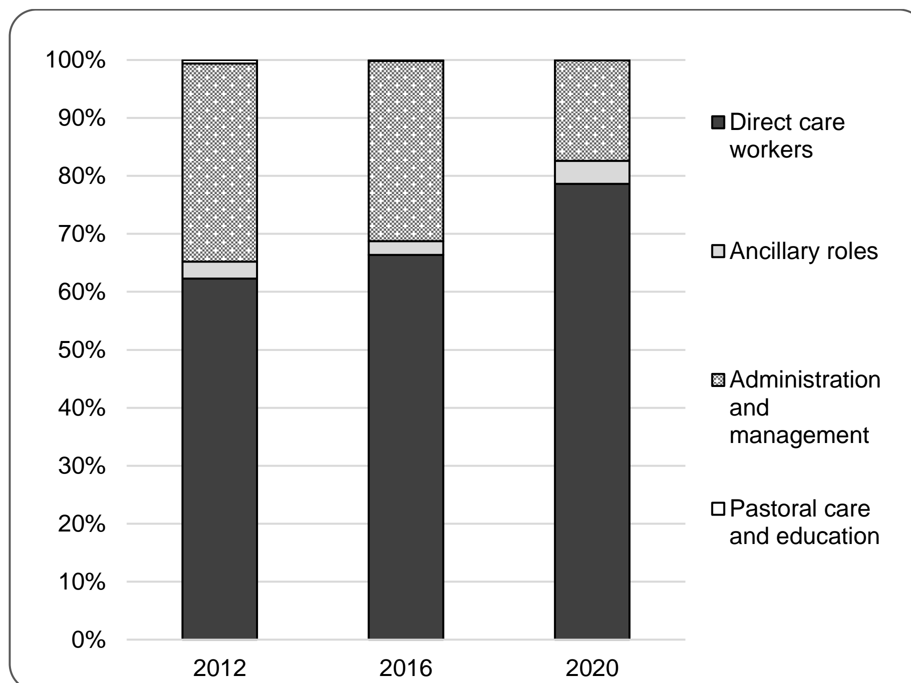
[79] Sources: Years 2007, 2012, 2016 from Mavromaras et al. (2017), Table 3.3, and for 2020 from Department of Health (2021a), Tables 3.1 (HCP workforce) and 4.1 (CHSP workforce).

Figure 4: Direct care employees and main groups of non-direct care employees in home care and home support, 2012, 2016 and 2020, percent of the total workforce, headcount measure)



4. Sector trends impacting the skills, responsibilities and judgement required in home care and support work

Trends in home care and support, with some exceptions, mirror many of the trends in residential aged care documented in the earlier report to which this is a supplement. The skill, responsibility and judgement demands of work in home care and support have increased because of the trends identified above: high and increasing needs and diversity among older people, enhanced principles of care quality and care regulation, new models of care, and the changing staffing profile in the sector. As in residential care, these trends can pull in contradictory directions, and front-line community care workers are called upon to negotiate and manage these contradictions in their daily work.

First, there is evidence that **the needs profile of older people receiving community care has increased, as care at home has become a 'viable alternative' to residential care.**

Second, **there is significant turnover in the population of older people receiving care at home**, so that community care workers likely work with a steady stream of new clients, along with those receiving care over the longer term. Community care workers are required to get to know the needs and preferences of a range of people and respond to them in an individualised way throughout their work days and weeks.

Third, **in addition to higher turnover among older people receiving care at home is increased recognition of diversity in this group**, not least in the concept of special needs

groups in aged care policy. As discussed in detail in the main report,[80] Aged Care Quality Standards require that staff have and exercise skills and knowledge about a wide range of social groups so they can meet their individual needs.

Fourth, **prevailing regulatory and community standards have increased expectations of the capacity and quality of home care and support.** As in residential care, responsibility for realising increased expectations falls to home care and support staff, who are required to care for and support older people in ways that respond to their individual needs, goals and preferences, and promote their emotional, spiritual and psychological well-being in all aspects of their work. Again, as in residential care, **to provide person-centred and relationship-based care, a task-oriented approach to aged care work is not appropriate.** Instead, home care and support staff need to get to know each older person as an individual, and be enabled with the skills, knowledge and work environment necessary to provide care that meets each person's specific needs.

Fifth, **new technologies** are being incorporated into home care and support practice, both with older people directly, and with care staff.

Finally, **the COVID-19 pandemic has made heightened awareness of infection control and emphasised the need for all care workers to have up-to-date knowledge and skills about infection control procedures and practices.**

4.1 Some 'basic' features of home care work and an apparently 'basic' task

The findings of a recent study summarise some essential features of home care and support work, and the skills involved in doing it. The study 'examined the challenges faced by home-care workers and the strategies they used to manage these challenges'. The authors found that:[81]

> Challenges included time allocation for visits, completing care plan tasks, lone working, communication and understanding, refusals of care, and client behaviours. To mitigate these challenges, home-care workers utilised system support, time management, training and experience and enacted a caring relationship, thought about their approach, and used distraction and communication skills. Workers relied on skills such as, relationship building, team working, observation, communication, decision making and interpersonal sensitivity. They drew on knowledge about the person, the person's needs, their own abilities, company policies and procedures and their role and responsibilities as a home-care worker.

Before discussing the impact of the trends outlined above in more detail, **it is important to note a basic difference between residential care work and work in home care and support: community care workers largely work alone in their day-to-day practice with older people.** In addition to the trends summarised above, working alone makes particular

[80] Meagher (2021), Section 4.
[81] Backhouse & Rushton (2021), page 1. The study was carried out in England, but its findings are wholly applicable in Australia.

demands on the skills, responsibility and judgement they are called upon to exercise in their daily work.

Further, **even a 'basic' service such as domestic assistance makes some strong demands on community care workers' skills, responsibility and judgement.** As shown above, domestic assistance is one of the services most used by older people receiving HCPs and services from the CHSP. As a publicly-subsidised service directed at meeting a need that is recognised in policy as an entitlement, domestic assistance is different in important ways from what might seem equivalent work in cleaning the home of an able-bodied adult in a private context. Community care workers need to exercise situational judgement about how to organise and prioritise their tasks in consultation with their clients, within the framework of services they can reasonably be expected to provide. Care workers meet older people in their own homes, and negotiating the boundaries of their work can call for sensitivity, tact and ethical decision-making – for example in relation to requests to complete tasks from friends or relatives present who are not clients, or in dealing with unexpected extra work related to clients' pets.

Moreover, **community care workers providing domestic assistance may be the most frequent, or sometimes the only, regular contact an older person has with an aged care organisation,** particularly for the large proportion of clients who live alone. On average, the 330,000 older people who received domestic assistance in 2018-19 had around 22 sessions per year, or a bit less than fortnightly. The 70,000 who received personal care had on average 55 sessions a year, or a bit more than weekly. These community care workers are in a position to observe closely an older person's condition and make an assessment about whether they should report any changes, perhaps even when an older person does not want them to. They may also be a highly trusted person to whom an older person gives information about their needs and concerns. Given the general level of physical ill-health and frailty of the client group, the large number of medications they take on average, their additional susceptibility to falls, and their high rates of dementia and depression, community care workers' opportunities for 'gentle oversight' of older peoples' well-being is potentially important in enabling timely intervention when an older person's condition deteriorates.

The point is that **even community care workers providing 'only' domestic assistance are in a position of responsibility in relation to the wellbeing of many frail older people.** Home care managers often describe community care workers as 'the eyes and ears' of the organisation.[82] This position requires skills of observation and assessment and of relationship-building and interpersonal sensitivity to gain trust, and it demands judgement about what, when and to whom to communicate about an older person's (changing) condition. Research with home care providers and workers has found the exercise of these skills and judgement can be decisive for a person's well-being, even survival, especially for older people with limited decision-making capacity. One study gives the example of 'not noticing or not acting on a chest infection [which] could mean the client would become very ill'.[83]

[82] See, for example, Payne & Fisher (2019), page 198.
[83] Backhouse & Rushton (2021).

These skills, responsibilities and judgements are also exercised by community care workers offering personal care and social support to older people and respite for their carers, often to an even higher level.

- Providing high quality *personal care* requires community care workers to maintain an older person's safety and dignity in the context of intimate personal care tasks such as toileting and bathing. This care requires both technical (for example, in relation to manual handling and infection control) and ethical and interpersonal skills.
- When providing *social support*, community care workers need to engage older people and to offer activities that meet their social and emotional needs. In addition to any specific technical skills related to an activity, offering social support calls on high level interpersonal skills and the exercise of judgement to negotiate the boundaries of the relationship, in adherence with ethical requirements and workplace policies.[84]

When home care and support clients live alone, community care workers may be the only person their clients regularly meets. However, some home care and support clients have a carer, and community care workers need skills and judgement to negotiate a positive working relationship with their client's carer.

