SUBMISSION

RESPONSE TO PRODUCTIVITY COMMISSION WORKPLACE RELATIONS FRAMEWORK: ISSUES PAPERS

27 March 2015

About Us

The Health Services Union (HSU) is a growing member-based union with over 70,000 members working across the health and community services sectors in every state and territory.

Our members work in aged care, disability services, community health, mental health, private practices and hospitals. Members are health professionals, paramedics, scientists, aged care workers, nurses, technicians, personal care and support workers, clerical and administrative staff, disability support workers, managers, doctors, medical librarians and support staff.

We are committed to advancing and protecting the wages, conditions, rights and entitlements of members through campaigning and workplace activism. HSU also provides a range of services and support to assist members with many aspects of working and family life.

We are a driving force to make Australia a better place.

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

Contact:
Chris Brown
National Secretary

Leigh Svendsen
Senior National Industrial Officer

Mark Farthing
Senior National Project Officer

Introduction

HSU National welcomes the opportunity to provide a response to the Productivity Commission's (the Commission) inquiry into Australia's workplace relations framework. At the outset we would like to clarify that this submission does not address every issue identified in the five issues papers. Instead, the purpose of this submission is to highlight our particular knowledge of the health and community services sectors and raise issues of particular importance to our members, specifically minimum rates and penalty rates. For our views on the complete array of topics identified in the five issues papers, we refer the Commission to the Australian Council of Trade Unions' (ACTU) comprehensive submission, which the HSU both contributed to and endorses.

The health and community services sectors are broad and diverse. They cover everything that people require to keep them mentally and physically well from birth to death; cover the myriad of differences that makes a person, including whatever disability they are born with, inherit or acquire, whether at work, play or simply through the natural process of living and ageing. The sector is intended to meet the needs of each of us as individuals through providers run by governments, the not-for-profit and for-profit sectors and from small to large international organisations. While the sectors are not singular and can be separated in a multiplicity of fashions, there are some significant similarities that apply to the workforces within each.

The clearest and most obvious similarity is the interplay between wage rates and government funding. While there are numerous theories of wage determination, at a general level, it is broadly recognised that insufficient supply, or labour shortages, will generally put upward pressure on wages.[1] However, in Australia, remuneration in the health and community service sectors is governed largely by the quantum of public funding allocated to these sectors by state and federal governments. The unresponsiveness of these sectors to usual labour market triggers for higher wages is also demonstrated by new research examining the relationship between vocational education and training (VET) qualifications and rates of pay in modern awards. Oliver and Walpole's (2014) analysis found that a Certificate IV qualification in health and community services is worth considerably less in the labour market than a Certificate IV in other fields, particularly compared to traditional "blue-collar" occupations found predominantly in the private sector.[2] Indeed, award rates for VET-qualified workers in the Community Services and Health industry are only slightly higher than the minimum wage and well below average weekly earnings (see Table 1).

[1] Kent, C. (16 June 2014) 'Cyclical and Structural Changes in the Labour Market' *Address on Labour Market Developments, hosted by The Wall Street Journal,* available at: http://www.rba.gov.au/speeches/2014/sp-ag-160614.html

[2] Oliver, D., & Walpole, K. (2014) *Missing links: Connections between VET qualifications and pay in modern awards*, paper presented at the 23rd National Vocational Education and Training Research Conference: Melbourne.

Table 1 Award pay rates for selected VET-qualified roles in health and community and services

Classification	Award	Required qualification level	Award weekly rate (full-time)	As a% of full-time national min. wage[1]	As a % of AWOTE[2]
Aged Care Employee Level IV	Aged Care Award	Certificate III	$746.2	116%	51%
Enrolled Nurse pay point 1	Nurses Award 2010	Diploma	$760.1	119%	52%

Source: Adapted from Table 5 in Community Services and Health Industry Skills Council (CS&HISC), (Unpublished Final Draft) *Environmental Scan 2015: Building a Healthy Future.*

