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Submission of Liquor Hospitality and Miscellaneous Union (LHMU), Western Australian Branch into House of Representative Inquiry into Pay Equity and Associated Issues Relating to Increasing Female Participation in the Workforce

This submission needs to be read in conjunction with the Combined Council of Trade Unions (ACTU) and Joint State Union Peak Councils submission (#125), the LHMU, Queensland Branch submission (#138) and the LHMU, National Office submission (#138.1).

The implementation of the principle of pay equity, equal remuneration for men and women employees for work of equal or comparable value, requires a means of determining what is equal or comparable. The purpose of this submission is to focus the Committee's attention on the aged care sector, the ways in which the work of aged care workers is de-valued on a gender basis and how this is perpetuated through current structural arrangements other than through the industrial relations systems (which has been fully addressed in the submissions referred to above). The LHMU represents some 75% of the direct care workers employed in the aged care sector. In this submission reference will be made to the residential aged care sector.

AUSTRALIA'S AGEING POPULATION

Australia's population is ageing. In 2007 13.4% of the population was aged over 65 years (2.8 million). By 2047 it is predicted that 25.3% of the population will be aged over 65 years (13.4 million) (Intergenerational Report, 2007, Table 2.2 p16).

In 2008 there were 153,000 people residing in residential aged care homes. By 2047 it is expected that this figure will exceed 400,000. At 30 June 2008 70% of residents of aged care homes required high level care and during 2007-08 63% of newly admitted permanent residents were assessed as requiring high level care (Aust. Institute of Health and Welfare 2009, p44).

The prevalence of chronic diseases amongst our aged is increasing, for example, the number of Australians with dementia is expected to increase from around 220,000 to over 730,000 between 2007 and 2050. There will also be a growing prevalence of co-morbidity (people living with two or more diseases at the same time). This changing pattern of disease will create greater diversity in the care needs of older people. (Productivity Commission, 2008, pXVIII).

THE AGED CARE WORKFORCE

The aged care workforce is increasing in size. Between 2003 and 2007 the total employment in aged care homes rose from about 157,000 to about 175,000, with direct care employees increasing from about 116,000 to about 133,000. Ninety three percent of residential aged care workers are female and 60% are older than 40 years. (Martin B & King D, 2008, pXIV).

There has been a significant reorganization of care in residential nursing homes. More care is now provided by personal carers (PCs) and less by nurses and it appears that the trend towards increasing use of PCs will continue (Martin B & King D, 2008, p8).

In 2007, 9% of direct care workers were on permanent full-time contracts, 69% on permanent part-time contacts, and 22% on casual contracts. The trend has been to employ more direct care workers on casual contracts (Martin B & King D, 2008, p9).

AGEING - A GROWTH INDUSTRY

The aged care sector is undergoing significant growth and, being labour intensive in nature, has a growing need for labour. In this environment it could be assumed that demand and supply would lead to higher employee remuneration. Direct care workers however continue to be amongst the lowest paid.

As noted above the aged care workforce is almost entirely comprised of middle aged females, employed either on part-time or casual contracts. The significance of these workforce characteristics in an industrial relations context have been well explained in other submissions to the Committee (refer ACTU submission # 125).

THE 'CARE' PENALTY

The devaluing of care skills in the workplace has been well recognized in feminist theory and literature. There has however been little research into how the process of devaluing care skills occurs in the workforce and the LHMU, WA Branch believes that further research into this area needs to be undertaken.

In a recent research article it was argued *that aged care employers are not passive beneficiaries of this historical undervaluation of women's work but instead actively reproduce a particular logic of care which supposes 'quality' care work to be done for reasons of altruism rather than pay (Palmer E. & Eveline J., 2009).* Palmer and Eveline argue that this is achieved in part by:

- Employers applying an familial logic of care to define aged care as appropriately low paid;
- Actively seeking family-embedded female workers who, theoretically, have a lesser requirement for financial rewards;
- Defining care skills as natural to women,' soft' and intangible; and
- Promoting the notion that aged care work therefore needs little or no professional 'hard' skills.

In this scenario any further qualifications are not seen as bringing further skills to the workplace. For example, an advanced skilled PC with a certificate IV is paid around $0.60 per hour more than a level 1 PC who may not possess any additional qualifications.