4.2 Changing occupational profile, increasing work demands

Together with the growing share of older people in the population, increased use of home care means that the total workload in home care is considerably larger now than a decade ago. *Table 5* reveals a similar trend to that in residential aged care: **increased levels of need and a larger total workload in home care and support have not been reflected in a larger or more qualified workforce.**

Table 5 shows that:

- **The total workload in home care and support increased substantially between 2012 and 2020.** The number of home care packages more than doubled between 2012 and 2020 (141% increase), as did the share of high level packages (125% increase). Total annual hours of selected CHSP services (domestic assistance, personal care, flexible respite and individual social support), have increased by more than a third (36%).
- **The size of the workforce that provides home and community care appears to have fallen since 2012.** Data presented above show that tasks performed by community care workers consume the vast majority of hours of service in HCPs, and *Table 5* presents evidence that these workers have provided a growing absolute number of hours of service in the CHSP.
- In relation to the occupational profile of the workforce, **increased levels of need among older people receiving home and community care have not resulted in a more highly trained workforce.** Rather, the share of community care workers among the direct care staff has increased from 76% in 2012 to 83% in 2020. Data presented in Table 4 and

[84] Lam & Baxter (2020).

Figure 2 above show a corresponding decline in the share of registered and enrolled nurses and allied health professionals and aides.

Table 5: Services and staffing in home care and support, 2012-2020[85]

	2012	2014	2016	2018	2020	*% change*
Number of home care packages#	59,201	66,954	79,819	91,847	142,436	*141*
Level 3 and 4 packages (% of total)#	21	20	30.4	38.7	47.2	*125*
Annual hours of selected CHSP services for people >65 years of age (million)*	12.2	11.8	14.0	15.6	16.5	*36*
Community Care Workers (FTE)^	54,537		44,087		46,932	*-14*
Share of CCWs in direct care staff (FTE, %)^	75.9		78.7		83.2	*10*

It is difficult to assess the quality of the workforce data and to verify the apparent decline in the size of the home care and support workforce overall. There may have been significant undercounting of community care workers in 2020, perhaps related to problems with conducting the Aged Care Workforce Survey during the COVID-19 pandemic. However, it does not seem plausible that the scale of undercounting could be so great as to obscure major growth in the workforce.

Even taking the potential for undercounting into account, these data support the inference that **fewer home care and support workers are caring for more older people, a growing proportion of whom are recognised as having a high level of needs. Accordingly, the amount of care work needed is greater, and the content of the work is more skilled, complex and demanding.** For example, in the context of providing personal care, community care workers may also carry out skilled medical tasks such as urinary catheterisation and giving medication.

Moreover, as the group of older people receiving care and support at home becomes frailer and sicker, their condition and care needs become more unpredictable. As members of an already stretched workforce, community care workers are also increasingly likely to confront unplanned-for situations that require them to make situational judgements about what to prioritise and how to handle smaller or larger emergencies. To ensure safe and accountable care, community care workers need communication skills to support timely, accurate written

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[85] Sources: # As at 30 June in relevant year; for 2012, Aged Care Financing Authority, *Inaugural Report on the aged care sector – 30 June 2013*, page 26, note that Community Aged Care Packages are counted as Level 1 and 2 packages for the purpose here, and Extended Aged Care at Home (EACH) and EACH(Dementia) packages are counted as levels 3 and 4; for 2014-2018, Report on Government Services (RoGS) 2019, Table 14A.9, for 2020, RoGS 2021, Table 14A.9. * Authors' calculations based on RoGS 2017 Tables 14A.21 and Table 14A.1 for 2011-2017; RoGS 2021 Tables 14A.23 and 14A.1 for 2018-2020; includes personal care, domestic assistance, individual respite, and individual social support as provided to people over 65 and ATSI clients aged 50-64; figures for 2015-16 not available during transition from HACC to CHSP so data for 2016-17 reported instead; ^ Mavromaras et al. 2017, Table 5.3 for 2012 and 2016; author's calculations based on Department of Health 2021, Tables 3.1 and 4.1 for 2020.

reports to their employing organisations and to their colleagues who work with the same client.[86]

Working with older people with dementia in combination with other chronic diseases further increases the skill and responsibility demands of home care and support work. These older people typically have difficulty undertaking aspects of routine self-management of their health, including understanding their condition, taking medication, and following action plans on exacerbation. These limitations make additional demands on community care workers, who observe and make decisions about how to meet the person's needs outside the structured context of a residential aged care facility where disease management would not be delegated to the older person.[87]

In addition, a significant minority of home care and support clients have unmet or under-met need, which further increases work demands. As noted above, most older people assessed as needing a high level home care package are currently not offered one for 9-12 months; this waiting time has been longer in past years. In the meantime, some receive a lower level package or support under the CHSP. These 'fallback solutions' create challenges for home care organisations and community care workers, who work with significantly fewer resources than have been determined as necessary to meet their needs in caring for and supporting these older people. To manage such situations optimally in daily practice requires community care workers to maintain close communication and negotiation with both their managers and their clients, and to make judgements about priorities in care within tightly constrained conditions. Further, the likely high levels of frailty and ill-health among HCP clients assessed as eligible for high level packages make strong demands, even when there are adequate resources to meet needs.

4.3 Changing models of care, increasing work demands

New models of care include wellness and reablement and consumer directed care, which demand new skills and responsibilities to the work of community care workers.

Consumer directed care in the HCP program introduces new ways of working with older clients, who have the right to decide on how the funds in their package are spent (within the permitted range of services) and receive a monthly account setting out expenditures. Consumer directed care can also confer on community care workers more responsibility to their clients. One aspect of the change is a change in the HCP clients' relationships with the service providing organisation. Under CDC, clients may receive fewer visits from the service coordinator, and if they request additional visits or contacts by telephone, these are charged against their accounts. According to one study:

> This has had the effect of discouraging clients to make calls or to request visits, resulting in an increase in home support workers' responsibility for clients' welfare and understanding of the [CDC] model.[88]

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[86] Processes as described in Prgomet, Douglas, Tariq, Georgiou, Armour et al. (2017), pages 113-114.
[87] Baird, Woolford, Young, Winbolt & Ibrahim (2019).
[88] Payne & Fisher (2019), page 9.

In some organisations, CDC may also have increased documentation requirements on community care workers.[89] In addition to these enhanced responsibilities and a new educative role, community care workers working within CDC also now have more autonomy to respond to clients' requests for changes. Managers emphasised that community care workers were expected to respond to such requests 'within reason', to avoid risk to both the client and the worker. Studies find that managing client expectations under the new model of care is a major challenge experienced at the frontline by community care workers. Thus, the expectation of increased responsiveness also increases the expectation that care workers interpret what is 'within reason'. They need to make judgements, taking into account organisational policies, individuals' care plans, and clients' requests on the day, about what they do and when.

Another role community care workers have in the context of CDC is as the 'face' of the provider organisation at the front-line, managing any concerns clients may have locally, to avoid escalation. This may require community care workers to make ethical judgements about the validity of client concerns, and to negotiate perhaps conflicting interests of the provider organisation (their employer) and the client.

Realising wellness and reablement principles in home care and support has far-reaching implications for the skills, responsibilities and judgement required by community care workers. As noted above, meeting the full range of older people's needs, allowing older people's goals to drive care planning and seeking to maintain and rebuild older people's capacities gives community care workers a role in exercise interventions, health literacy training, social and recreational support, improving oral health care, and palliative care among other things. These enhancements to home care and support are being offered in a context where a smaller proportion of the workforce has specialised skills. Some of the skills required of community care workers include specific technical and interpersonal skills related to these various domains of practice and working in interdisciplinary teams. One study of implementing a reablement intervention found that community care workers used skills to carefully assess their client's progress in rebuilding their capacity to do tasks, to maintain progress without under-supporting the client or taking over from them.[90]

Further, research has found that reablement practices are not always welcomed by older people, and community care workers need skills to manage this in their daily work. A study on exercise interventions to prevent falls, for example, found that some older people resisted community care workers' attempts to engage them in reablement activities. Instead, older people said things such as 'I don't want to do any of that, I just want you to clean the house', 'I am too old for this', 'I can't be bothered', or 'oh no I was forced to do that in hospital (exercises), and you're not going to force me to do it in my own home'.[91] In such cases, community care workers need to use interpersonal and negotiation skills as they manage the

[89] Mackay & Goodwin-Smith (2019).
[90] Maxwell, Bramble, Prior, Heath, Reeves et al. (2021).
[91] Burton, Boyle, O'Connell, Lewin, Petrich et al. (2021), page 421.

sometimes conflicting principles of reablement on one hand and consumer choice and control on the other.