Despite all the changes to the labour market over the past hundred years—including the dramatic structural changes from 1980 onwards—the notion that human labour is a commodity remains an absurd proposition. As Buchanan and Oliver put it: "there is no 'natural' state of labour in which it exists as a 'pre-given' entity independent of social relations."[3] Many of the arguments we make in this submission must be considered in light of this in addition to the legislative framework governing the Commission. As Issues Paper 1 succinctly states: "as with all Productivity Commission inquiries, under its Act the Commission is required to recommend policies to maximise the wellbeing of the community as a whole."[4] We argue that on the issue of maintaining and improving the wages and conditions of health and community services workers, the interests of the HSU and the community most definitely overlap.

Indeed, workers in the health and community services sectors sit at a unique juncture in the Australian labour market. As the largest grouping of workers, both now and for the foreseeable future, their level of pay has an influence on nearly aspects of the economy–from the amount of income taxation revenue collected by governments through to the level of consumer demand for discretionary goods and services produced by other sectors of the economy. Furthermore, these workers provide an essential service for the community. With an ageing population and increasing demand for disability, aged and healthcare services, the community expectation for timely and quality care is not going to go away, yet nor will it be met by running a race-to-the bottom on the wages, conditions and skills of those who care for us in our moments of need.

This submission draws on a variety of sources including a survey of members, interviews with workers and various data collections from the Australian Bureau of Statistics (ABS), the Department of Employment and research conducted by the Fair Work Commission (FWC). We thank the Commission for the opportunity to present our views and would welcome the opportunity to provide further evidence throughout the Commission's enquiry period.

[3] Buchanan, J. and Oliver, D. (2014) '"Choice" and "Fairness": the hollow core in industrial relations policy' in Miller, C. and Orchard, L. (eds.) *Australian Public Policy: Progressive Ideas in the Neoliberal Ascendancy* (Policy Press: Bristol), p. 99.

[4] Productivity Commission (2015) *Workplace Relations Framework: the Inquiry in Context – Issues Paper 1,* p. 15.

Recommendations

Recommendation 1

Given the impact of the 'minimum rates' on award-reliant employees, plus the forecast increase in government funded sector workforces, in particular in aged care and disability services, the Commission should recommend the continuation of a minimum rate mechanism.

Recommendation 2

Given the likely impact on attraction and retention of workers in the health and community services sectors—which are already suffering from workforce shortages—if penalty rates were abolished or reduced, the Commission must recommend continuation of penalty rates for unsociable work hours in all sectors of the economy.

Recommendation 3

Given government statements that penalty rates will not be considered as part of the Productivity Commission Workplace Relations Inquiry, the Commission should seek amended terms of reference for its current enquiry, which exclude consideration of penalty rates.

Recommendation 3

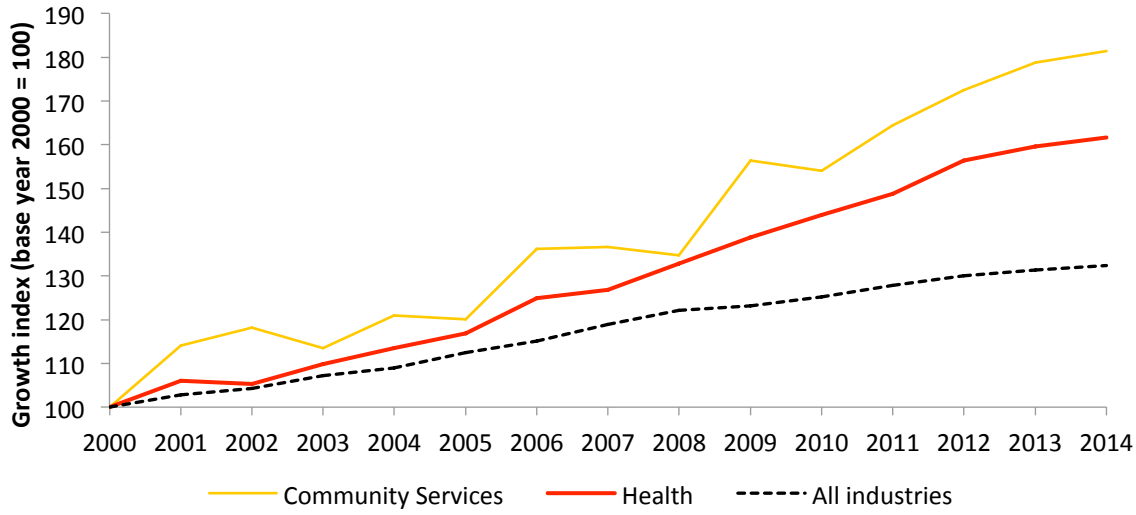
Given the problems inherent in bargaining in the health and community service sectors as a consequence of government effectively being a third party through the provided funding levels, the Commission must recommend an increased capacity for intervention by the Fair Work Commission.