QUARANTINED FUNDING FOR STAFF

There has been a number of inquires and reports lately about the aged care sector (e.g. Department of Health and Ageing inquiry into the Conditional Adjustment Payment, Senate Standing Committee on Finance and Public Administration's Inquiry into Residential and Community Aged Care in Australia). The overwhelming message from aged care providers is that the Commonwealth's funding of aged carer is insufficient to meet the costs of providing quality care. In this funding environment providers simply do not have the financial means of addressing the issue of pay equity for care workers. The quality of the aged care provided is inextricably linked to the quality of the workforce providing the care. The quality of the workforce is dependent upon the aged care sector being able to offer competitive wages and

conditions capable of attracting and sustaining a quality workforce. The LHMU is of the strong opinion that wage outcomes that recognize the skill level of quality care workers and therefore address the pay inequities can only be achieved by the Commonwealth Government allocating:

1. 'catch up' funding to immediately address the inadequate remuneration of aged care workers; and
2. recurrent funding to providers specifically for the purpose of remunerating care workers to ensure that their wages remain at a competitive level.

STAFF: RESIDENT RATIOS IN NURSING HOMES

One of the structural arrangements that impacts disproportionately upon care workers is the failure of the Government to regulate minimum staff: resident ratios in nursing homes. From 2003 the number of full-time equivalent direct care employees has decreased relative to the increase in resident numbers. The NILS Report shows that a significant proportion of direct care workers feel they do not spend sufficient time with residents, spend significant time engaged in non-direct care work, and feel pressured to work harder. *Since ... aged care workers derive much of their job satisfaction from feeling that they do a good job in providing care to the elderly, it remains of substantial concern that workers feel they are not able to do the job to their satisfaction. Especially in an industry that is unlikely to be able to compete with other potential employers on wages or employment conditions, this issue must remain central to workforce planning* (Martin B & King D, 2008, p31).

Australia does not have prescribed staff: resident ratios in nursing homes. As noted by Ms Linda Sparrow of Aged Care Crisis (consumer advocacy group): *We find that particularly in the evening and night shifts, we have really low staff resident ratios very often. We hear as low as one carer on for 100 at night* (*In the National Interest*, ABC Radio National 29 May 2009).

Quality care requires time, but time costs money. Hence we need to build in mechanisms to ensure that time is available for quality care through mechanisms such as staff: resident ratios that ensure sufficient staffing levels, Care work cannot be subject to the same sorts of efficiency and productivity improvements that non-service jobs can be. Providers are therefore tempted to cut costs by cutting staff, to the detriment of care quality, or to suppress wages, which exacerbates shortages of quality workers.

The United States of America's Nursing Home Reform Act 1987 requires, in part, nursing homes that wish to be certified for participation in Medicare or Medicaid to provide a minimum of eight hours per day of registered nursing (RN) service and 24 hours per day of licensed nursing (LN) service (LN = enrolled nurse) per resident day. In a Report to Congress, Abt Associates Inc (2002) forecast that wages in nursing home in the USA would increase between 2.5%-7% for RNs and between 10-22% for PCs as a consequence of mandated staff: resident ratios. (p3.20). Whilst it is recognized that this applies to the United States it does highlight that mandated staff: resident ratios is a means of recognizing the true value of the skills and importance of care workers and is a mechanism for improving the wage outcomes for those workers. Unfortunately there has been little or no research in Australia of the impact of introducing mandated staff: resident ratios.

TRANSPARENCY AND ACCOUNTABILITY

The LHMU, WA Branch, has for some time been concerned about the lack of financial accountability and transparency within the care sector and particularly the aged care sector. Although the providers of aged care facilities are substantially government funded ($44 billion budgeted over the next four years) there is little or no financial public accountability required of aged care providers. As noted in the Parliament of Australia's *Aged Care Amendment (2008 Measures No. 2) bill 2008 Bill Digest: The current legislative framework reflects the 'cottage industry' that was present when the Act was introduced.*

Most providers are not subject to the same disclosure requirements of say a publically listed, multinational mining company. Sixty two percent of aged care homes are operated by not-for-profit organizations that are subject to State legislation and therefore have minimal financial disclosure requirements. The same can be said of the 12% of nursing homes operated by government bodies, which are mostly attached to public hospitals. Twenty seven percent of nursing homes are operated by for-profit organizations however the majority of these are not subject to financial disclosure provisions of the *Corporations Act 2001.*

The lack of transparency is another structural arrangement that may impact negatively in the negotiation of wages for workers employed in the age care sector. This can be illustrated by comparing the aged care sector to a male dominated workforce, such as the mining industry. Workers within the mining industry have access to their employer's detailed financial information when entering into wage negotiations. This puts them in a better bargaining position to achieve equitable outcomes. In contrast aged care providers often actively seek to avoid making any financial disclosure to their workers and, concurrently, expect their workers to accept (patriarchal) assurances that they don't have the financial wherewithal to make significant improvements to wages and conditions.

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