4.4 Digital technologies in home care work

Digital technologies have an increasing role in most workplaces and require new skills and new safeguards for client privacy. As noted above, under CDC home care clients are to receive itemised accounts, which has prompted some provider organisations to develop their IT infrastructure to digitise various aspects of their operations, such as client records and staff rostering.[92] There is little research on the use of digital technologies in home care work in Australia, although implementation of these technologies is established and expected to accelerate.[93] An authoritative evidence review by the UK organisation, Skills for Care, identified the following digital skills for frontline adult social care workers, many of which would be exercised by community care workers whose employers have already digitised their operations:[94]

a) Handling and managing information and content
b) Problem solving and communication
c) Ethics and service delivery involving digital technology
d) Understanding the needs of others in using and supporting access
e) Cyber security including data sharing and data protection
f) Safety and safeguarding

5. Work value issues in home care and support

To deliver home care and support that meets community standards and government-mandated quality requirements, community care workers carry out care work that:

a) demands a variety of technical and interpersonal skills
b) gives them responsibility for the safety and well-being of vulnerable older people, and
c) requires them to exercise judgement about clients' condition, priorities within their work, and ethical courses of action when the principles of new models of aged care compete.

Yet the exercise of these skills, responsibilities and judgement are undervalued in the industrial instruments that cover their work. Please refer to the main report for discussion of work value issues in home care and support. That section dealt with the general problem of undervaluation of care work, which applies to both residential care work and work in home care and support.

[92] Prgomet, Douglas, Tariq, Georgiou, Armour et al. (2017)
[93] Barnett, Livingstone, Margelis, Tomlins, Gould et al. (2020).
[94] Skills for Care (2021). Skills for Care is an independent charity that works as a delivery partner for the UK Department of Health and Social Care to 'create a well-led, skilled and valued adult social care workforce'; see https://www.skillsforcare.org.uk/About/About-us.aspx.

Conclusion

Several policy changes on the horizon that mean it is very timely to recognise the value of work in aged care. The Home Care Packages program and the Commonwealth Home Support Program are slated for unification into a Single In-Home Care Program.[95] Another policy under discussion is alignment of regulation across Australia's care and support sectors, which takes in aged care, disability support and veteran's care. Announced in the 2021-22 Budget, the government's aim is to:

> align regulation to improve quality and safety for participants and consumers and remove unnecessary duplication of obligations for service providers and *workers to work more seamlessly across different types of care*.[96] (emphasis added)

In the context of these reforms, it is desirable to have the problems of the undervaluation of care work in aged care resolved.

[95] https://www.health.gov.au/health-topics/aged-care/aged-care-reforms-and-reviews/reform-to-in-home-aged-care-to-create-a-single-system.
[96] https://www.health.gov.au/initiatives-and-programs/aligning-regulation-across-the-care-and-support-sectors

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HSU NATIONAL

Tuesday 27 July 2021

Professor Gabrielle Meagher
Macquarie School of Social Sciences
25 Wally's Walk
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By Email: gabrielle.meagher@mq.edu.au

Dear Professor Meagher,

RE: Health Services Union – Work value claim for aged care workers working in home care settings under the SCHCDS Award

On 31 May 2021, the Health Services Union ('**HSU**') filed an application to vary the *Social, Community, Home Care and Disability Services Industry Award 2010* ('**SCHCDS Award**') seeking an increase in wages for home care workers providing aged care who are covered by the Award ('**the Application**'). A copy of the Application is **enclosed** for your perusal.

The Application is advanced on a similar basis to that made by the HSU in relation to the Aged Care Award late last year, in which you have already provided an expert report ('**Aged Care Award Application**').

On 1 July 2021, the Fair Work Commission ('**Commission**') determined that the Application will be joined with the Aged Care Award Application, and a further separate application by the Australian Nursing and Midwifery Foundation to vary the Aged Care Award and the Nurses Award. In the result, the matters will be heard jointly by one Full Bench and any evidence given in the matters will be admitted in relation to all of them.

By way of background:

1. The employment conditions, classifications and wages of many employees working in aged care home care services are governed by the Award, or by enterprise agreements for which the Award is the reference instrument for the purposes of the application of the better off overall test.
2. The Award came into effect on 1 January 2010 after the Award Modernisation ('**Award Modernisation**') proceedings before the Fair Work Commission.
3. The HSU seeks to create, by the Application, a new definition of 'home aged care worker' in the Award and a 25% increase in the rates applying to those workers on work value grounds.

4. The Commission's power to vary the Award is governed by s.157 of the *Fair Work Act 2009* (Cth) ('**the Act**'). It may make a determination varying modern award minimum wages if satisfied that making the variation is justified by 'work value reasons', being reasons justifying the amount that home aged care employees should be paid for doing the work they do. Those reasons are set out at s.157(2A) of the Act and are reasons related to any of the following:
    a. The nature of the work;
    b. The level of skill or responsibility involved in doing the work;
    c. The conditions under which the work is done.
5. In considering the 'work value reasons', the Commission will also consider the extent to which there have been changes in the nature of the work, changes to the skills required to perform that work, changes to the responsibility involved in doing the work, and changes to the conditions under which the work is performed which have occurred over time.
6. To make any determination varying modern award minimum wages outside the annual wage review process, the Commission must also be satisfied that the variation it determines to make is necessary to achieve the 'modern awards objective'. The modern awards objective requires the Commission to ensure that modern awards, together with the National Employment Standards, provide a fair a relevant minimum safety net of terms and conditions, taking into account the following (s.134(1) of the Act):
    a. Relative living standards and the needs of the low paid; and
    b. The need to encourage collective bargaining; and
    c. The need to promote social inclusion through increased workforce participation; and
    d. The need to promote flexible modern work practices and the efficient and productive performance of work; and
    e. The need to provide additional remuneration for:
        i. Employees working overtime; or
        ii. Employees working unsocial, irregular or unpredictable hours; or
        iii. Employees working on weekends or public holidays; or
        iv. Employees working shifts; and
    f. The principle of equal remuneration for work of equal or comparable value; and
    g. The likely impact of any exercise of modern award powers on business, including on productivity, employment costs and the regulatory burden; and
    h. The need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards; and
    i. The impact of any exercise of modern award powers on employment growth, inflation and the sustainability, performance and competitiveness of the national economy.
7. The Commission is obliged, when exercising its powers to vary modern award minimum wages to apply the 'minimum wages objective' which requires the Commission, when setting modern award minimum wages, to establish a safety net of fair minimum wages taking into account:
    a. The performance and competitiveness of the national economy, including productivity, business competitiveness and viability, inflation and employment growth; and
    b. Promoting social inclusion through increased workforce participation; and

c. Relative living standards and needs of the low paid; and
d. The principle of equal remuneration for work of equal or comparable value; and
e. Providing a comprehensive range of fair minimum wages to junior employees, employees to whom training arrangements apply and employees with a disability.

8. In performing its functions and exercising powers, the Commission is also obliged, by s.578 of the Act, to take into account:
   a. the object of the Act, which is set out at s.3 of the Act;
   b. equity, good conscience and the merits of the matter;
   c. the need to respect and value the diversity of the work force by helping to prevent and eliminate discrimination on the basis of race, colour, sex, sexual orientation, age, physical or mental disability, marital status, family or carer's responsibilities, pregnancy, religion, political opinion, national extraction or social origin.
9. The HSU will ask the Commission, in the exercise of its powers, to have regard to the Final report of the Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect* about the conditions under which aged care work is performed, and the workforce needs of the aged care system.