Changing Labour Market Trends in the 21st Century and Beyond: the Health and Community Services Sectors

Employment Growth

From around 1980, structural changes in the economy led to a rapid decline in employment in agriculture and manufacturing towards service industries. Over a 20-year period, employment growth concentrated in retail, hospitality, finance, property and business services (in the private sector) and in education, health, care of older people and child care (in the public sector).[5] Since 2000, Australia's most pronounced employment growth has been in the health and community services sectors (see Figure 1).

Figure 1 Employment growth index: Health, Community Services, All Industries (2000-2014)



Source: Australian Government Department of Employment (2014) *Skill Shortage List: Australia*
NB: Figure shows relative growth in employment not actual growth. Reference month for series is May.

Underpinning this growth is the simple fact that those requiring assistance and care are increasing in number. People are living longer; are surviving traumatic illnesses or accidents with lifelong acquired disabilities; and children with congenital or hereditary disabilities or diseases are increasingly surviving birth and living into adulthood. These are the benefits of available and accessible care coupled with improved knowledge and skills and advances in technology and as a result employment growth shows no signs of abating.

[5] Buchanan, J. and Oliver, D. (2014) '"Choice" and "Fairness": the hollow core in industrial relations policy', p. 98.

The Department of Employment expects that one in every four new jobs created between 2013 and 2018 will be within the health and community services sectors.[6] Longer-term forecasts predict that the aged care sector alone will require an additional 1 million workers by 2050[7] whilst the disability workforce will need to at least double by 2020 to cope with the full implementation of the National Disability Insurance Scheme (NDIS).[8] Yet despite commitments by both sides of politics and all levels of government, growth in public funding for health and community services remains decoupled from growth in demand.[9]

The aged care system is already struggling. Rebecca, a Care Assistant working in Geilston Bay, Tasmania, has worked in the aged care sector for the last four years. The impact of low wages offered in sector is demonstrated in shortages reported across Australia (both in the community and in residential care) driven by a 65 per cent increase in the number of community aged care places.[10] Rebecca describes how this plays out on the ground: "It's very hard to find carers. It's very hard work, and the rate that we are on, for the work that we do, is pitiful. So it's hard to even entice people to get into that industry. In a lot of nursing homes, if somebody is off sick, well then we end up working short because there isn't staff." The latest *Environmental Scan* from the Community Services and Health Industry Skills Council (CS&HISC) specifically mentions the challenge of low pay and poor conditions in attracting and retaining workers in these sectors.[11] This mention is particularly telling given CS&HISC's bipartite governance arrangements have, by convention, historically excluded any mention of pay and conditions in commentary on workforce challenges.

Changing Funding Models

At the same time this employment growth is occurring funding models undergoing a dramatic transformation. Governments are moving away from block funding (where funds are allocated to service providers who are required to meet established criteria set by governments) to client-focused models that are based on individual care needs of the client.