We request that you prepare a report in relation to the Application. In doing so we ask that you provide your expert opinion on the following matters:

1. The history of the evaluation of wages rates for aged care workers, including a description of the nature of the industrial history of setting the terms and conditions of workers in aged care covered by the Award;
2. The demographics of the workforce in home aged care including a description of the nature of the workforce in home care;
3. Whether challenges have been faced by unions and employees in achieving higher wage rates in home aged care through industrial arbitration and enterprise bargaining, and if so, the nature of those challenges;
4. Whether you believe the work performed in the industry is currently properly valued by reference to the work value reasons set out above. If not, please identify any factors that have contributed to any undervaluation of work in the home care sector of aged care, including any contribution the gender composition of the workforce may have had to the undervaluation of work performed;
5. Whether there has been a change in the composition of the workforce in the provision of aged care in the home, and if so, what change/s. Please provide a description of the nature of these changes and the impact (if any) the change in composition has had on the duties, responsibilities, and skills required of workers in the aged home care services;
6. Whether there has been a change in the nature of the work performed (being care work) in the home aged care sector (including personal care, maintenance, domestic and support services covered the Award) over time, and if so, what change/s. Please provide a description and explanation of the reasons for, and nature of, those changes (if any);

7. Whether there has been a change in the skills required to perform work in the aged home care sector (including personal care, maintenance, domestic and support services covered the Award), and if so, what change/s. Please provide a description and explanation of the reasons for, and nature of, those changes (if any);
8. Whether there has been a change in the responsibility involved in doing work in the home aged care sector over time (including personal care, maintenance, domestic and support services covered the Award), and if so, what change/s. Please provide a description and explanation of the reasons for, and nature of, those changes (if any);
9. Whether there has been a change in the conditions under which work in the home aged care sector is done (including personal care, maintenance, domestic and support services covered by the Award), and if so, what change/s. Please provide a description and explanation of the reasons for, and nature of, those changes (if any).

In preparing your report, should you consider that there are other issues, not encapsulated in the questions above which are relevant to the issues arising on the application before the Commission, please identify and address those issues.

At the hearing of this matter, set down for between 26 April to 11 May 2022 (inclusive), the HSU intends to lead evidence (including your Report and any reply to evidence filed by parties who oppose the Application). You may be required to attend the hearing as a witness to provide your evidence to the Commission.

The HSU's evidence, including any expert reports, is due to be filed on 8 October 2021, and our preference would be to receive your Report on or before **20 September 2021**.

We **enclose** a copy of Rule 23.13 of the Federal Court Rules and ask that you ensure your Report complies with the same. In addition to your Report and to facilitate your giving evidence in the Commission, we also request that you read the **enclosed** Expert Witness Code of Conduct. We will ask you to affirm or swear an affidavit that includes a statement that you have read the Expert Witness Code of Conduct and agree to be bound by its terms. Please also identify your training, study/qualifications and experience which provide you with the specialised knowledge to prepare your Report and an acknowledgement that those things have been relied upon to provide the opinions contained in your Report.

Please do not hesitate to contact me on 0418 538 989 or Louise de Plater on 0429 928 192 if you would like to discuss the matter further.

Yours sincerely,

Leigh Svendsen
Senior Industrial and Compliance Officer

Form F46 – Application to vary a modern award

Fair Work Act 2009, ss.157–160

This is an application to the Fair Work Commission to make a modern award or make a determination varying or revoking a modern award, in accordance with Part 2-3 of the Fair Work Act 2009.

The Applicant

These are the details of the person who is making the application.

Title	[ ] Mr [ ] Mrs [ ] Ms [ ] Other please specify:		
First name(s)			
Surname			
Postal address	Suite 46, 255 Drummond St		
Suburb	Carlton		
State or territory	VIC	Postcode	3053
Phone number	0418 538 989	Fax number	
Email address	leighs@hsu.net.au; louised@hsu.net.au		

If the Applicant is a company or organisation please also provide the following details

Legal name of business	Health Services Union
Trading name of business	Health Services Union
ABN/ACN	68 243 768 561
Contact person	Leigh Svendsen leighs@hsu.net.au 0418 538 989 Louise de Plater louised@hsu.net.au 0429 928 192

Does the Applicant need an interpreter?

If the Applicant requires an interpreter (other than a friend or family member) in order to participate in conciliation, a conference or hearing, the Fair Work Commission will provide an interpreter at no cost.

[ ] Yes – Specify language

[X] No

Does the Applicant require any special assistance at the hearing or conference (eg a hearing loop)?

[ ] Yes – Please specify the assistance required

[X] No

Does the Applicant have a representative?

A representative is a person or organisation who is representing the applicant. This might be a lawyer or paid agent, a union or employer organisation, or a family member or friend. There is no requirement to have a representative.

[ ] Yes – Provide representative's details below

[X] No

Applicant's representative

These are the details of the person or organisation who is representing the Applicant (if any).

Name of person			
Firm, organisation or company			
Postal address			
Suburb			
State or territory			
Phone number			
Email address			

Is the Applicant's representative a lawyer or paid agent?

[ ] Yes

[ ] No

1. Coverage

1.1 What is the name of the modern award to which the application relates?

Include the Award ID/Code No. of the modern award

Social, Community, Home Care and Disability Services Award 2010 [MA000100] (**SCHCDS Award**)

1.2 What industry is the employer in?

That part of the home care sector (as defined in the SCHCDS Award) which operates in the aged care industry.

2. Application

2.1 What are you seeking?

Specify which of the following you would like the Commission to make:

[X] a determination varying a modern award

[ ] a modern award

[ ] a determination revoking a modern award

2.2 What are the details of your application?

1. The Applicant applies to amend the SCHCADS Award as follows:

A. To insert into clause 3.1, the following definition:

Home aged care employee *means a home care employee providing personal care, domestic assistance or home maintenance to an aged person in a private residence;*

B. To amend the heading to clause 17 as follows:

Minimum weekly wages for home care employees other than home aged care employees.

C. To insert clause 17A, as follows:

17A. Minimum weekly wages for home aged care employees

17A.1 Home aged care employee Level 1

	Per week
	$
Pay point 1	1014.13

17A.2 Home aged care employee Level 2

	Per week $
Pay point 1	1074.88
Pay point 2	1082.25

17A.3 Home aged care employee Level 3

	Per week $
Pay point 1 (certificate III)	1097.00
Pay point 2	1130.75

17A.4 Home aged care employee Level 4

	Per week $
Pay point 1 (certificate IV)	1196.88
Pay point 2	1220.75

17A.5 Home aged care employee Level 5

	Per week $
Pay point 1 (degree or diploma)	1283.13
Pay point 2	1333.75

D. To make such further or other amendments to the SCHCDS Award as appear appropriate to the Commission in light of the evidence in the proceeding.

Attach additional pages, if necessary.

2.3 What are the grounds being relied on?

Using numbered paragraphs, specify the grounds on which you are seeking the proposed variations.

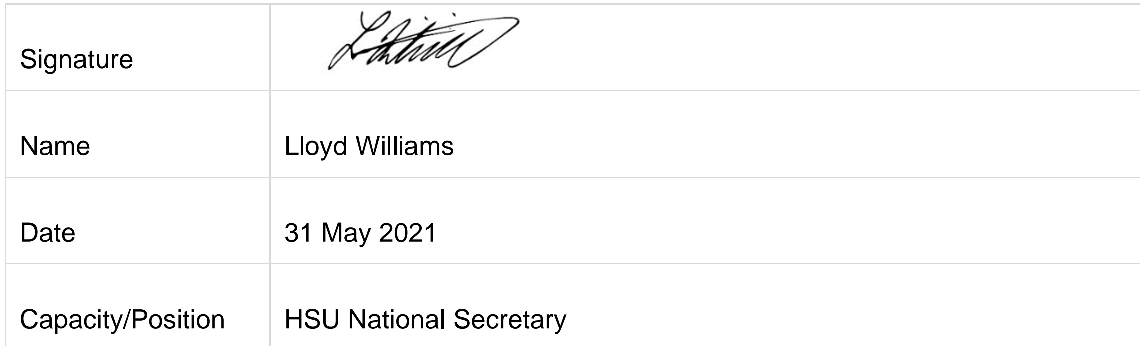
You must outline how the proposed variation etc is necessary in order to achieve the modern awards objective as well as any additional requirements set out in the FW Act.

The grounds relied upon by the Applicant are contained in Annexure A to this application.

Attach additional pages, if necessary.

Signature

If you are completing this form electronically and you do not have an electronic signature you can attach, it is sufficient to type your name in the signature field. You must still complete all the fields below.

Signature	
Name	Lloyd Williams
Date	31 May 2021
Capacity/Position	HSU National Secretary

Where this form is not being completed and signed by the Applicant, include the name of the person who is completing the form on their behalf in the **Capacity/Position** section.

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR OWN RECORDS

ANNEXURE A

GROUNDS AND REASONS FOR APPLICATION

INTRODUCTION

1. This application raises for consideration a number of issues that arise in respect of the application by the Health Services Union to vary the Aged Care Award 2010 [MA000018] (**Aged Care Award**) in proceedings number 2020/99 and the application by the Australian Nursing and Midwifery Federation in proceedings number 2021/63 to vary the Aged Care Award and the Nurses Award 2010 [MA000034] (**Nurses Award**).

2. Employees, other than nurses, providing aged care in residential aged care facilities are covered by the Aged Care Award 2010. Employees providing aged care in home settings (**the home aged care employees**) are covered by the Social, Community, Home Care and Disability Services Industry Award [MA000100] (**SCHCDS Award**).

3. As is the case with the minimum wage rates contained in the Aged Care Award, the minimum wage rates in the SCHCDS Award pertaining to home aged care employees were not evaluated during the award modernisation process which led to the making of the SCHCDS Award. No consideration of the minimum wages (other than by annual minimum wage adjustments) or the work value of the work performed by home aged care employees covered by the SCHCDS Award has been conducted since that Award commenced to operate in 2010.

4. The current minimum wage rates pertaining to home aged care employees in the SCHCDS Award do not recognise the nature of work, the level of skill and responsibility involved in performing the work, nor the conditions under which the work is performed by home aged care employees providing aged care services in home settings.

5. The current minimum wage rates pertaining to home aged care employees in the SCHCDS Award undervalue the work of employees currently covered by that Award by more than 25 percent.

6. The Applicant seeks an increase in wages of 25 percent for home aged care employees at all classification levels in Schedule E of the Award to rectify the undervaluation.

7. The claimed increase would address the historic establishment of Award wages and recognise significant increases in work value of home aged care employees.

8. In considering the application, the Commission would be informed by the findings of the Final Report of the Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect* (**Final Report**) about the conditions under which aged care work is performed, and the workforce needs of the aged care system.

9. The claimed increase would give effect to Recommendation 84 of the Final Report, namely:

   Recommendation 84: Increases in award wages

   Employee organisations entitled to represent the industrial interests of aged care employees covered by the Aged Care Award 2010, the Social, Community, Home Care and Disability Services Industry Award 2010 and the Nurses Award 2010 should collaborate with the Australian Government and employers and apply to vary wage rates in those awards to:

a. *reflect the work value of aged care employees in accordance with section 158 of the Fair Work Act 2009 (Cth), and/or*
b. *seek to ensure equal remuneration for men and women workers for work of equal or comparable value in accordance with section 302 of the Fair Work Act 2009 (Cth).*

S.157(2A) - WORK VALUE REASONS

9. Section 157(2) of the *Fair Work Act* 2009 (**the Act**) enables the Commission to make a determination varying modern award minimum wages, where such variation is justified by work value reasons and making the determination outside the system of annual wage reviews is necessary to achieve the modern awards objective. 'Work value reasons' are addressed at section 157(2A) of the Act.

10. Whilst no specific datum point is required for an analysis of work value, the Commission should have regard to: changes in the nature of the work, the skills required to perform that work; the responsibility involved in doing the work; and the conditions under which work is performed which have occurred over time.

11. Any consideration by the Commission should readily ascertain that the variation is justified based on the following work value reasons.

The nature of the work – s 157(2A)(a)

10. The nature of the work of home aged care employees justifies the variation to applicable minimum Award wages sought by the Applicant. The work performed includes a broad range of duties and requires a broad range of knowledge, skills and sound judgment in order to (in sum):
    a. Understand and assess the needs of an ageing population with an increased level of frailty, vulnerability and/or behavioural and psychological symptoms of dementia or equivalent. Those needs include the physical, mental, social, emotional, nutritional and hygiene needs of clients;
    b. Provide high quality physical, social and emotional care that is appropriate to the needs of people who require it;
    c. Provide care that protects the safety, health and wellbeing of aged care clients in home settings;
    d. Provide care that supports psychological, cultural and emotional wellbeing of aged care clients in home settings;
    e. Provide re-ablement to the aged;
    f. Provide specialist care in key areas of need, such as palliative or dementia care;
    g. Provide care in an increasingly diverse aged care population;
    h. Allow the aged to be able to exercise choice and be treated as individuals;

i. Liaise with clinical, health professional and supervisory staff to ensure the changing care needs of aged care clients in home settings are reported and can be reassessed when required;

j. Facilitate the engagement, social participation and independence of aged care clients in home care settings in the context of an ageing population;

k. Communicate effectively with a range of stakeholders, from family members to clinical and health professionals, on issues which are often of a sensitive nature.

l. Operate autonomously with a high level of responsibility and limited level of supervision and support;

m. At higher levels, manage day to day compliance with an increasingly complex regulatory regime (including quality and safety standards) and Aged Care industry policies and guidelines;

n. Perform a broad range of administrative and human resource related duties including recruitment processes, rostering, induction, orientation, staff liaison and event organisation;

o. Perform sales and promotional functions, targeted at prospective residents;

p. Manage and evaluate capacity to deliver care to clients, making arrangements with potential clients, preparing paperwork for new clients including contracts, reconciling payments for care, admitting new clients and discharging clients;

q. Deal with external auditors and compliance officers;

r. Deal with resident, family and staff complaints and enquiries;

s. Oversight of staff and outsourced providers;

t. Manage the financial affairs of the service (including accounts payable and receivable, payment of invoices, checking of invoices, purchasing, managing petty cash, banking, receiving residents' payments); and

u. Operate in an increasingly sophisticated care environment.

11. There have been significant changes in the nature of the work performed by home aged care employees resulting from:

    a. Changes in the acuity levels of aged care clients in home settings (with an increase in those with higher needs requiring a higher degree of responsibility from personal care workers, a higher level of care, a greater breadth of care and assistance and an increase in those with higher needs requiring a higher and more diverse range of paperwork and assessments to be performed prior to and whilst receiving care);

    b. Changes in theories and models of care;

c. Increased requirements to, in consultation with the client, assess the medical, physical, emotional, social, dietary, nutritional and mobility needs of aged care clients in home settings and to assist clients with medication and medical needs;

d. Increases in the need to, in consultation with the client, devise and provide individualised and complex physical, social and emotional care for each client, to document same and to report on significant developments to the client, employers and family members;

e. Increases in the need to, in consultation with the client, plan and administer the provision of home aged care;

f. Increasingly complex duties in financial management, oversight of outsourced providers, dealing with external auditors and compliance officers, human resource functions, managing accreditations and ensuring compliance, regulator and staff liaison;

g. Increased community expectations with regard to the extent and quality of care;

h. Increased skills required in providing client choice-centred care and assessing, planning and implementing the same;

i. Employer requirements for higher qualifications and training, the content and complexity of which are increasing;

j. Changes to infection control procedures;

k. Changes to requirements when preparing client directed care documentation arising from (without limitation) altered government regulation, increased governance and accreditation requirements;

l. Increased use and implementation of technology, including assisting and instructing older persons on the same;

m. Increased delegation of more sophisticated work, once associated with specialist management roles, such as procurement, human resources/employee relations, finance, governance, regulatory and compliance and facilities management;

n. Demands and pressures arising from the management of client directed care packages, and inadequate allowance for care in those packages.

o. Other related productivity measures.

The level of skill or responsibility involved in doing the work – s 157(2A)(b)

12. The work of home care employees providing aged care in home settings increasingly requires Certificate III or IV qualifications and additional formal specialised training (for example, in dementia care or medication dispensation).

13. Home care employees have a high level of responsibility in a broad range of areas arising from their role as carers of uniquely vulnerable, highly dependent aged people of Australia. This responsibility is to provide care in all aspects for the aged and extends to responsibility

for the physical, emotional and mental wellbeing of some of the most acutely ill and highly dependent cohorts in Australian society.

14. Home care employees work, almost exclusively, alone without direct support or supervision. They are solely responsible for the care provided, monitoring, observing and reporting changes in the client's physical and mental health, activity and cognitive functions to ensure responses, intervention or reassessment of their needs by the appropriate health professionals.

15. Home care employees frequently provide care for periods in excess of their engagement, or at levels above their classification where the home care package allocated to the client is insufficient to provide an appropriate level of care to the client.

16. Home care roles have become increasingly complex with the necessary attainment and exercise of a higher level of skill arising from (without limitation) the factors set out above as well as the evolution of a more complex regulatory environment resulting in increased responsibility for care workers and a greater emphasis on regulatory compliance, increased accreditation requirements for employers, and increased responsibility for assessing the medical needs of residents and assisting clients with medication and medical needs.