Allowing clients to determine their own needs and to choose tailor-made services is supported by everyone engaged in both sectors: from carers and employees to peak bodies and employers, all believe the needs of the client should drive service delivery. However, service models that deliver tailored care and assistance, by their very nature, cost more. Services must go to the client as opposed to being delivered in a central location; care is provided to an individual, often in the home, and requires time to travel from one location to another before assisting the next person. While government funding continues to grow it is failing to keep pace with the demand for the expanding

[6] Community Services and Health Industry Skills Council (CS&HISC), (Unpublished Final Draft) *Environmental Scan 2015: Building a Healthy Future*, p. 3.
[7] CEPAR (2014) *Aged care in Australia: Part I – Policy, demand and funding: CEPAR research brief 2014/01*, Australian Research Council. NB: 1 million growth figure is based off 2012 levels.
[8] PwC (2012) *Planning for a sustainable disability workforce report – additional material.*
[9] CS&HISC, (2015 - Unpublished Final Draft) *Environmental Scan 2015: Building a Healthy Future*, p. 3.
[10] The number of community aged care places is expected to grow by 65% from 2011-12 to 2016-17, from 60,900 places to just over 100,000. See: CS&HISC, (2015 - Unpublished Final Draft) *Environmental Scan 2015: Building a Healthy Future*, p. 53.
[11] CS&HISC, (2015 - Unpublished Final Draft) *Environmental Scan 2015: Building a Healthy Future*, p. 3.

range of services on offer. We are now witnessing the collision between the expansion and growth of services with the rationing of public funding.

Of further concern is the significant impact the changes, in both funding and service delivery models, are having on employment models currently in use or being foreshadowed by service providers. The initial view of the now National Disability Insurance Agency (NDIA) was that the majority of the expanded disability workforce delivering the NDIS would operate as "independent" contractors or

THE NDIS - CHANGING SERVICE DELIVERY MODELS: RISKS AND CHALLENGES

The NDIS marks a paradigm shift in how funding is directed to users and how users access services. It is also an ideal case study for demonstrating the changing nature of the labour market in the disability sector and the critical importance of proper wages and conditions to ensure both the wellbeing of the workforce and the broader community.

Under current arrangements governments provide block funding to disability providers who then deliver a pre-determined set of services to users, whereas under the NDIS government funding follows the user enabling them or their plan manager the discretion to choose the provider(s), supports and services that best meet their needs. While providing more choice for participants, this arrangement shatters the business models of most disability service providers who are reliant on the economies of scale and administrative efficiencies provided by block funding. The Standing Parliamentary Enquiry into the NDIS in its June 2014 report acknowledged this issue, stating, "in terms of service providers, there is a significant challenge of transitioning from a block funded system to one based on a fee for service." Compounding this problem is the National Disability Insurance Agency's (NDIA) decision to reduce the amount of money it will pay disability service providers participating in the NDIS. From 1 July 2014, the indexed hourly rate paid to disability service providers in the scheme will be gradually reduced from $38.78 per hour for weekdays to $36.70 per hour by 1 July 2016.

The risk is that this will force downward pressure on wages and an erosion conditions, making the sector less attractive to prospective workers at the same time it needs to undergo a rapid expansion. Without the ability to attract and retain skilled and qualified workers, the goal of the NDIS to ensure genuine choice and control for people with a disability will, at best, remain forever unfulfilled, or at worst, reduce the quality of care for people with a disability, their families and loved ones. In a race-to-the-bottom on wages, conditions and skills we are likely to witness increasing cases of violence, abuse and neglect committed against people with a disability. As one of our members, Sharon, starkly put it: "the people we support are vulnerable and can often be taken advantage of by unscrupulous relatives and support workers. Therefore the industry needs to attract the best people available."

subcontractors.[12] Anecdotal evidence emerging from NDIS trial sites is that employees are being employed as casuals or on possibly illegitimate zero or minimum hours contracts as part-time employees, thereby avoiding casual loadings and minimising paid leave entitlements.

In the NDIS trial sites, the HSU is hearing increasing reports that employees are lucky to be engaged in even a part-time capacity. Providers appear to be responding to funding shortfalls by engaging workers as casuals on limited hours and sometimes less than minimum engagements. Members are reporting paying for the cost of their own transport between clients using their own vehicles without any payment until the next block of time for another clients sometimes in another town. Anecdotally and as self-reported, what keeps employees working under these conditions is two-fold: a commitment to the type of work and their clients, and the increase to their base wage through penalty rates and allowances—a topic to which we return later in this submission.