17. The level of skill and responsibility required of home aged care employees has increased arising from (without limitation):

    a. Increased reliance on workers to assess the medical and other needs of clients, to assist clients with medication and medical needs (rather than reliance on Allied Health Professionals, nurses and doctors) and liaise with medical practitioners and other health professionals;

    b. Increased prevalence of high acuity clients with more varied and high needs and a consequential need to assess, plan around and treat increasingly complex physical, social and emotional needs of residents;

    c. Changes in qualification requirements;

    d. Increased minimum standards and regulatory requirements for employers;

    e. Changes in technology used in performance of the work;

    f. Increased skills and responsibilities arising from the shift to the provision of *client directed care* and assessing, planning and implementing the same;

    g. More responsibility for the provision of physical, social and emotional care of clients;

    h. Increasing ongoing quality assessment and accreditation requirements;

    i. Reduction in the use and availability of registered nursing care and assessment;

    j. Increasingly complex duties of financial management, oversight, compliance, human resource functions, liaison and more varied and more complicated maintenance and other functions;

    k. The need to perform sales and promotional work at higher levels;

l. The need to implement and oversee policies and protocols governing the delivery of services.

The conditions under which the work is done – s 157(2A)(c)

18. Home care employees perform work in a diverse range of environments, without supervision;

19. The provision of aged care in the home has changed markedly since the SCHCDS Award was made as a result of (without limitation):

    a. Changes in the model of care (including the introduction of client directed care, specialist dementia care and palliative care);

    b. Changes in the philosophy of care (including the shift to the provision of client directed care and the decreased role of health professionals in the home care environment);

    c. Increased prevalence of high acuity clients with varied and higher needs including clients with later stage dementia and/or palliative care needs as more people choose to die at home;

    d. An increase in the sophistication of care and the regulatory framework that care operates in;

    e. Changes arising from COVID-19 that will likely continue, including:

        i. Changes in infection control procedures;
        ii. Changes in the use of technology; and
        iii. Changes in emotional needs of clients arising from increased isolation.

20. In addition, it is anticipated that further changes to the conditions under which work is performed will result from the report of the Royal Commission into Aged Care Quality and Safety.

MODERN AWARD AND MINIMUM WAGES OBJECTIVE – SS 157(1)(b), s134(1) and 284(1) – FAIR AND RELEVANT SAFETY NET

Relative living standards and the needs of the low paid

21. Many employees in the aged care sector, including home aged care employees, are paid minimum Award rates. Home aged care employees are predominantly engaged in roles for less than full time hours. The Award rates do not provide a relevant safety net of minimum wages. For the reasons set out above, the current Award rates significantly undervalue the work performed by home aged care workers. Even where rates of pay are set by enterprise agreements these rates are little more than Award rates of pay.

The need to encourage collective bargaining

22. There are significant and widespread difficulties associated with collective bargaining in the aged care sector with the result that the majority of employees are being paid minimum rates pursuant to the Award or rates set under enterprise agreements that are usually no higher than 5 percent above the minimum rates set under the relevant Award.

23. Factors impeding enterprise bargaining include:

    a. the fact that the majority of funding for the sector comes from the Commonwealth Government.

    b. the lack of incentive for employers to bargain with employees due to the existing low wage rates;

    c. the dispersed nature of the work;

    d. the undesirable interruptions to client care posed by industrial action.

24. The variations sought in this application would encourage employers to engage in collective bargaining by:

    a. increasing the relevance of the minimum rates applicable to the work performed;

    b. encouraging industrial parties to bargain for particular arrangements in workplaces to improve productivity and properly utilise a skilled workforce; and

    c. increasing the competitiveness of enterprises who currently engage in enterprise bargaining.

The need to promote social inclusion through increased workforce participation

25. Given an overwhelming majority of employees in the aged care sector are women, creating an incentive for employees to remain in the sector (by increased rates of pay and an enhanced classification structure), has the potential to increase the workforce participation of women. Further, given women still perform the majority of unpaid caring responsibilities to 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.

The need to promote flexible modern work practices and the efficient and productive performance of work

26. The undervaluation of the work performed in the aged care sector is a significant obstacle to attracting and retaining skilled aged care workers. This presents a material risk to the efficient and productive performance of work in the sector given that it is estimated that in order to maintain adequate levels of care, three times the current numbers of aged care workers will be required to sustain the sector by 2050. This is largely due to the ageing population, and the expectation that the number of persons requiring aged care is likely to increase significantly during that time.

27. The challenges in retaining and attracting staff as a result of disproportionately low wages is well documented. The inability to retain and attract staff is a contributing factor to understaffing, increased workloads and more challenging working conditions within the sector which necessarily has a negative impact on the quality of care provided to clients. As a result, the persistence of the undervaluation of aged care work is likely to dramatically decrease the efficient delivery of a high standard of care within the sector.

28. Further, granting the variation sought, is also likely to provide incentives for aged care workers to increase their qualifications and skills, which would necessarily translate into productivity gains.

Equal remuneration for work of equal or comparable value

29. As demonstrated comprehensively above, unlike other comparable professions, an increase in the qualifications, knowledge and skills required to perform work in the aged care sector, has not led to an increase in wages.

30. The workforce is female dominated. The undervaluation of aged care work has been contributed to significantly by the fact that the work has commonly been considered 'women's work' and is therefore inherently undervalued. Granting the variation sought would address the inherent undervaluation of feminised work and would be an important step in closing the gender pay gap that currently exists and is concentrated in the caring sectors (including in aged care).

31. The need to increase wages for aged care workers in order to achieve this objective is recognised in Recommendation 84 of the Final Report.

Likely impact on business, including on productivity, employment costs and the regulatory burden

32. The variation sought is likely to address the skill shortage that currently exists in the aged care sector. This skill shortage is forecast to dramatically increase in the coming decade, addressing this issue will increase productivity and benefit business.

The need to ensure a simple, easy to understand, stable and sustainable modern award system for Australia that avoids unnecessary overlap of modern awards

33. Granting the variation sought is crucial to ensuring a stable and sustainable modern award system. The variation will simplify progression for home aged care workers, through the inclusion of tenure-based progression and will set wages that accurately reflect the value of the work performed. This is fundamental to the integrity of the modern award system and maintaining its relevance to the labour market. Indeed, maintaining wage rates that are fair and equitable is a key component of an Award system that is simple and easy to understand.

Likely benefit to the sustainability, performance and competitiveness of the national economy

34. An aged care system which provides good quality and reliable care to the elderly is critical in permitting the working-age population to contribute to the economy, reducing pressures on the health care system and supporting economic activity, competitiveness and growth.

35. The setting of proper and fair rates of remuneration for home aged care employees will foster an efficient, productive and skilled workforce and support an aged care system which is able to contribute to the maintenance of a sustainable, productive and competitive national economy.

Other discretionary reasons

36. The correlation between adequate remuneration and the provision of a high level of care to elderly Australians is well documented. Increasing the minimum wage rates in the Award is fundamental to attracting and retaining skilled members of the workforce in the aged care system. Without the ability to retain employees in the system, the standard of care able to be provided is significantly reduced. Providing a level of care to elderly Australians which affords them dignity in their old age, is an essential feature of a just and prosperous society.

Conclusion

37. On the basis of the above the variations sought are:

    a. justified by work value reasons pursuant to s.157(2A);
    b. meet the minimum wages objective pursuant to Part 2-6 of the Act; and
    c. necessary to be varied as soon as possible in order to achieve the modern awards objective pursuant to s.157(2)(b).

Federal Court Rules 2011

Select Legislative Instrument No. 134, 2011

made under the

Federal Court of Australia Act 1976

Compilation No. 7

Compilation date:	2 May 2019
Includes amendments up to:	F2019L00665
Registered:	21 May 2019

Prepared by the Office of Parliamentary Counsel, Canberra

Division 23.2—Parties' expert witnesses and expert reports

23.11 Calling expert evidence at trial

A party may call an expert to give expert evidence at a trial only if the party has:

(a) delivered an expert report that complies with rule 23.13 to all other parties; and

(b) otherwise complied with this Division.

Note: ***Expert*** and ***expert report*** are defined in the Dictionary.

23.12 Provision of guidelines to an expert

If a party intends to retain an expert to give an expert report or to give expert evidence, the party must first give the expert any practice note dealing with guidelines for expert witnesses in proceedings in the Court (the ***Practice Note***).

Note: A copy of any practice notes may be obtained from the District Registry or downloaded from the Court's website at http://www.fedcourt.gov.au.

23.13 Contents of an expert report

(1) An expert report must:

(a) be signed by the expert who prepared the report; and

(b) contain an acknowledgement at the beginning of the report that the expert has read, understood and complied with the Practice Note; and

(c) contain particulars of the training, study or experience by which the expert has acquired specialised knowledge; and

(d) identify the questions that the expert was asked to address; and

(e) set out separately each of the factual findings or assumptions on which the expert's opinion is based; and

(f) set out separately from the factual findings or assumptions each of the expert's opinions; and

(g) set out the reasons for each of the expert's opinions; and

(ga) contain an acknowledgement that the expert's opinions are based wholly or substantially on the specialised knowledge mentioned in paragraph (c); and

(h) comply with the Practice Note.