[12] This was communicated verbally by FaHCSIA officials prior to the commencement of the NDIA in a meeting with HSU Officials in late 2012.

Minimum Rates

Minimum rates are an integral part of the safety net standards set through the Modern Award and National Employment Standards. They remain the only wage rate for employees who are award dependent. The arguments being deployed to support their abolition seem framed variously from the small number of employees allegedly on minimum wage to the apparent negative impact they have to discouraging bargaining. Further the conversation is, publically at least and probably deliberately, confusing the national minimum wage order–singular–and the wage rates that flow directly from that decision and figure.

At least one organisation making a submission to the Commission in its current inquiry appears to believe that the number of people receiving minimum rates can be determined by simply measuring annual incomes against a single income figure, adjust this data by the average number of hours worked and introduce a margin of error. This analysis is deeply flawed, yet has been used to argue that very few people earn the minimum wage and that therefore it has no role to play. Not only does this type of analysis ignore the concept of the safety net—including more than a single standard or including rates above the starting grade/level of the award—it fails the basic test of accounting for earned penalty rates, allowances or intermittent adjustments to number of hours worked. It also fails to account for, or acknowledge, the more recent labour market trend to more precarious forms of employment, which has both negatively impacted on employment security and increased worker reliance on penalty rates and allowances.

For great swathes of the health, welfare, aged care and disability services sectors the minimum rates contained in the relevant modern awards are the applicable and only rates. A 2013 Fair Work Commission's (FWC) research paper found more than 50 per cent of non-public sector organisations were award-reliant. Award reliant employees are identified as employees being paid according to the award rate, or having their wages set according to the award rates, whether in an agreement or not, and covered by the national workplace relations scheme.[13] Under this definition, award-reliance is rising in the health sector and particularly in the community and disability services sectors with the aged care sector also following this trend.

Government funding for the health, welfare and disability sectors use the award rates and entitlements as the basis for the development of the relevant model of funding on either an ongoing or project funded basis. Without or without changes and regardless of whether the actual employer is a non-government, public or private organisation, government has effectively determined the rates of pay in these sectors for years. Government will continue to effectively determine the rates for at least the foreseeable future. Fundamentally, there is no surplus included in a funding profile to enable a provider to negotiate wage rates with their employees. The floor becomes the ceiling by default and therefore the applicable rates are the minimum rates.

[13] Wright and Buchanan (2013) *Research report 6/2013, Award Reliance*, Workplace Research Centre: University of Sydney Business School (Commissioned by the Fair Work Commission).

Bargaining and Minimum Rates

Government funding levels for the health and community services sectors are developed using the award rates and entitlements as the basis for relevant model of funding in either an ongoing or project funded basis. This provides a significant skewering of rates to at, or barely above, the award rates of pay. Bargaining takes on a different complexity when the employer is government funded, but not funded to a level that would enable them to legitimately bargain with their employees. The default rate of pay becomes the minimum applicable award rate of pay and there are no choices, either for employers or the employees. At best, government is a third party at the bargaining table and directly determines the package of funds available, the matters the employer is permitted to bargain on and the matters the employer is able to reach agreement around. The CPSU paper concerning bargaining in the public sector identifies many of the issues and problems associated with bargaining directly and indirectly with government.[14]

In the funded sector, as opposed to the public sector, the problems are heightened. Government determines the levels of available funds but is not even a third party in enterprise negotiations. Indeed it doesn't even negotiate with providers around the cost of contact for delivering the services. There are no excess funds to enable any real bargaining around wages in these sectors. What is achievable frequently sits in the no cost /low cost areas of agreements: dispute settling or consultation processes, union notice boards, leave without pay and training agreements.

The HSU is also aware of a recent move in the aged care sector where there was a proposal to start the next round of bargaining at the level of the relevant modern award, rather than the current agreement, thereby removing any wage gains previously made.[15] Ultimately the impact is that even where agreements are achieved the wage rates of the employees in the organisation are essentially the rates under the modern award. The award rate is the bargained rate; the minimum rate is the applicable rate.

Any national picture of the numbers of employees currently on 'minimum rates' is also obscured by the number of agreement that contain rates that are essentially restricted to the award rate of pay. These rates are either actually the award rate or so close to the award rate that the agreement includes, in addition to the agreed rate rises, a guarantee that any rise in the national minimum wage rate, which exceeds the agreed rates, will be immediately passed on to employees. Ultimately, these employees are award-reliant despite being employed according to an Enterprise Agreement.

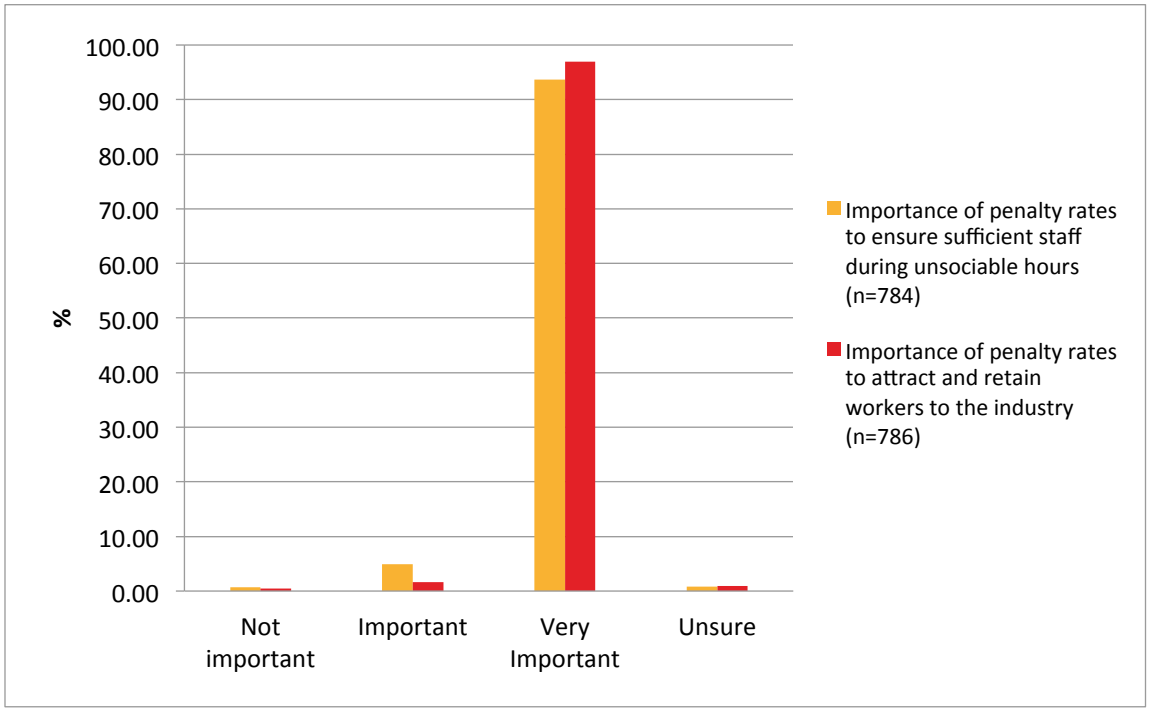
[14] Community and Public Sector Union (CPSU) SPSF Group - Workplace Relations Framework - Public inquiry
[15] HACSU Tasmania

Penalty Rates

In preparing our submission to the Commission, HSU National developed a survey that asked members about the role penalty rates play in attracting and retaining workers in their industry, ensuring there is sufficient staff available to work during unsociable hours and maintaining a decent standard of living. This survey was distributed to members in Victoria and Tasmania and received 787 responses in the short time it was open. Respondents worked across the health and community services sectors. The two largest groups of respondents were those working in health services (43 per cent) and disability services (39 per cent), with the remainder in aged care (14 per cent) and community services (4 per cent). Numerous respondents indicated that they worked across sectors, with crossovers particularly between disability and aged care.