(2) Any subsequent expert report of the same expert on the same question need not contain the information in paragraphs (1)(b) and (c).

23.14 Application for expert report

A party may apply to the Court for an order that another party provide copies of that other party's expert report.

Annexure A

HARMONISED EXPERT WITNESS CODE OF CONDUCT[2]

APPLICATION OF CODE

1. This Code of Conduct applies to any expert witness engaged or appointed:

   (a) to provide an expert's report for use as evidence in proceedings or proposed proceedings; or

   (b) to give opinion evidence in proceedings or proposed proceedings.

GENERAL DUTIES TO THE COURT

2. An expert witness is not an advocate for a party and has a paramount duty, overriding any duty to the party to the proceedings or other person retaining the expert witness, to assist the Court impartially on matters relevant to the area of expertise of the witness.

CONTENT OF REPORT

3. Every report prepared by an expert witness for use in Court shall clearly state the opinion or opinions of the expert and shall state, specify or provide:

   (a) the name and address of the expert;

   (b) an acknowledgment that the expert has read this code and agrees to be bound by it;

   (c) the qualifications of the expert to prepare the report;

   (d) the assumptions and material facts on which each opinion expressed in the report is based [a letter of instructions may be annexed];

   (e) the reasons for and any literature or other materials utilised in support of such opinion;

   (f) (if applicable) that a particular question, issue or matter falls outside the expert's field of expertise;

   (g) any examinations, tests or other investigations on which the expert has relied, identifying the person who carried them out and that person's qualifications;

   (h) the extent to which any opinion which the expert has expressed involves the acceptance of another person's opinion, the identification of that other person and the opinion expressed by that other person;

   (i) a declaration that the expert has made all the inquiries which the expert believes are desirable and appropriate (save for any matters identified explicitly in the report), and that no matters of significance which the expert regards as relevant have, to the

[2] Approved by the Council of Chief Justices' Rules Harmonisation Committee

knowledge of the expert, been withheld from the Court;

(j) any qualifications on an opinion expressed in the report without which the report is or may be incomplete or inaccurate;

(k) whether any opinion expressed in the report is not a concluded opinion because of insufficient research or insufficient data or for any other reason; and

(l) where the report is lengthy or complex, a brief summary of the report at the beginning of the report.

SUPPLEMENTARY REPORT FOLLOWING CHANGE OF OPINION

4. Where an expert witness has provided to a party (or that party's legal representative) a report for use in Court, and the expert thereafter changes his or her opinion on a material matter, the expert shall forthwith provide to the party (or that party's legal representative) a supplementary report which shall state, specify or provide the information referred to in paragraphs (a), (d), (e), (g), (h), (i), (j), (k) and (I) of clause 3 of this code and, if applicable, paragraph (f) of that clause.

5. In any subsequent report (whether prepared in accordance with clause 4 or not) the expert may refer to material contained in the earlier report without repeating it.

DUTY TO COMPLY WITH THE COURT'S DIRECTIONS

6. If directed to do so by the Court, an expert witness shall:

(a) confer with any other expert witness;

(b) provide the Court with a joint-report specifying (as the case requires) matters agreed and matters not agreed and the reasons for the experts not agreeing; and

(c) abide in a timely way by any direction of the Court.

CONFERENCE OF EXPERTS

7. Each expert witness shall:

(a) exercise his or her independent judgment in relation to every conference in which the expert participates pursuant to a direction of the Court and in relation to each report thereafter provided, and shall not act on any instruction or request to withhold or avoid agreement; and

(b) endeavour to reach agreement with the other expert witness (or witnesses) on any issue in dispute between them, or failing agreement, endeavour to identify and clarify the basis of disagreement on the issues which are in dispute.

Curriculum vitae

March 2021

Gabrielle Anne Meagher

Home address

[redacted]

University address

School of Social Sciences,
Macquarie University, NSW, 2109
email: gabrielle.meagher@mq.edu.au

Education

1999	PhD, Faculty of Economics and Business, The University of Sydney
1992	Bachelor of Economics (Social Sciences), Hons Class I & University Medal, The University of Sydney

Employment

2015–2019	**Professor** Department of Sociology, Macquarie University
2015–2019	**Guest Professor** (0.2 fraction) Department of Social Work, Stockholm University
2015–2018	**Head of Department** Department of Sociology, Macquarie University
2012–2015	**Associate Dean and Director, Office of Doctoral Studies** Faculty of Education and Social Work, The University of Sydney
2007–2015	**Professor and Chair of Social Policy** Faculty of Education and Social Work, The University of Sydney
Oct 2013–Jun 2014	**Guest Professor** Department of Social Work, Stockholm University (Funded by an Excellence Grant by the Swedish Research Council for Health, Working Life and Welfare)
Jan–May 2009	**Guest Professor** Department of Social Work, Stockholm University (Funded by the office of the Vice-Chancellor of Stockholm University to promote gender equity in the University's professoriate)
2003–2006	**Senior Lecturer** Discipline of Political Economy, School of Economics and Political Science, Faculty of Economics and Business, The University of Sydney
1995–2002	**Lecturer** Discipline of Political Economy, School of Economics and Political Science, Faculty of Economics and Business, The University of Sydney
1992–1994	**Associate Lecturer** Department of Economics, Faculty of Economics, University of Sydney

Honorary appointments

2020–	**Professor Emerita** School of Social Sciences, Macquarie University
2020–	**Affiliated Professor** Department of Social Work, Stockholm University, Sweden
May–Jul 2010	**Visiting Professor** Department of Social Work, Stockholm University, Sweden
Feb–Apr 2010	**Visiting Professorial Fellow** Social Policy Research Centre, University of New South Wales, Australia
Mar–May 2005	**Visiting researcher** National Institute for Working Life, Stockholm, Sweden
Jan–Mar 2005	**Visiting researcher** School of Human and Health Services, University of Huddersfield, England
Jul–Dec 2002	**Visiting researcher** Social Policy Research Centre, University of New South Wales, Australia
Jul–Dec 1999	**Visiting researcher** Australian Centre for Industrial Relations Research and Training, University of Sydney, Australia

Publications

Peer-reviewed journal articles

1. Shanks, E., Lundström, T., Meagher, G., Sallnäs, M., Wiklund, S. (2021) Impression management in the market for residential care for children and youth in Sweden. *Social Policy & Administration*, 55(1), 82-96.
2. Meagher, G., Szebehely, M. (2019) 'The politics of profit in Swedish welfare services: four decades of Social Democratic ambivalence', *Critical Social Policy*, 39(3), 455-476.
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3. Meagher, G., Wilkins D.P. (2018) Private interests and problem frames in social policy reform: An Australian case study combining corpus linguistics and critical discourse analysis, *Critical Approaches to Discourse Analysis across Disciplines,* 10(2), 1-29.
4. Szebehely, M., Meagher, G. (2018) Nordic eldercare – weak universalism becoming weaker?, *Journal of European Social Policy*, 28(3), 294-308.
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5. Meagher, G., Lundström, T., Sallnäs, M., Wiklund, S. (2016) Big business in a thin market: Understanding the privatization of residential care for children and youth in Sweden, *Social Policy & Administration*, 50(7), 767-883.

6. Meagher, G., Szebehely, M., Mears, J. (2016) How institutions matter for job characteristics, quality and experiences: A comparison of home care work for older people in Australia and Sweden, *Work, Employment and Society*, 30(5), 731-749.
7. Cortis, N., Meagher, G. (2012). Recognition at last: care work and the Equal Remuneration Case. *Journal of Industrial Relations*, 54(3), 377-385.
8. Cortis, N., Meagher, G. (2012). Social work education as preparation for practice: evidence from a survey of the New South Wales community sector. *Australian Social Work*, 65(3), 295-310.
    - *Received Norman Smith Research Award for best research paper published in ASW in 2012.*
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10. Connell, R., Fawcett, B., Meagher, G. (2009). Neoliberalism, new public management and the human service professions: Introduction to the special issue. *Journal of Sociology*, 45(4), 331-338.
11. Healy, K., Meagher, G., Cullin, J. (2009). Retaining novices to become expert child protection practitioners: creating career pathways in direct practice. *British Journal of Social Work*, 39, 299-317.
12. Cortis, N., Meagher, G. (2009). Women, work and welfare in the activation state: an agenda for Australian research. *Australian Bulletin of Labour*, 35(4), 629-651.
13. Meagher, G., Wilson, S. (2008). Richer, but more unequal: perceptions of inequality in Australia 1987-2005. *Journal of Australian Political Economy*, 61, 220-243.
14. Tham, P., Meagher, G. (2008). Working in human services: how do experiences and working conditions in child welfare social work compare? *British Journal of Social Work*, 39(5), 1-21.
15. Briggs, C., Meagher, G., Healy, K. (2007). Becoming an industry: the struggle of social and community workers for award coverage, 1976-2001. *Journal of Industrial Relations*, 49(4), 497-521.
16. Healy, K., Meagher, G. (2007). Social workers' preparation for child protection: revisiting the question of specialisation. *Australian Social Work*, 60(3), 321-335.
    - *Received Norman Smith Research Award for best research paper published in ASW in 2007.*
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18. Meagher, G. (2006). What can we expect from paid carers? *Politics and Society*, 34(1), 33-53.
19. Meagher, G., Parton, N. (2004). Modernising social work and the ethics of care. *Social Work and Society*, 2(1), 10-27.
20. Meagher, G., Nelson, J. (2004). Survey article: Feminism in the dismal science. *Journal of Political Philosophy*, 12(1), 102-126.
21. Healy, K., Meagher, G. (2004). The reprofessionalization of social work: collaborative approaches for achieving professional recognition. *British Journal of Social Work*, 34(2), 243-260.
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- Included in: Hodge, D., Lacasse, J., Benson, O. (2012) Influential publications in social work discourse: The 100 most highly cited articles in disciplinary journals: 2000–09, *British Journal of Social Work*, vol. 42(4).

22. Meagher, G., Healy, K. (2003). Caring, controlling, contracting and counting: governments and non-profits in community services. *Australian Journal of Public Administration,* 62(3), 40-51.
23. Meagher, G., Wilson, S. (2002). Complexity and practical knowledge in the social sciences: a comment on Stehr and Grundmann. *British Journal of Sociology,* 53(4), 659-666.
24. Meagher, G. (2002). Is it wrong to pay for housework? *Hypatia: A Journal of Feminist Philosophy*, 17(2), 52-66.
    - Reprinted in: D. Barker & E. Kuiper (Eds) (2009). *Feminist Economics*, *Volume II, Households, Labour and Paid Work*, Routledge Major Works Series: Critical Concepts in Economics. London: Routledge.
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26. Meagher, G. (2000). A struggle for recognition: strategies for work life reform in the domestic services industry. *Economic and Industrial Democracy*, 21(1), 9-37.
27. Buchanan, J., O'Keeffe, S., Bretherton, T., Arsovska, B., Meagher, G., Heiler, K. (2000). Wages and wage determination in 1999. *Journal of Industrial Relations*, 42(1), 109-145.
28. Meagher, G. (2000). Social sustainability in Australia. *Canberra Bulletin of Public Administration*, 96, 63-78.
29. Meagher, G. (1999). A classroom strategy for teaching the social sciences in Women's Studies. *Women's Studies Quarterly*, 27(3&4), 36-48.
30. Bittman, M., Matheson, G. & Meagher, G. (1999). The changing boundary between home and market: Australian trends in outsourcing domestic labour. *Work, Employment and Society*, 13(2), 249-273.
31. Meagher, G. (1998). "A woman seldom runs wild after an abstraction": feminist contributions to economics. *Economic Papers*, 17(1), 51-69.
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    - Reprinted in: L. Benería, A.M. May & D. Strassmann (Eds) (2011). *Feminist Economics*, *Volume II: Households, Paid and Unpaid Work, and the Care Economy*, The International Library of Critical Writings in Economics, Edward Elgar, Cheltenham.
33. Meagher, G. (1994). Evaluating women's work: New South Wales nurses and professional rates. *Journal of Australian Political Economy*, 34, 77-102.

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34. Fawcett, B., Goodwin, S., Meagher, G., Phillips, R. (2010). *Social Policy for Social Change*. Australia: Palgrave Macmillan.
35. Meagher, G. (2003). *Friend or Flunkey: Paid Domestic Workers in the New Economy.* Sydney: UNSW Press.

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36. Meagher, G., Goodwin, S. (2015). *Markets, Rights and Power in Australian Social Policy.* Sydney: Sydney University Press.
37. King, D., Meagher, G. (2009). *Paid Care in Australia: Politics, Profits, Practices.* Sydney: Sydney University Press.
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43. Meagher, G. (2014). Persistent inequalities: the distribution of money, time and care. In S.K. Schroeder & L. Chester (Eds.), *Challenging the Orthodoxy: Reflections on Frank Stilwell's Contribution to Political Economy*, (pp. 79-100). New York: Springer.
44. Meagher, G., Szebehely, M. (2013). Long-term care in Sweden: trends, actors, and consequences. In C. Ranci & E. Pavolini (Eds.), *Reforms in Long-Term Care Policies in Europe: Investigating Institutional Change and Social Impacts*, (pp. 55-78). New York: Springer.
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47. King, D., Meagher, G. (2009). Introduction: Politics, profits and practices in child and aged care. In D. King & G. Meagher (Eds.), *Paid Care in Australia: Politics, Profits, Practices*, (pp. 1-11). Sydney: Sydney University Press.
48. Meagher, G., Cortis, N. (2009). The political economy of for-profit paid care: Theory and evidence. In D. King & G. Meagher (Eds.), *Paid Care in Australia: Politics, Profits, Practices*, (pp. 13-42). Sydney: Sydney University Press.

49. Meagher, G., Cortis, N., Healy, K. (2009). Strategic challenges in child welfare services: a comparative study of Australia, England and Sweden. In K. Rummery, C. Holden & I. Greener (Eds.), *Social Policy Review 21: Analysis and Debate in Social Policy*, (pp. 215-242). Bristol: Policy Press.

50. Meagher, G., Wilson, S. (2007). Are unions regaining popular legitimacy in Australia? In D. Denemark, G. Meagher, S. Wilson, M. Western & T. Phillips (Eds.), *Australian Social Attitudes 2: Citizenship, Work and Aspirations*, (pp. 195-216). Sydney: UNSW Press.

51. Wilson, S., Meagher, G. (2007). Howard's welfare state: how popular is the new social policy agenda? In D. Denemark, G. Meagher, S. Wilson, M. Western & T. Phillips (Eds.), *Australian Social Attitudes 2: Citizenship, Work and Aspirations*, (pp. 262-285). Sydney: University of New South Wales (UNSW) Press.

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54. Meagher, G., Wilson, S., Reusch, T. (2005). Where to for the welfare state? In S. Wilson, G. Meagher, R. Gibson, D. Denemark & M. Western (Eds.), *Australian Social Attitudes: The First Report*, (pp. 101-121). Sydney: University of New South Wales (UNSW) Press.

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56. Meagher, G. (1996). Gender in the economy. In F. Stilwell and G. Argyrous (Eds.), *Economics as a Social Science*, Pluto Press, Sydney (second edition 2003, third edition 2011).

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57. Meagher, G., Cortis, N. Charlesworth, S., Taylor, W. (2019). *Meeting the Social and Emotional Support Needs of Older People Using Aged Care Services.* Sydney: Macquarie University, UNSW Sydney and RMIT University (92 pp.). http://doi.org/10.26190/5da7d6ab7099a

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59. Meagher, G. (2016). *Care Work in Aged Residential Care Facilities in New Zealand: Structure, Workforce and Pay Equity Issues*, Research Report (39 pp.).

60. Cortis, N., Meagher, G., Chan, S., Davidson, B., Fattore, T. (2013). *Building an Industry of Choice: Service Quality, Workforce Capacity and Consumer-centred Funding in Disability Care*, Social Policy Research Centre, University of New South Wales, Sydney (42 pp.).

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62. Meagher, G., Szebehely, M. (2010). *Private Financing of Elder Care in Sweden: Arguments for and Against.* Institute for Future Studies, Stockholm, Sweden (32 pp.).
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64. Meagher, G., Healy, K. (2006). *Who Cares? Volume 2: Employment Structure and Incomes in the Australian Care Workforce.* Paper 141, Australian Council of Social Service, Surry Hills (98 pp.).
65. Meagher, G., Healy, K. (2005). *Who Cares? Volume 1: A Profile of Care Workers in Australia's Community Service Industries.* Paper 140, Australian Council of Social Service, Surry Hills (84 pp.).
66. Meagher, G. (2002). *Making Care Visible: Performance Measurement in Welfare Services*. UnitingCare Burnside, North Parramatta (20 pp.).
67. Meagher, G. (2002). *The Politics of Knowledge in Social Service Evaluation.* UnitingCare Burnside, North Parramatta (25 pp.).