Given the 24/7 nature of care work, it was unsurprising that the large majority of respondents worked and received penalty rates on weekends (88 per cent), public holidays (81 per cent) and afternoon/night shifts (76 per cent). Just over half of respondents (58 per cent) also received penalty rates for overtime, which aligns with what we have previously stated about the recruitment and retention challenges in the health and community services sectors. Respondents were asked to indicate the level of importance they believed penalty rates played in both ensuring there were sufficient staff to work unsociable hours (distribution of the existing workforce) and in attracting and retaining workers to the industry more broadly (expansion of the workforce). As shown in Figure 2, respondents overwhelmingly indicated that penalty rates play a vital role in achieving both objectives.

Figure 2 Importance of penalty rates in ensuring sufficient staff during unsociable hours and in attracting and retaining workers to the industry more broadly



Hundreds of respondents also took the opportunity to explain the reasons why they thought this to be the case. Their comments should alarm anyone concerned about the workforce capacity challenges facing the health and community services sectors. A small sample of their comments is set out below:

"If penalty rates are taken away - there will be a mass exit of staff in the disability sector. The ordinary hour rate would not be enough to live on."

Janis, Disability Support Worker, Victoria

"We have difficulty at times as it is getting staff to work weekends. If there are no penalty rates we won't be able to cover shifts. For our industry, penalty rates are the main reason we are able to get staff to work in disability

Maureen, Disability Support Worker, Victoria

"Aged care - low wages, poor working conditions, no career path or incentive for advancement, high attrition rate - would struggle to attract and retain workers if penalty rates were abolished."

Lili, Aged Care Worker, Tasmania

"If penalty rates are taken away staff will leave and seek alternative work...not only will staff morale decline but residents will suffer as they will lose committed staff who have advocated on behalf of them…we will have staff retire early and the message that the government is clear: we're not seen as professionals and nor is the commitment we make to our residents valued."

Melanie, Disability Support Worker, Victoria

"I know for certain in my workplace that we would not have sufficient staff to work weekends and overnights as well as public holidays if there was not the incentive of penalty rates. Even as it stands it is often difficult to get these shifts filled. Overnights is a particularly difficult shift to fill."

Lorraine, Disability Support Worker, Victoria

"I can't see that too many people, myself included, would have gone to university to earn such a low salary."

Adam, Intensive Care Paramedic, Tasmania

"Our system of care would collapse without them."

Alan, Disability Support Worker, Victoria

Another member who responded to our survey, Sollest, a Registered Nurse working in Hobart, clearly articulates the critical role penalty rates play in not only attracting and distributing labour across the health, but also their compensatory role for workers who compromise their personal health, well-being and family time for the greater good of the community: "If they cut penalty rates from the health sector, I will leave nursing and do a much less stressful job. A job which is appropriately staffed and looks after the health and well-being of their staff instead of making them do late-early shifts and over time for less pay. It's bad for our health, we're sick and tired, literally,

but have to keep fighting for things which should have been addressed long ago! Have you ever driven home after working a double shift (late then night shift)? You wouldn't want to! It's extremely dangerous yet nurses do it all the time! Take our penalty rates and you will have a massive health care crisis."

The importance of penalty rates in boosting wages to maintain a decent standard of living was also made clear by our members. Almost two thirds of respondents (61 per cent) indicated that they were very reliant on penalty rates to maintain their current standard of living and would struggle to make ends meet should they be cut. It is worth highlighting that over 70 per cent of survey respondents earned less than the average full-time adult employed in the healthcare and social assistance industry, which was $72,779 in November 2014.[16] Figure 3 shows a breakdown of respondents total wage earnings, however this must be seen in context with the data presented in Figure 4, which reveals that without penalty nearly half of respondents would lose 25 per cent or more of their average fortnightly wage.

Figure 3 Annual total wage earnings before tax (n=773)

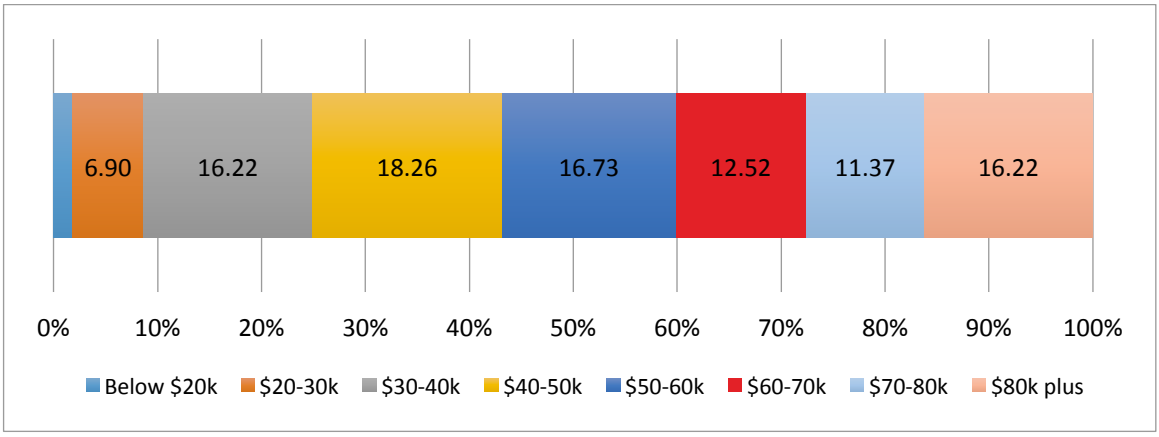
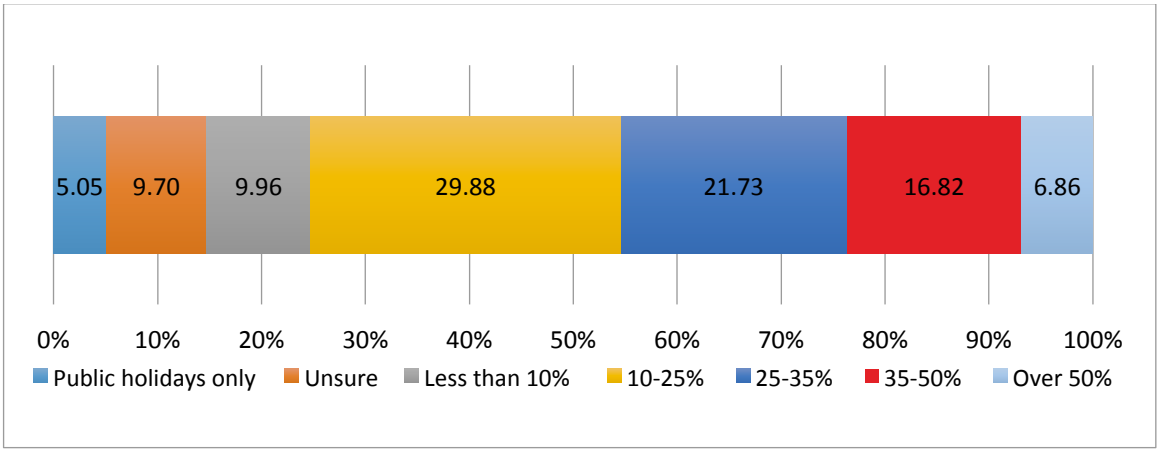


Figure 4 Penalty rates as a proportion of average fortnightly wage (n=773)



[16] The 70 per cent comparison claim has been calculated using Full-time Average Weekly Ordinary Time Earnings (AWOTE) trend figures from November 2014 for persons employed in the healthcare and social assistance ANZSIC classification. See: ABS 6302.0 *Average Weekly Earnings, Australia, Nov 2014.*